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EXPERIENCE REPORT
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Experience of a pilot implementation of the Daily Huddle methodology in an intensive care unit

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ABSTRACT

Communication failures during shift handover in intensive care units (ICUs) are among the main causes of adverse events. This experience report describes the pilot implementation of the Daily Huddle methodology as a structured strategy to improve information transfer and coordination within the nursing team. The intervention was carried out in a 20-bed multipurpose ICU of a tertiary-level public hospital in Spain. The process included an initial mapping phase, the appointment of leaders, a preparatory phase, and a four-week operational pilot implementation, with evaluation through 30 structured observations. The Daily Huddle was conducted in 90% of the sessions, with full participation in 77.8% and an average duration of 16.9 minutes. Interruptions, mainly caused by patient-monitoring alarms or care workload overload, reflected the dynamics of the critical environment without compromising the feasibility of the model. The experience confirmed that the methodology is feasible, low-cost, and replicable, demonstrating its potential to strengthen structured communication and the safety culture in critical care. Further evaluation of professionals' perceptions and the long-term impact on clinical outcomes is recommended.

Keywords: critical care; shift handover; patient safety.

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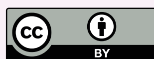

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Scientific Contribution:

The pilot experience of implementing the Daily Huddle methodology in an intensive care unit provides evidence regarding the feasibility and operational sustainability of a structured communication tool in critical care. Findings demonstrate high adherence and participation, as well as the feasibility of integrating this strategy into routine clinical practice without requiring additional resources.

INTRODUCTION

Communication among healthcare professionals constitutes one of the fundamental pillars of patient safety. The World Health Organization (WHO) (1) has identified that up to 60% of serious adverse events in healthcare are related to communication failures during clinical care or transitions of care. Similarly, the Joint Commission International (JCI) (2) reports that more than 70% of sentinel events reported in hospitals are associated with communication errors among healthcare teams.

In high-complexity settings such as intensive care units (ICUs), where multiple professionals and a high technological burden converge, the risk of communication failures increases considerably. The literature has shown that ineffective handoffs can lead to duplication of procedures, delays in care, and an increased risk of clinical errors (3, 4). To mitigate these risks, several structured communication strategies have been promoted globally, including the Bedside Shift Report (BSR) and the Daily Huddle, both aimed at standardizing information exchange and strengthening the culture of safety among healthcare teams (5, 6).

The Daily Huddle methodology, which emerged in the context of High Reliability Organizations (HROs) and was later adapted to the healthcare setting, consists of brief, periodic meetings in which frontline staff review safety issues that have occurred, anticipate risks, and collaboratively plan the day (7). Its implementation in institutions in the United States, Canada, and the United Kingdom has demonstrated significant improvements in situational awareness, interdisciplinary coordination, and response to critical events (8, 9).

Despite its consolidation in highly reliable healthcare systems, where safety huddles are recognized as effective tools for improving communication and clinical risk management (10), its application within critical care nursing remains limited and poorly documented in scientific literature. In Spanish-speaking countries, available publications are scarce and focus primarily on non-intensive settings, such as emergency departments (11) or pediatric units (12). Although isolated experiences in ICUs have been described (13, 14), an evidence gap persists regarding their specific impact on nursing practice and intra-team communication in critical care environments.

Within this context, the main objective of this study is to describe the implementation of this handoff methodology in a nursing ICU setting, evaluating its operational feasibility, team participation, and lessons learned for its institutionalization in an area where evidence regarding this practice remains limited. Secondary objectives included identifying facilitators and barriers encountered during the intervention, as well as formulating practical recommendations that would enable the replicability of this strategy in other units with similar characteristics.

EXPERIENCE PRESENTATION

Unit context and participating team

The experience was conducted in a mixed medical–surgical intensive care unit (ICU) of a tertiary-level public hospital in the Community of Madrid, Spain. The unit had 20 beds and a staff of 93 healthcare professionals: 57 nurses and 36 nursing care assistants (NCAs). The nurse-to-patient ratio was 2:1, and the NCA-to-patient ratio was 4:1. In both professional categories, work shifts were organized into morning–night or afternoon–night rotations.

