THE SAFETY HUDDLE AS A TOOL FOR COORDINATING NURSING CARE IN THE INTENSIVE CARE UNIT

SAFETY HUDDLE COMO FERRAMENTA PARA COORDENAÇÃO DO CUIDADO DE ENFERMAGEM NA UNIDADE DE TERAPIA INTENSIVA

LA REUNIÓN DE SEGURIDAD COMO HERRAMIENTA PARA COORDINAR LA ATENCIÓN DE ENFERMERÍA EN LA UNIDAD DE CUIDADOS INTENSIVOS

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ABSTRACT

The study aimed to analyze nurses' perceptions of the applicability, effectiveness, and impacts of the Safety Huddle in coordinating and promoting safe nursing care in Intensive Care Units. This is a descriptive study with a qualitative approach. Depicted through semi-structured interviews recorded with 29 nurses between September and November 2025 at a hospital in Rio de Janeiro, Brazil. The data obtained were processed using IRAMUTEQ software, version 8.0, alpha 7. This processing was carried out using Descending Hierarchical Classification, resulting in four interrelated and interdependent classes. These emphasize the Safety Huddle as a proposed framework for the foundation of safe nursing care and health risk management. The applicability and efficiency are based on the commitment of the multidisciplinary team and the effective leadership of the intensive care nurse. The findings, therefore, emphasize the Safety Huddle as a tool capable of generating learning and knowledge with the potential to add quality and safety to nursing care practice.

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RESUMO

O estudo teve como objetivo analisar a percepção de enfermeiros sobre a aplicabilidade, efetividade e os impactos do *Safety Huddle* na coordenação e promoção do cuidado de enfermagem seguro nas Unidades de Terapia Intensiva. Trata-se de uma pesquisa descritiva com abordagem qualitativa. Retratada por entrevistas semiestruturadas gravadas com 29 enfermeiros, no período de setembro a novembro de 2025, em um Hospital do Rio de Janeiro, Brasil. Os dados obtidos foram processados no *software IRAMUTEQ*, versão 8.0, *alpha* 7. Tal processamento se deu por meio da Classificação Hierárquica Descendente de forma a resultar em quatro classes inter-relacionadas e interdependentes. Essas enfatizam o *Safety Huddle* como estrutura proponente para a base de um cuidado de enfermagem seguro e o gerenciamento de riscos à saúde. Sendo a aplicabilidade e eficiência pautadas no comprometimento da equipe multiprofissional e liderança eficaz do enfermeiro intensivista. Os achados, portanto, enfatizam o *Safety Huddle* como instrumento capaz de gerar aprendizados e conhecimentos com potencialidade para agregar qualidade e segurança à prática assistencial da enfermagem.

Palavras-chave: Unidades de Terapia Intensiva. Segurança do Paciente. Enfermagem. Cuidados de Enfermagem. Protocolos Clínicos.

RESUMEN

El estudio tuvo como objetivo analizar las percepciones de las enfermeras sobre la aplicabilidad, la eficacia y los impactos del Safety Huddle en la coordinación y promoción de la atención de enfermería segura en las Unidades de Cuidados Intensivos. Se trata de un estudio descriptivo con enfoque cualitativo. Retratado a través de entrevistas semiestructuradas grabadas con 29 enfermeras entre septiembre y noviembre de 2025 en un hospital de Río de Janeiro, Brasil. Los datos obtenidos fueron procesados mediante el *software IRAMUTEQ*, versión 8.0, *alpha* 7. Este procesamiento se realizó mediante Clasificación Jerárquica Descendente, dando como resultado cuatro clases interrelacionadas e interdependientes. Estos enfatizan el Safety Huddle como un marco propuesto para la base de la atención de enfermería segura y la gestión de riesgos para la salud. La aplicabilidad y eficiencia se basan en el compromiso del equipo multidisciplinario y el liderazgo efectivo de la enfermera de cuidados intensivos. Los hallazgos, por tanto, enfatizan el Safety Huddle como una herramienta capaz de generar aprendizaje y conocimiento con el potencial de agregar calidad y seguridad a la práctica de la atención de enfermería.

Palabras clave: Unidades de Cuidados Intensivos. Seguridad del Paciente. Enfermería. Atención de Enfermería. Protocolos Clínicos.

1 INTRODUCTION

The Intensive Care Unit (ICU) is a sector prone to adverse events. In this context, the fragmentation of health care emerges as a challenge, in order to highlight the effectiveness of coordination in the care process. Based on multidimensionality, this is demonstrated as a deliberate organization of activities aimed at the continuity of care. Coordination should be developed through the establishment of bonds between the various participants in the care process, so that the exchange of information becomes qualified, without gaps in the provision of care (Cruz *et al.* 2022).

Therefore, when considering evidence-based care, it is essential to implement health technologies, which include methods, procedures, practices, techniques, and equipment. These are handled as a form of care, which makes it necessary to know why to use them and how to use them, in order to reduce the chance of errors (Teixeira *et al*., 2024).

From this perspective, Safety Huddle stands out. Tool that is configured as "safety meetings". This methodology aims to improve care results and is dimensioned as quick meetings that count on the participation of health professionals and managers. Defined as a time limit, the *Safety Huddle* should last, on average, from 05 to 15 minutes, with the duration time being directly associated with the team's needs (Moraes *et al*., 2023). Carried out with a pre-defined schedule, this methodology promotes the sharing of relevant information, performance review and signals safety issues that require priority attention from the team (Correa *et al*., 2025).

