BMJ Open Quality

Power of daily huddles in COVID-19 pandemic: a QI initiative

Manju Puri, Swati Agrawal, Reena Yadav, Deepika Meena, Nishtha Jaiswal, Shilpi Nain

To cite: Puri M, Agrawal S, Yadav R, *et al*. Power of daily huddles in COVID-19 pandemic: a QI initiative. *BMJ Open Quality* 2022;**11**:e001839. doi:10.1136/bmjoq-2022-001839

Received 31 January 2022
Accepted 31 May 2022

Obstetrics & Gynaecology, Lady Hardinge Medical College, New Delhi, India

Correspondence to
Dr Swati Agrawal;
drswatilhmc@gmail.com

India is experiencing the third wave of COVID-19 presently, with an exponential rise in the number of cases. This has been attributed to the high infectivity of the Omicron variant, whose R-naught is 2.69, which means every 100 infected people can spread the infection to 269 people.[1] Although the hospitalisation rates are much lower with this variant, it has the potential to overwhelm the healthcare infrastructure of the country. Each wave is unique and by the time we understand the dynamics of the new variant, the peak is past. In this ongoing pandemic, there is an urgent need for being in a state of preparedness and have a mechanism of rapid review and assessment of the impact of new variant and prompt response to minimise the damage to both the patients and healthcare workers (HCWs). In heavy load public facilities such as ours, which manages about 13 000 deliveries per annum, regular daily feedback, effective communication and dissemination of change ideas is a challenge. The authors wish to share their experience of one powerful strategy, 'daily huddle', which helped them sail through the first two waves of COVID-19 and is helping in managing the third wave too.

A huddle is a brief, regularly recurring meeting (usually not more than 15 min) that is usually scheduled once at the start of each workday in a clinical setting. It provides a forum for front-line personnel to share safety concerns, develop plans and celebrate successes with the administrative heads.[2] The problems can be flagged and change ideas aimed at improvement in the system can be identified by those facing the problem on ground, which can later be subjected to in-depth discussion in longer team meetings.[3]

We, at the department of obstetrics & gynecology at a tertiary care hospital in Delhi, developed the strategy of daily morning huddles at the advent of COVID-19 in our institution to cope with the challenges forced on us by this never seen before pandemic. Our huddles were facilitated by the head of the department (HOD) at 9:00 every day and attended by the outgoing 24 hours duty consultant with the entire team of residents from the previous day duty and incoming 24 hours consultant. The leader (HOD) reviewed the previous 24 hours statistics of patients admitted, critically ill patients, number of deliveries or caesarean sections, any other surgeries, number of COVID-19-positive patients admitted, any adverse events, waiting time of patients for consultation and admission in emergency room etc. Everyone was invited to raise safety concerns related to patients, staff or infrastructure. It initially started as a morning review huddle lasting 15–20 min but gradually its scope increased, and it became an extended huddle lasting 30–35 min; the golden 30 min every morning. The whole department was aware of this huddle and anyone was welcome to flag any concerns irrespective of their cadre be it a doctor, nursing officer or support staff. Most of the concerns were resolved by the leader right there with the assistance of the incoming consultant and support staff. The consultant on duty recorded the concerns, which needed follow-up and further discussion in departmental meetings. All the decisions taken in the huddle were mutually agreed on and disseminated widely in a common departmental WhatsApp group for speeding up the implementation. The basic idea was having everyone on the same page.

The daily huddles gave birth to many change ideas to tackle day-to-day practical problems, which ultimately took the shape of dedicated quality improvement (QI) projects. One such problem was lack of rooming-in of mother–newborn dyads in COVID-19 suspect postnatal wards till the time their RT-PCR report for COVID-19 was available. With the help of policy development and assigning dedicated caretaker with each mother, we were able to achieve 100% rooming-in of mother–baby dyads in COVID-19 suspect wards in 6 weeks' time. Another problem identified was admission of asymptomatic COVID-19-positive

women in COVID-19 non-suspect wards, which led to infection of many HCWs. The problem was flagged at a daily huddle and a QI project was initiated, which reduced the incidence of COVID-19 positivity in non-suspect zones from 20% to <5% in 7 weeks' time with subsequent reduction in infection of HCWs. This was achieved by interventions such as universal testing of all obstetric admissions and creation of a grey zone for untested asymptomatic obstetric patients.[4] These QI projects were successful only because a daily review of the implementation of the interventions was taken at the morning huddle along with analysis of the data, which led to prompt redressal of problems encountered by front-line HCWs. Moreover, these meetings sensitised various levels of healthcare providers to QI culture and encouraged them to identify problems as well as solve them effectively.

