



Making the **safety** of patients
everyone's highest **priority**

Leadership for Safety: Supplement 1

Patient Safety Walkrounds

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WalkRounds™ is trademarked and, for the purpose of this document, will be referred to as walkrounds.

Patient Safety Walkrounds

Connecting executives with frontline staff

Introduction

This document is a short how-to guide aimed at helping organisations start out on this important element of the Leadership for Safety intervention which has helped many organisations make a significant impact on their safety culture. It may also be of value to organisations already carrying out walkrounds to refine the process, ensuring they make the most of this valuable time spent between leaders and frontline staff.

There is no absolute approach to carrying out patient safety walkrounds but there are some key aspects which need be incorporated into the process, to make them as effective as possible.

As with any intervention linked to the Campaign, you are encouraged to use the Model for Improvement to refine the process as you progress and make it work in your organisation. Further information on the Model for Improvement can be found in The Quick Guide to Implementing Improvement, and an example of a plan-do-study-act (PDSA) cycle is suggested in the How-to Guide for Leadership for Safety, both available at www.patientsafetyfirst.nhs.uk.

Background

As described in the Campaign's Leadership for Safety How-to Guide, strong effective leadership is essential to build a safety-oriented organisational culture, as evidence suggests that without this, many other interventions are likely to fail. Leaders of all organisations must be seen to be committed in both word and deed to the primary aim of 'first, do no harm'. To deliver the necessary culture change, leaders are required not only to 'talk the talk' but to 'walk the walk'.

Patient safety walkrounds are a way of ensuring that executives are informed first hand, regarding the safety concerns of frontline staff. They are also a way of demonstrating visible commitment by listening to and supporting staff when issues of safety are raised. Walkrounds can be instrumental in developing an open culture where the safety of patients is seen as the priority of the organisation. This kind of activity is not new. Many businesses and organisations have long seen the value of going 'back to the floor' and finding out for themselves what staff are thinking. In Lean methodology, which has been increasingly applied to healthcare settings in recent years, it is known as 'gemba', which roughly translates as 'the place where the truth can be found'.

As a more formalised framework, patient safety walkrounds were initially introduced by Allan Frankel, MD at Brigham and Women's Hospital, Massachusetts and have since been developed by the Institute for Healthcare Improvement as a tool to engage leaders and frontline staff in a meaningful discussion of patient safety concerns with agreed actions.

Patient safety walkrounds can be conducted in any care setting where patient care is being provided such as wards, A&E departments, operating theatres and community settings but should not be limited to these. They are also useful in support services such as pathology and portering or other areas that may affect patient care or the efficiency and safety of the organisation such informatics and finance. They provide a formal process for directors to talk with frontline staff about safety issues in their department and show their support of staff for reporting errors/near misses. However, this does not mean that such conversations should never happen outside of this process; indeed such informal discussions should be encouraged, and occur whenever the opportunity arises.

