Impact of Staff-Led Safety Walk Rounds

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Abstract

Objectives: The primary objectives of this study were to provide a venue for discussing safety concerns and to facilitate finding solutions for everyday safety issues. **Methods**: The multidisciplinary patient safety committee (Team Safety) at Kosair Children's Hospital began safety rounds in January 2007. Each month, several teams walked through patient care areas and talked to staff. Responses to questions and other comments mentioned during rounds were recorded. Between safety rounds, the Team Safety chairperson met with the Vice President of Clinical Operations to discuss the findings, assign priorities, and develop action plans. **Results**: From January 2007 through August 2007, Team Safety members talked with 182 staff from at least 10 disciplines and recorded 79 different concerns; 39 percent of these have been completely or partially resolved. More staff know how to report events and near misses and can describe how the information is used. **Conclusion**: Frontline caregivers can conduct effective safety walk rounds.

Introduction

Patient Safety Leadership WalkRounds™ have been shown to improve the safety culture of hospitals.[1] Safety walk rounds consisted of a core group of senior executives and/or vice presidents walking through the hospital on a weekly basis. During rounds, members of the group asked questions about near misses, adverse events, and system issues contributing to these events. The events were analyzed to determine priorities. Subsequently, executives provided quarterly reports detailing actions taken to address the events. The authors suggest that the improvement in safety culture attributed to walk rounds was related to the education that leadership provided and to the increased rate of safety-based changes.

In a subsequent study, change in safety culture was measured using the Safety Climate Survey before executive walk rounds began and again 2 months after they ended.[2] The authors reported that staff who had participated in walk rounds had higher safety climate scores compared to those who had not participated in walk rounds. An Internet search using "safety walk rounds" as the query yielded several articles and newspaper style stories from a number of hospitals that described the success of executive walk rounds.[3, 4, 5]

Unit-based patient safety walk rounds represent one modification of hospital executive walk rounds. Implementation of safety walk rounds led by the emergency department director, associate director, nurse director, the clerical staff manager, and leaders of the Nurses' Quality Council in the Pediatric Emergency Department at the Children's Hospital of Philadelphia resulted in an improvement in safety culture and quality of care.[6]

In January 2007, members of the Kosair Children's Hospital Team Safety began safety walk rounds. The objectives were similar to those reported for Patient Safety Leadership WalkRounds™ and other executive walk rounds programs: to improve safety culture throughout the hospital and to facilitate resolution of safety concerns in a timely manner. An additional objective was to demonstrate that safety walk rounds led by bedside providers can achieve success that is comparable to safety walk rounds led by hospital executives and managers.

Methods

Team Safety is the hospital's multidisciplinary patient safety committee. Members include physicians (attendings, trainees), staff nurses, and staff representatives from respiratory therapy, pharmacy, and the clinical laboratory. Other members include staff from risk management, clinical resource management, and education. The chief nursing officer attends the monthly meetings but does not participate in safety walk rounds. The hospital medical director is a member of the team and does participate in safety walk rounds.

Monthly safety walk rounds began in January 2007. Four teams of two to three Team Safety committee members walked through six to eight patient care areas of the hospital each month for 45 to 60 minutes and talked with staff from all disciplines. Only the Team Safety chair (author) has participated in all safety walk rounds. Other members participated as their clinical schedule allowed. Managers of the patient care areas did not participate. No advance notice was provided.

Team members carried a "toolbox" on safety walk rounds. The toolbox comprised the script, data collection forms, and giveaways (e.g., covered notepad, candy, and pocket-size hand sanitizer) that were embossed with the Team Safety's logo. Team members used a script consisting of eight questions to initiate discussion (Appendix A). All comments made by staff were recorded. Data recorded by team members included the patient care areas visited and the number and disciplines of staff who participated in safety walk rounds. Team members did not record the names of staff members who participated in walk rounds. Although staff members were not anonymous to the members when we walked, no comment was labeled with a staff member's name unless the staff member requested feedback. If a staff member requested direct feedback, the staff member's name was recorded, and a member of Team Safety provided the staff member with followup.

