Executive/Leaders WalkRounds for patient safety

1 Overview

The annual Metro North Patient safety culture survey adapted from the Agency for Healthcare Quality and Research (AHRQ) surveys on patient safety culture[1] revealed that Management Support for Patient safety was less positive than predicted. As a result, Metro North, Queensland established a leadership rounding program for the Hospitals and Health services framed in patient safety evidence.

The following WalkRound program has been briefly adapted to suit local needs and draws on Australian and international evidence[2].

Acknowledgement

Without the dedication and support of multiple staff this program could not have been implemented. In particular, we would like to thank the Royal Brisbane and Women's Hospital who were actively involved in the design of the program and for testing and refining an approach to WalkRounds that meets local needs. From these trails, Metro North has an adaptable tool that may be applied to multiple healthcare contexts to improve patient safety culture based on evidence and user experience.

2 Introduction

Improving patient safety is a high priority for healthcare leaders. To achieve this direct and regular contact with real-time care delivery enables executive/leaders to understand the problems of staff and clinicians to deliver safe care.

The program provided here gives executive/leaders tools to enable staff to engage directly in discussions about improving patient safety.

> "By walking through hospital units to conduct face-to-face conversations with any staff member or physician with a safety concern, leaders can learn more about errors or hazards that could or did cause harm; and on the basis of issues identified during the WalkRounds, the leadership can identify opportunities for improving patient safety. These informal discussions are thus an essential catalyst for change because they enable the organization to improve our reporting systems and enhance our knowledge about how to ensure a safe environment"[3p. 29.]

These ideas frame the approach here through the provision of a standardised interview tool (checklist) that enables a scribe to capture the WalkRound narrative as textual data to provide an analytical lens.

WalkRounds are best when they are conducted weekly and should only be conducted monthly in exceptional circumstances[4]. WalkRounds should never be cancelled.

Three distinctive phases comprise the WalkRounds:

- Preparation: develop a facility schedule for the walk-around, membership, checklist.
- The WalkRound: structured questions, identify patient/staff concerns

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[1] Agency for Healthcare Research and Quality. Surveys on patient safety culture (2016); Retrieved from http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html
[2] Health Research and Educational Trust. Transforming healthcare through research and education (2016). Retrieved from http://www.hret.org/quality/projects/walkrounds.shtml
[3] Feitelberg, S. Patient safety executive WalkRounds. The Permanente Journal (2006);10(2).
[4] Frankel, A. WalkRounds improve patient safety: Gaining feedback to provide exceptional care (2008); Healthcare Executive, Mar/Apr 23,(2) 23-28

- Follow-up: Immediate actions, review transcript of discussions, feedback, data analysis, measure of success.

These are defined in section 6.

3 Objective

The purpose of the program is to provide a clear process that is duplicable and informed by best practice[2,3]

The objectives of the WalkRounds are:

- Create an environment of trust where staff can easily make connect and comment with hospital leaders
- Elicit staff concerns honestly with promises that staff will be informed about how things will improve
- Identify 'real-time' patient safety issues and the responsibility to fix them
- Establish an operational framework to
  - Log every comment or concern to be elicited and aggregated later
  - Assign responsibility for identified issues
  - Provide feedback
  - Measure performance

4 Target audiences

- All staff
- Consumers of clinical services

5 Key messages

- One approach to improve safety culture is leadership WalkRounds where Exc/Leaders take time to talk to staff real time.
- The WalkRounds are weekly and should not be cancelled.
- Executive/Leaders visibility at the coal face fosters stronger relationships and demonstrates a commitment to patient safety.
- The Patient safety WalkRounds program is a systematic process to improve patient safety culture.

6 WalkRounds adapted from Frankel 2008;

6.1 Preparation

6.1.1 Develop a facility walk around schedule

Develop an annual spread sheet inclusive of date, time and place (ward/units/department) and Executive/Leaders attendees. This is distributed within the facility to inform staff of WalkRound visits.

WalkRounds should occur at any site where employees and clinicians are involved in patient care.