In this bias, the multifaceted role of the nurse who enters this context as an applicator, feeder and supervisor of the instrument is highlighted, with a view to the continuous improvement of the care process. To promote quality and patient safety, nurses need leadership, clinical competence and communication skills, and the diversity of challenges is a factor that directly impacts the complexity of the hospital environment (Bispo, 2023).

Furthermore, noting nursing as the predominant bedside category, there is a need to explore and understand experiences of care practice for theoretical/practical correlation with the tool in question. After all, in this way, learning and knowledge are generated capable of resulting in transformations that add quality to care practice (Pinto; Santos, 2020).

In the Brazilian context, the leadership of nurses in the ICU is a fundamental part of the sustainability of safe practices. The nurse acts as the main articulator of the multiprofessional team, being responsible for direct supervision and care management. However, the operationalization of the *Safety Huddle* still faces structural and cultural barriers, such as work overload and excessive hierarchization of professional categories, which can

limit the effectiveness of the tool and the engagement of the entire team, especially nursing technicians (Brass *et al*, 2018).

In view of this panorama, the need to understand how nurses perceive and use this tool in their intensive care routine is justified. Investigating the strengths and weaknesses of the *Safety Huddle* allows not only to strengthen the institutional safety culture, but also to equip nurses in their role as care coordinator. The relevance of this study lies in the possibility of offering subsidies for the improvement of care protocols, aiming at a more coordinated, humane and harm-free care. Thus, the objective of this study was to analyze nurses' perceptions of the applicability, effectiveness and impacts of the *Safety Huddle* tool on the coordination and promotion of safe nursing care in Intensive Care Units.

2 METHODOLOGY

This is a research with a descriptive profile with a qualitative approach. The descriptive profile stands out as the one that represents the characterization of the aspects of a defined conjuncture, studying its peculiarities and individualities (Hochman *et al.*, 2005). The qualitative approach seeks to understand the totality of the phenomenon, in order to identify a universe of values, aspirations, attitudes, meanings, beliefs and motivations (Minayo, 2001 *apud* Rhoden; Zancan, 2020).

According to the scientific literature, a set of communication analysis techniques aims, through systematic and objective procedures, to describe the contents of messages. In this way, indicators are obtained that will allow the inference of knowledge related to the conditions of production and reception of messages. The literature mentioned above proposes thematic content analysis in three stages: pre-analysis; exploration of the material and treatment of the results obtained and interpretation, which will be used in this study (Bardin, 2016).

Data collection was carried out in a large municipal hospital located in the northern part of the city of Rio de Janeiro. The unit offers the public health network 420 beds, 245 of which are for Intensive Care. With regard to human resources, the unit has about 466 nurse employees, of which 162 are allocated to the ICU, 19 of whom are routine nurses and the rest are nurses on duty. Such professionals are inserted in workloads of 30 to 40 hours per week. The routines fulfill their workload from Monday to Friday from 7 am to 4 pm and the on-call staff have a 12-hour work schedule for 60 hours of rest.

Nurses working in intensive care units were considered eligible for the study. Nurses on duty and day laborers participated in this study. The exclusion criteria were those

incorporated into the night shift and by nurses on sick leave or because they were on vacation during the period in which data collection occurred.

First, the research subjects were invited in person, presenting the objectives of the study and the means of data collection. After accepting to participate, the Informed Consent Form (ICF) was presented, which evidenced the objectives of the research. All participants signed, consenting to the recording of the interviews and aware of the full right to refuse to answer any question and to withdraw from the survey at any time, without the need for justification and without professional, legal or administrative implications (Brasil, 2018).

Data collection took place through semi-structured interviews, carried out from September to November 2025, each lasting approximately sixteen minutes. The script presented sociodemographic markers for the general characterization of the target audience such as gender, race/color, age group, professional training and time working in the profession and the following guiding questions related to the research theme: "What are the main challenges identified in the application of Safety *Huddle* on a daily basis in the Intensive Care Unit?"; "Does the applicability of Safety *Huddle* interfere with patient safety in the Intensive Care Unit?"; "Does the use of the *Safety Huddle* influence Nursing care in the Intensive Care Unit?" and "What recommendation would you give to improve the applicability of the *Safety Huddle* in the Intensive Care Unit?". The interview took place in person and was recorded on a *smartphone*, belonging to the main researcher for later transcription, exploration and treatment of the data obtained.

It should be noted that throughout the data collection phase, there were limitations, especially with regard to the recruitment of volunteers. This situation was established due to the work process with demands that generate an impediment to their absence in the sector and, consequently, cause the scarcity of time to go to a quiet place where they could talk about their experiences, without interruptions or noise.

In order to ensure the anonymity of the participants, an alphanumeric code was used as a form of identification, namely: "Enf" (referring to nurse), accompanied by a sequential ordinal number (Enf_01, Enf_02,...) in sequential order according to the order of the interviews.

Qualitative research takes place in the need to reach the information. The sample size in this type of study is measured through data saturation (Polit; Beck, 2019). Data collection was considered saturated when there was no new element added to the interview and recurrent ideas were presented in the participants' statements. In the present study, saturation was reached in the 29th interview, which was confirmed in the level of use of the analyses.

