QuickSafety
An advisory on safety & quality issues

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Daily safety briefings — a hallmark of high reliability

Issue:

A daily safety briefing is one of the hallmarks of high reliability organizations (HROs), which operate under continuously trying conditions, yet have fewer than their fair share of major incidents.[1] Also called safety huddles, daily check-ins or daily safety calls, these daily meetings are applicable to health care organizations, where they are used to give frontline staff and organization leadership the opportunity to stay informed and aware.

The briefing is a short, (15-minute) stand-up meeting to share issues that occurred in the last 24 hours, anticipate adverse conditions or disruptions in the next 24 hours, and review the steps taken to resolve previously identified issues or resources assigned to correct newly identified issues.

What is a daily safety briefing?

The briefing is a short, (15-minute) stand-up meeting to:

- Share issues that occurred in the last 24 hours
- Anticipate adverse conditions or disruptions in the next 24 hours
- Review the steps taken to resolve previously identified issues
- Review resources assigned to correct newly identified issues

Since the publication of the Institute of Medicine report (IOM) *To Err is Human* in 2000, health care organizations have been seeking solutions to reduce medical errors and improve patient safety through safer health system design.[2] A 2003 IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, further specified that health care should adopt practices from other industries that share the complexity inherent in health care. Such industries include nuclear power, chemical processing and aviation.[3]

Briefings are frequently used in HROs to help address the five key principles of high reliability by Weick and Sutcliffe:[1]

- The opportunity to share unexpected events (preoccupation with failure)
- Providing multiple perspectives and levels of experience in addressing issues (reluctance to simplify)
- Continual awareness of the stress levels within the organization (sensitivity to operations)
- Quickly addressing the issues that are brought up (commitment to resilience)
- Frontline staff frequently have a good sense of what needs to be done, but sometimes do not have the resources to accomplish these remedies (deference to expertise)[4]

Benefits of daily safety briefings

There are numerous benefits to conducting daily safety briefings — both at the organization level and at the unit or department level. Most significantly, senior leaders demonstrate commitment to reducing patient harm and increasing safety when they promote and support daily briefings. At the organization level, daily safety briefings:

- Are valuable in identifying close calls and proactively identifying hazards and unsafe conditions
- Improve patient safety[5-7]
- Promote safety culture
- Help to create vigilant teams
- Improve team dynamics[5-7]
- Alert staff to concerns or issues, such as equipment failures

(Cont.)

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- Make others aware of potentially adverse patient outcomes, such as falls, near misses and medication errors

In addition, if done consistently, unit- or department-level briefings serve to channel information up to an organization-level briefing, so that information flows up and down the chain of command.

Success story from a health system
At AnMed Health, 64 clinical and operational areas across the system participate in a 15-minute secure conference call with the CEO and other top executives at 8:30 a.m. each day. In addition to the usual participants, board members have a standing invitation to participate in the calls, further emphasizing the system's top-to-bottom approach to safety culture.

AnMed Health has two acute care facilities located about 2.5 miles from each other, as well as 65 physician practices. Call participants represent every area within the system that has a potential impact on patient or worker safety. Many of these units gather in daily huddles at 8 a.m. to discuss safety issues and prepare for the system-wide daily operations briefing.

After each daily briefing, a team of 15 to 20 individuals debrief and decide how to further investigate or involve themselves or others in resolving the issues that have been identified. Recently, a briefing created awareness that 130 patients with the same or similar name as another patient were receiving care. This situation caused AnMed Health to issue a name alert process, which triggers protocols designed to prevent a mistaken identity and potential adverse event.

Among the tangible benefits created by the daily operations briefings at AnMed Health is a significantly reduced *C. difficile* infection rate – down 44% from its highest rate. The briefings also have helped AnMed Health to better manage situations, such as high patient volumes and flu outbreaks. One CEO from another organization who was invited to call into AnMed Health's daily briefing remarked, "I now know more about their hospital than I do mine."

Safety Actions to Consider:

Health care organizations can promote immediate, real-time identification of adverse events and unsafe conditions and spread awareness and understanding of these issues by committing to and adopting daily safety briefings.