After each of the walk rounds, the teams met for debriefing. The chair of Team Safety took notes and collected the data sheets from the teams. Subsequent to each debriefing session, the chair collated the responses, categorized safety concerns into one of eight categories based on the focus of the concern, and identified who would resolve each of the issues. As issues were addressed and ultimately resolved, the chair updated the safety walk rounds in an Excel® worksheet to reflect the progress.

Concerns that represent immediate risk were addressed/resolved within 24 to 48 hours by actions initiated by members of the committee, the chair, or the medical director in conjunction with appropriate hospital managers and leaders. Concerns that impacted one or two care areas and required few resources for resolution were usually addressed by the chair, members of the committee, or the medical director with the appropriate managers and leaders of the care areas.

The chair met with the vice president of clinical operations on a recurring basis to discuss what was reported during safety walk rounds. These discussions resulted in the development of action plans to address the more complex, hospital-wide concerns, provided the opportunity to review successes, and served to keep hospital executives informed of the committee's actions. A summary of findings from the walk rounds, as well as the action list, were presented at the monthly Team Safety Committee meeting. In addition, the committee reported the results of safety walk rounds to other hospital committees and in various internal hospital publications.

Results

Safety walk rounds have occurred seven times between January and August 2007. Walk rounds were not held in April 2007 due to scheduling conflicts. We talked with 182 staff from at least 10 disciplines (Figure 1).

A total of 79 different safety concerns from eight categories have been identified during safety walk rounds. (Figure 2) Twenty-four percent of the concerns related to equipment, 20 percent to care delivery, 15 percent to the work environment, 10 percent to medication, 1 percent to staffing, 8 percent to communication, 8 percent to intrahospital transport, and 6 percent to security issues.

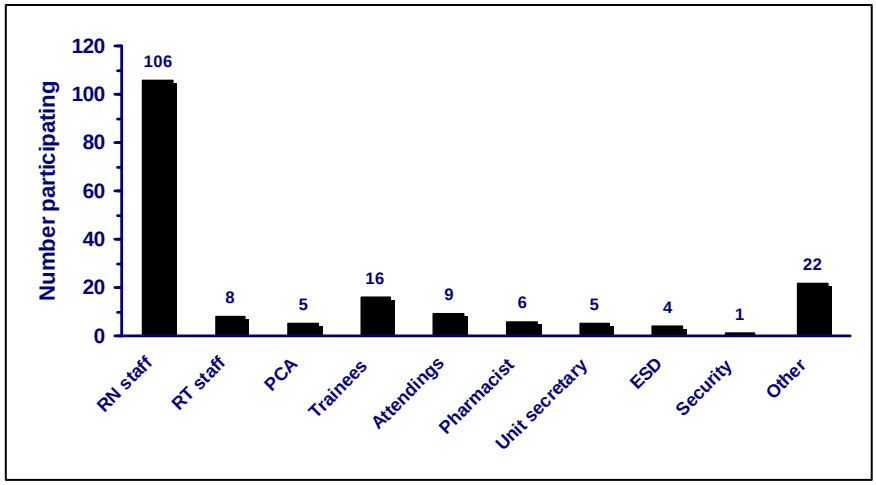

Figure 1. Number and discipline of staff participating in safety walk rounds

RN = registered nurse; RT = respiratory therapist; PCA = patient care associate; ESD = environmental services department

Table 1 lists examples of concerns expressed to members of Team Safety. Of 79 action items, 31 (39 percent) have been resolved or are in the process of being resolved. Issues that were reported and resolved include:

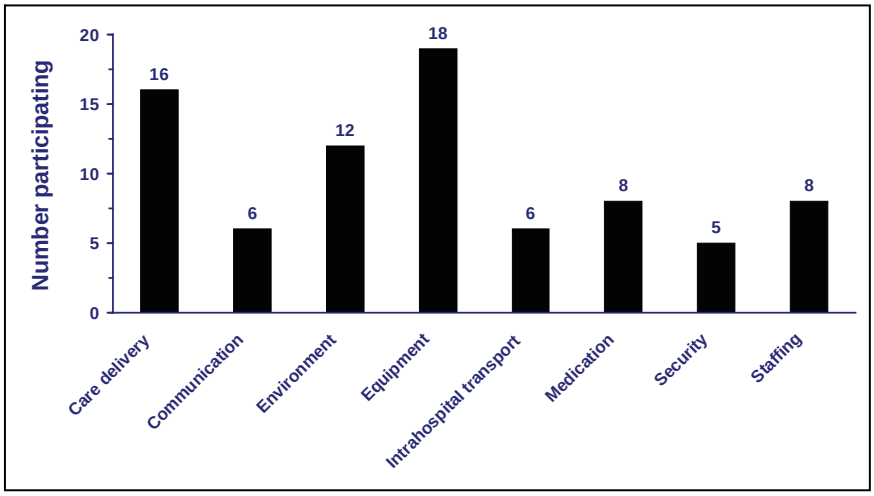

Figure 2. Classification of safety concerns identified during safety walk rounds

- Chemotherapy for different patients with the same last name dispensed to the oncology unit packaged in the same outer bag.
- Inadequate hand-off tool between staff of the cardiac catheterization laboratory, the post-anesthesia care unit, and the critical care center.
- Inaccessibility of policies and procedures stored in electronic format.
- Cumbersome event reporting system for physicians (a user-friendly format already existed for nurses).
- Inability to access the hospital's electronic medical library and drug dosing and administration references from portable computers.
- Inconsistent labeling of trimethoprim-sulfamethoxazole.
- New order sets for insulin dosing and administration.
- New forms and additional venues for reporting near misses and adverse events.
- New processes for intrahospital transport.

Table 1. Examples of comments made to Team Safety members during walk rounds

Care delivery	• Request for education and consistency regarding insulin administration. • Missed and delayed orders after new order process implemented. • Difficult to access virtual medical library and electronic drug handbook.
Communication	• Incomplete hand-off from cardiac catheterization laboratory to other areas. • Difficult to access electronic version of policies and procedures.
Environment	• Plastic bags covering clean linens pose risk to toddlers. • Nail and screw tips protruding into drawers pose risk to staff and visitors.
Equipment	• Insufficient number and remote placement of resuscitation bags and masks. • Missing pieces on ECG machines.
Intrahospital transport	• Inadequate communication between RN, transporter, and radiology department. • Lack of process for providing staff to accompany and stay with patient.
Medication	• Inconsistent naming of trimethoprim-sulfamethoxazole (generic vs. trade). • Risk of medication error involving patients with same last name.
Security	• Difficult to distinguish patients from visitors with current system. • Difficult to monitor/control visitor movement in/out of care areas.
Staffing	• Acuity/census changes faster than number of RNs increase. • Difficult to maintain appropriate skill mix when acuity rapidly changes.

An interesting observation—and hopefully, one that suggests a stronger safety culture throughout the hospital—is an increase in the number of staff who know how to report a near miss or actual event and what happens to the reported information. During the early months of safety rounds, members of Team Safety noticed that few staff members knew how to report a near miss or actual event or what was done with the information if a report was made. Duing the last 2

months of walk rounds, only 4 of the 52 staff members interviewed during safety walk rounds were unaware of how to make a report or how the information was used. Unfortunately, data were not collected during the early months of safety walk rounds to allow a statistical analysis of this observation.

Twenty-eight different safe habits have been reported in response to the question, "Have you developed any habits that you think help you deliver safer care?" Examples of new safe habits are listed in Table 2. Safe habits are shared with staff during safety walk rounds and through various hospital publications.

Discussion

Our results demonstrate that safety walk rounds led by frontline caregivers can lead to the identification and resolution of safety concerns important to frontline providers. Based on the number of staff who now know how to report events and understand how the information is used to improve patient care, we suggest that the enthusiasm, interest, and safety knowledge demonstrated by peers can positively influence a hospital's safety culture. To our knowledge, we are the first to implement a safety walk rounds program that does not include unit managers and executives. Our results mirror the successes demonstrated in Patient Safety Leadership WalkRounds™ and other programs in which rounds are led by hospital leaders.[1-5]

