## Perceived Value of the Daily Safety Briefing

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#### **EXECUTIVE SUMMARY**

A hospital-level daily safety briefing (DSB) is a time for leaders to come together and address recent and upcoming safety challenges in the hospital. As tools to facilitate communication and teamwork, DSBs are important, but their value has not been extensively studied. We studied the value of the DSB by means of a prospective written survey of participants of the DSB at an urban academic medical center. Participants were unit managers, directors, vice presidents, and various other hospital leaders.

Ninety-seven of 114 participants completed the survey (85%). Of all the activities rated, preprocedural time-outs had the highest rating in terms of impact on patient safety (4.87  $\pm$  0.50 on 5-point Likert scale). The DSB had a rating (4.44  $\pm$  0.77) that was on par with The Joint Commission accreditation activities (4.47  $\pm$  0.68) and higher than use of the Morse Fall Scale (4.10  $\pm$  0.83). Overall, 95% of the participants felt that a DSB was an effective use of participants' time. The top two benefits of the DSB were keeping patient safety a focal point in the organization (4.54  $\pm$  0.74) and increasing awareness about patient safety issues (4.52  $\pm$  0.93).

We conclude that the DSB improves communication among team members and is a valuable use of healthcare leaders' time.

For more information about the concepts in this article, contact Dr. Pham at jpham@queens.org. The authors declare no conflicts of interest. © 2019 Foundation of the American College of Healthcare Executives DOI: 10.1097/JHM-D-17-00198

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#### INTRODUCTION

Briefings are an essential tool for facilitating communication and teamwork, especially in fast-paced and complex environments. Their value can be seen in a variety of industries such as sports (e.g., football huddles, timeouts), airlines (preflight checks), and the military (premission briefings). They are an invaluable tool of high-reliability organizations (HRO) when they are performed around safety at the start of each day (Stockmeier & Clapper, 2011). HROs are those that have succeeded in avoiding catastrophes in an environment where normal accidents can be expected as results of risk factors and complexity (Weick & Sutcliffe, 2011).

One manifestation of this in healthcare is the daily safety briefing (DSB) (Aulisio, 2015; Goldenhar, Brady, Sutcliffe, & Muething, 2013). The concept is to bring together leaders in the organization for a brief period at the start of each day to discuss the patient safety issues that have occurred over the previous 24 hours and to discuss issues for the day ahead. Other names and variations on this concept include "safety huddle" (Hall, Hicks, & Chamberlain, 2015), "AM briefing," or "daily check-in" (Jones, Krupa, & Scott, 2014; Stockmeier & Clapper, 2011).

Although this practice makes sense conceptually and is advocated by a variety of organizations including the Washington State Hospital Association and the Institute for Healthcare Improvement (Wagner, Theel, & Handel, 2015), it can be time-consuming. Drawing organizational leaders away from their work areas and primary responsibilities might be a distracting, inefficient use of their time. Moreover, it is unclear if leaders find value in these briefings. The purpose of this study was to assess the value of the DSB in an absolute sense and in relationship to other patient safety activities performed at the hospital. Additionally, we explored the facets of the DSB that respondents found most valuable.

#### METHODS

We performed a prospective written survey of DSB participants at The Queen's Medical Center, an urban 535-bed acute care hospital. Participants were unit managers, directors, vice presidents, and various other hospital leaders. The DSB at the academic medical center consists of a 15-minute meeting among leaders at 8:45 a.m. Monday through Friday. The DSB has been conducted at the organization since June 2012. The meeting is attended in person in a centralized location. Departments (> 60) represented include all clinical units, risk management, biomedical engineering, facilities, environmental services, pharmacy, quality and patient safety, security, information technology, and others. A vice president (usually the vice president of medical affairs) calls out each unit using a standardized template (Figure 1). Each unit leader shares any issues and needs that arose in the past 24 hours and any anticipated issues. At the end of each unit's report, another vice president (usually the chief nursing officer) summarizes the top issues within the organization and shares a "patient safety message" for the day.