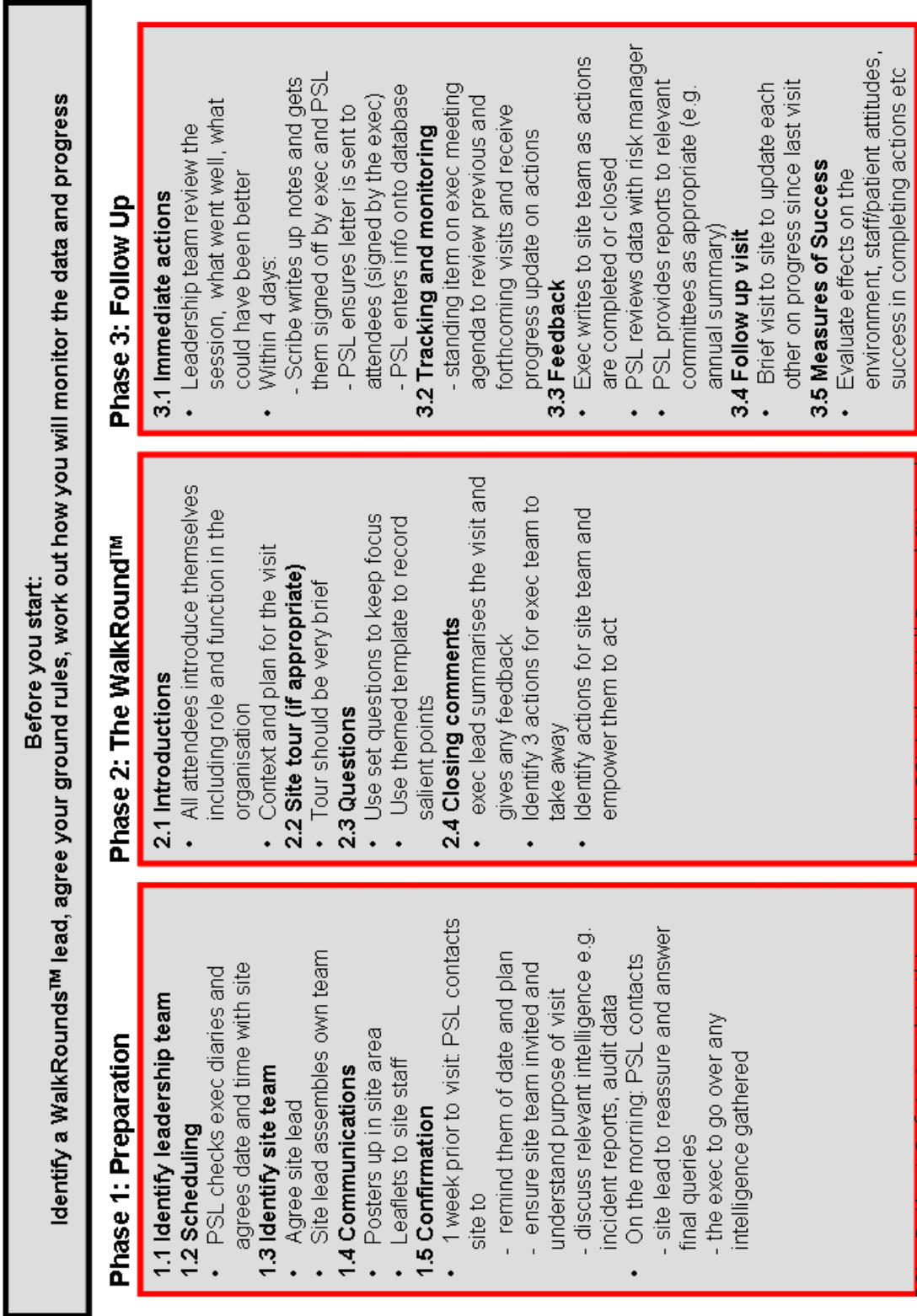
In summary, walkrounds can:

- demonstrate top level commitment to patient safety
- establish lines of communication about patient safety among employees, executives, and managers
- provide opportunities for senior executives to learn about patient safety
- identify opportunities for improving safety
- encourage reporting of issues, errors and near misses
- promote a culture for change pertaining to patient safety
- establish local solutions to minimise risk.

The following sections provide a detailed overview of the process but a summary table of all the steps can be found in Figure 1.

Figure 1

The 3 phases of successful WalkRounds™



PSL - Patient Safety Lead. In this example the PSL is the WalkRounds™ Lead.

The three phases of successful walkrounds

Walkrounds are not a one off event but part of a continuing cycle of improvement. Although we would encourage leadership to get started, it is essential to realise that the actual walkround needs to be built into a rigorous, organised process which has measurable outcomes or else it could run the risk of being seen as simply a 'nice thing to do' that has little or no effect. To ensure a commitment to action and impact there are, therefore, three phases to the walkround process, each containing a series of steps that need to be followed: preparation, the walkround and follow up.

However, before any walkround process is started, there are three key decisions to be made: who will lead the process, what the ground rules will be, and how executives intend to record data and progress.

Identifying a lead: For the process to work effectively, an individual should be identified who can co-ordinate the whole programme. This individual needs to have appropriate authority, resources and time to effectively manage the process. For the purposes of this guide we have termed this individual the Patient Safety Lead (PSL).

Ground rules: Clear ground rules help the team understand the commitment they are making to the walkround process and the relative value of the walkround to the organisation. This understanding can also assist with prioritisation of time.

Whilst ground rules should be determined locally, the following list identifies some key elements for successful walkrounds:

1. The times and location of all walkrounds will be agreed a significant period in advance. An annual programme will be produced which covers all clinical areas in the organisation and all participating sites and executives will be made aware of the date of the walkround at least 3 months in advance.
2. No walkround should be cancelled by the Executive team except in extenuating circumstances. If the nominated executive is no longer able to participate in the visit they should request that another executive from the team cover the visit. The site areas should also only cancel in extenuating circumstances e.g. infection outbreak, major incident. If this is the case a new date should be established within one week.
3. Walkrounds should not last longer than 1 hour.
4. Walkrounds should be as close to the clinical area as possible e.g. Sisters office, Theatre coffee room.

