

SESLHD GUIDELINE COVER SHEET

NAME OF DOCUMENT	Post Incident Bedside Safety Huddles and effective use of the HUDDLE UP tool
TYPE OF DOCUMENT	GUIDELINE
DOCUMENT NUMBER	SESLHDGL/072
DATE OF PUBLICATION	June 2021
RISK RATING	Low
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards including: Standard 1 - Governance for Safety and Quality in Health Service Organisations Standard 2 - Partnering with Consumers Standard 5 - Comprehensive Care Standard 6 - Communicating for Safety
REVIEW DATE	June 2026
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR	Director Clinical Governance and Medical Services
AUTHOR	Carmelle Moses Falls Prevention Program Coordinator
POSITION RESPONSIBLE FOR DOCUMENT	Falls Prevention Program Coordinator
FUNCTIONAL GROUP(S)	Falls Prevention Clinical Governance
KEY TERMS	Safety huddles, incident, adverse event, patient care, falls, pressure injury, medication error, personal security
SUMMARY	The purpose of this document is to provide recommendations and guidance for staff to complete post incident safety huddles using the HUDDLE UP tool effectively and efficiently

THIS DOCUMENT IS A GUIDE FOR BEST PRACTICE
This Guideline is intellectual property of South Eastern Sydney Local Health District.
Guideline content cannot be duplicated.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Post Incident Safety Huddles and effective use of the HUDDLE UP Tool

Section 1 - Background	3
Section 2 – Principles	4
Section 3 – Definitions.....	5
Section 4 – Responsibilities.....	6
Team Leaders are responsible for:.....	6
Team members are responsible for:.....	6
Section 5 – Completion of the HUDDLE UP tool	7
Section 6 – Documentation	8
Section 7 – Audit	8
Section 8 – Resources	9
Section 9 – References	10
Section 10 – Revision and Approval History	10
Appendix A: HUDDLE UP Post Incident Safety Huddle Tool	11
Appendix B: Suggested Observational Audit Tool	13

Section 1 - Background

Huddles are a recognised initiative in healthcare which increase the safety and quality of patient care and systems.^{1,2} The Institute for Healthcare Improvement (IHI) and the Clinical Excellence Commission (CEC) support safety huddles as recommended best practice in healthcare settings.^{3,4}

Safety huddles improve efficiency, quality of information sharing and accountability. They foster a sense of community, and create a culture of collaboration and collegiality that increases collective awareness and capacity for reducing harm.⁵

Post incident safety huddles can be completed for any adverse event, including but not limited to falls, medication errors, pressure injury, near misses, aggression/personal security threat and equipment failure.

As the principles and strategies are consistent for management of all adverse clinical events, the need for a standardised, district wide safety huddle tool to guide clinicians through the process was identified.

South Eastern Sydney Local Health District (SESLHD) have developed a tool which is based on recommendations from the IHI and CEC. The 'HUDDLE UP' tool (Appendix A) was designed to support clinicians in completing and documenting a post incident safety huddle effectively and efficiently.

Section 2 – Principles

Post Incident Safety Huddles:

- Are not appropriate for any Harm score (HS) 1 incident. HS 1 events are reviewed by privileged Preliminary Risk assessment (PRA) and Serious Adverse Event Review (SAER).
- HS 2 incidents that result in significant patient harm may be managed by PRA and SAER
- Completion is **not** mandatory but strongly recommended
- Should occur within 24 hours of the incident, where possible
- Huddles are non-punitive; they should reinforce the intent to improve clinical care and prevent a recurrence of a similar incident. Staff members involved in the incident, where applicable, should remain anonymous where practicable
- Huddles aim to ensure the appropriate care and support is provided to those involved in the incident
- The patient and/or support person should be included in the huddle
- The team leader should check if the patient requires an interpreter (language other than English or deaf) and arrange for one
- Should take place at the site of the incident, if feasible, or otherwise at the patient's bedside
- Should include representation from the multidisciplinary team including nursing, medical and allied health staff, where possible
- For fall incidents: The safety huddle does not replace post fall management documentation or completion of the Falls Risk Assessment and Management Plan (FRAMP). The post fall safety huddle should be done in **addition** to standard post fall management care.

Section 3 – Definitions

Post Incident Bedside Safety Huddle:

An immediate evaluation of each patient safety incident, by an interdisciplinary team and the patient by the bedside, or in the environment where the incident occurred, with the goal to share information and raise situational awareness to reduce the risk of recurrence.