Sociodemographic data were organized using Microsoft *Office Excel*, 2016, and analyzed through univariate and bivariate descriptive statistics using the *R software*. Qualitative analysis was performed using the *IRAMUTEQ software* (*Interface de R pour les Analyses Multidimensionnelles de Textes et de 101 Questionnaires*) version 8.0 *alpha* 2, it is a *software* free access that allows statistical analysis on textual *corpus* that proposes to organize the discourses of different discourses and multiple contexts (Camargo; Justo, 2013).

Once the full transcription of the interviews was concluded, a textual *corpus* was constructed, duly structured by specific command lines for processing in the *IRAMUTEQ software*. Subsequently, the data were submitted to multivariate analyses, including the Descending Hierarchical Classification (DHC), which allowed the segmentation of the content into classes of meanings with the identification of the predominant lexical structures.

After processing the data in the proposed *software*, the results were interpreted by thematic analysis (Dias; Mishima, 2023). Through the detailed reading of the text segments (TS), the data interpretations were carried out, identifying the nuclei of meaning of the answers, enabling the understanding of the object of study.

For this study, the Reinert method was chosen, based on the Descending Hierarchical Classification (DHC). This is done by classifying the text segments in relation to their vocabularies in view of the distribution and frequencies of words already lemated, obtaining the classes of units of Elementary Context Units (ECU) (Camargo; Justo, 2013).

The research complied with all ethical aspects and was approved by the Research Ethics Committee (CEP) of the Municipal Health Department of Rio de Janeiro (SMS.RJ) on August 4, 2025. Opinion No. 7.744.225, CAAE 90650825.4.0000.5279.

3 RESULTS AND DISCUSSIONS

Descriptive statistical analysis was performed to assess the sociodemographic characteristics of the research participants. A total of 29 nurses were interviewed, a sample with a majority of women (n: 21; 72.4%), in terms of race/color, according to the nomenclature of the Brazilian Institute of Geography and Statistics (IBGE), prevalence of self-declared whites (n:12; 41.4%), age group 25 to 30 years (n: 9; 31%), with time of experience between 0 and 5 years (n: 9; 31%). Regarding professional training, 17 employees have specialization (58.6%). Given this conjuncture, table 1 demonstrates the aforementioned characterization of the participants.

Table 1

Sociodemographic and professional characterization of the nurses participating in the study (N = 29)

Variable	n	%
Gender		
Women	21	72,4
Male	8	27,6
Race/Color		
White	12	41,4
Brown	11	37,9
Black	5	17,2
Yellow	0	0
Indigenous	1	3,4
Age group (years)		
25–30	9	31
30–35	4	13,8
35–40	5	17,2
40–45	5	17,2
≥ 45	6	20,7
Length of experience in Nursing (years)		
0–5	9	31
6–10	7	24,1
11–15	6	20,7
16–20	6	20,7
≥ 20	1	3,4
Professional training		
Specialization	17	58,6
Residence	12	41,4

Source: Survey data (2025).

According to a survey by COFEN/RJ, the Brazilian nursing team is mostly composed of female individuals, which demonstrates that the historical construction of the category endures and ratifies the findings of the present study (Cofen, 2017). In the conjuncture presented under the analysis of the ethnic-racial composition of the participants, there is a higher percentage of respondents as self-declared white. However, it should be noted that the sum of self-declared blacks and browns is characterized as the black population. Thus, this population constitutes 16 participants, comprising 55.1% of the nurses interviewed, constituting a greater number. This data is of paramount scientific relevance, as it reflects the demographic profile of the Brazilian nursing workforce, as pointed out by studies by the Federal Council of Nursing (COFEN), where there is a growing insertion of historically marginalized populations in higher education and in highly complex specializations, such as the ICU (COFEN, 2017).

With regard to the age group, it is observed that the younger professionals (25–30 years) are fully concentrated in the range of 0 to 5 years of experience, while older age groups have a greater dispersion of the time of experience. Professionals with 16 years or more of experience are mostly concentrated among those aged 40 years or older, indicating professional progression compatible with the work life cycle.

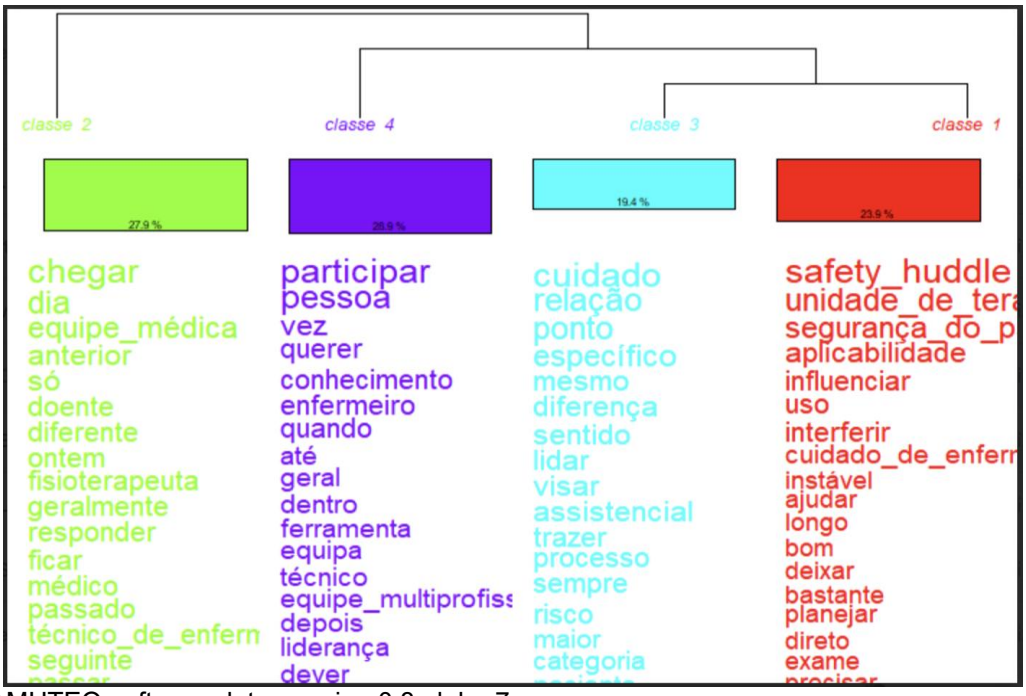
In this sense, it is highlighted that professionals at the beginning of their careers may have learning gaps in intensive care training, which can result in a lack of homogeneity and systematization in the care process. That said, Safety *Huddle* acts as a crucial lifelong education strategy. By promoting quick meetings to share information, the tool accelerates the learning curve of younger nurses, allowing them to anticipate risks that more experienced professionals already intuitively recognize.

