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Implementation of a Multidisciplinary Weekly Safety Briefing in a Tertiary Paediatric Cardiothoracic Transplant Unit

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Abstract : Context: A multidisciplinary weekly safety briefing was implemented at the Paediatric Cardiothoracic Unit at the Freeman Hospital in Newcastle-upon-Tyne. It is a tertiary referral centre with a quarternary cardiac paediatric intensive care unit and provides complexed care including heart and lung transplants, mechanical support and advanced heart failure assessment. Aim: The aim of this briefing is to provide a structured platform of communication, in an effort to improve efficiency, safety, and patient care. Problem: The paediatric cardiothoracic unit is made up of a vast multidisciplinary team including doctors, intensivists, anaesthetists, surgeons, specialist nurses, echocardiogram technicians, physiotherapists, psychologists, dentists, and dietitians. It provides care for children with congenital and acquired cardiac disease and is one of only two units in the UK to offer paediatric heart transplant. The complexity of cases means that there can be many teams involved in providing care to each patient, and frequent movement of children between ward, high dependency, and intensive care areas. Currently, there is no structured forum for communicating important information across the department, for example, staffing shortages, prescribing errors and significant events. Strategy: An initial survey questioning the need for better communication found 90% of respondents agreed that they could think of an incident that had occurred due to ineffective communication, and 85% felt that incident could have been avoided had there been a better form of communication. Lastly, 80% of respondents felt that a weekly 60 second safety briefing would be beneficial to improve communication within our multidisciplinary team. Based on those promising results, a weekly 60 second safety briefing was implemented to be conducted on a Monday morning. The safety briefing covered four key areas (SAFE): staffing, awareness, fix and events. This was to highlight any staffing gaps, any incident reports to be learned from, any issues that required fixing and any events including teachings for the week ahead. The teams were encouraged to email suggestions or issues to be raised for the week or to approach in person with information to add. The safety briefing was implemented using change theory. Effect: The safety briefing has been trialled over 6 weeks and has received a good buy in from staff across specialties. The aim is to embed this safety briefing into a weekly meeting using the PDSA cycle. There will be a second survey in one month to assess the efficacy of the safety briefing and to continue to improve the delivery of information. The project will be presented at the next clinical governance briefing to attract wider feedback and input from across the trust. Lessons: The briefing displays promise as a tool to improve vigilance and communication in a busy multi-disciplinary unit. We have learned about how to implement quality improvement and about the culture of our hospital - how hierarchy influences change. We demonstrate how to implement change through a grassroots process, using a junior led briefing to improve the efficiency, safety, and communication in the workplace.

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