Journey to High Reliability:  
Implementing a Daily Safety Brief at CHS Union  

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Patient Safety

Introduction

The Daily Safety Brief is a deliberate, intentional, purposeful report and conversation among leaders about safety events and potential safety risks. It is a brief between the senior leader and direct reports at the start of each day to maintain awareness of operations and to give direction about priorities and responsibility for problem resolution. The Daily Safety Brief is utilized to assign resources for appropriate follow up on events that have occurred or potential events that may occur to reduce the risk of harm to patients, families, caregivers, visitors, and teammates.

Why do we use it?
Evidence from established High Reliability Organizations (HRO’s) such as the nuclear power and aviation industries has consistently shown that implementation of a Daily Safety Brief is one of the most meaningful ways to change the safety culture in an organization. It is recognized as a key strategy to achieving operational excellence, not only in the Quality and Safety space but also in Teammate Engagement, Efficiency, and Patient Experience. It can help increase Teammate Engagement for both leaders and teammates because it provides a safe place for leaders to report problems or safety concerns identified by their teams within their departments, ask for assistance in solving those problems, and report back ideas and solutions to their teams. Leaders no longer “operate in silos” because the Daily Safety Brief creates a shared awareness of other departments’ activities and concerns and other department leaders often offer help before it is requested. It also serves as a tool to promote accountability for safety between the senior leader and the direct report which is vital to resolving problems quickly, especially when barriers are encountered. As problems get resolved and solutions are shared back to teammates, leader engagement grows as they no longer feel “on their own” to solve complex problems and teammate engagement grows as they see problems they may have reported getting corrected, leading to more efficient processes. More efficient, highly reliable processes lead to a better patient experience and ultimately, better outcomes for patients. Our objective has always been to create a safe environment for patients, families, visitors, teammates, physicians, volunteers, and others.

Logistics

- 15 Minute Call, 9:45AM Daily M-F
- Led by Senior Leader, Usually CNE
- All Department leaders expected to report
- Preparation for report occurs 7-9AM using MDI huddles, rounds on teammates, or email.
- Structured Report Out with direct patient care leaders reporting first to keep focus on operations.
- Patient Safety “Coach” reporting last to serve as a “catch all” for events department leaders may not have reported

Tools

- Department Pocket Cards- Department specific pocket cards to assist leaders with identifying types of events specific to their units to report out
- Senior Leader Pocket Card- provides questions to ask during Daily Safety Brief and additional general guidance

Keys to Success

- Senior Leader facilitating call –authority to make decisions, allocate resources, and delegate responsibility.
- Mandatory Department Leader Participation- All department leaders (managers or directors only) required to participate 90% of time and send a department representative if unable to attend (clinical supervisor only on occasion)
- Structured Report Out -to keep brief short
  - Look Back- problems last 24 hours
  - Look Ahead- Anticipated problems in next 24 hours
  - Follow Up on Start-the-Clock Critical Safety Issues
  - New Start-the-Clock Critical Safety Issues
- Patient Safety Coach- Reviews all CareEvents submitted in previous 24 hours and reports any that were not reported by department leader at end of call. 1:1 coaching with leaders on missed opportunities for reporting.

Outcome

Goal One: Steady increase in Significant Event Reporting Percentage.
- Significant Event Reporting Percentage = number of CareEvents received per department per day, adjusted to remove events considered trend monitoring (IV infiltrations, leaky specimen containers, etc.) compared to number of events reported by the department on the Daily Safety Brief. Indicates increasing trust in Daily Safety Brief process.

Goal Two: Steady increase in CareEvent Reporting Rate
- CareEvent Reporting Rate = total number of CareEvents in the measured month calculated per 1,000 adjusted patient days.

Goal Three: Steady increase in Good Catch Nomination Rate
- Good Catch Nomination Rate= total number of Good Catch Nominations in the measured month calculated per 1,000 adjusted patient days. Dip to baseline in April corresponding to system trend but back up in May.

Goal Two and Three indicates growing accountability for safety amongst Leaders and Teammates.

As of March 2018, a Daily Safety Brief was implemented in 50% of hospitals within Atrium Health and another 20% in progress. The CHS Union Leadership team becoming such a strong advocate for the Daily Safety Brief to their peers, speaking to the benefits of implementation of a Daily Safety Brief and allowing others across the system to listen in on their calls have been key in the fast spread and adoption of the Daily Safety Brief as a best practice across Atrium Health.

Contact Info

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