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| Huddle sheets & supporting document |
| The huddles sheets aim to encourage non-judgemental, open reflection amongst oral health and dental care teams in primary care, to further embed learning from patient safety incidents. They expand upon existing [safety standards](https://www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/locssips-toolkit-dental-extraction/) and toolkits, facilitating systematic evaluation of the impact of patient safety events on clinical sessions/days and team members, identifying any potential additional support and training required. The documents provided:  1. Daily safety huddle sheet: provides a framework for discussion, enabling issues to be raised at the start/end of a session. Can be performed verbally, as well as written down.

 1. Post-patient safety event huddle sheet: to be used shortly after a patient safety event, in conjunction with local incident reporting mechanisms.

 1. Reflection huddle sheet: to be used a significant amount of time after a safety incident, near-miss, or major event.

 1. Huddle supporting document: assists in the completion of the huddle sheets and encourages systematic evaluation of elements comprising the working system and environment. It prompts teams to identify human factors which can be modified to maximise performance and processes in primary dental care settings. It serves as a guide, created with the knowledge that each event and team are unique, possessing their own considerations.

 **Teams are encouraged to download and edit the huddle sheets, so that they may be adapted to meet individual practice needs. Maintaining copies of both the post-patient safety event and reflection huddle sheets is advised, to support and evidence learning.**  |
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## Daily patient safety huddle

* Enables any issues to be raised at the start/end of the day or session.
* It is a guide and does not need to be completed on paper.
* Can be completed verbally between the practice team or the operator and the dental nurse.
* It can also be written on a board in a mutual staff area.
* Copies of the document do not need to be kept from the huddle.

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| **Daily patient safety huddle** | **Date:** |
| Who is present for the huddle? |  |
| Are staffing levels sufficient today? Is everyone here that needs to be? What is your role today?  |  |
| Environment:Any equipment issues? |  |
| Patient related issues: Risks to patient safety today? |  |
| Team Well-being: Any issues or additional stresses to share? |  |
| Any other updates or concerns?Are any reasonable adjustments required? |  |

###  End of the day huddle

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| **End of the day huddle** | **Date:** |
| Who is present for the huddle? |  |
| What went well today? |  |
| Patient related issues: Any concerns from the day? |  |
| Team Well-being: Any issues or additional stresses to share? |  |
| Anything to take forward for tomorrow?Were any reasonable adjustments fulfilled? Were any inequalities identified and require addressing?  |  |

## Post patient safety event huddle

* Patient safety huddles should be carried out following a safety incident, near-miss, or major event.
* Allow staff to express themselves in a safe, supportive, and learning environment.
* Maintain a non-judgmental and open discussion.

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| Patient Safety Event Review | Date: |
| Who was involved/affected? What was your role? Is everyone here that needs to be? |  |
| Discuss the patient safety event, what happened or could have happened? What was intended to happen? Provide a brief summary of the event.  |  |
| Has the event had an impact on patient care for the day? Are there any immediate actions or changes required? |  |
| How has the event been recorded and where?  |  |
| Has the patient expressed any immediate feedback following the event? Are staff aware of the patient perspective?  |  |
| Has the patient had a follow up call? If no, then please expand.If yes, what was discussed?  |  |
| What emotional support does the team require? |  |
| List changes in systems/processes to be implemented following the event to prevent this from happening again. Anything further to add? |  |
| Arrange a review of changes implemented and if they have been effective? Include a time frame.  |  |

## Reflection huddle

* Reflection huddles should be carried out a significant amount of time after a safety incident, near-miss, or major event. Their purpose is to provide a reflective insight in to preventing the event in the future, as well as discussing the lessons learnt.
* Allow staff to express themselves in a safe and supportive environment, to help facilitate learning.
* Maintain a non-judgmental and open discussion.
* Focus the discussion on existing processes/systems rather than individuals.