The research team, composed of three nurses with extensive clinical experience in critical care and training in structured handoff methodologies, led the project with the support of the unit nurse manager and the patient safety team. The experience was designed as a descriptive study in the form of an experience report, focused on the implementation of the Daily Huddle methodology as a communication strategy among nursing staff.

Initial diagnosis and justification for intervention

During the months preceding the intervention, substantial variability was identified in how nursing professionals conducted shift handoffs, both in message structure and in the locations where they occurred (nursing station, hallways, among others). This heterogeneity generated communication gaps with a potential impact on the safety of critically ill patients.

In response to this situation, the research team proposed implementing the Daily Huddle as a structured internal communication strategy aimed at strengthening coordination, efficiency, and patient safety. To achieve this, the model proposed by the American Medical Association (AMA) was adopted, which includes the phases of preparation, piloting, consolidation, and final implementation (15). However, due to the characteristics of the critical care environment and the exploratory nature of the project, only the first two phases (preparation and initial piloting) were implemented to evaluate operational feasibility and team acceptance before future full integration within the unit.

As a preliminary step to the preparatory phase, findings from an initial mapping conducted the previous year

were considered. This mapping aims to explore team perceptions regarding communication during handoffs and their readiness for change; the results are presented below.

Implementation phases

Initial mapping (exploratory phase)

Between July and September 2024, an exploratory qualitative study was conducted with 12 nursing professionals from the unit through semi-structured interviews, with the objective of understanding the baseline context before implementation. 100% of participants agreed that the Daily Huddle methodology could optimize care and safety during shifts and improve workload management and the work environment. They also highlighted the need to establish prior guidelines to facilitate the meeting dynamics and systematization.

Preparatory phase (planning, decalogue, ambassadors, and resources)

Based on the mapping findings, the preparatory phase began between February 1 and February 15, 2025. A set of ten operational principles (Table 1) was developed to define the essential elements for implementing the Daily Huddle immediately after the routine shift handoff between the outgoing and incoming staff members. These meetings, with a maximum duration of 20 minutes, focused on collective shift planning and the resolution of clinical incidents, promoting a structured team coordination space before the start of clinical activities.

Table 1. Decalogue of operational guidelines for conducting the Daily Huddle.

No.	Title	Content
1	Scheduling	Meetings will be held at the beginning of each shift, following the routine shift handoff.
2	Location	Meetings will take place at the nursing stations to facilitate patient visualization and central monitoring.
3	Participation	Attendance of the entire nursing team is recommended to promote information exchange and reinforce patient safety.
4	Availability	If a team member cannot attend, they must request the information discussed during the meeting.
5	Duration	Meetings will last 15–20 minutes to avoid delaying the start of clinical care activities.
6	Topics	The following information will be addressed: primary diagnosis, clinical status, recent changes, procedures and potential issues, risks to patient and staff safety, and relevant data for continuity of care.
7	Individual matters	Issues not relevant to the team as a whole and that require individual discussion should be addressed afterward at a more appropriate time.
8	Synergy	A space will be provided to share observations, resolve questions, and balance workload distribution.
9	Respect	A friendly environment will be promoted, avoiding confrontation and non-clinical opinions.
10	Objective	The goal is to improve patient care and strengthen teamwork.

In parallel, the selection of leaders or ambassadors was carried out using the Delphi method, achieving consensus among the research team, the unit nurse supervisor, and a representative from the Patient Safety Committee. A total of 11 nursing leaders and 6 NCA leaders were appointed and organized based on work shifts. These ambassadors were responsible for convening the team, facilitating the meetings, and ensuring adherence to the process.

The dissemination strategy included posters in common areas, communication via institutional email, and professional messaging groups. This phase also defined the human and material resources required, characterized by their low cost and high operational feasibility, focusing on the involvement of the healthcare team and simple communication and monitoring tools. Table 2 summarizes the resources used during the different phases of the Daily Huddle.

Table 2. Resources used during pilot phases.

Phase	Human resources	Resources used
Initial mapping	• Research team (3 nurses with extensive clinical experience)	• Interviews with 12 nursing professionals
Preparatory phase	• Principal investigator • Research team • Unit supervisor • Patient safety team • Ambassadors (11 nurses and 6 NCAs) / Ambassadors (11 nurses and 6 NCAs)	• Scientific literature (15 references) • Preparation of a training decalogue • Informational posters and dissemination (corporate emails and messaging groups)
Operational pilot	• Safety team	• Daily checklist

NCAs: Nursing Care Assistants.