The approach to safety walk rounds described in this report varies from the process previously described for executive walk rounds in several ways. Members of Team Safety who lead safety walk rounds have no formal instruction on how to conduct walk rounds or patient safety. They are provided the script and asked to talk with their peers in a nonthreatening setting with the primary goal of identifying safety issues that are important to frontline providers. Although finding safe solutions may not be intuitive, identification and discussion of safety issues by frontline providers seems to be inherent in daily workflow. Members of Team Safety are very aware of the work environment and what is unsafe. Frontline providers talk about what works and does not work on a daily basis. However, a venue for addressing and resolving safety issues is frequently absent or lacks structure. The author believes that our format for safety walk rounds provides a structured venue for staff to express their concerns and contribute to developing a safer environment within the hospital.

Despite the differences, there are common elements between Patient Safety Leadership WalkRounds™ and Team Safety walk rounds. Members of Team Safety are dedicated to improving patient and staff safety and the safety culture of the hospital, as are executives who participate in safety walk rounds. In both approaches, participants usually use a script to guide the discussion. Others have reported that the success of safety walk rounds depends on executives, who are knowledgeable in safety principles, are firm believers in the benefits of safety walk rounds, and are vested in improving safety.[1] Our success depends on hospital leaders possessing these same qualities. Although hospital executives and managers do not participate in Team Safety walk rounds, they are essential to the success of our program. There must be a venue for sharing the information with hospital leadership. Meetings between the chair of Team Safety, the vice president of clinical operations, and other managers are key to implementing change, especially when financial resources are required to completely resolve a concern.

Feedback to the staff is essential for success of safety walk rounds, whether led by staff or executives. Feedback occurs in our program via e-mail, hospital committee meetings, a monthly hospital nursing publication, a bimonthly hospital physician publication, other means of communication as appropriate, and during safety walk rounds.

The distribution of the types of concerns expressed during staff-led safety walk rounds are similar to the findings during patient safety leadership walk rounds described by Grillo, et al.[5] During our safety walk rounds, 24 percent of concerns related to equipment, 20 percent to care delivery, 10 percent to staffing, and 8 percent to commmunictions. Grillo reported that 30 percent of the comments reported during their safety walk rounds related to equipment, 13 percent to communication, and 6 percent to workforce.

Conclusion

We implemented monthly safety walk rounds to identify safety concerns and improve safety awareness. Our results demonstrate that safety concerns are readily identified by frontline providers, and they can be identified and resolved utilizing safety walk rounds led by peers. Successful resolution of safety concerns depends on hospital leadership who are supportive and share the team's passion for decreasing adverse events in the hospital and providing safer patient care. Future directions for our safety walk rounds include visiting non-patient care areas such as the clinical laboratory and outpatient registration, walking during evening and weekend hours, and attending staff meetings to provide opportunities for more staff to participate in safety rounds, disseminate safety information, and report the impact that their safety concerns have had on creating a safer patient care environment.

Acknowledgments

I would like to thank the members of Team Safety for their participation in Safety Walk Rounds. I thank the hospital executives for recognizing that progress in patient safety is key to the success of our hospital, providing ample opportunity for me to discuss the findings of safety walk rounds and working with Team Safety to develop solutions.

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Appendix A

Safety walk rounds script

- Are you aware of any “near misses” – events that almost caused patient harm but didn’t – that occurred sometime during the last several shifts that you worked?
- What are the barriers that prevent reporting of “near misses” or actual error?
- Do you know how the information from occurrence reports is used in this hospital? Do you have any ideas on how the information should be used? Have you ever received feedback?
- Were you able to care for your patients during your last three shifts as safely as possible? If not, what were the barriers/hindrances?
- What is your biggest safety concern on your unit? Is there anything that could be done to prevent the next adverse event or to address your safety concern?
- What would help improve the safety consciousness in this hospital?
- What is one thing that you think could happen today that would improve patient safety on your unit?
- Have you developed any habits that help you decrease the risk of making an error? If yes, what are they?

Source: Adapted from Frankel A, Graydon-Baker E, Nepl C, et al. Patient Safety Leadership WalkRounds™. Jt Comm J Qual Saf 2003; 29: 16-26.