Patient Safety Leadership WalkRounds™

By using Patient Safety Leadership WalkRounds™ weekly, senior leaders of health care organizations can demonstrate to staff the organization's commitment to building a culture of safety. WalkRounds are conducted in patient care departments (such as the Emergency Department, Radiology Department, and operating rooms), the pharmacy, and laboratories. They provide an informal method for leaders to talk with front-line staff about safety issues in the organization and show their support for reporting of errors.

This tool describes the format for WalkRounds, suggests questions to ask staff, and indicates which senior leaders should participate and where to conduct the rounds. Review and modify the instructions as needed for your organization before initiating this program. Many organizations that have conducted WalkRounds™ in conjunction with Safety Briefings have achieved greater success in changing the culture than organizations that use either tool alone. Focusing solely on safety during these rounds is a more successful strategy for promoting creating a culture of safety than digressing to other topics such as budgets and patient satisfaction.

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This tool contains:

- Background
- Why Should Organizations Implement WalkRounds™ ?
- Aims
- Measures of Success
- Instructions for WalkRounds™
- Senior Leaders Script for WalkRounds™

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Background

The Institute for Healthcare Improvement formed the Idealized Design of the Medication System (IDMS) Group in May 2000. The group of 30 physicians, pharmacists, nurses, and statisticians established an aim to design a medication system that is safer by a factor of 10 and more cost effective than systems currently in use. An important element of such a system was the strong commitment of senior leadership to a culture that encouraged safety. Allan Frankel, MD, conceived of WalkRounds during these IHI meetings, as a tool to connect senior leaders with people working on the front line — as a way both to educate senior leadership about safety issues and to signal to front-line workers the senior leaders' commitment to creating a culture of safety.

Why should organizations implement WalkRounds™?

- Demonstrate commitment to safety.
- Fuel culture for change pertaining to patient safety.
- Provide opportunities for senior executives to learn about patient safety.
- Identify opportunities for improving safety.
- Establish lines of communication about patient safety among employees, executives, managers, and employees.
- Establish a plan for the rapid testing of safety-based improvements.

Aims

- One hundred percent of employees will believe that a non-punitive policy regarding medical adverse events is in effect and working.
- Spontaneous reporting of adverse drug events (ADEs) and other adverse events will increase by 400 percent.
- Each manager will implement four safety-based changes per year based on information obtained in part through the WalkRounds.
- Eighty percent of managers will respond that their attitudes toward adverse events have changed as a result of the WalkRrounds in a manner that improves the delivery of care.
- A decrease in adverse events by 50 percent will be achieved hospital-wide, as ascertained by a hospital-wide system of surveillance of adverse events.

Measures of Success

- Response to cultural survey of front-line workers and managers (process measure)
- Number of errors reported per month from voluntary reporting systems (outcome measure)
- Number of safety-based changes made by managers per year
- Percent of changes in overall surveillance data (for example, infection rates)

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Instructions for WalkRounds™

Ground Rules

Organizations should decide whether or not to announce the time and place of WalkRounds, and the decision should be agreed to by senior leaders and managers.

Organizations should reassure employees that all information discussed in WalkRounds is strictly confidential.

Who should conduct WalkRounds?

Senior leaders, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Medical Officer (CMO), and Chief Nursing Officer (CNO).

How often?

Senior leaders should commit to conducting WalkRounds at a minimum of once per week, for a minimum of one year, with no cancellations. (Circumstances may demand postponement from an originally scheduled date, but the WalkRounds should still occur within the scheduled week.) Members of the senior executive team can rotate for easier scheduling, but ideally every senior leader should perform WalkRounds every week.

Where?

- Patient care units
- Operating rooms
- Emergency Department
- Radiology Department
- Pharmacy
- Laboratories

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What format?

A conversation with the leader and three to five employees that can be structured in various ways, including:

- Hallway conversations
- Individual conversations in succession
- Conversations with employees in a specific type function or job
- Conversations in the same location each week

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Senior Leaders Script for WalkRounds™

Opening Statements

"We are moving as an organization to open communication and a blame-free environment because we believe that by doing so we can make your work environment safer for you and your patients."

"We're interested in focusing on the system and not individuals (no names are necessary)."

"The discussion we're interested in having with you is confidential — purely for patient safety and improvement; what we talk about won't go beyond this small group if you don't want it to."

"The questions are very general, to help you think of areas to which the questions might apply consider medication errors, miscommunication between individuals (including arguments), distractions, inefficiencies, invasive treatments, falls, protocols not followed, etc."

Questions to Ask

"Can you think of any events in the past day or few days that have resulted in prolonged hospitalization for a patient?"

Examples:

- Appointments made but missed
- Miscommunications
- Delayed or omitted medications

"Have there been any near misses that almost caused patient harm but didn't?"

Examples:

- Selecting a drug dose from the medications cart or pharmacy to administer to a patient and then realizing it's incorrect.
- Misprogramming a pump, but having an alert warn you.
- Incorrect orders by physicians or others caught by nurses or other staff.

"Have there been any incidents lately that you can think of where a patient was harmed?

Examples:

- Infections
- Surgical complications
- Complications secondary to drugs
- Side effects secondary to drugs

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"What aspects of the environment are likely to lead to the next patient harm?"

Examples: Consider all aspects of admission, hospital stay, and discharge

Consider movement within the hospital

Consider communication

Consider informatics and computer issues

"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 and workflow

"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

Requirements that are unnecessarily time-consuming

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

Examples: Organize interdisciplinary groups to evaluate a specific problem.

Assist in changing the attitude of a particular group.

Facilitate interaction between two specific groups.

"What would make the WalkRounds™ more effective?"

Examples: Informal conversations in the hallway instead of organized conversations

Individual conversations instead of group discussions

Ensure free time to discuss issues

"How are we actively promoting a blame-free culture and working on the development of a blame-free reporting policy?"

Examples: We do not penalize individuals for inadvertent errors.

The institution grants immunity to individuals who report adverse events in a timely fashion (where criminal behavior is not an issue).

Closing Comment

"We're going to work on the information you've given us. In return, we would like you to tell two other people you work with about the concepts we've discussed in this conversation."

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