Incident:

[NSW Ministry of Health Policy Directive PD2020_047 - Incident Management Policy](#) defines an incident as an unplanned event that results in, or has the potential for: injury, damage or loss, including near misses. An incident is also known as an ‘adverse event’.

Harm score:

A score from 1 to 4 applied to clinical and corporate incidents based on the outcome and additional treatment and/or resources required.

- Clinical Harm Score 1 - Unexpected death or Australian Sentinel Event
- Corporate Harm Score 1 - Unexpected death of a worker or visitor or a complete loss of service
- Harm Score 2 – Major harm
- Harm Score 3 – Minor harm
- Harm Score 4 – No harm or near miss

Team leader:

- Coordinates the location, time and staff attendance at the huddle, as well as signs off that actions were delegated to team members for follow up
- Recommended to be a senior clinician in a nursing or allied health role who is routinely notified of clinical incidents on the ward/service.

Team member:

- Ward/service based clinicians from nursing, allied health and medical backgrounds
- Includes any other staff members relevant to the particular incident
- The patient and/or support person are also considered to be an integral member of the huddle team.

Support Person:

- The person nominated by the patient to attend/participate in the safety huddle, either in addition to the patient or as their designated representative.

Section 4 – Responsibilities

Team Leaders are responsible for:

- Identifying the relevant clinicians for each safety huddle
- Coordinating the time and place of a huddle with nominated clinicians and patient/support person as soon as possible. Communication of details may be through the use of phone calls, mobile phone text messages, or pagers
- Leading and coordinating the huddle discussion as guided by the HUDDLE UP tool
- Offering an apology to patient/support person on behalf of the ward/service and providing the patient/family the opportunity to tell their version of events in line with the [Ministry of Health Policy Directive PD2014_028 - Open Disclosure Policy](#).
- Completing the documentation in patient's health care record
- Delegating completion of allocated responsibilities with identified team members.

Team members are responsible for:

- Attending the safety huddle as requested by the team leader
- Actively participating and contributing professional expertise to discussion
- Completing all allocated responsibilities within an appropriate timeframe
- Documenting completion of allocated responsibilities in patient's health care record.

Section 5 – Completion of the HUDDLE UP tool

<p>H Hello and huddle up</p>	<p>Introduction, explain purpose of huddle Acknowledge and introduce each person who is present and explain their role. Explain purpose of huddle to patient, which is to try and prevent recurrence of a similar incident.</p>
<p>U Understand what happened</p>	<p>Document incident type e.g. fall, aggression, medication error Patient/ family member should be given the opportunity to describe the incident from their perspective Any staff members involved should provide their version of the events. Staff members must be de-identified: refer to position title, not to person's name. Inform the patient/family that incident will be recorded into the Incident Management System (ims+) Outline any harm/injuries the patient sustained.</p>
<p>D Open Disclosure</p>	<p>Offer an apology Team leader offers an apology to the patient and/or family on behalf of the ward/service for the incident that occurred. Provide the opportunity for the patient/family to contribute their version of events. Outline what actions have been taken by team since event e.g. observations, investigations</p>
<p>D Discuss what contributed to the event</p>	<p>Discuss contributing factors Examples may be: items inaccessible, bed rails up, wet floor, inappropriate devices, incorrect dose/type of medication given, documentation of risk assessment, communication barriers (interpreter not used). Review the pre-incident documentation to identify gaps in prevention and management of risks.</p>
<p>L List the risk factors</p>	<p>Review and list risk factors Examples may be: postural hypotension, reduced mobility, cognitive impairment, visual impairment, delirium/dementia, incontinence, sensory impairment, medical devices, equipment, patient speaks language other than English or is deaf.</p>
<p>E Eliminate or manage risk factors</p>	<p>What will help manage/reduce the risk? Identify and outline specific strategies. For further support: <ul style="list-style-type: none"> Refer to Incident Management PD, Open Disclosure PD, Pressure Injury Prevention and Management PD, Medication Handling PD, Protecting People and Property Information Bulletin Refer to relevant SESLHD Procedures/guidelines. </p>
<p>U Undertake actions and allocate responsibilities</p>	<p>What do we need to do?</p> <ul style="list-style-type: none"> Provide education to the patient employing the 'Teach Back' method, which confirms the patient's understanding of care instructions by asking them to repeat the education using their own words. Interpreters should be used for patients from a Culturally and Linguistically Diverse (CALD) background. Identify who is responsible for each task to ensure the actions are followed up. Notify the incident into IMS+ and recording the IMS+ reference number in the medical record. Involve and collaborate with patient/ family when developing the plan, where possible. Handover of all the recommendations provided to nursing, medical and allied health staff caring for patient.
<p>P Plan</p>	<p>What have we learned from this event? What will change because of this incident?</p> <ul style="list-style-type: none"> Consider sharing as a case study at team meetings.

