

Introduction of a safety huddle on delivery suite at St George's Hospital

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Introduction

The tertiary delivery suite at St George's hospital has approximately 4500 births every year. The workload and acuity necessitate an effective multidisciplinary handover addressing clinical factors, operational issues and human factors. The 'Each Baby Counts' report in 2018 highlighted human factors as paramount in contributing to adverse maternal and fetal outcomes. Local standards exist for handover but they do not include operational issues which may affect safety. Following a multidisciplinary morbidity and mortality meeting in which a near miss was attributed to human factors, a project was approved to improve discussion of non-clinical factors on delivery suite. During this meeting, a safety huddle was proposed:

- Safety huddles have traditionally been used outside of healthcare in high-risk industries such as aviation to identify potential threats and act pre-emptively to mitigate these
- Checklists are often utilised in order to reduce human error
- Within the hospital environment, they have been used in high acuity environments such as intensive care
- They have been shown to improve situational awareness, communication and teamwork but also to aid in planning and coordinating workload ¹
- Safety huddles have been introduced successfully in maternity units in the UK and have facilitated staff in discussing and escalating operational issues. This has focused the team on unified goals for the shift and allowed potential risks to be addressed ²

Methods

A survey was developed with the obstetric and midwifery teams, incorporating the local standards for handover and non-clinical factors seen in safety huddles in other trusts, critical care and other industries

Twice daily handovers were surveyed for nine days by members of the anaesthetic team who were not actively involved in the handover. Ethical approval was not required

A safety huddle was developed based on national guides ³ and human factor training. This consisted of a structured standard template with four sections; flow, staffing, equipment & medicines and learning

A working group was formed to review this and a standard operating policy was written

The safety huddle was introduced

A four day re-survey was completed after six months



Results

The initial survey found good adherence to local standards for handover but scarce discussion of non-clinical factors. At six months, there was 89% use of the safety huddle with improved discussion of non-clinical factors

	Discussion before safety huddle	Discussion after safety huddle
Flow	15%	100%
Staffing	10%	97%
Equipment and medicines	0%	95%
Learning	0%	75%

Table 1: results of discussion of the non-clinical domains before and after introduction of the safety huddle

Qualitative feedback was also encouraging:

'I really like seeing the theatre team for the day and engaging them with any concerns'

'I have found the huddle useful'

'I wouldn't have known about some issues if it hadn't been for the safety huddle'

Discussion

Teamwork, communication and situational awareness are key contributors to errors in obstetrics and the use of a safety huddle can reduce human error. Our safety huddle has allowed us to formalise discussion of non-clinical issues amongst the multidisciplinary team. It has also allowed us to incorporate members of the wider team and improve engagement on delivery suite of the theatre team in particular. As with most new initiatives, we faced challenges, the biggest being utilisation of the safety huddle and encouraging a culture change. With perseverance over six months, it has become part of the usual daily working on delivery suite. Although its quantitative effectiveness is yet to be determined, qualitative data has been supportive

References

1. Franklin BJ, Gandhi TK, Bates DW, et al. Impact of multidisciplinary team huddles on patient safety: a systematic review and proposed taxonomy. *BMJ Quality & Safety* 2020;29:1-2
2. Improving maternity: Learning from reviews of maternity series. Royal College of Midwives. The Solution Series May 2021 [the-solution-series-1-improving-maternity-services.pdf](#) (rcm.org.uk)
3. Safety Huddles Implementation Guide. NSW Government Clinical Excellence Commission [Safety Huddles Implementation Guide \(nsw.gov.au\)](#)