We developed a 28-question survey to assess the value of the DSB, both in absolute terms ("The DSB improves patient safety") and in comparison to other common patient safety practices (e.g., hand hygiene, preprocedural time-outs). Parking and volunteer services were included as

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#### FIGURE 1 Daily Safety Briefing Sheet

	NS 4 Sale		DAILY SAFETY BRIEF				
Dat	e:						
٥	Census:						
	Days since last <u>Potential</u> Seriou Days since last Staff Injury:	s Sa	nfety Event:				
Pat	atient Safety Message: Tool #2: Clear Communications: SBAR, 3 way repeat back, ask clarifying questions, phonetic & numeric clarification.						
	<u>Unit/Departm</u>	ient	Check in:	Star	ndard Report Format: (10 seconds each)		
0	Emergency Department		Physicians	1.	This is ( <u>name</u> ) reporting for ( <u>unit</u> or <u>department</u> )	).	
	Acute Hernodialysis Pauahi 7 Pauahi 6 Pauahi 4 Towor 10 L&D/PP/NSV		Crisis Nurses & Staffing Transplant Diabetes Ed Center Lab-Clinical (DLS) Pathology	2.	Report Significant events in last 24 hours (example: Serious safety events, safety events that r resulted in minimal harm or no harm, Near Miss event Significant event reports, med errors and what they significant patient/family concerns)	eached the ents, Good are, equip	patient & Catches, ment failure,
0	Tower 9 Ewa / Iolani 2 Tower 9 DH	0	Respiratory Therapy OT/PT/ST	3.	Report only Codes, RRT, left AMA only IF Needs for today	a problen	n
	Tower 8 Tower 7 Tower 6 & 3	0	Social Work Case Management	4.	Significant events anticipated in next 24 hours		
	Tower 5& 4D Tower 4M Tower 4C	Ц П П	Transfer Call Center Patient Relations Volunteers	5.	End with: "End of report"		
0	Kekela Family Treatment Center Hale Pulama Mau		Pharmacy Environmental Services	Leader Summary:			
	Operating Room PACU, Kinau 3, Kamehameha		<ul> <li>Food &amp; Nutritional Svs</li> <li>Central Transport Svs</li> <li>Housekeeping</li> </ul>	1.	Follow-up of top 3 -4 "Hot List" Items		
	4, Endo Same Day Surgery Kamehameha 3		Central Distribution Biomed	2.	Plan /Challenge for the Day (Surg, surveyors, drills	etc.)	
	Urology Cancer Center		Facilities Security	3.	Special Announcements		
	Radiation Therapy Colon Screening Program	0	CareLink IT	4.	Be safe message		
	Infusion Center		Infection Control	Summary of top significant issues/Follow-up Hot List:			
	Trauma Services Women's Health Center	0	Risk Management Quality & Patient Safety		What	Who	When
	Wound Center Queen Emma Clinic Dental Clinic			1.			
	Sleep Lab Cardiac Invasive/CRU Cardiac Non Invasive			2.			
U	Carulac Non Invasive			3.			

Source. The Queen's Medical Center.

reference points ("anchors") for activities that would not be expected to affect patient safety. Furthermore, the survey explored what specific value the DSB brings toward improving patient safety. The survey was developed by one physician and three clinical nurse process improvement coordinators based upon review of the literature.

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Over the course of three meetings, the questions were identified and refined and were later selected.

The survey was administered at the beginning of the DSB over 1 week (September 27–October 4, 2016). On average, survey completion required fewer than 5 minutes. Participants were given a piece of candy for their participation. To evaluate the varying perceptions of the DSB, according to demographics, we performed subgroup analyses looking at sex, work area, and presence in the organization before versus after DSB implementation. A *p* value of < .05 was considered statistically significant.

#### RESULTS

The completed survey was received from 97 of 114 possible participants (85%). Overall, most of the participants were female (71%). Most were managers (52%) from areas with direct clinical care (47%). About half the participants worked in the organization before the DSB began (56%), while about half did not (Table 1).

# TABLE 1 Daily Safety Briefing Participant Demographics

	<i>N</i> = 97
Sex (female)*	71% (69)
Male	27% (26)
Missing	2% (2)
Years in current position	
0–6 months	7% (7)
6 months–year	13% (13)
1 year–2 years	20% (19)
2 years–5 years	24% (23)
5 years–10 years	13% (13)
> 10 years	23% (22)
Role	
Manager	52% (50)
Director	12% (12)
Physician/advanced practice registered nurse/pharmacist	6.2% (6)
Vice president	5% (5)
Coordinator	5% (5)
Staff	4% (4)
Other	15.5% (15)
Work area	
Direct clinical care	47% (46)
Indirect clinical care	30% (29)
No clinical care	23% (22)
In leadership role at this organization since daily safety briefings began?	
Yes	56% (54)
No	44% (43)

\*Two missing responses.

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Of all the activities rated, preprocedural time-outs had the highest rating in terms of impact on patient safety (4.87  $\pm$  0.50 on 5-point Likert scale) (Table 2). Parking services had the lowest rating (3.70  $\pm$  1.03), as would be anticipated of an anchor element not expected to affect patient safety. The DSB had a rating (4.44  $\pm$  0.77) that was on par with The Joint Commission accreditation

activities  $(4.47 \pm 0.68)$  and higher than use of the Morse Fall Scale  $(4.10 \pm 0.83)$ . Overall, 95% of participants felt the DSB was an effective use of everyone's time.

