

# How patient safety walkrounds help to put safety first in healthcare delivery

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Patricia O'Connor describes the impact of patient safety walkrounds on clinical practice and safety in NHS Tayside.

In his *Safety First* review of patient safety systems in the UK, chief medical officer Professor Sir Liam Donaldson asked organisations to redouble their efforts to implement systems and interventions that actively and continuously reduce risk to patients<sup>1</sup>. At NHS Tayside, part of the The Health Foundation's Safer Patients Initiative, we are trying to put patient safety at the heart of healthcare delivery. We have introduced patient safety walkrounds as part of our patient safety programme and these have produced rapid results in risk identification and mitigation.

## The aim of walkrounds

The extent of harm in healthcare is generally accepted worldwide as 1 in 10 of all hospital admissions<sup>2</sup>. We continue to report these levels of harm despite our awareness of systems failures<sup>3</sup>, improved training in adverse event management and searching for root causes<sup>4</sup>. We also know from the *Safety First* report<sup>1</sup> that we are still unable to assure patients that all organisations are learning from experience to prevent harm. Improving patient safety requires the involvement of all staff, so how do organisations listen to, capture and address their patient safety concerns?

We know that incident reporting will not identify all patient safety risks, and for most patients involved in these events it's already too late. When harm occurs we need to improve our systems to ensure that the effect on patients is minimised. This suggests we need to identify more effectively sources of harm, with a faster response. Routinely identifying patient safety concerns can be a challenge<sup>5</sup>. NHS Tayside, a large teaching healthcare system with 2,400 beds providing tertiary, acute and primary care, has implemented an idea from the Institute of Healthcare Improvement (IHI) in Boston – patient safety walkrounds<sup>6,7</sup> – to improve identification of patient safety issues.

## KEY WALKAROUND QUESTIONS

- Were you able to care for your patients this week as safely as possible? If not, why not?
- Can you think of any events in the past day or few days that have resulted in prolonged hospitalisation for a patient?
- Can you think of a scenario or example of a patient safety incident where a patient was harmed?
- What do you think this unit could do on a regular basis to improve safety?
- What specific intervention from leadership would make the work you do safer for patients?
- Can you give any examples of local good practice to improve safety that we can share throughout the organisation?

These walkrounds, developed with the IHI and introduced in February 2005, differ considerably from leadership walkrounds in management literature<sup>8</sup>, as they are designed specifically to focus on and improve patient safety. Their aim is to:

- increase awareness of patient safety issues among all clinicians and leaders;
- make safety a high priority for senior leadership;
- obtain information from staff about barriers to safety;
- act quickly, after careful analysis, on information collected from staff;
- promote a patient safety culture and improve reporting of adverse events and near misses; and
- consistently give feedback to frontline providers and leadership on improvements made in the name of patient safety.

## Developing the walkround process

Within NHS Tayside, our patient safety walkrounds involve at least one member of the executive team, a scribe, the local staff and a patient representative. A typical visiting team might include the director of finance, director of nursing, lead for patient safety, and an administrator to document the process. The departmental team may include a staff nurse and lead doctor, a pharmacist, the housekeeper, and a patient representative. Prior to a walkround, we plan the timing of the visit in collaboration with local service demands and executive lead availability. Information leaflets describing the process and purpose of the patient safety walkrounds are sent to the ward/department for circulation to staff and patients several weeks in advance.

We visit one department every week for approximately 30 minutes. The purpose of patient safety walkrounds is explained, emphasising the importance of confidentiality. To encourage openness and transparency, participants are not named but recorded by role and designation. Permission to share information regarding good practice or local solutions is obtained from those attending. Each of the visiting team are introduced; then they ask a series of questions (see box at left).

The emphasis in these questions is on identification of the precise leadership interventions needed to facilitate a safe environment for frontline staff and patients. During the course of the conversation, key patient safety issues emerge. The scribe records the main concerns, summarises and then asks attendees to agree three actions to be taken forward. Each action is prioritised and a named individual is identified to follow up action within a specified timeframe. The scribe will record the key actions in the walkrounds database and send a report to the local area within 48 hours. Regular monthly reports on follow-up are presented to the executive team and shared throughout the organisation through management structures for risk, governance and safety.