With regard to training, it is noteworthy that 58.6% of the interviewees have specialization and 41.4% completed residency. The high rate of postgraduates suggests a technically qualified team to deal with the complexity of the ICU. However, the literature warns that the title alone does not guarantee adherence to good practices if there is no institutionalized security culture (Fragata, 2014). Nurse leadership emerges as the link between technical qualification and tool effectiveness. As the data show a team at different stages of professional maturity, it is up to the nurse leader — especially those with more than 11 years of experience (approx. 24% of the sample) — to act as a facilitator, ensuring that the *Safety Huddle* is not perceived as a bureaucratic "*checklist*", but as a coordination space that gives everyone an active voice (Sobrinho *et al*, 2018).

In relation to the information processed through the interviews, through the reflective and thematic analysis of the data, it is possible to observe the deductions obtained to the detriment of the objective proposed in this research. The *corpus* was separated into 29 initial context units (ICUs), divided into 371 segments of elementary context units, with 12,971 occurrences. The analysis of the classes, carried out through the Descending Hierarchical Classification (DHC), resulted in four classes. These were distributed as follows: class 2 represents 27.86% of the findings, class 4, with 28.86%; class 3, with 19.4% and class 1, which obtained 23.88%, as illustrated in Figure 1.

Figure 1

Descending Hierarchical Classification Dendrogram



Source: IRAMUTEQ software data, version 0.8 alpha 7.

3.1 CLASS 1: *SAFETY HUDDLE* AS THE BASIS FOR SAFE NURSING CARE.

Class 1 comprises 48 segments of texts, in order to compose 23.88% of the *corpus* analyzed. In this class, the terms "safety huddle", "intensive care unit", "patient safety", "nursing care" stand out. The testimonies demonstrate that through the *Safety Huddle* it is possible to obtain information that will allow the efficient planning of nursing care for patients of high complexity, mapping their dependence on such care. Through the tool, an overview of the needs of hospitalized patients is obtained, as well as the emergence of weaknesses and challenges evidenced during the continuity of care, in order to revisit points inherent to patient safety. Thus, at the beginning of each shift, the professional becomes able to manage care by visualizing the work process schedule, thus promoting quality and safety in care.

> […] You can demand more specific care for patients who need it most. You can be more attentive to the patient's needs, to the issues of what that patient needs, so this makes you more alert and I think this generates more safety for the patient [...] (Enf_04)
> […] You are aware of the lesions, patients who are unstable, patients who are scheduled for extubation, pending exams. I think it's very important for you to plan care throughout that day and that patient who demands more attention from you [...] (Enf_05)
> [...] Precisely so that we know the patients who are pending, the care we must have, the patients who have exams, the preparations for the exams. So, it interferes with care throughout the shift. It directs me, the patients who, for example, are more serious, I know what the conduct

> is when I am going to enter the patient, the approach that is made and the care of this patient, this is all passed on in Safety [...] (Enf_17)
> [...] It provides better conditions of care. At the time of Safety, I will discuss the difficulties I have, I will see my weaknesses that I have in the sector with that patient and then I will draw up a plan to improve the service. From the information I take from *Safety*, I will draw up a daily plan for the care of those patients. What does that patient need? Which test was not done? Why wasn't it done? What is the difficulty? So, it gives me elements that I have to act on to improve the conditions of care for my patient. […] (Enf_19)
> [...] Safety is the moment to externalize all these things, so that they start the shift in an organized way, know exactly where to focus more energy, where they need more attention, what to take into account, what was perhaps being ignored. Safety leaves this information more exposed to the team as a whole[...] (Enf_21)
> [...] In this case, Safety *Huddle* is still a tool that contributes a lot to the dynamics in relation to the shift. You do that brainstorming, where we can, at the beginning of the shift, encompass what our structural problems are and what are the demands that we will have during the shift. Define some conducts related to the immediate care and care of this patient and be able to recover some things from what happened in the previous shift to continue the care. […] (Enf_25)

However, some of the reports evidenced a perspective of lack of knowledge about the implications of the *Safety Huddle* tool, demonstrating the perception of a sense of purposeless execution on the part of other professionals, making the effectiveness of the instrument unfeasible. This situation is highlighted in the repetition that this would be a tool for checking pending exams and aligning the preparation of exams, with the dimensioning, lack of knowledge and the belief of irrelevance of the knowledge coming from the visualized tool being cited as a barrier to its efficiency by some professionals.

