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Feasibility and Implementation of a Daily Safety Brief at a Children's Hospital-in-a-hospital

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Background

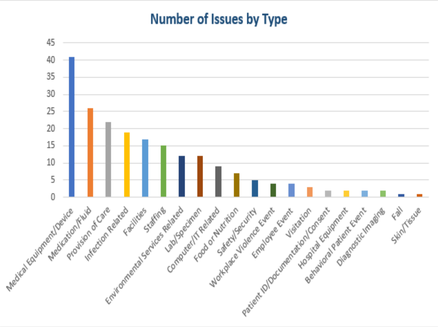
The daily safety brief (DSB) has been implemented in many free-standing children's hospitals,[1,2] that participate in Solutions for Patient Safety (SPS) but its implementation in a children's "hospital-in-a-hospital" has not been well-described. The DSB is a time-limited meeting focused on patient safety and daily readiness,[3] described as a face-to-face meeting with available remote participation.[4] All departments/units involved in delivering care to the children's hospital report recent safety events, potential near-future safety concerns, and provide status updates affecting safety or operations.[5]

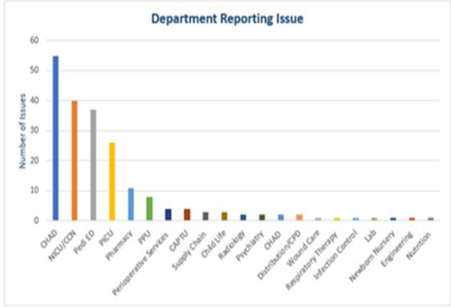
Objective

To implement a 15-minute DSB at a children's hospital-in-a-hospital while tracking initial trends in daily metrics of departments originating safety concerns, types of safety concerns, and number of safety concerns.

Methodology

After completing the SPS Culture Wave, a gap was identified: the absence of a DSB. Subsequently, we identified sponsors, organized stakeholders, and attended SPS leadership methods training. A focus group was created to develop, organize, and train departments. An invitation from the Chair of Pediatrics was sent to involved departments and units, a logo was created for branding, and a template was created for structure that included staffing, bed capacity, rapid response team/code blue/code yellow (security event) pages, employee safety, patient safety events, high-risk therapies/procedures, family concerns, restraints, equipment, drug shortages, and other events increasing chance for errors.





Results

Over the initial 4.5 months of implementation, inpatient units (acute care unit, NICU/CCN, PICU) and the pediatric ED brought forth the most concerns. The largest number of concerns were classified as being related to medical equipment/devices, medication/fluids, and provision of care (Fig. 1). Inpatient units/ED brought forth the most concerns (Fig. 2). The number of safety concerns decreased from a 7-day average of 6.0 at the start of implementation to 1.7 at the conclusion of data collection, with an overall average of 2.7/day.

Conclusion

DSB implementation is feasible in a children's hospital-in-a-hospital, where many reporting departments are not pediatric-focused. Safety concerns were typically related to medical equipment/devices and originated from patient care units. Challenges included keeping to time constraints and refocusing back to DSB structure while diverting larger scale issues to alternative venues. Short-term gains identified included improved situational awareness, allocation of material and personnel resources, and timely resolution of safety concerns. These gains were valuable during the concurrent pandemic, as a team approach with shared resources was critical. Trends in the safety concern reporting will require further investigation to elucidate the reasons behind these trends. Further improvements based on QI methodology are planned for the future.

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