The top two benefits of the DSB were keeping patient safety a focal point in the organization ( $4.54 \pm 0.74$  on a 5-point Likert scale) and increasing awareness about patient safety issues ( $4.52 \pm 0.93$ ) (Table 3).

### TABLE 2

Value of Daily Safety Briefing Compared to Other Patient Safety Activities

		$Mean \pm SD$ $N = 97$	p Value
1.	Preprocedural time-outs improve patient safety.	$4.87\pm0.50$	< .01
2.	Handwashing improves patient safety.	$4.82\pm0.73$	< .01
3.	Risk management activities improve patient safety.	$4.70\pm0.62$	< .01
4.	Hourly bedside rounding improves patient safety.	$4.62\pm0.73$	.04
5.	Root cause analysis improves patient safety.	$4.61\pm0.61$	.03
6.	The Joint Commission activities improve patient safety.	$4.47\pm0.68$	.79
7.	Daily safety briefing improves patient safety.	$4.44\pm0.77$	Reference
8.	Morse Fall Scale improves patient safety.	$4.10\pm0.83$	< .01
9.	Hospital volunteers improve patient safety.	$3.92\pm0.89$	< .01
10.	Parking services improve patient safety.	$3.70 \pm 1.03$	< .01
In terms of patient safety, is the 15 minutes spent in the daily safety			, )
briefing an effective use of everyone's time? (% Yes)			

Note. 5-point Likert scale (1 = strongly disagree, 5 = strongly agree).

#### TABLE 3 Benefits of Daily Safety Briefing

		$Mean \pm SD$ $N = 97$
1.	Helps keep patient safety a focus within the organization	$4.54\pm0.74$
2.	Increases awareness about patient safety issues throughout the organization	$4.52\pm0.93$
3.	Advances organizational communication	$4.43\pm0.99$
4.	Encourages teamwork among leaders	$4.40\pm0.92$
5.	Educates leaders on patient safety topics	$4.39\pm0.88$
6.	Improves response time to issues	$4.18 \pm 1.11$
7.	Encourages staff to speak up	$4.00 \pm 1.04$
8.	Holds individuals accountable	$3.86 \pm 1.22$
9.	Encourages staff reporting of events	$3.86 \pm 1.10$

*Note.* 5-point Likert scale (1 = strongly disagree, 5 = strongly agree).

	Daily Safety Briefing Improves Patient Safety	p Value	DSB Is an Effective Use of Everyone's Time	p Value	
Sex					
Female	4.37 + 0.85	.03	97%	.31	
Male	4.68 + 0.48	-	92%	-	
Work area					
Direct clinical care	4.41 + 0.84	-	93%	-	
Indirect clinical care	4.62 + 0.49	.75	97%	1.00	
No clinical care	4.44 + 0.88	1.00	95%	1.00	
In leadership role at this organization since daily safety briefings began?					
Yes	4.43 + 0.77	.91	98%	.13	
No	4.45 + 0.77	-	91%	-	

#### TABLE 4 Value of Daily Safety Briefing, Comparing Subgroups

Note. 5-point Likert scale (1 = strongly disagree, 5 = strongly agree).

In evaluating the difference in responses between different DSB participant groups, females were more likely to find DSB an effective use of their time (97% vs. 92%, NS) compared to males (Table 4). Those representing direct clinical care areas were less likely to find DSB effective compared to those with indirect clinical care areas (93% vs. 97%, NS). Those working within the organization before DSB started were more likely to find it effective compared to those starting afterward (98% vs. 91%, NS).

#### DISCUSSION

In this study, we found that participants overwhelmingly found the DSB to improve patient safety. This was true for both participants who had been in the organization before DSB began and those who joined after DSB inception. Regarding efficiency, participants overwhelmingly (95%) found it to be a good use of their time.

The DSB has several potential benefits. It has been touted as a method to improve communication (Goldenhar et al., 2013; Hatva, 2013), increase situational awareness and improve time to resolution of safety issues (Hatva, 2013; Stockmeier & Clapper, 2011), heighten risk awareness (Stockmeier & Clapper, 2011), and increase accountability for safety (Goldenhar et al., 2013; Stockmeier & Clapper, 2011). While the potential benefits of a DSB are well described, the actual benefits have not been well studied. Anecdotal reports suggest that it may lead to lower rates of serious safety events (Jones et al., 2014; Stockmeier & Clapper, 2011), decrease time to resolution of issues (Aulisio, 2015), increase safety culture (Hall et al., 2015), and increase reporting of adverse events (Aulisio, 2015; Hall et al., 2015; Jones et al., 2014). Moreover, healthcare leaders agree that the DSB leads to "somewhat-tosignificant" impacts on safety (Stockmeier & Clapper, 2011), but to our knowledge, these results have not been studied in a rigorous fashion.