> [...] help in relation to exams, can put there which exams were not performed [...] (Enf_02)
> [...] Exam planning, especially [...] (Enf_03)
> [...] the main one is the dimensioning, lack of knowledge, belief in the irrelevance of knowledge [...] (Enf_23)

In summary, this class comprises perspectives that emphasize the *Safety Huddle* as a tool that helps the coordination of nursing care, conferring efficiency to the management of nursing care. The concept of care coordination reflects the idea of continuity and integrality of care actions over time (Magni; Fontana, 2024). In this sense, in the environment of an Intensive Care Unit, the need for systematized care is reinforced aiming at organizational efficiency and the promotion of patient safety (Silva *et al,* 2021).

Thus, it is highlighted that, imbued with their participation in the tool, in view of having the largest contingent of professionals working under its management and these professionals being the ones who have the longest direct and uninterrupted contact time with patients, nurses are evidenced as maintainers of the quality of care and safety culture (Lucchesi *et al.,* 2024). In this context, the *Safety Huddle* proves to be a crucial instrument in the collection of information and planning of nursing actions, so that such actions culminate in the continuity of care, minimize errors and promote patient recovery, making it possible to form safe and effective nursing care (Gomes *et al.*, 2024).

Regarding the barriers to the tool's efficiency, the "lack of knowledge" about the tool, the "belief in the irrelevance of knowledge" arising from the methodology and the "dimensioning" of human resources that affects the participation and applicability of the tool stand out. Safety culture is the product of values, both individual and group, comprising attitudes, perceptions, competencies, and patterns of behavior. Such components establish the commitment and proficiency of managing a safe and healthy organization (Costa *et al*, 2018).

In this sense, the search for quality and safety of care is possible through the development of a culture of safety through institutional commitment, in order to highlight the figure of the institution as a promoter of the necessary subsidies for the application and maintenance of instruments that enable the construction and promotion of a culture of patient safety (Afonso *et al*, 2019).

The scientific literature presents six subcultures that comprise the patient safety culture, namely: leadership, teamwork, evidence-based care, training, efficient communication, and patient-centricity (Brás; Ferreira, 2016). With regard to training, studies highlight that the variation in the care offered by intensive care nurses, resulting in a lack of homogeneity and systematization of the process, points to learning gaps in intensive care nurse training in Brazil (Gomes *et al.,* 2024).

In view of the above, it was observed that the compromise of patient safety and the effectiveness of clinical practice is related to the lack of knowledge of professionals, generating obstacles to the advancement of health technologies. Regarding dimensioning, the scientific literature shows that one of the greatest challenges for nursing managers is to ensure safe patient care actions, in order to consider the appropriate allocation of nursing staff in line with the patients' direct and indirect care needs. After all, the quality of nursing care is a high-impact factor for favorable outcomes and excellent results in clinical practice (Melo *et al,* 2020).

Although the results indicate that *the Safety Huddle* allows for more specific care planning and alerts to the needs of unstable patients, a critical concern emerges: the perception of some professionals that the tool is only used for the bureaucratic checking of pending exams. This "false checklist sense" threatens the essence of the methodology, which should focus on collective situational awareness and risk anticipation. The literature reinforces that when routines become mechanized and superficial, they fragment work and act as barriers to safety (Pradelli *et al.*, 2025). Therefore, the tool should be rescued as a space for care *brainstorming* and not just as a fulfillment of an administrative task.

3.2 CLASS 2: COMMITMENT OF THE MULTIPROFESSIONAL TEAM TO THE EFFICIENCY OF THE *SAFETY HUDDLE TOOL*

Class 2 represents 56 segments of texts, with 27.86% of the *corpus*. In this class, the terms "medical team", "physiotherapist", "nursing technician" and "responder" are repeated. The excerpts from the interviews reveal that only with the active participation of the multiprofessional team is it possible to confer effectiveness to the *Safety Huddle*. Some of the interviewees emphasize that, without the dynamics of building *Safety* through the commitment of the entire team, it becomes just an instrument with questions, which are not always answered successfully.

In addition, some fragments of the volunteers' speech highlight the perspective of a medical tool, needing to become a collective construction that gives voice and a sense of belonging to all professionals in the multiprofessional team. In addition, in some statements, the need for the participation of the nursing technician was reinforced, since this is the employee with the longest time working at the bedside.

> [...] Everyone should fill out the *Safety Huddle* with the data that is pertinent to their category. Physiotherapy fill out a script for them, medicine a script for them, so that everyone has to talk and show that they really researched, that they were at the bedside, that they really know what is going to be passed, that they really know the patient [...] (Enf_08)
> [...] The technician spends much more time with the patient than any other health professional, so the participation of the technician is very important, sometimes he was able to see things that the nurse did not see and that the doctor did not see [...] (Enf_19)
> [...] Once the employee becomes aware of all the problems or at least has a notion of everything that is involved in the care of that patient, integrating the assistance of the physiotherapist, the doctor, his own profession, the vision of another professional from the multiprofessional team, a speech therapist, psychologist or even spiritual, if he is aware that all this exists and is a professional involved, This will generate an extra motivation, an extra path, for him to have a critical thought about that patient, if he is going to do a certain procedure, stop doing it or do it more [...] (Enf_21)

The assertions about the adherence of the on-call physicians refer to the need for continuity of care information in the face of gaps in the transition of care revealed in the shift changes. Certain research subjects attribute to Safety *Huddle* the significance of being a methodology that makes it possible to fill these gaps in information in multiprofessional care, because it is a tool with contributions from various professional categories, aiming at caring for the individual in its entirety.