5. All information discussed in a walkround is confidential and no comments will be attributed to an individual without their permission. The information gathered, however, will be shared with other colleagues to learn lessons.
6. We will support and empower employees to discuss safety issues openly without fear of recrimination.
7. We will feedback and praise staff when areas of good practice are identified.

Monitoring data and progress: For walkrounds to be effective they need to be integrated into the operational management of the organisation. The use of a database to achieve this is essential. The database should assign actions to individuals and indicate where progress against an action will be monitored e.g. Executive team meeting, Divisional Management team, etc. as well as time scales.

Phase 1: Preparation

1.1 Identify the leadership team

It is essential that the Chief Executive Officer (CEO) takes a major role in walkrounds. It is also expected that the Medical Director and Director of Nursing would want to be part of the team but where walkrounds have proved most effective all the executive team have been involved, in particular the Directors responsible for Finance, Performance, Operations and Human Resources. In larger Trusts the size of the Leadership team may need to be expanded to cover the programme of work but essentially walkrounds should not become a delegated task.

The leadership team for each walkround should consist of at least:

- an Executive Director
- the Patient Safety Lead
- a scribe (usually a member of the Executive team's secretariat.)

A number of executives may feel apprehensive about leading safety oriented discussions, or may feel that such activity does not play to their personal strengths. Therefore it is important to include a development programme for the team and new members as they join. One way of achieving this is to pair a clinical leader with a non clinical leader at first, until the latter feels confident to go alone. Pairing of executives may not be possible in all visits but can be useful in terms of providing mutual feedback and a support framework for progressing action.

Some Trusts have expanded the team to include Non-Executive Directors and patient representatives, but the Patient Safety First Campaign would suggest that such action be integral to a development programme and not an initial feature of an introductory and

roll out plan. It is vital that the numbers of the leadership team are small and never outnumber the frontline team, to assure appropriate dynamics and relationships to facilitate non confrontational dialogue.

1.2 Scheduling

The Patient Safety Lead compiles a comprehensive list of all potential sites to be visited. Once this is finalised an annual plan of visits should be agreed between the Executive team and the individual sites. Walkrounds can be conducted in any care setting where patient care is being provided such as the following:

- wards
- operating theatres
- A & E
- diagnostic services
- clinical support services.

Walkrounds should take place as close to the working environment as possible to:

- minimise the inconvenience for the staff working in the area
- maximise time available where the walkround includes a tour of the unit
- ensure further information is easily accessible if necessary
- enable the executive team to quickly 'go and see' if something is raised in the discussion that is better understood by seeing it for themselves.

It is important that mutually agreed times are arranged to ensure minimum distraction and maximum staff involvement.

1.3 Identify the site team

It is recommended that an individual is identified as the lead for each site. This will usually be the ward/unit manager or head of department. The Patient Safety Lead then liaises with this individual to agree the location of the walkround and the representative staff group who will attend. A group of around 5 staff, who reflect the staff mix in the area, is ideal. This mix should include non professional staff such as domestics and volunteers where appropriate. It is important that these individuals spend time with their colleagues beforehand so that they can reflect others' views at the walkround.

It is important to set the context of the meeting in advance so the purpose of the visit is made clear – it is vital that staff are assured that the visit is not an inspection, but an opportunity for leadership learning to identify and prioritise actions to improve patient safety. This shared understanding regarding focus is vital if the associated inhibiting issues of hierarchy and fear of disclosure (commonly associated as challenges to a patient safety oriented culture) are to be overcome.

1.4 Communications

There needs to be a clear communication strategy for the programme. All staff need to know about walkrounds in general and what the aim is. This may be achieved by including information in established organisational communications e.g. newsletters, team briefings, Intranet. The walkround team also need to ensure that the aims are clear to middle management to allay any concerns that they have about issues arising within their services. The team may choose to approach communications with this group differently.

In addition there needs to be focussed communication with each site in advance of a visit. We recommend the use of posters to announce the visit and information leaflets for staff who may wish to attend. Examples of these are found in Appendices 1 and 2.

1.5 Confirmation

One week prior to the visit the Patient Safety Lead contacts the site lead to remind them of the walkround schedule and plan, ensuring that the site team have been invited and everyone understands the aim of the visit. The Patient Safety Lead also checks with the site lead that any relevant information that can inform the discussion e.g. incident reports, risk register, complaints, is available. At this time it may be helpful to give a list of frequently raised issues that might be applicable to the area and suggest that these are only raised again for detailed discussion if there is something particularly pertinent about them to that area. If it is a follow up visit it is important to see what actions have been taken with regard to previously identified issues.