### Improvements as a result

More than 700 staff from all disciplines have participated in the safety walkround programme to date. The response has been very positive. More than 500 simple improvement interventions at both system and local level have been made, including:

- introducing safety briefings to daily practice;
- small improvements to the environment, such as extra electric points, new lighting, and security measures;
- spreading the use of a patient safety communication tool;
- starting an equipment library for intravenous infusion devices;
- a review and redesign of the paediatric medications room;
- introducing improved medication systems;
- spreading patient safety solutions; and
- improved handover systems.

On a larger scale, an organisational review of charge nurse administration time was undertaken, and several areas have embarked on changes to improve practice in positive patient identification. Many examples of good practice from local developments are shared widely throughout the organisation in this way. Since February 2005 more than 90 walkrounds have taken place in clinical areas, outpatients, the laundry, the laboratories, the portering service and many more. Return visits are now under way. In 20 months the programme has enabled the lead executives to visit all departments in the organisation.

Many of the actions taken by those participating, particularly the executives, are completed the same day as the visit. A telephone call or discussion with a peer is often all it takes to make a small change. Local managers are included in all interventions by executives to ensure their confidence and credibility is not undermined. All executive directors participate in the programme, including clinical and non-clinical lead, and patient safety is discussed weekly at the executive team meetings. This emphasis sends a clear message to all, that "patient safety is everyone's business." Most local interventions are addressed within a month and post-visit follow-up reports, circulated within 48 hours, keep everyone involved in the plan to take action. Larger-scale organisational issues that require a whole system review or considerable resources are reviewed by the executives every quarter.

### Key benefits of implementing walkrounds

The system is simple to operate and monitor, and takes a proactive approach to patient safety. It does not rely on staff time to complete a formal report and brings together frontline staff and decision-makers in face-to-face discussion. Unlike incident or near-miss reporting, these discussions can often identify patient safety risks that have not yet had any impact for individual patients but which pose a potential threat that staff recognise and want to share.

Above all, the system has become a visible demonstration of the organisation's commitment to patient safety. Staff report that they welcome the opportunity to discuss patient safety collectively with the senior leaders. Comments from staff on the wards include:

"It's a much faster way for me to communicate the patient safety issues in my area of work ... It would take me ages to formally record an incident report, get some feedback and action and I wouldn't have the opportunity to raise multiple issues like this."  
(ward assistant, Dec 2006)

"The safety walkrounds are a great way to meet and discuss our patient safety concerns with the senior leadership of the organisation. I really felt my concerns were listened to and acted upon quickly."  
(staff nurse, May 2006)

"It's great to see the senior executives coming to have joint discussions about patient safety issues. The concerns I raised were actioned very quickly and I received feedback about the issues we had agreed within a couple of days. I also received an update report a couple of months later to advise me of the progress on the bed issues that I raised."  
(senior charge nurse, June 2006)

The system has also had an impact on the way senior leaders view their role in safety:

"This process has really brought home to me that my job is all about patient safety. It gives me a clear understanding of the impact of some of the estates and facilities decisions and how they affect the delivery of patient care."  
(director of operations, Feb 2005)

"... sending a message up the ranks to me can often take so long and be so cumbersome staff don't believe it's worthwhile. This process gives staff an additional, fast and efficient way to talk about patient safety and see action taken as a result."  
(chief executive, June 2006)

Patient safety walkrounds link frontline staff, patients and the executive team to develop joint patient safety solutions. Clear lines of communication for patient safety are established. The process also acts as a vehicle to promote and encourage other methods of detecting potential or actual harm. In 20 months at Tayside, reporting of events and near misses has increased by 15%. This suggests a more safety-aware culture, not a more risky or harmful one.

Developing a walkround system is relatively simple. First, find a good organiser and develop a schedule of departments to visit within your healthcare setting. Then identify a list of executive team members to participate, matching the departments with the executive team availability list, and notifying departments at least one week in advance of the visit.

NHS Tayside's experience is that patient safety walkrounds help to establish patient safety improvement as a core component of healthcare activity. This takes up Sir Liam's challenge to "create an environment that motivates and inspires staff to insist that all care must be as safe as possible"<sup>1</sup>. NHS Tayside agrees with him that "the stakes could not be higher nor could our responsibilities to succeed be more important."  
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### References

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