> [...] The main difficulty in adherence is for the on-call staff who are not here every day and when they receive it, they receive information from the day before or transition information, from one day to the next, and it turns out that there may be a lag during this transition of care in the shift change [...] (Enf_15)
> [...] Once the employee becomes aware of all the problems or at least has a notion of everything that is involved in the care of that patient, integrating the assistance of the physiotherapist, the doctor, his own profession, the vision of another professional from the multiprofessional team, a speech therapist, psychologist or even spiritual, if he is aware that all this exists and is a professional involved, This will generate an extra motivation, an extra path, for him to have a critical thought about that patient, if he is going to do a certain procedure, stop doing it or do it more [...] (Enf_21)

Inadequate human resource sizing was cited as a significant barrier. However, the discussion must go beyond lack of time; The "belief of irrelevance" and the "lack of knowledge" indicate a cultural resistance. The search for quality care depends on the development of a safety culture that is not punitive, but educational. The nurse, as a leader, must move from a supervisor posture to that of a permanent educator, using the tool to dispel misconceptions and promote mutual respect among the teams (Trochin; Melleiro; Mota, 2006).

The concept of a multidisciplinary health team refers to the collaboration of professionals with diverse backgrounds who work together, sharing responsibilities in the planning, execution, and evaluation of the care provided (Abrams *et al*., 2024; Pinho *et al,* 2025). Factors such as clear communication, leadership, a positive organizational climate, and an explicit definition of the scope of work are indispensable components of multidisciplinary practice. The absence of these elements compromises the coordination of actions, promotes work overload and generates implications for the efficiency of health interventions (Pradelli *et al.*, 2025).

A collaborative variable related to information sharing, established in a recent international study, discerns that the lack of confidence in the competence of the other categories undermines the principles of comprehensive care. This study points out that prejudices manifest themselves as role stereotypes and biases based on personal sympathies or secondary information, and such notions are shaped by generalizations or

informal judgments, in order to limit opportunities for collaboration and mutual respect (Pradelli *et al.*, 2025).

In addition, a scientific study highlights that the medical team is unaware of many aspects of the responsibilities and workflow of nurses in the units. In this sense, this research highlights that the *Safety Huddle* has the ability to dispel misconceptions between nursing and medical teams, promoting a favorable environment for safe care practice (Aldawood *et al*, 2020).

Thus, it should be noted that the recognition of the value of teamwork strengthens the sense of belonging on the part of health professionals, in order to foster mutual respect and improve team collaboration and resilience (Pradelli *et al*., 2025). Ratified by scientific publications, a tool efficiently executed by the multidisciplinary team has the ability to provide a reliable structure for communication and interprofessional action. This situation enables the engagement and co-responsibility of the professionals involved in care, which offers direct benefits for the patient's clinical outcomes and the well-being of the professionals. In this sense, multidisciplinary action should be understood as a dynamic process of cooperation that requires investment in interpersonal relationships, participatory management, and collaborative practices (Garcia *et al*., 2023).

A central finding of this study is the pressing need to include the nursing technician in the *Safety Huddle.* As he is the professional with the longest time of direct work at the bedside, his exclusion generates an "information vacuum" that compromises security. The active participation of all categories, including physiotherapists and physicians, is what gives the instrument real effectiveness. Without this collective commitment, it becomes a "voiceless instrument", where questions remain unanswered and the team's sense of belonging is weakened (Garcia *et al*, 2023). In this sense, for the Safety Huddle to reach its maximum potential, it is recommended to formalize protocols that guarantee the active voice of the nursing technician and the regularity of multiprofessional meetings. Institutionally, it is necessary to invest in permanent education strategies that combat "protocol fatigue" and reinforce the value of situational awareness.

In addition, the scientific literature certifies that the applicability of strategies with active methodologies occurs with resoluteness when applied with monthly meetings with the care team to analyze the results. In this way, the continuity of positive results is stimulated and negative results are discussed with the team, aiming at structuring new improvement strategies to be tested. Such meetings encourage the participation of employees in the institution's change process, thus contributing to the quality of care and patient safety (Henrique *et al*, 2025).

3.3 CLASS 3: HEALTH RISK MANAGEMENT THROUGH SAFETY HUDDLE

Class 3 contains 39 segments of texts, with 19.4% of the *corpus.* In this class, the centrality of the terms "care", "assistance", "risk", and "process" is reflected. A perspective is observed in the reports that emphasizes the importance of the tool in the management of potential problems, prevention of complications, improvement in the management of complications, maintenance of efficient communication, understanding and updates regarding the clinical status of patients, prevention of care risks, opportunities for improvement in the work process and reduction of infections.

The reflections guided by nurses working in intensive care units demonstrate their role in risk management. The characterization of the *Safety Huddle* as an anticipation strategy highlights its potential as a tool to promote patient safety, directly impacting the quality of care. In addition, certain statements reinforce the need for the tool to become a cultural process, not being mechanized, designating for this purpose, the need for training the employees of the multiprofessional team in the use of the methodology.