Section 6 – Documentation

It is the responsibility of the team leader (or a designated clinician) to provide an accurate written description of the post clinical incident safety huddle in the patient's health care records as per [SESLHDPR/336 – Documentation in the Health Care Record](#).

The incident is to be notified in IMS+

The HUDDLE UP tool is available on paper (SES060188) (Appendix A). It is anticipated that an electronic version of the tool will also be made available.

Section 7 – Audit

A suggested observational audit tool is included within this guideline to evaluate the post incident safety huddle process (Appendix B).

Section 8 – Resources

1. [SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care](#)
2. [SESLHDGL/044 - Falls prevention and management for non-admitted patients](#)
3. [SESLHDPR/336 - Documentation in the Health Care Record](#)
4. [SESLHDPR/267 - Medicine: Continuity of Management and Documentation](#)
5. [SESLHDGL/058 - Open Disclosure](#)
6. [NSW Ministry of Health Policy Directive PD2020 047 - Incident Management Policy](#)
7. [NSW Ministry of Health Policy Directive PD2014 028 - Open Disclosure Policy](#)
8. [NSW Ministry of Health Policy Directive PD2014 007 - Pressure Injury Prevention and Management](#)
9. [NSW Ministry of Health Policy Directive PD2013 043 - Medication Handling in NSW Health Public Health Facilities](#)
10. [NSW Ministry of Health Policy Directive PD2020 045 - High-Risk Medicines Management](#)
11. [NSW Ministry of Health Information Bulletin PD2013 024 - Protecting People and Property: NSW Health Policy and Standards and Security Risk Management](#)



Section 9 – References

1. Criscitelli, T. (2015). Fostering a Culture of Safety: The OR Huddle. *AORN*, 102:6, p 656-659
2. Sikka, R., Kovich, K, and Sacks, L. (2014). How Every Hospital Should Start the Day. *Harvard Business Review*.’
3. Wagner, C et al (2015). *Safety Huddles a Guide to Safety Huddles*. Washington State Hospital Association. Seattle.
4. [Clinical Excellence Commission \(2017\) Safety Huddles Implementation Guide](#)
[Accessed online 29 October 2018](#)
5. [Boushon, B., Nielsen, G., Quigley, P., Rutherford, P., Taylor, J., Shannon, D., Rita, S. How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2012. Accessed online 29 October 2018](#)
6. Goldenhar, L.M., Brady, P.W., Sutcliffe, K.M., Muething, S.E. (2013) Huddling for high reliability and situation awareness. *BMJ Qual Saf*. Nov. 22 (11): 899-906

Section 10 – Revision and Approval History

Date	Revision no:	Author and approval
September 2018	DRAFT	Carmelle Moses, Falls Prevention Program Coordinator
October 2018	DRAFT	Draft for Comment period
November 2018	DRAFT	Final draft endorsed by Executive Sponsor
November 2018	DRAFT	Processed by Executive Services prior to Clinical & Quality Council approval
December 2018	1	Approved for publishing by Clinical & Quality Council
June 2021	2	Minor review by Jamie Hallen, Falls Prevention Program Coordinator. Changes to references and to reflect MoH PD2020_047 requirements. Approved by Executive Sponsor.

Appendix A: HUDDLE UP Post Incident Safety Huddle Tool

 SEI060.188	 Health South Eastern Sydney Local Health District Newcastle Local Health District	FAMILY NAME	MRN	HUDDLE UP: POST INCIDENT SAFETY HUDDLE TOOL	
	Facility:	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
		D.O.B. ____/____/____	M.O.		
		ADDRESS			
	HUDDLE UP POST INCIDENT SAFETY HUDDLE TOOL	LOCATION / WARD			
		COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
	STEPS <i>(See Page 2 for facilitation guide)</i>	DOCUMENTATION			
	H ello / huddle up <i>Introduce team, explain purpose of huddle</i>	Team leader: Team members:			
	U nderstand what happened <i>Document incident type e.g. fall, aggression, medication error Ask for patient's perspective of events</i>	Incident type:			
	O pen D isclosure <i>Offer an apology and outline what actions have been taken by team since event e.g. observations, investigations</i>				
	D iscuss what contributed to the event				
	L ist risk factors				
	E liminate or manage risk factors <i>Identify specific strategies</i>				
	U ndertake actions and allocate responsibilities <i>Include patient/family</i>				
	P lan <i>What will change because of this incident?</i>				
	Team Leader Signature: _____ Date: _____ Pager / Phone: _____				