Limit the WalkRounds schedule to 1 -2 wards/department/unit only. Engage with 1 or 2 staff and consumers at each WalkRound.

It is optimal to base dates and times on staff availability rather than executive availability. Take into consideration nursing shifts, lulls in activity and physician rounds.

The frequency of WalkRounds state one round per week as a good "rule of thumb", however this is adaptable.

Adopt the WalkRound checklist (appendix 1).

6.2 The WalkRound

6.2.1 Script for WalkRounds

The aim of the walk around program is to make visible key leaders of the Hospitals and Health Services to staff and consumers that senior healthcare leaders have patient safety as a top priority.

The program provides a structured methodological approach to provide regular opportunity for staff and consumers to engage with key leaders to discuss their concerns and to raise awareness of issues that influence patient safety. It is also an opportunity to show case patient safety initiatives, performance boards and new ideas. Importantly, WalkRounds give staff and consumers a 'voice' by engaging directly with organisational leaders.

To engage effectively a script has been provided derived from local and international patient safety evidence[2,3,5.] While it is acknowledged that the script question may appear restrictive, the point of asking one or two defined questions is to standardise information, focus the discussions and to be able to analyse the text consistently.

Consumer engagement processes were applied to determine questions relevant to the consumer section of the script.

Opening statements may include:

"We are moving through the hospital on a regular basis to open communication and to learn more about patient safety issues that are important to you. We believe that by doing this your work environment will be safer for you and your patients"

6.2.2 WalkRound team

The WalkRound team comprises 2 – 3 healthcare leaders. These include but are not limited to Executive, Directors, Nurse Unit Managers, S&Q officers, Nurse/Medical leads.

The WalkRound should take no longer than 30-45 minutes.

A regular scribe (generally from Safety and Quality) is assigned to the WalkRound. The scribe takes notes on the checklist (which doubles as an interview tool), of the WalkRound discussions and identifies actions for Executive that are generated from staff discussions.

At the end of each WalkRound, either the executive or patient safety manager should explain to participants what will be done with the information obtained.

6.3 Follow-up

6.3.1 Journal and Actions

The scribe later expands the notes into a WORD document 'Journal' to collate the dialogues and provide a comprehensive view of the discussion(s).

The 'journal' (Appendix 2) is emailed to the WalkRound participants to be checked for accuracy. Actions that arise from the WalkRound are reported on the registry below for follow-up (Appendix 3).

1	Location	Pt Safety Area of concern	Executive	Clinical leaders	Completed	Closed	Communicated
Date							
Identified issues							
Actions							
Vincent Factors							

[5] South Australia Department of Health. Executive and change team information: know the plan/share the plan; patient safety executive walk-arounds. (2014). Retrieved from www.sahealth.sa.gov.au

Elicit episodes of harm and concerns about risk

Assign action items.

- Produce reports of prioritized (traffic light system) WalkRounds comments, and distribute the reports to senior executives, patient safety committees, and the hospital Board.
- Determine action items using comments, priority scores, and contributing factors recorded in the WalkRounds registry
- On a monthly basis, convene a committee of clinical leaders, administrative directors and executives to review monthly reports of both open and closed action items.
- The patient safety manager should establish communication mechanisms for transferring information from those responsible for actions being taken.

6.3.2 Collect and analyse data

Track all individuals who participated in the rounds; the date, time, and location of the rounds; and all comments heard.

Data analysis draws on principles of content analysis where the Journal script, checked by WalkRound participants, provides data that is organised into smaller categories to expose patient safety issues. Here, content analysis is considered 'flexible and there is not simple right way of doing it'[6p.113]

The method of data analysis involves sorting the text into smaller ideas to understand more about patient safety and safety culture. Patient safety concerns as identified from the journal transcripts are grouped into 6 recognised patient safety domains, as determined by Vincent (1995)[7] categories.

In this approach, principles of content analysis that are not unfamiliar to healthcare reviews, apply methods to understand organisational patient safety issues. A connection between patient safety concerns as extant concepts and systemic safety categories, Vincent Categories[7] are counted to expose recurring groups. The number of recurring sub-categories determines specific safety areas for action.