> [...] Everyone is informed about what is happening about the patient. Each one has the same information, but takes the most important point for their professional category [...] (Enf_07)
> [...] reduce the chance of infection in that patient. So, the removal of invasive devices is very important to avoid infection, the more devices we take from that patient, the better we get from that patient. Because, in this case, the goals that we will have throughout the day are addressed and we will treat the patient based on what was treated, such as: we will remove the probe, change of decubitus, evaluate the lesion in that patient more [...] (Enf_12)
> [...] We can also control our care to provide the patient with care that does not bring greater risks to him [...] (Enf_15)
> [...] When you understand the scenario in which you are going to act in those 12 hours, you can prevent, elaborate and understand what the demands are, what are the processes and results that you need to achieve within those 12 hours [...] (Enf_18)
> [...] It would improve the training process, I think that first of all not to mechanize the team but to make it a cultural process [...] (Enf_25)
> [...] understand that there will be problems and situations that can be anticipated and these situations that we can bring opportunities for corrections so that the outcome does not have so much impact on the patient's life and clinical prognosis [...] (Enf_29)

In intensive care units, the risk of acquiring healthcare-associated infections (HAIs) is aggravated due to the characteristics of the critically ill patient, due to metabolic alterations, immunosuppression, and the use of invasive devices. However, the literature shows that even in possession of knowledge about prevention measures anchored in the best evidence, health professionals do not adhere to the conformity of good practices. This is a critical scenario in acute care settings, where rapid decision-making is essential (Henrique *et al*, 2025).

In this sense, risk management is highlighted. This consists of the systematic application of procedures, conducts, and resources in order to identify, control, and evaluate risks and adverse events (AEs). In this way, it seeks to mitigate conjunctures that affect the safety of patients, the integrity of health professionals and, consequently, the image of the institution. To this end, the inclusion of strategic planning, quick decision-making, and a proactive posture in the face of stipulated strategies is demonstrated (Dallacosta *et al*, 2023).

In this context, the nurse stands out as the main author in the risk management process. Given that this professional is responsible for the implementation and implementation of actions that aim at patient safety through the evaluation of the care provided, health education, and the incorporation of instruments that promote the quality of the care offered (Lara *et al*, 2021). In addition, education and continuous training are vital components in nursing education, emphasizing the need for attentive and evidence-based practice (Silva; Diaz, 2024).

Given the scenario, the role of the *Safety Huddle* in effective communication is highlighted, which occurs when health employees receive, filter, organize and choose the appropriate channel to transmit the message completely and accurately, delimiting assertive conducts of passing on, receiving and understanding information clearly. This tool proves relevant because it promotes this type of communication between teams. The methodology instigates discussion on issues pertinent to safe care, in order to provide decision-making, improving the care process and anticipating errors (Moraes *et al*, 2023).

Scientific evidence relates *Huddles* to improvements in the quality of information exchange, efficiency, responsibility, individual qualification, and sense of collectivity. In this way, there is the promotion of a culture of cooperation that favors collective situational awareness and fosters a culture of security (Moraes *et al,* 2023). Thus, it is an environment that promotes the improvement of care coordination and rapid decision-making, in order to ensure the continuity of care and the therapy adopted, which is essential in acute care environments, especially for the prevention and mitigation of adverse events (Pradelli *et al*, 2025; Torrente *et al,* 2024).

However, when these routines become too rigid, they lead to fragmentation of work between different professional categories. This scenario makes care practices mechanized and superficial, acting as a barrier to problem-solving and effective teamwork. In view of the above, a caveat is made that a multidisciplinary team routine must be consolidated, stable and shared, which facilitates the management of risk interventions, promoting coordinated actions and clear delimitation of functions, directly impacting the quality of care and, therefore, patient safety (Pradelli *et al.*, 2025).

3.4 CLASS 4: THE NURSE'S LEADERSHIP IN THE ICU FOR MAINTENANCE AND APPLICABILITY OF THE SAFETY HUDDLE TOOL

Class 4 is composed of 58 segments of texts, with 28.86% of the *corpus*. In this class, the terms "participate", "knowledge", "nurse" and "leadership" are highlighted. Such lexical contents include testimonies that express the multifaceted role of nurses in the *Safety Huddle,* given their role as an encourager, applicator, feeder and supervisor of the instrument. The excerpts from the participants' speeches emphasize the role of leadership in maintaining the methodology, good structuring and application, and in the participation and engagement of the team with the tool. In addition, the linking of leadership to knowledge and problem-solving capacity is highlighted.

> [...] The nurse is a key player in the multiprofessional team, being a leader of both the technical team, but also a great leader in the Multiprofessional Team, being important in decision-making and in the discussion of clinical cases [...] I can only have leadership, work in the sector, be a team member who is really resolute, when I have knowledge [...] (Enf_18)
> [...] It is up to the Nurse to guide and adapt his team, make a schedule so that he is not overloaded or elect a person who has more aptitude and wants to participate playing a role of propagator, leaving all the others aware and oriented about all that [...] (Enf_23)
> [...] The role of the nurse, as in other situations, is a leadership role. He is the great protagonist of *Safety,* he is the one who organizes, questions the data, collects the information and makes the trials so that the right answers are raised. Without a nurse to do this interview, direct the questions, ask the professionals, build the line of reasoning of the questions in an appropriate way [...] 99% of the time, the great protagonist for Safety to happen and have positive developments is linked to the figure of the Nurse [...] (Enf_29)

High complexity units require a high level of coordination and interprofessional communication. In this sense, the literature highlights the systematic use of the *Safety Huddle* as a tool that creates an equitable environment in which the team can actively discuss (Aldawood *et al,* 2020). In addition, scientific studies show the role of leadership in the effective performance of the multidisciplinary team. This role is played by a recognized and respected professional, given his or her skills and decision-making skills (Pradelli *et al.*, 2025).

