Patient Safety Tip of the Week

October 7, 2014

Our Take on

Patient Safety Walk Rounds

We think that Patient Safety Walk Rounds are one of the most important tools you should have in your patient safety programs. You've often heard us in our Patient Safety Tips of the Week say "…another good thing to add to your Patient Safety Walk Rounds".

This month's BMJ Quality & Safety issue has an excellent article on Patient Safety Walk Rounds (Singer & Tucker 2014). It's a review of the literature on patient safety walk rounds and provides concise summaries of the published studies in tabular form. It emphasizes that there are actually many limitations to studies previously done, including selection bias, lack of controls, and lack of objective measures. In addition, most studies come from single sites so the generalizability is questionable. They do note that a small subset of studies have reported positive outcomes on both quality/safety metrics and safety climate measures.

One of the most important points in their review is that Patient Safety Walk Rounds **can be counterproductive**. That is, if the issues raised fail to be resolved, frontline staff become frustrated and the safety climate may actually deteriorate. They note studies show a negative impact when rounds are done "as a form of surveillance and control" rather than "inquiry and support".

The authors do note that there appears to be a **dose-response relationship** in that involving as many staff as possible is important in successful implementation.

Singer and Tucker also discuss **variations of safety rounds**. One is the "**adopt-a-work-unit**" program or the **CUSP** program (Comprehensive Unit-Based Safety Program). We discussed CUSP's in our March 2011 What's New in the Patient Safety World column "Michigan ICU Collaborative Wins Big" and our July 22, 2014 Patient Safety Tip of the Week "More on Operating Room Briefings and Debriefings". We've also referred readers to Pronovost 2006 and Timmel 2010 for good descriptions of the CUSP model. The CUSP model is also nicely described in Peter Pronovost's book "Safe Patients, Smart

Hospitals" (see our July 6, 2010 Patient Safety Tip of the Week "Book Reviews: Pronovost and Gawande"). In such models senior management work with a unit on a continuous basis rather than rotating.

Singer and Tucker also note that safety rounds can be successfully used to identify safety issues when done by people other than senior management, such as frontline staff themselves or departmental managers. Also, in our December 23, 2008 Patient Safety Tip of the Week "Why Safety Alerts Often Fail" we discussed a unique "**safety coach**" program that utilizes frontline staff and includes elements similar to those used in walk rounds (Lindberg 2008).

Our own take on Patient Safety Walk Rounds is less scientific and based on our own experience. But we think our observations, nevertheless, provide some good insights.

How often should you do Walk Rounds? Unfortunately there are no hard and fast guidelines. We usually recommend that each unit be visited at least every two months, perhaps supplemented by monthly rounds done by other staff.

One bad habit organizations have is only doing Patient Safety Walk Rounds on the day shift. It is extremely important that you **do them on all shifts**. That takes planning and commitment. Why is it important? Because two-thirds of the staff you want to include in your safety culture work on those other shifts! Not only do you need to convey to them your commitment to improving patient safety but you will also better see and hear about some of the barriers to patient safety on the evening and night shifts.

Who should be there on Patient Safety Walk Rounds? Your core team should include your **CEO, COO, CMO, CNO, and head of Quality and Patient Safety**. But there are others that should also participate. You'll want a **pharmacist** for rounds on almost all units. Bringing your **CFO** on such rounds is a good way of giving him/her a better understanding of how patient safety issues can impact the bottom line. Your **CIO** may also gain valuable insights into how staff interact with technology and many of the safety issues resulting from complex IT issues or ones that could use an IT solution. Including representatives from other departments (eg. engineering, housekeeping, SPD, etc.) can also bring unique perspectives. We also recommend that you include your **Board members** in Patient Safety Walk Rounds. Not every rounds, but mandate that each Board member attend at least one walk rounds session annually. Not only will that help educate them about patient safety but you'll be pleasantly surprised by the insights they bring to your rounds, either by their perspective as a "consumer" or patient or the perspective of whatever industry they happen to come from. For example, a banker might cringe looking at patients in line in your antiquated patient registration system and have good ideas for improving efficiency and patient flow. Note also that the current Singer & Tucker review mentions the importance of including **physicians** in such rounds. We wholeheartedly agree. Almost every study done on culture of safety shows disparities between the impressions of frontline staff and physicians (and administrators). However, equally important is not having the physician presence stifle open discussion of issues with staff. We've all too often seen situations in which behavior of a physician is the

critical safety issue and staff are unwilling to speak about it in front of another physician, even the CMO. Lastly, some include a **patient or patient family member**. A Board member might fulfill that role but Board members may have an “insider” bias. Having an “outsider” pair of eyes and ears may be important.