Vincent's categories[4] are compatible with Reason's (1990) organisational safety defences represented in the Swiss Cheese model. Not only are Reason's safety defences familiar to healthcare, as the first column of the table below reveals, they provide a consistent frame to group patient safety matters from the WalkRounds into specific areas for intervention. The second column of the table identifies specific patient safety sub-categories to focus strategies for intervention.

Categories of Vincent Factors[4]	
Organisational and Management Factors	Financial resources and constraints Organisational structure Policy standards and goals Safety culture and priorities
Work Environment	Staffing levels and skill mix Workload and shift patterns Design, availability and maintenance of equipment Administrative and managerial support
Team Factors	Verbal communication Written communication Supervision and seeking help Team structure
Individual (staff) factors	Knowledge and skills Motivation physical and mental health
Task Factors	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results
Patient Characteristics	Condition (complexity and seriousness) Language and communication Personality and social factors

[6] Elo, S. & Kyngäs, H. The qualitative content analysis process (2007). Journal of Advanced Nursing 62(1), 107-115.
[7] Vincent C.A., Bark, P. Accident investigation: Discovering why things go wrong. In Vincent, C. editor. Clinical risk management(1995). London: BMJ Publishing Group, 391-410

The text of the journal transcript is the data. An iterative and reflexive approach is applied to analyse the data to provide understanding and to develop meaning[8]. While it is not the intent here to provide a difficult or complex methodology, this approach acknowledges a simple framework for healthcare workers to apply qualitative data analysis techniques to the WalkRound process. As noted through the transcription process and in qualitative inquiry, common ideas arise as the text is read and re-read. These take the form of patient safety issues that are identified during the round or through the transcription that is reviewed by the WalkRound team. Patient safety issues are then sorted and organised into one of the 6 Vincent categories using a 'best fit' methodology. In this way and as patient safety issues appear a "process of meaning-making"[8] applies to the text that fits the most relevant category. Overtime these primary categories expose a frequency of factors that acknowledge system safety failures to focus organisational interventions.

6.3.3 Closing the loop

Give feedback to Board, leadership, management, and staff.

- Develop a plan for feeding information back to rounds participants, senior leaders, committees, and the Board.
- Leverage hospital marketing resources to develop a communication plan for actions taken as a result of WalkRounds.

At the time of the WalkRound issues are identified and Exc/leaders take responsibility to complete actions arising from the WalkRound.

Safety and Quality manage and feedback the progress and completion of the actions to the ward/ department/ unit via email. These are then closed in the WalkRound registry and disseminated more widely to staff via e-bulletin, e-newsletters, staff forums etc.

Overtime, recurring groups derived from Vincent methodology frame the development of further strategies to address underlying organisational safety concerns.

Measure progress.

- Refer to actions taken as the result of WalkRounds during later visits to each unit.
- Measure safety climate changes periodically, using a validated and reliable patient safety culture survey
- Continually track follow-up comments, time to complete action items, frequency scores, and other indicators recorded in the WalkRounds registry.
- Metro North is currently developing an electronic database to support recording of transcriptions, data analysis and reporting of WalkRounds.

[8] Srivastava,P. A practical iterative framework for qualitative data analysis. (2009). International Journal of Qualitative Methods; 8(1).

