CREATION OF A PICU QUALITY AND SAFETY TEAM

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Category: Patient Safety

Background
The department of pediatrics and Texas Children's Hospital are experiencing incredible growth and expansion. This is demonstrated by the opening of new community hospital campuses, hiring of new staff and faculty, and increased expertise and recognition in multiple disease states. The pediatric intensive care unit (PICU) has experienced this same growth with increasing acuity and patient load. Like most endeavors of expansion, the PICU leadership appreciate increased strain in the front line providers caring for patients. In addition to increasing our shear numbers of new hires, we established a multi-disciplinary quality and safety team to foster a culture of shared responsibility and safety.

Objectives
We had multiple aims by the creation of this team. First, we wanted to create a system for personal delivery of quality and safety concerns (in addition to traditional avenues of anonymous on-line submission or email communication). Second, we desired to mix the on-service front-line providers with leadership to enhance our ability to make and monitor changes in the PICU. Third, we wanted to demonstrate our commitment to multi-disciplinary teamwork. Lastly, we wanted to systematically discuss every mortality in our PICU.

Methods
The original design had 3 tiers. We conducted a daily operational brief (DOB) at 7 am on weekdays to discuss issues in the past 24 hours. Next, we conducted a weekly review of events in order to identify themes and improvement opportunities. Then we held an every 2 week meeting to perform more in-depth review of moderate safety concerns and mortalities.

Results
Since the creation of our quality and safety team in August 2015, we have successfully instilled a local DOB and week-in-review process during which we discussed 1936 quality or safety events separate from our on-line safety event program (tallied 1921 concerns). We also solicited at least 465 positive "kudos" (a system developed after 9 months of team formulation). We have shared key highlights with all PICU team members via distribution of 11 newsletters. Finally, we have systematically evaluated and discussed all 254 PICU mortalities.

Discussion
We have successfully integrated our front-line providers with medical and nursing leadership to create a culture of safety in our high acuity PICU. We have demonstrated that a local multi-disciplinary quality and safety team can solicit twice as many specific concerns as a traditional on-line submission program. We theorize that this improves learning and the quality of care provided to our patients.