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| Reflection huddle sheet | Date: |
| In hindsight, what happened during the event or near miss? What could have happened? |  |
| Reflect on the event anddiscuss the lessons learnt.  |  |
| What went well? |  |
| Factors | What are the environmental factors? |  |
| What are the Human factors?Clarify the human factors using the supporting document. |  |
| What are the systemic factors? |  |
| What processes were followed to record the event? |  |
| Has there been any further feedback from the staff or patient(s) involved?  |  |
| Any additional team training requirements identified? |  |
| Are there any areas that need to be reviewed in the future? What are they and how often? |  |

## Huddles supporting document

* Aids in the completion of the huddle sheets.
* Adapted from the Safety Engineering Initiative for Patient Safety (SEIPS), a core component of the Patient Safety Incident Response Framework (PSIRF).
* Enables teams to systematically evaluate each element comprising the work system and identify human factors which can be modified, to maximise performance and processes in the clinical environment.
* Serves as an adjunct to the huddle sheets, providing prompts to teams when undertaking their safety and reflection huddles.
* This document is a guide, with each event and team being unique, possessing their own considerations.

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| Factors | Considerations | Examples |
| **People and teams** | **How can we support and optimise the performance of individuals and teams?** * Can we adjust training to meet individuals and team learning needs?
* Was there effective communication between the dental team members and the patient?
* Were individual roles and responsibilities clearly defined and understood?
* Were there any role or goal conflicts identified?
* Do people feel safe to raise questions or concerns with colleagues and management?
* How are people treated when they do raise concerns or are involved in an adverse event?
 | * Positive guidance and mentorship for all team members is encouraged and staff feel supported and competent to perform their tasks and raise questions or concerns.
* Training needs have met CPD requirements and staff have been supported with resources to complete this.
* Staff recognising when they themselves/colleagues may need additional training and supporting them to achieve this.
* Staff clearly understood their individual and team roles and responsibilities such as:
1. ensuring the clinician always has the responsibility of disposing of their own sharps.
2. nurses responsible for giving post-operative instructions, whilst implementing and providing patient leaflets for each type of procedure.
* No goal conflicts were identified such as fatigue versus production pressures.
* Clear, jargon-free effective communication with patients in a language and format that was understood, whilst maintaining a duty of candour.
* Patients’ opinions and concerns are listened to and acknowledged.
* Effective team and management communication is encouraged.
* Alternating colleagues/staff involved in particular teams/treatment sessions, as they may have additional qualifications and experience to help maintain performance and safety levels i.e. a nurse with additional qualifications in managing patients receiving IV sedation.
* Inclusive engagement of all team members in daily team huddles is encouraged.
* There is a focus on learning what happened to improve safety and not who is to blame during team debriefings following a near miss or adverse event.
* Staff are supported and signposted to guidance if they are involved in an adverse event.
* Ensuring patients requiring additional needs or adjustments are highlighted at time of booking appointments, and the staff involved with treatment are notified and can prepare in good time. This may include accommodating for hearing needs, ensuring a carer is present, or translation services.
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| **Tasks** | **How can we make tasks, and procedures easier for people to understand and perform, to minimise the cognitive and physical workload required?*** Were there high, physical task demands?
* Did the task involve high cognitive demands and concentration levels involving complex decisions?
* Can we optimise staffing and appointment scheduling to support the safety of task performance?
 | * Adequate time was allocated to complete the task safely.
* Highly complex tasks were not scheduled back-to-back and buffer time slots were included in appointment scheduling allowing for complications in high-risk tasks.
* Regular short breaks were allocated.
* Full chairside support was allocated.
* Staff are regularly consulted on the design of appointment scheduling that affects them.
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| **Tools and Equipment** | **Are there adequate tool and equipment resources available that optimise performance and treatment outcomes?*** Are there adequate quantities of tools, equipment and PPE available?
* Are staff consulted on equipment procurement decisions that affect them?
* Do all tools and equipment purchased meet the CE mark standard?
* Are tools and equipment safely decontaminated, stored and transported?
* Are tools and equipment adequately maintained and serviced.
* Are the most efficient and effective tools and technology available?