Our results suggest that DSB participants find that the DSB indeed improves

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patient safety. Specifically, the DSB is more influential in improving patient safety than some common hospital patient safety practices such as use of the Morse Fall Scale to predict patients at high risk for falls (Morse, Morse, & Tylko, 1989). The DSB was on par with other common practices, such as The Joint Commission accreditation activities aimed at hospital safety standards. The DSB does not have as much value as bedside patient safety activities such as preprocedure time-outs or handwashing, although one might not expect it to have such profound effects.

One concern that we had was that the new staff who had been hired after we started performing the DSB would be biased. They had never experienced a time when the DSB was not performed, so perhaps they would rate its value higher because they had been conditioned to attend the DSB since being hired. In fact, we found the opposite. Those who had been with the organization before the DSB found similar value of the DSB and were perhaps more likely to find that it was a good use of everyone's time. This supports the notion of its value, because these individuals who had been with the organization before DSBs began had an experiential comparison group.

Our results confirm previously described specific values of the DSB. Participants found that it keeps the organization focused on patient safety and increases situational awareness about patient safety issues. The DSB holds individuals accountable for safety issues and encourages staff reporting of events to a lesser extent. This shortcoming may be a result of our implementation of the DSB rather than a reflection of the DSB itself, and provides us an area of opportunity for improvement.

Having performed the DSB for several years, we offer several "secret" factors in its success. First, have senior leadership (chief medical officer and/or chief nursing officer) lead the DSB. This reinforces its importance and makes sure people will attend. Second, force everyone to speak up (e.g., with a roll call) even if they do not have any issues. This gets people used to speaking up, acknowledges their importance, and makes it more comfortable for them to speak up when issues arise. Third, the DSB has to be brief; ours is 15 minutes. You are taking the time of all the leaders within the organization, so you must be efficient and effective with their time. (As a corollary to this, always start on time; we start at 8:45 a.m. on the dot. Along with respecting people's time, a prompt start will train your team that this time is nonnegotiable.) Fourth, make the meeting face-to-face. The value of face-to-face interactions in building trust, improving communication, and forcing accountability cannot be underestimated. In addition, many problems can be fixed in the few minutes before or after the DSB by means of face-to-face interactions. Often, the value comes from follow-up conversations after the DSB has been completed or before the DSB starts. We recognize that this may not be feasible for large organizations, so some iterations of the DSB have leaders calling in by phone. Fifth, have a standard format for the DSB (Figure 1). This will help keep the DSB flowing and moving at a fast pace. Finally, have a system for following up on outstanding items. We continue to struggle with this factor, as evidenced by our results-especially for issues that require several days or weeks to address.

Organizations may face several barriers to DSB implementation. One major barrier is time. Although the benefits of the 15 minutes spent during the DSB outweigh the time taken away from the clinical area, this commitment can be difficult to make initially. Another potential barrier is a lack of support from senior leaders because making the DSB a part of hospital operations requires their commitment. Their support can speak volumes about an organization's priorities and change the safety culture of the organization. As more research on the value of the DSB emerges, their commitment should come more easily.

#### **STUDY LIMITATIONS**

There are several potential limitations to this study. First, this represents the perceived value of the DSB among participants. Evidence of the effect of the DSB on patient safety outcomes, such as fewer adverse events, would be more compelling. Unfortunately, this data point is not readily available, measurement or surveillance is not standardized, and patient safety is affected by factors besides the DSB. Moreover, we did not measure some of the perceived benefits of the DSB, such as time to resolution of issues, quality of communication, or situational awareness. Future studies might measure some of these benefits. Second, this represents the results of one iteration at one organization. There are variations of the concept, and its performance at other organizations might be different.

#### CONCLUSION

We found that the DSB improves communication among team members and is a valuable investment of healthcare leaders' time.

#### NOTE

This study was approved by the institutional review board of The Queen's Health Systems. The findings and conclusions of this study do not necessarily represent the views of the organization.