Operational pilot phase (observation, outcomes, and adjustments)

The operational pilot was conducted between February 15 and March 15, 2025. Previously, a structured observation checklist was designed *ad hoc* to the characteristics of our unit (Table 3), based on the report by the Agency for Healthcare Research and Quality (AHRQ) (16). The purpose of this tool was to record meeting implementation, punctuality, duration, participation, and the occurrence of interruptions.

Table 3. Observation checklist based on the Agency for Healthcare Research and Quality

Observation date: ____/___/___	Huddle start time: ____ : ______
0. Implementation record	Was the huddle conducted? / ☐ Yes / ☐ No Reason: ______________________________
1. Ambassador availability	☐ The ambassador needed to call the rest of the team to initiate the meeting.
2. Team review	Were all scheduled professionals present? ☐ Nursing Staff/ ☐ NCAs Causes: _____________________
3. Meeting dynamics	☐ Did it start on time? / ☐ Duration >20 min? / ☐ Were the decalogue topics addressed? ☐ Were key clinical aspects discussed? / ☐ Was the visual guide used? / ☐ Was collaboration and task distribution observed?
4. Interruptions during the meeting	Were there interruptions? / ☐ Yes / ☐ No Type of interruption: ☐ Clinical alarms / ☐ Patient demand / ☐ Intervention by another professional / ☐ Other: _______
5. Huddle closure	☐ Concluded on a positive note. / ☐ Participation was acknowledged. / ☐ Information was recovered.
	Huddle end time: _____:_____

NCAs: Nursing Care Assistants.

During this period, 30 Daily Huddle meetings were observed, evenly distributed across the three main shifts (morning, afternoon, and night; 10 observations per shift). The session was conducted on 27 occasions (90%), whereas in 3 cases (10%) it was not carried out due to excessive clinical workload or the need to care for unstable patients. The number of observations was determined based on operational saturation and feasibility criteria, given that this was an exploratory pilot phase aimed at covering all shifts and care contexts without interfering with clinical practice.

Regarding team participation, 77.8% (n = 21) of the sessions included full attendance from both nursing staff and nursing care assistants (NCAs). In the remaining 22.2% (n = 6), one or more team members were unable to attend due to emergent clinical demands. In those cases, an information recovery strategy was implemented, whereby a verbal summary of the topics discussed was provided to those who were absent.

The mean meeting duration was 16.9 minutes (range: 10–22 min), remaining within the 20-minute limit established in the protocol. Punctuality was observed in 56.7% (n = 15) of the sessions, while minor delays occurred in the remaining sessions, attributable to concurrent clinical workload.

Interruptions were identified in 59.3% (n = 16) of the meetings. Of these, 62.5% corresponded to technical alarms; 25% to unplanned interventions by other professionals; and 12.5% to direct patient demands. In 7 meetings (25.9%), information recovery was documented for professionals who were unable to participate, reinforcing the practical applicability and flexibility of the implemented model (Table 4).

Table 4. Operational results of the Daily Huddle pilot (n = 30 observations).

Indicator: Meetings conducted	**Overall result** 90% (n = 27/30)	**Comment:** Three not conducted: overload or unstable patient
Punctuality	56.7% (n = 17/30)	Occasional delays due to clinical activity
Full participation	77.8% (n = 21/27)	22.2% partial or absent
Mean duration	16.9 min (range 10-22 min)	Within the protocolized timeframe
Total interruptions	59.3% (n = 16) of meetings:	Mainly technical alarms (62.5%)
Types of interruption	• Technical alarms: 62.5% (n = 10/16)	Technical alarms were the primary cause.
	• Unplanned interventions: 25.0% (n = 4/16)	
	• Patient demand: 12.5% (n = 2/16)	
Information recovery	25.9% (n = 7/27)	Absent staff were informed afterward.

The implementation of this methodology enabled the consolidation of a structured, sustainable communication practice with high adherence, demonstrating its feasibility in highly complex critical care environments.