On the morning of the walkround it is recommended that the area is visited by the Patient Safety Lead to reassure them and deal with any final queries. The Patient Safety Lead should also arrange to meet with the Executive lead to go over relevant intelligence identified above so they are fully briefed.

Whilst cancelling of the visit is strongly discouraged there may be occasions where the staff team are under abnormally high pressure for a particular reason such as low staff numbers or a higher number of admissions. At such times the site may feel it inappropriate to host a visit at that time and request a postponement. Where this kind of pressure is more common the site team should assess whether having a leadership team see this first hand is of such value as to consider continuing with the visit, providing this does not place patients and staff at additional risk.

Phase 2: The walkround

2.1 Introductions

Each attendee introduces themselves, their role and function within the organisation.

The executive explains the purpose of the visits, that the team are interested in systems rather than people or individuals and that the organisation is actively encouraging fairness and openness.

The following may be helpful:

“We as a hospital are committed to ensuring the safety of our patients. To do this we must all understand the processes we carry out that could lead to harm to patients.

We need to have an open culture and we need to focus on the systems and not the individuals. These sessions are confidential and are purely for learning how we can improve patient safety.”

Explain that questions will be general but in order to get them thinking, examples of patient safety incidents may be given.

The following may be helpful:

“The questions are very general but to help you think of areas to which the questions might apply consider medication errors, miscommunication between individuals, distractions, inefficiencies, falls, protocols not followed etc.”

Explain that some notes will be taken but no comments will be attributed to an individual without their permission.

Take a register of who is there for purposes of communication after the event.

2.2 Site tour (if appropriate)

The team can then take a tour of the site as per any plan arranged by the clinical staff. This may involve the team talking with other staff and patients as appropriate. Any tour should be very brief and focussed as otherwise it will eat away at the precious time available for the safety discussion with the allocated site team.

2.3 Questions

It is important that open discussion is encouraged and that the views of all present are heard. Without proper facilitation discussions may be dominated by senior individuals so the Executive team may need to draw in the opinions of quieter members of the group. Care also needs to be taken to prevent the meeting being hijacked for other agendas.

Whilst there may be some other issues that staff are anxious to raise, it is suggested that the primary focus should be patient safety.

For this reason we would encourage the use of an agreed set of questions for all walkrounds. These can be adapted for individual sites but it will encourage a focussed discussion whilst ensuring all major issues are covered. Appendix 3 gives a set of sample questions.

It is important to document the salient points. One way of sorting this is into key themes. One suggestion is to use a template form. Suggested themes are:

- Communication
- Environment
- Training
- Team work
- Incident reporting
- Equipment
- Staffing
- Process

2.4 Closing comments

The Executive lead summarises the walkround. Suggested content for closing summary and remarks is:

- Thank them for their time
- Feedback and praise staff where areas of good practice identified
- Inform the staff that you will work on the information and provide feedback regarding outcome - this may mean sharing some of this with other colleagues to spread solutions and prevent issues occurring in other departments
- Identify all the issues that will be taken away and recorded on the database
- Identify areas where the site itself felt they should take action and empower them to do so
- Identify no more than 3 key action points related to safety which the executive will take away, record and action appropriately. Caution should be taken in choosing what the executives agree to action as choosing issues they may not be able to solve in any short timeframe (e.g. high influx of medical outliers on a surgical ward) will create frustration when little progress is seen to be made
- Identify any quick fixes which can be solved straight away
- Ask those present to inform others about the event and feedback any further thoughts to the Patient Safety Lead.

The following may be helpful:

“We are going to work on the information you have given us. In return we would like you to tell two other people you work with about the subjects we have discussed today.

We have heard a lot of interesting concerns and these will all be entered on a database which will allow us to get an overall picture of the hospital and know what we must focus on. However if you could prioritise three issues you would like resolved we will take those away with us now and feed back what we can do.”

Phase 3: Follow Up

3.1 Immediate actions

Immediately after the walkround the leadership team discuss what went well, what could have been better and what was learnt.

Then, within 4 working days:

- the scribe writes up the notes using a standard format to include who was present and the issues discussed under themed headings. This should include the 3 issues that were agreed to be progressed
- the Patient Safety Lead signs off the notes with the executive and ensures a personalised letter is sent to each attendee signed by the executive (see Appendix 3 for an example)
- the Patient Safety Lead enters the information onto a database for monitoring and reporting on progress. This may be prioritised and ranked using a severity scoring system if helpful.