- ***Determine who will be involved*:** Every department and unit within the organization should participate, both clinical and operational. One representative who can quickly report on current issues and anticipated issues can attend via telephone or in person.
- ***Establish when and how often the briefing will occur*:** It should occur at a standing time and, initially, be held Monday through Friday, later expanding to seven days a week. A typical time to hold the briefing is 9 a.m.
- ***Decide who will lead the briefing*:** Organizations, such as Cincinnati Children's, the Veterans Affairs Ann Arbor Healthcare System (VAAAHS), and AnMed Health, have adopted various approaches to these briefings. The meeting might be facilitated by the Patient Safety Department leader, the Patient Safety Officer of the Day, or the CEO.[8-10]
- ***Identify how people will participate*:** Some organizations conduct the organizational level briefing solely by telephone, with only the leaders of the call in the same room together.[8-10] Others request that all available staff report to a central 'command' location, if possible, while others from off-campus locations can call in. The point is to make it as easy as possible to facilitate communication.
- ***Determine what will be shared*:** It is frequently helpful to develop a tool or outline to help guide the briefing. Over time, this structure may need additional modification as staff become used to this method of communication and seek to be more efficient. In addition, it is useful to have a set

order of reporting and have this detailed on a template, so that those calling in can follow along. A simple outline can list[9] prompts, such as:
  - Look back: Review significant safety or quality issues from the past 24 hours
    - Patient level: injuries, delays, falls, medication errors
    - Employee level: slips/trips/falls, infectious exposures, assaults
  - Look ahead: Anticipate safety or quality issues in the next 24 hours
    - Anything new that could create an error—new procedures, new equipment, short supplies of equipment, planned downtime of systems, such as the electronic health record (EHR) or overhead paging system
    - Existing concerns—currently non-operational equipment (such as MRI scanners or elevators), weather issues, social safety, staff deficiencies
  - Follow up on previously reported issues—person assigned responsibility reports on progress and anticipated closure
- ***Develop a robust follow-up process:*** The objective of the process is to raise awareness and to facilitate improvement. If leadership fails to institute a robust follow-up methodology to address issues raised during the briefing, trust will be lost and safety culture will take a backward step. Staff are more willing to report things if they see such reports acted upon.[11] After the briefing, a select team of leaders can debrief and decide who will take on accountability to address issues identified. This may require further investigation of the issue or it may be a decision to 'just do it.' System issues, such as repeated IV pump failures, might require additional information prior to addressing, while a weather alert might require immediate planning and action.
- ***Organizations initiating this process should commit to continue this practice for at least six months***: The benefits of this process may not always be apparent at the beginning, and managing the change and scheduling challenges may be overwhelming or discouraging at first. For this reason, leadership commitment is crucial in getting started. Persistence, however, will pay off by improving risk identification and increasing the organization's proactive approach to risk reduction.

Resources:

1. Weick KE, Sutcliffe KM. *Managing the Unexpected,* 2nd ed. San Francisco: Jossey-Bass, 2007.
2. Institute of Medicine. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academies Press, 2000.
3. Institute of Medicine. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: National Academies Press, 2003.
4. Goldenhar LM, Brady PW, Sutcliffe KM, Muething SE. Huddling for high reliability and situation awareness. *BMJ Quality & Safety,* 2013; 22:899-906.
5. Edelson DP, Litzinger B, Arora V, *et al.* Improving in-hospital cardiac arrest process and outcomes with performance debriefing. *Archives of Internal Medicine,* 2008;168:1063-1069.
6. Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *Quality & Safety in Health Care,* 2004; 13(Suppl 1):i85-90.
7. Makary M, Mukherjee A, Sexton J, *et al.* Operating room briefings and wrong-site surgery. *Journal of the American College of Surgeons,* 2007;204:236-243.
8. Morvay S, Lewe D, *et al.* Medication event huddles: a tool for reducing adverse drug events. *The Joint Commission Journal on Quality and Patient Safety,* 2014;40(1):39-45.
9. Paterson C, Miller K, *et al.* The safe day call: reducing silos in health care through frontline risk assessment. *The Joint Commission Journal on Quality and Patient Safety,* 2014;40(10):476-480.
10. Health Facilities Management. Daily briefing puts safety first for staff, patients. *Upfront.* 2012.
11. Chassin MR, Loeb JM. High-reliability health care: getting there from here. *Milbank Quarterly* 2013;91(3):459-90.

Additional resources:

- Shaikh U. Improving Patient Safety and Team Communication through Daily Huddles. Agency for Healthcare Research and Quality, Patient Safety Network. Jan. 29, 2020.
- Institute for Healthcare Improvement. Safety Briefings Tool (2004).

Note: This is not an all-inclusive list.

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