DISCUSSION

Although this experience does not constitute a full institutional implementation, the pilot results demonstrate operational trends similar to those described in other specialized hospital settings: in emergency departments, where improved shift planning has been reported (11); in pediatric units, with positive effects on patient safety (12); and in intensive care units (ICUs), where it has been associated with greater team cohesion during critical periods such as the COVID-19 pandemic (13). These results are consistent with the principles of High Reliability Organizations (HRO) and with the recommendations of the American Medical Association (AMA) (15), which promote brief, structured meetings as key tools for building safer, more efficient, and resilient teams, fostering both increased incident reporting and the strengthening of the institutional culture of safety (17, 18).

The high adherence and participation observed suggest strong acceptance of the methodology among healthcare staff, reinforcing its operational feasibility and short-term sustainability. This finding is consistent with the literature highlighting the rapid integration of the Daily Huddle when implementation is accompanied by participatory leadership and team engagement (11–13, 19, 20). However, the coexistence of high adherence with partial absences or delays reflects a dynamic balance between the team's willingness to maintain the practice and the structural constraints of the critical care environment. In this regard, the flexibility demonstrated by the model—particularly by allowing information recovery through formal or informal channels—constitutes a resilience factor that supports its consolidation, even in contexts of high clinical workload.

The interruptions recorded, mainly due to clinical alarms or workload overload, should be interpreted as a reflection of the real conditions of an ICU rather than methodological shortcomings. The literature agrees that such interruptions are inherent to the critical care environment and that their presence does not invalidate the value of the safety huddle as a tool to reinforce situational awareness and patient safety (7, 9, 10, 19). Nevertheless, their frequency suggests the need to further optimize the physical and organizational environment by promoting strategies that enable sustained focus without compromising immediate clinical response.

Partial participation by some team members, particularly during certain shifts, highlights the influence of organizational factors on meeting continuity. However, the team's willingness to review information after the meetings and the consistency in conducting them reflect an emerging dynamic of shared accountability, aligned with the literature that identifies cohesion and shared leadership as key factors for the success of the team huddles (8, 9, 19, 20). This balance between formal structure and operational flexibility represents one of the most relevant aspects of the experience, demonstrating that the Daily Huddle can be naturally integrated into clinical workflows without generating resistance or disruptions.

As an exploratory pilot experience, this study presents some limitations. First, the intervention period was brief (30 days), which may have limited the consolidation of the cultural change necessary to integrate the methodology into clinical practice; nevertheless, the observations conducted and subsequent follow-up demonstrated adequate adherence to the model. Second, healthcare professionals' perceptions after the intervention were not explored, which would have allowed for a more comprehensive analysis of perceived impact. Finally, the single-center nature of the project may limit the generalization of the results; however, the participation of many professionals and the consistency of the findings support its transferability to other ICUs with similar organizational characteristics (14, 19).

CONCLUSIONS:

The pilot implementation of the Daily Huddle in ICUs represents an operationally feasible, safe, and low-cost practice, capable of improving nursing team coordination and information transfer efficiency. The experience demonstrated high adherence and professional acceptance, as well as tangible benefits in healthcare planning and clinical risk management.

These findings reinforce that structured and systematic communication constitutes an essential pillar for consolidating a culture of safety in highly complex healthcare environments. The applied model appears replicable and adaptable to other critical care units, provided it is accompanied by clinical leadership and institutional support.

Future research is recommended to expand the scope of this experience by exploring its impact on clinical care indicators, organizational climate, and professional satisfaction through mixed designs and longitudinal follow-ups to assess its long-term sustainability.

Conflict of interest:
The authors declare no conflict of interest.

Funding:
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Ethics approval:
The study did not require approval from the hospital's Ethics Committee (certified in Minutes No. 20/2025), as it did not involve patient health data or biological samples, in accordance with current Spanish legislation (RD 1090/2015).

Authorship contribution:
FPG: conceptualization, methodology, supervision, formal analysis, validation, visualization, writing of the original draft, writing - review & editing.
EPV: project coordination, supervision (dissemination and implementation), validation, writing - review & editing.
SRL: conceptualization, methodology, supervision (patient safety), validation, writing - review & editing.
EGG: research, data curation, project administration (pilot phase), validation, writing - review & editing.

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