 | * Equipment was appropriate, in good working order, and maintained.
* All staff are involved with equipment and tool procurement decisions.
* Checklists are visibly accessible for decontamination, procedures and the storage and transportation of instruments with regular auditing assurances carried out and staff feedback given.
* Maintenance checklists are available, and staff practices are audited.
* Ensuring medical emergency equipment is regularly checked/audited and this process is recorded.
* Adequate quantities of tools, equipment and PPE is available for the clinic to run sufficiently. reducing the risk of decontamination implications.
* Contaminated and decontaminated instruments and equipment are clearly identifiable.
* IT hardware equipment and software were up to date and easy to use.
* The dental chair and suction is regularly maintained and serviced and is in good working order.
* Adequate ergonomic equipment for staff is provided such as adjustable saddle chairs or loupes.
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| **Working environment** | **What changes are needed to reduce risk and improve the working environment?** * How can the room’s physical layout be altered to improve working postures, manoeuvrability and patient access?
* Can the practice and surgery environment be accessed safely by people with disabilities such as sight impairment or wheelchair users?
* Is there adequate lighting to perform tasks?
* Is the temperature controllable and adequate?
* Are there high levels of noise that can impair communication and decision making?
 | * Staff understand the importance of keeping distractions and interruptions to a minimum.
* Surgery layout is organised with adequate space to access and manoeuvre.
* HSEs use of display screen equipment guidance is followed.
* Room ventilation, lighting, and heating levels were adequate.
* Hazards such as loose wires or tripping hazards have been risk assessed and removed and wheelchair access is available.
* Location and size of the decontamination area is accessible and optimal to support decontamination procedures and safe transportation of instruments to and from all surgeries.
* Ensuring patients who need additional access needs such as wheelchair users, are booked into the correct surgery/clinical room with adequate space, access and limited obstructions to facilitate movement and transfers with ease.
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| **Organisation** | **Is management commitment to safety placed high in the organisation’s priorities?** * Is the leadership style supportive of raising patient safety and health and wellbeing concerns?
* Are staff given timely feedback on management actions following their concerns?
* Does management encourage the participation of staff in decisions that affect them?
* Which policies and practices need to be adapted and how will this be communicated to staff to reduce risk?
* Are there suitable plans in place to address issues such as staff retention, sickness absences and shortages?
 | * A pathway of raising concerns is clearly communicated with all staff with advice on how this will be dealt with.
* An open-door, blame-free culture is encouraged, where staff feel safe to raise safety and health and wellbeing concerns.
* Management regularly seeks feedback from staff on decisions and actions that affect them
* Management understands and complies with the HSE Management Standards Document.
* Standard operating procedures are regularly reviewed and audited to meet patient safety needs.
* Risk management policies are in place to identify and address potential hazards and reduce risks to as low as reasonably practicable
* Working hours and appointment scheduling consider the health and wellbeing of the team and work-life balance to reduce stress, fatigue, burnout and sickness absence and to increase staff retention.
* Adjustments are made to assist staff with particular health conditions and protocols in place to ensure that both adequate support is given to staff to manage their health needs, as well as enabling sufficient clinical cover to maintain patient safety.
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| **External** **factors**  | **Are there any external legal, regulatory, social, psychological, logistical or financial concerns that affect team members or patients and how can they be supported?** | * All clinical staff were GDC registered with professional indemnity in place and checked.
* Clinical staff had sufficient understanding of the GDC professional standards and their scope of practice and were compliant.
* Staff felt that if they were involved in an unintentional adverse event, they could be honest with the patient and management without fear of retribution and would be treated fairly if it was brought to the attention of the GDC.
* All Staff were aware of their statutory and regulatory duty of candour and compliance.
* Staff were aware of the CQC regulatory Key Lines of Enquiry (KLOE) and all staff were informed of the incident reporting criteria and pathway with regular feedback and updates.
* Individual’s difficulties and concerns such as health, financial or social concerns outside of the practice are treated with respect, empathy and confidentiality, with consideration of reasonable adjustments and appropriate signposting for support.
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