7 Implementation

Table 1 Implementation details

Channel/tools	Date	Additional Information
All Staff email	<u>Week 1:</u> Introduce the plan to the Board, S&Q Executive, Directors, managers, supervisors and S&Q. Utilise the templates – data registry and journal provided Pilot the plan to test the concept and identify local issues	• First week of (month) announcement from Chief Executive
Local e-newsletter, e-bulletin, committee.	<u>Week 2:</u> Nominate a local committee to discuss data and actions. Develop WalkRound schedule. Timeframe is 6 – 12 months Identify local feedback loops to inform staff of the progress of the WalkRounds.	• Announcement from local Executive Director. • Distribute WalkRound schedule. • Gather commitment from local Exc/Leadership team to participate.
Undertake a pilot WalkRounds. Seek volunteer wards/units/departments to participate in the pilot Local e-newsletter, e-bulletin, committee.	<u>Week 3:</u> Notify the Hospital/ Health Service for the WalkRounds. Commence pilots with feedback and reporting processes in place Initiate feedback processes for participants immediately following the WalkRounds to discuss any concerns. Notes from the walk-around are transcribed and emailed back to the participants for their review and to accuracy of events Develop a feedback plan for staff about actions with timeframes Develop reports from the WalkRounds for dissemination to staff and ratifying at local committees.	• Assign S&Q officer to co-ordinate WalkRound teams and act as scribe • Establish timeframes for review of transcripts • Review and feedback.

Channel/tools	Date	Additional Information
All Staff email Local e-newsletter, e-bulletin, committee.	Week 4: Report to S&Q committees at 6 weeks and 12 weeks initially.	Establish outcomes expected from the program. For example • Improvement in patient safety culture • Measure effects on safety culture • Staff perceptions of patient safety WalkRounds. Consider posters and local visual advertising
Screensavers; posters, staff forums,.	TBC	Artwork consistent with local healthcare graphics.
Patient Safety Culture Survey	Annual	All staff
FAQs of patient safety WalkRounds available on S&Q intranet	Uploaded	

8 Appendix 1: Checklist / Interview tool

CHECKLIST

MNHHS Checklist v.02 Oct 2016

MNHHS Patient **Safety WalkArounds**. (PSWA)	Hospital area(s):……..... Date:…….….....

Names of Exc/Leaders attending:

Executive: ……

……..

NUM: ……..……

S&Q: ……

Designation - please tick '✓' (or mark 'D' if delegate)

ED	EDFS	EDMS	EDNS	EDAH	Corp	ED Canc	ED Crit	ED IMS	ED MHS	ED Surg	ED WNB

Start time: **End time:**

Discussed purpose: "*We are moving through the hospital on a regular basis to open communication and to learn more about patient safety issues that are important to you. We believe that by doing this your work environment will be safer for you and for our patients"*

Key Questions:	Staff comments
How are you involved in patient safety on this unit?	
What do you think this unit could do to improve patient safety?	
	Consumer comments
Can you describe the units ability to work as a team?	

Wrap up with staff (Thank participants highlight positives, recap any key actions to pursue)

POST WALKABOUT

☐ **Follow up contact: Name of staff……**

Actions required (e.g email/phone) to local areas :

……

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Information to be entered on the S&Q database for PSLWA. Contact: Safety & Quality reporesentative

9 Appendix 2: Journal template.

Walkarounds journal

Date:

Location:

Time:

Executive in attendance:

[Body text]

NUM:

[Body text]

Patient safety issues:

1. [Body text]
2. [Body text]
3. [Body text]

Journal:

(Transcribe the discussions and send back to participants to review)

[Body text]

10 Appendix 3: Vincent categories

Categories of Vincent Factors[4]	
Organisational and Management Factors	Financial resources and constraints Organisational structure Policy standards and goals Safety culture and priorities
Work Environment	Staffing levels and skill mix Workload and shift patterns Design, availability and maintenance of equipment Administrative and managerial support
Team Factors	Verbal communication Written communication Supervision and seeking help Team structure
Individual (staff) factors	Knowledge and skills Motivation physical and mental health
Task Factors	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results
Patient Characteristics	Condition (complexity and seriousness) Language and communication Personality and social factors

11 Appendix 4: Walk around Register

Walkaround Register

1	Location	Pt Safety Area of concern	Executive	Clinical leaders	Completed	Closed	Communicated
Date							
Identified issues							
Actions							
Vincent Factors							

The table is to be copied each walk around and a traffic light system (Red/Amber/Green) can be applied to the register to flag areas

Vincent factors are identified and classified from the Patient safety areas. Over time the frequency of recurring Vincent factors determines areas that focus further strategies to improve organisational safety issues.