Holes Punched as per AS2828.1: 2019
 BINDING MARGIN - NO WRITING

HUDDLE UP: POST INCIDENT
 SAFETY HUDDLE TOOL

SEI060.188

NO WRITING

Page 1 of 2

 Health South Eastern Sydney Local Health District Iwama Shoalhaven Local Health District	FAMILY NAME	MIRN
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Facility:	D.O.B. _____ / _____ / _____	M.O.
	ADDRESS	
HUDDLE UP POST INCIDENT SAFETY HUDDLE TOOL	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	
	FACILITATION GUIDE:	
<p>✓ Safety huddles should be completed after clinical adverse events such as falls, pressure injuries, certain medication errors and security/safety threats. Clinical judgement must be exercised in clinical event management and completion of safety huddles.</p> <p>✓ Safety huddles are not appropriate for any Harm score (HS) 1 incident. HS 1 events are reviewed by privileged Preliminary Risk assessment (PRA) and Serious Adverse Event Review (SAER).</p> <p>✓ It is recommended to nominate a senior member of staff as team leader for consistency.</p> <p>✓ Teams should include all members of the multi-disciplinary team.</p> <p>✓ The huddle should occur with the patient and their carer/family member at the location where the incident occurred (if feasible) or at the bedside, and ideally within 24 hours of the adverse event.</p> <p>✓ Please refer to 3E8LHDGL072 Post Incident Safety Huddles and effective use of the HUDDLE UP Tool for more information</p>		
H ello / huddle up	Introduction, explain purpose of huddle <ul style="list-style-type: none"> Team leader to coordinate time and place of huddle Introduce team members and explain purpose of huddle, which is to try and prevent recurrence of a similar incident, to patient and / or family 	
U nderstand what happened	Patient / family member should be given the opportunity to describe the incident from their perspective <ul style="list-style-type: none"> Outline incident type and any harm / injuries to the patient Any staff members involved should provide their version of the events (staff members must be de-identified: refer to position title, not to name) Inform the patient / family that the incident will be recorded into the Incident Management System (ims+) 	
O pen D isclosure	Offer an apology <ul style="list-style-type: none"> Team leader offers an apology to the patient and / or family on behalf of the ward / service for the event that occurred Outline what actions have been taken by team since event e.g. observations, investigations 	
D iscuss what contributed to the event	Discuss contributing factors <ul style="list-style-type: none"> For example: items inaccessible, bed rails up, wet floor, inappropriate devices, incorrect dose / type of medication given Review the pre-incident documentation to identify gaps in prevention and management of risks 	
L ist risk factors	Review and list risk factors <ul style="list-style-type: none"> For example: postural hypotension, reduced mobility, cognitive impairment or dementia, visual impairment, incontinence, sensory impairment, medical devices, equipment 	
E liminate or manage risk factors	What will help manage / reduce the risk? <ul style="list-style-type: none"> Identify and outline specific prevention strategies e.g. review medication 	
U ndertake actions and allocate responsibilities	What do we need to do? <ul style="list-style-type: none"> If appropriate, provide education to the patient employing the 'Teach Back' method which confirms the patient's understanding of care instructions by asking them to repeat the information using their own words. Interpreters should be used for all Culturally and Linguistically Diverse (CALD) patients Identify who is responsible for each task to ensure the actions are followed up Involve and collaborate with patient / family in plan as feasible Hand over the recommendations to relevant team members 	
P lan	What have we learned from this event? What will change because of this incident? <ul style="list-style-type: none"> Consider sharing as a case study at team meetings 	
Acknowledgement to: Clinical Excellence Commission, "Post Fall Huddle: Information for Clinicians and Health Professionals," 2017; Institute for HealthCare Improvement, "How to Guide: Reducing Patient Injuries from Falls," 2012		

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING



Appendix B: Suggested Observational Audit Tool

Does the post incident safety huddle process include:	Yes	No	Action Required
Did the safety huddle occur within 24 hours of the incident?			
The use of the HUDDLE UP tool?			
Introduction of team members, explanation of purpose?			
Inclusion of the patient/support person as a member of the team?			
Is the team leader identified?			
Do both clinicians and patient/support person provide their versions of the events?			
Does the team leader offers an apology to patient/ support person?			
Are risk factors listed?			
Are there specific and individualised strategies outlined to help minimise risk of recurrence?			
Is the allocation of responsibilities outlined?			
Are there plans for completion and follow up of responsibilities?			