

INTRODUCTION

- Goals: Patient safety, Effective communication, Teamwork, Team coordination
- Aim: daily engagement and proactive communication, identify best practices and processes to ensure smooth functioning of regional anesthesiology service, and address barriers
- Challenges: multiple rotators and attending daily, busy academic regional anesthesiology service
- Huddles shown to improve team functioning and communication. Improve patient care, reduce adverse events, *improve provider engagement and* supportive practice, improved situational awareness and safety climate, and increased patient satisfaction
- Little published literature on the use of
- huddles in regional anesthesiology
- Quality improvement (QI) project to *introduce huddles*

MATERIALS & METHODS

- Checklist of huddle items, via feedback from attending, rotating residents, fellows, and nurses
- Events included: nerve catheters not being communicated to the weekend team, missed orders for nerve catheter infusions, missed nerve catheter connections in the PACU, missed documentation
- Baseline data on items missed over three weeks, identified barriers to the huddle
- "go-live" announcement
- Data collected every day items that were missed
- PDSA (Plan-Do-Study-Act) cycles and run charts with weekly data to monitor and evaluate the impact of the huddle
- Every two weeks, shared data n commonly missed items with the team.

Implementation of Daily Huddle Improves Transitions and Patient Safety on a Busy **Academic Regional Anesthesiology Service: A Quality Improvement Project** Ashley Moore, Jahnavi Trivedi, Michael Gonzalez, Michael Savilla, Stuart Grant, Monika Nanda **Department of Anesthesiology, University of North Carolina, Chapel Hill**

RESULTS







Figure 2A: Graph showing the percent of days with missed items at baseline, and at two-week intervals after go-live.



course of the project. Most common items planning for next day (orders and pre-ops).

Figure 2B: Scatter plot of missed items by

RESULTS

- shown in figure 2B.
- decreased.

DISCUSSION

- key to successful implementation
- safety practices.

REFERENCES

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15.6% no events at baseline, improved to 59% 76% of days with at least one missed item to 37% and 32% in subsequent 2 week intervals. (figure 2A). Marked reduction in the number of missed items, as

Commonly missed items: planning for next day Missed discharge summary documentation steadily

Daily huddles led to reduction in near misses, *improved planning and team efficiency* Requires buy-in from all members Regular communication and identification of barriers

We demonstrate the effectiveness of daily huddles in improving team functioning and adherence to patient

Further research is needed to understand broader impact of huddles and to determine the best practices for implementing and maintain them.

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