AKERSHUS UNIVERSITETSSYKEHUS

“Yes, please. To both”

Norwegian and Swedish healthcare professionals´experiences with reflections in safety huddles in a Safety-I and –II approach

Image from A.A.Milne

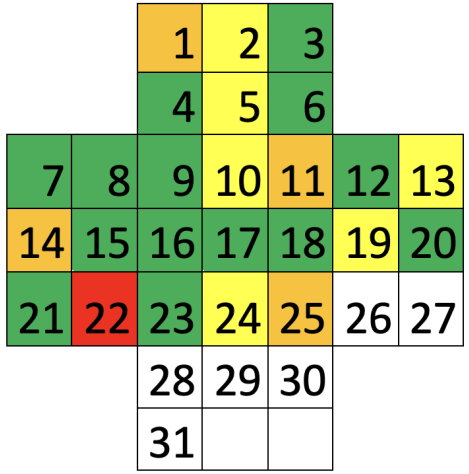
Karina Wahl, RN, Region Jönköpings län, Sweden
Gørill Birkeli, CCN, PhD candidate, Ahus, Norway

Region Jönköpings län

Reflections in safety huddles in the two approaches:

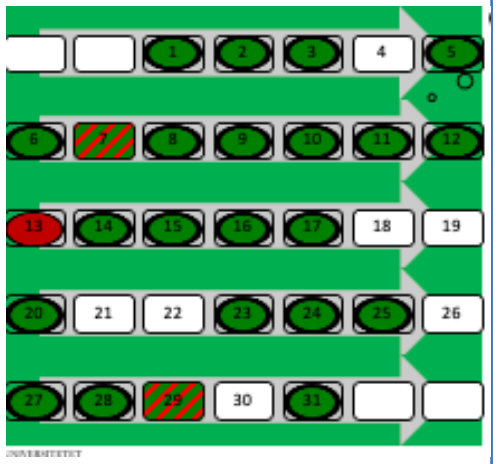
Safety I: Norwegian nurses

Green Cross method

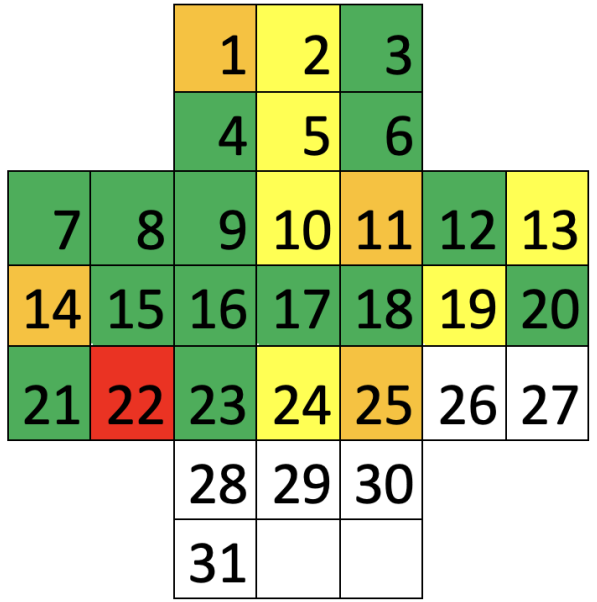


Safety II: Swedish health professionals

Green Line method



Methods: Green Cross method



Implemented in a PACU 2019

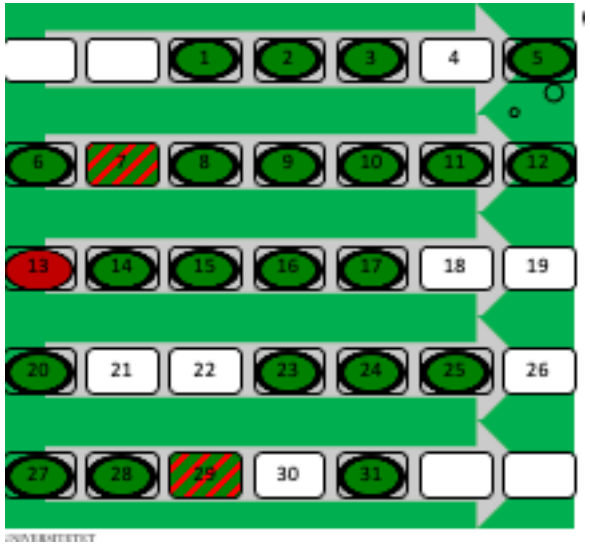
Evaluated by focus group interviews

Four focus groups were conducted before the implementation (n= 19 nurses)

Four after the implementation (n= 16 nurses)

Analysed using qualitative content analysis Graneheim & Lundman (2004)

Methods: Green Line



Quantitative:
Questionnaire on patient safety culture
151 individual responses
Four different occasions Oct 2018 - Dec 2020
Mann Withney U-test and Kruskal Wallis ANOVA-test

Qualitative:
Interviews (n=14, assistant nurses, nurses, doctors, managers) and open questions in the questionnaires
Three different qualitative analyses
one deductive and two inductive thematic content analyses

Results: Safety huddles …

- were perceived useful for discussing events and to increase patient safety
- were perceived to provide interprofessional understanding and cooperation
- reflections were perceived positively in general

Results: There were challenges in…

- Engaging physicians
- Finding time that suited all professions
- Providing enough visible improvements
- Having a positive and permissive climate
- Longitudinal endurance
- Wanted to learn both from w**hat goes wrong** and from **what goes well**
- Facilitators need knowledge to engage deep reflections, and ask open questions

Region Jönköpings län

Conclusions:

Safety huddles suitable for Safety I and II

Safety huddles are perceived positive in general

Must be experienced as valuable and need support

More clinical research needed to improve interprofessional learning in safety huddles

Where to go from here?

Future studies…

How to study which effects safety huddles have on patient safety and patient safety culture?

How can patients & relatives' views be captured?

Thank you! Any questions?

For more information:
Karina Wahl
Karina.wahl@rjl.se

Gørill Birkeli
gobi@ahus.no

References

- Birkeli, G. H., Jacobsen, H. K., & Ballangrud, R. (2021). Nurses' experience of the incident reporting culture before and after implementing the Green Cross method: A quality improvement project. *Intensive and Critical Care Nursing*, 103166. https://doi.org/10.1016/j.iccn.2021.103166
- Hollnagel, E., Wears, R. L., & Braithwaite, J. (2015). *From Safety-I to Safety-II: A White Paper.* The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia. https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-whte-papr.pdf
- Hollnagel E. RPET The Resilient Performance Enhancement Toolkit. Available from: https://safetysynthesis.com/onewebmedia/RPET%20V8.pdf
- Källman, U., Rusner, M., Schwarz, A., Nordström, S., & Isaksson, S. (2020). Evaluation of the Green Cross Method Regarding Patient Safety Culture and Incidence Reporting. *Journal of Patient Safety*. https://doi.org/10.1097/PTS.0000000000000685
- Wahl, K., Stenmarker, M., Ros, A. (2022) Experience of learning from everyday work in daily safety huddles—a multi-method study. *BMC Health Services Research,* 10.1186/s12913-022-08462-9