The word competence refers to the ability to apply specific knowledge, skills, attitudes and values, aiming at a certain standard of performance required by a specific context (Aguiar *et al*, 2012). Given the aforementioned situation, the figure of the high-performance leader stands out as an essential component of the multidisciplinary team in an intensive care unit. This is configured in practices such as the perpetuation of the culture of transparency,

employee motivation, enhancement of professional maturity, and the preparation of constructive feedback to employees (Dallacosta *et al*, 2023).

In this way, a formal and authentic leader provides the team with clear direction and ensures that roles and responsibilities are well defined. Authentic leaders build trust, promote efficient communication, and favor the professional growth of their teams. Formal leaders provide the formation of technical and professional skills among employees, in order to recognize motivated and satisfied professionals as those who contribute to better patient care and greater team cohesion (Pradelli *et al.*, 2025).

In this context, it should be noted that nursing professionals characterize a significant portion of human resources in hospitals and, therefore, are directly related to the effectiveness, quality and cost of health care provided. That said, the promotion of competencies among these professionals reflects on the results obtained in health care (Moraes; Rodrigues, 2021).

In this sense, the literature highlights that among the individual variables of motivation, there are external and internal factors. External ones include recognition, professional development opportunities, financial incentives, and organizational support. These are motivating elements that encourage active participation and increase job satisfaction. The interns are determined as intrinsic factors, those that stimulate professional growth and drive the sense of commitment to patient care and the desire to achieve common goals of the multiprofessional team. These are components that favor engagement and resilience, which stands out especially in high-pressure environments, such as the acute care area (Pradelli *et al.*, 2025).

In view of this, the intensive care nurse professional stands out. Among their competencies certified in literature, they have: technical-scientific knowledge, teamwork, decision-making, nursing care management, human and material resource management, care performance, efficient communication, team training and humanization (Kremer; Chagas; Souza, 2023; Moraes; Rodrigues, 2021). Competencies that comprise observation skills, clinical judgment capacity, and critical thinking in the face of critical patients in highly complex environments (Perin *et al,* 2023). Thus, their leadership proves to be an essential condition for teamwork in intensive care units (Moraes; Rodrigues, 2021).

In view of these attributions and competencies, intensive care nurses have a primary role in the maintenance and applicability of tools related to improving care. This is because this professional has the power to add value and knowledge to professional practices, given his potential as a health educator. This potential occurs in the act of teaching through the creation of conditions for the critical construction of knowledge through the individual (Freire,

1996). Such mastery favors the team to perceive in their duties a motivation, so as to want to participate, associating the tool with the safe, efficient and problem-solving care process, according to the execution and supervision of their leadership.

4 CONCLUSION

The active Safety *Huddle* methodology provides a global view of complications, mapping of pending issues, risk management and updates of the clinical status of patients at the beginning of the shift. Thus, nurses are provided with an overview for planning and coordinating activities relevant to the care process, making it safe and effective. Thus, this tool is established as an efficient intervention model that strengthens the coordination of nursing care for critically ill patients in intensive care units.

Data analysis revealed that the *Safety Huddle* is perceived by nurses as the foundation for safe care in ICUs. However, the effectiveness of this tool is not automatic; It emerges from a complex web that involves leadership, organizational culture, and multiprofessional engagement.

In this sense, the results demonstrate interrelated, interdependent and recurrent categories. Thus, demonstrating that the *Safety Huddle* has its effectiveness based on the commitment and engagement of the multiprofessional team, a context that is directly linked to the effective leadership of the nursing professional, the sense of collectivity of the multidisciplinary team and the patient safety culture established by the institution. In this way, the tool generates significant impacts that demonstrate its problem-solving capacity and reverberate in better clinical outcomes for clients.

In addition, the active methodology, based on the figure of the nursing professional as care manager, proves to be capable of generating learning and knowledge that result in transformations that have the potential to add quality to care practice. The findings demonstrate that the tool should not be seen in isolation, but as a care management device that favors the anticipation of adverse events and the integration of the multiprofessional team. The role of the nurse stands out as a key piece in this mechanism, being the leader responsible for transforming the *Huddle* into a moment of collective learning and not a mere documentary formality.

In the scenario exposed, the need for nursing empowerment through knowledge, whether technical or behavioral skills, was demonstrated. The work of nurses in high-complexity units requires professional qualification beyond professional training, observation, clinical judgment, critical thinking, and, therefore, precision in intensive care. In this way, the

objective is to have a voice and give voice to its category, being under the command of a team that aims at high performance.

Furthermore, it should be noted that this study reflects the qualitative perception of professionals in a specific unit. Therefore, it is suggested that future research adopt quantitative approaches to measure the direct impact of *Safety Huddle* on the reduction of infection rates and other indicators of adverse events, ratifying evidence on its clinical efficacy in the Brazilian scenario.

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