#### REFERENCES

- Aulisio, A. S. (2015). The daily safety brief: A real-time review. [PowerPoint slides].
  America's Essential Hospitals. Retrieved from https://essentialhospitals.org/wpcontent/ uploads/2015/07/Aulisio\_060515\_vF.pdf
- Goldenhar, L. M., Brady, P. W., Sutcliffe, K. M., & Muething, S. E. (2013). Huddling for high reliability and situation awareness. *BMJ Quality & Safety*, 22, 899–906.
- Hall, C., Hicks, B., & Chamberlain, C. (2015).
  Daily safety huddles increase awareness. *Children's hospitals today*. Retrived from www.childrenshospitals.org/newsroom/
  childrens-hospitals-today/fall-2015/articles/
  daily-safety-huddles-increase-awareness
- Hatva, E. (2013). Daily briefing promotes hospitalwide transparency and patient safety. *Biomedical Instrumentation & Technology*, 47, 489–492.
- Jones, C., Krupa, T., & Scott, M. (2014). The daily safety check in: A strategy for reducing serious harm to patients [abstract]. *Journal of Hospital Medicine*, 9(suppl 2). Retrieved from https:// www.shmabstracts.com/abstract/the-dailysafety-check-in-a-strategy-for-reducing-seriousharm-to-patients/
- Morse, J. M., Morse, R. M., & Tylko, S. J. (1989). Development of a scale to identify the fall-prone patient. *Canadian Journal on Aging*, 8(4), 366–377.
- Stockmeier, C., & Clapper, C. (2011). Daily check-in for safety: From best practice to common practice. *Patient Safety & Quality Healthcare*. Retrieved from https://www.psqh.com/analysis/daily-check-in-forsafety-from-best-practice-to-common-practice/#
- Wagner, C., Theel, A., & Handel, S. (2015). *Safety huddles: Guide to safety huddles*. Seattle, WA: Washington State Hospital Association.
- Weick, K. E., & Sutcliffe, K. M. (2011). Managing the unexpected: Resilient performance in an age of uncertainty. San Francisco, CA: Wiley.

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## PRACTITIONER APPLICATION: Perceived Value of the Daily Safety Briefing

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s Pham, Laupola, Figueira, Bala, and Chun note in their article, briefings are essential for facilitating communication and teamwork in healthcare. They are a especially valuable tools of highly reliable organizations (HROs) when centered on safety matters at the start of each day.

It is also important to note that The Joint Commission identifies human factors, leadership, and communication as the top three causative factors in self-reported sentinel events at accredited organizations, and these factors directly affect hospitals' efforts to become HROs. Healthcare is now applying the principles of high reliability, two of which I consider to be especially pertinent to hospital leadership: "sensitivity to operations" and "deference to expertise." Leaders must be aware of how processes and systems might affect their healthcare organization. To gain awareness regardless of hierarchy, leadership needs to listen to people who are most knowledgeable about a task and encourage them to share their concerns, ideas, and input. Safety briefings are ideal venues to engage employees in safety efforts.

Typically at briefings, information or directives are given, especially before the start of any planned activity. Expectations are set, such as the aim of an activity and the roles and responsibilities of the people involved. Briefings allow time for questions to ensure that, in the end, everyone is on the same page. Conducted for up to 30 minutes at the start of the day, briefings provide opportunities for leadership to learn about the previous day's activities—what went well, what did not go so well, and what needs to be done to improve results.

As a hospital senior safety officer, I was encouraged by the results of the authors' survey of daily safety briefing participants at an urban academic medical center. The authors learned that participants overwhelmingly believed the briefings improved patient safety.

I also am aware of hospitals adopting the similar concept of leadership huddles. Like briefings, huddles require planning, practice, and a supportive culture. Huddles, however, take 15 minutes or less. And they are not sit-down meetings like briefings. Instead, people stand in a circle and report events that have either occurred or are anticipated. Participants generally hold managerial positions or above, including the nursing supervisor, heads of the emergency department and operating room, and others. Frontline staff such as nurses, therapists, or pharmacists may also attend and speak up at the leadership huddles. In this way, top management demonstrates a high level of attention to safety issues.

A huddle follows a shared governance model that allows leaders to hone their situational awareness. The reports facilitate a shared understanding of the general state of operations,

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which can include bed occupancy, staff injuries, errors, near misses, and delays in care. Each leader only reports noteworthy events related to safety, quality, and hospital services. Moreover, huddles are not meant to solve problems; the problem solving occurs after the huddle in more detailed discussions among all who are in positions to solve the problem.

Although Pham et al. are not able to conclude from their survey that safety briefings directly (and positively) affect outcomes, it is clear that briefings (and, I might add, huddles) can serve as effective communication opportunities and support the frontline staff's desire to provide the best care for their patients.