3.2 Tracking and Monitoring

The Executive team should have walkrounds as a standing item on their weekly meeting covering walkrounds carried out in previous week, key issues identified, walkrounds in following week and a progress update on the actions list.

3.3 Feedback

Executives are responsible for overseeing and closing of actions. As each of the 3 key issues is actioned the executive concerned should write back to the individuals who raised it to inform them of the progress. There may be certain issues that cannot be resolved at the current time for some reason and in this case it is important that the reason is given to the team in the letter and a statement that the action is closed so everyone is clear. An action should only be closed once a solution has been achieved or it is agreed that no further action can be taken.

Reviewing the data with the Trust Risk Manager can help to identify significant risks to the organisation and ensure appropriate links to the relevant risk registers.

An annual summary report produced by the Patient Safety Lead is beneficial for the Executive team and other relevant committees e.g. Quality Improvement and Patient Safety.

3.4 Follow up visit

At the subsequent visit it is essential to feed back on what actions have been achieved and to find out what progress has been made within the unit.

3.5 Measures of Success

After several visits it is worth evaluating if the walkrounds have had an effect on the environment including whether attitudes or actions in the department have changed. Possible measures of success which can be used are:

- number of walkround visits performed
- number of actions identified and completed
- response to safety culture assessment survey of frontline workers and managers
- % increase reporting of patient safety incidents/prevented patient safety incidents
- a decrease in risk/severity of outcome of adverse events identified through case note review using the Global Trigger Tool.

Where possible, link to measures you may already be collating. In essence these visits are about visible leadership in safety and not intended to create an additional data burden.

Appendix 1

Staff Information Leaflet example

<p>The Trusts Patient Safety Programme</p> <p>The Trust is committed to putting Patient Safety as its top priority and to this end has signed up to the national patient Safety Campaign</p> <p>We are striving to make real measurable improvements in the safety of the care for our patients by</p> <ul style="list-style-type: none"> <input type="checkbox"/> decreasing the death rates of patients within our hospital <input type="checkbox"/> decreasing the rate of adverse events <input type="checkbox"/> decreasing MRSA and C. Diff infections <input type="checkbox"/> reduction in harm from anticoagulants <input type="checkbox"/> reducing surgical infections <input type="checkbox"/> reducing crash calls <p>With your help we are already making real progress on all these measures.</p> <p>But we want to do even more than this for our patients and so the Executive team want to meet with the front line staff to hear about what else we need to do.</p> <p>That is the reason for the Safety Walkrounds</p>	<p>WHAT IS THE AIM OF THE WALKROUNDS?</p> <p>Dr Allan Frankel, an anaesthetist from Boston, USA, designed the idea of Patient Safety Walkrounds. The aim of the walkround process is to:</p> <ol style="list-style-type: none"> 1 Increase the awareness of safety issues among all clinicians 2 Make safety a priority for senior leaders by spending a dedicated time promoting a safety culture 3 Educate staff about patient safety concepts such as incident reporting 4 Obtain and act on information gathered that identifies areas for improvement 5 Build communication and relationships with frontline staff <p>WHO IS INVOLVED?</p> <p>You and members of the Executive Team: Chief Executive, Director of Patient Care and Nursing, Director of Planning and Facilities, Medical Director, Director of Finance and Performance, Director of Operations and Director for Staff. One member of the Executive Team will visit</p>	<p>each area accompanied by the Head of Clinical Governance.</p> <p>WHERE DOES THE WALKROUND TAKE PLACE?</p> <p>The Executive Team and the staff can meet and hold the discussions in any area that suits the clinical ward or department. Ideally this should be in or close to the clinical area.</p> <p>WHAT HAPPENS AT THE WALKROUND?</p> <p>A member of the walkround team will explain and introduce the process including the rules for confidentiality, anonymity, and patient safety disclosures. Members of the visiting walkround team will then ask a series of structured questions. All staff participating are encouraged to respond and have their responses recorded.</p> <p>What will we discuss together:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Your key patient safety concerns <input type="checkbox"/> What can we do together to improve? <input type="checkbox"/> Teamwork – how do your local teams operate? <input type="checkbox"/> Communication <input type="checkbox"/> How can leadership help? <input type="checkbox"/> Incident reporting
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At the end of the process we will agree three key actions to be taken forward to make your area safer for patients.

