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To huddle or not to huddle; your essential guide

The huddle concept is not new; many organisations & teams have tried this out & either succeeded or failed. Huddles take a variety of formats and are used for a variety of purposes. We urge you to give them another go, they really can make a difference.

Challenges include:

- getting everyone to stop what they are doing and gather into a huddle
- viewing the huddle as yet another task that takes you away from patients
- clearly demonstrating the benefits
- finding the right time

Make them brief – 5 to 10 minutes

Know when to make them multi-disciplinary or uni-disciplinary

Be clear about purpose

Reactive huddles – e.g. triggered by an event, to assess how it could have been prevented, what can be learnt and what could be done differently in that moment. A real time conversation rather than a full debrief.

Proactive huddles – preventing patient safety issues and staff concerns. Gather the team together to talk about the day, the shift, the next few hours., at any point in the day. Not a handover

Link and learn between different types of huddles

Formalised – planned huddles at specific times with attendance being mandatory in a designated area and facilitated by the most senior person

Information capturing – using tools to capture information e.g. a 'huddle sheet' which can list the areas of discussion such as a list of patients with indwelling catheters, a list of patients at risk of falling and so on

Unplanned impromptu – called at any time, to regroup, or seek collective advice. Can be called by anyone from the team. This could even happen in a patients room to assess what could be done differently after an incident.

And remember; huddles are not only for clinicians!

Learn more at
www.suzettewoodward.org