The improved communication between various cadres of healthcare providers in the department because of these daily huddles had many unexpected useful by-products. There was a significant fall in the caesarean section rate in the institution from approximately 32% to <25% because of daily scrutiny of indications of caesareans by the HOD and suggested interventions. The stillbirth rates due to inadequate intrapartum monitoring of fetal heart rate reduced. The morning huddles also instilled a sense of belongingness and cohesiveness in the residents, nursing officers, faculty and the support staff of the department as everyone was given an opportunity to raise their concerns that were respected and addressed to their satisfaction.

According to a recently published QI report, daily huddles have been shown to enhance communication among healthcare providers and patient safety responsiveness in an intensive care unit.[5] Another similar study, from a hospital where daily huddles were a part of the routine for the last decade, showed that this practice helped them tide the pandemic with ease and bridge gaps in patient care.[6]

The three core principles of managing this pandemic; early identification of problems, their prompt redressal and widespread dissemination of the solutions; helped us combat the first two waves of the COVID-19 pandemic in the best possible way, with the help of our daily huddles. The first golden 30 min each day were the most productive during the COVID-19 pandemic and enabled the team to keep pace with the daily change in scenario. With time, the concept of daily huddle has been ingrained in the department and the baton passed from one administrative head to another. COVID-19 or no COVID-19, the department has realised the benefits of this QI initiative and hopefully this zeal will help sustain it, even after the COVID pandemic ends. The authors hope that their experience will help other institutions develop similar strategies to tackle unprecedented challenges in patient care and safety.

Contributors MP and SA were involved in conceptualising the article and drafting it. RY gave intellectual inputs and helped in the draft of the article. DM, NJ and SN were involved in data collection and analysis. All the authors reviewed the draft and approved the final version.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors. Publication of this article is made Open Access with funding from the Nationwide Quality of Care Network.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval This work is exempt from institutional review board review because it involved the use of existing data, documents and records. These sources are publicly available, and the information was recorded by the investigators in such a manner that subjects cannot be identified directly or through identifiers linked to the subject.

Provenance and peer review Not commissioned; externally peer reviewed.

ORCID iDs
Nishtha Jaiswal http://orcid.org/0000-0003-0923-5642
Shilpi Nain http://orcid.org/0000-0001-9529-8134

REFERENCES

1 Ghosh P. R-value 2.69, higher than peak of 2nd wave: what centre said on 3rd wave in India. Available: https://www.hindustantimes.com/india-news/rvalue-2-69-higher-than-peak-of-2nd-wave-what-centre-said-on-3rd-wave-in-india-7-points-101641385221654.html [Accessed 16 Jan 2022].
2 Castaldi M, Kaban JM, Petersen M, *et al*. Implementing daily leadership safety Huddles in a public Hospital: bridging the gap. *Qual Manag Health Care* 2019 ;;28:108–13.
3 Daily Huddle Component Kit. *Agency for healthcare research and quality, Rockville, MD*, 2022. https://www.ahrq.gov/hai/tools/ambulatory-surgery/sections/sustainability/management/huddles-comp-kit.html
4 Puri M, Agrawal S, Singh A, *et al*. Notes from the field: dynamic triaging using quality improvement (Qi) methodology to prevent the admission of asymptomatic COVID positive obstetric patients in New Delhi, India. *Eval Health Prof* 2021;44:98–101.
5 Aldawood F, Kazzaz Y, AlShehri A, *et al*. Enhancing teamwork communication and patient safety responsiveness in a paediatric intensive care unit using the daily safety huddle tool. *BMJ Open Qual* 2020;9:e000753.
6 Schatz M, Bergren MD. The Huddle: a daily dose of communication. *NASN Sch Nurse* 2022;37:76–8.