We ask staff to think of a scenario or an example of a patient safety incident they have experienced and bring this to the meeting to share with us.

e.g. Patients not getting their medications on time, observations not being carried out, patients not being reviewed when required, variability of approaches by different clinical teams.

Patient safety is not just about hazards to patients ie falls, but the treatment and system failure that patients are subjected to.

WHAT WILL HAPPEN TO THE INFORMATION WE GATHER?

We will respond to the local team within 48 hours thanking all individuals for their participation and highlighting the main areas discussed and actions to be undertaken.

We will also follow up these actions at a later date and endeavour to ensure that the issues raised are indeed closed and resolved to everyone's satisfaction.

We will also feedback through the local management structures progress on the longer term issues.

The information on issues raised will be summarised and brought to the Executive Team's attention on a monthly basis.

References

Frankel,A., E.Graydon-Baker, C.Neppl, T.Simmonds, M.Gustafson and T.K.Gandhi 2003 "Patient Safety Leadership Walkrounds" *Joint Commission Journal on Quality and Safety* 29 (1):16-26

Leonard M, Frankel A., Simmonds T., Vega K. Achieving Safe and Reliable Healthcare Strategies and Solutions 2004. Health Administration Press. Chicago IL

For further information please contact

Contact details to be added

Hospital logo

PATIENT SAFETY WALKROUNDS

Insert picture of CEO on walkround with staff

An opportunity for frontline staff to raise patient safety issues with the Executive Team

Appendix 2
WalkRounds™ Poster example



Patient Safety

★ Leadership Walkrounds ★

As part of the Hospitals Programme of Patient Safety, two members of the Trust's Executive Team, along with the Head of Patient Safety will be visiting this ward on:

Friday 22 February 2008 at

10am



The visit will be an opportunity for members of the team to talk about any concerns they have around the safety of patients.

All team members who can spare time to talk to the Executives are warmly invited to do so, in particular we would want to invite allied health professionals, medical staff, domestics, clerks and nursing staff to join this meeting.

If you can spare the time please come and join us and share your views.

Look forward to seeing you.



Courtesy of Barts and the London Hospital

Appendix 3

Sample questions list

1. When was the last patient harmed (or had a near miss) in your area? What happened?
(Good starting question to get the discussion going and include less senior staff).
2. Would you be happy for a member of your family to be treated in this area? *(Good finishing question which can be profoundly indicative of a serious problem).*
3. Were you able to care for your patients this week as safely as possible? If not, why not?
4. Can you describe how communication between caregivers either enhances or inhibits safe care on your unit?
5. Can you describe the unit's ability to work as a team?
6. Have there been any near misses that almost caused patient harm but didn't?
Examples:
 - Taking a drug to give to a patient and then realizing it is incorrect
 - Misprogramming a pump, but having an alert warn you
 - Incorrect orders by physicians or others caught by RNs or other staff
7. What aspects of the environment are likely to lead to the next patient harm?
Examples, consider:
 - All aspects of admission, hospital stay and discharge
 - Movement within the hospital
 - Communication
 - Informatics/computer issues
8. Is there anything we could do to prevent the next adverse event?
Examples:
 - What information would be helpful to you?
 - Consider alterations in the interaction between clinicians
 - Consider teamwork
 - Consider environment, workflow
9. What do you think this unit could do on a regular basis to improve safety?
Example:
 - Would it be feasible to discuss safety concerns, e.g. patients with same name, near miss that happened, etc. during report?

10. Can you think of a way in which the system or your environment fails you on a consistent basis?

Examples:

- Not enough information available
- Requirements that don't make sense or that seem unnecessarily time consuming

11. When you make an error, do you always report it?

12. If you prevent/intercept an error, do you always report it?

13. If you make or report an error, are you concerned about personal consequences?

14. Do you know what happens to the information that you report?

15. Have you developed any personal practices that you do to specifically prevent making an error (memory aids, double-checking, forcing functions, etc.)?

16. Have you discussed patient safety issues with your patients or their families? Do patients and families voice any safety concerns?

17. What specific intervention from leadership would make the work you do safer for patients?

Examples:

- Organizing interdisciplinary groups to evaluate a specific problem
- Assist in changing the attitude of a particular group
- Facilitating interaction between two specific groups

18. What would make these executive walkrounds more effective?

Examples:

- Hallway vs. organized conversations
- Individual vs. group discussions
- Managers ensure you have free time to discuss issues

19. What are the 'pebbles in your shoes' that get in the way of you delivering safe care?