Should all those individuals be on every Walk Rounds? Definitely not. Having too many upper management people on rounds can be very intimidating to staff. So split them up. Have 2-3 team members do walk rounds on one unit and others do them on another unit or another shift. You really want to be able to interact with your frontline staff and make them feel comfortable in speaking up.

What units should get Walk Rounds? Answer: **all of them**. But some may need particular attention, particularly those that are **“melting pots” like the Radiology suite**. In our October 22, 2013 Patient Safety Tip of the Week “How Safe Is Your Radiology Suite” we discussed the multitude of safety issues seen in Radiology suites that have little to do with radiology per se.

Remember, you are not just doing walk rounds for show. The most important thing you can do is identify issues and **follow up**. One member of each team should keep a formal **issues log** that includes action items and dates for expected actions. **Timely feedback** to frontline staff on actions taken for each item is extremely important. And beware of simply telling staff “that’s been referred to Committee X” because that often conveys the message “nothing is going to be done”. You will encounter some items that cannot be fixed simply or expediently. In such cases you need to be honest with your staff and tell them, for example, that a current budgetary or technical restraint won’t allow a quick fix (eg. “that is in the software version update to be installed in 3 months”). But at least they will know that it is still on your list. Singer & Tucker also stress that frontline staff become frustrated when senior management spends too much time prioritizing issues rather than taking actions.

Body language on Walk Rounds is extremely important. Not theirs, yours!!! The old adage that 90% of communication is nonverbal holds true. If your body language conveys disinterest or “let’s just get this over” it won’t matter what you are saying with your staff. They will recognize that such rounds are perfunctory.

We agree with Singer & Tucker that “surveillance” on walk rounds can be counterproductive but that applies mainly to surveillance of people. That doesn’t mean you shouldn’t look for some unsafe conditions when doing your safety rounds. For example, if your facility handles behavioral health patients (even if it is only in your ER) you should be looking for things like “loopable” items in the bathrooms in your radiology suite that might be used for suicide. Or you might check floor stock to make sure you don’t have vials of concentrated heparin that might mistakenly be given to patients during a heparin “flush”. Or some of the battery charging/recharging issues we raised in our February 4, 2014 Patient Safety Tip of the Week “But What If the Battery Runs Low?”. And we always recommend vigilance to alarm safety issues during Walk Rounds (see our July 2, 2013 Patient Safety Tip of the Week “Issues in Alarm Management”).

The most important thing on Walk Rounds is **encouraging staff to speak up** about potential safety issues. To do this you need a comfortable, nonpunative culture in which staff understand that they will be praised, not vilified, for their openness. For example, we all know that **workarounds** are usually potentially dangerous yet they are ubiquitous. Workarounds are almost always a sign of an underlying root cause that needs to be fixed so identifying workarounds is important. When you ask staff about workarounds you need to let them know you are looking to fix whatever problem makes them do a workaround and that you are not going to punish them for doing a workaround.

Walk Rounds are also a good way to **get a feel for safety culture on each unit**. We feel you get a much better understanding of "local (unit)" culture on such rounds than you get on the many formal safety culture assessment tools used by many organizations.

Lastly, **how do you measure** the impact of your Walk Rounds? That, of course, is difficult because it's hard to separate out the results from Walk Rounds from all the other patient safety activities your organization is doing. Nevertheless, you should at least be able to look at your issues log and be able to report the percentage of safety issues identified and resolved. You can also elicit feedback from staff on how they perceive such rounds.

Admittedly, the evidence base for Patient Safety Walk Rounds is less robust than many of our other patient safety interventions. Nevertheless, such rounds make a lot of common sense. Just beware of potential downsides of such rounds if they are done poorly and without conviction.

References:

Singer SJ, Tucker AL. The evolving literature on safety WalkRounds: emerging themes and practical messages. BMJ Qual Saf 2014; 23: 789-800
http://qualitysafety.bmj.com/content/23/10/789.full.pdf+html

Pronovost PJ, King J, Holzmueller CG, et al. A Web-based Tool for the Comprehensive Unit-based Safety Program (CUSP)**.** Joint Commission Journal on Quality and Patient Safety 2006; 32(3): 119-129
http://www.ingentaconnect.com/content/jcaho/jcjqs/2006/00000032/00000003/art00001

Timmel J, Kent PS, Holzmueller CG, et al. Impact of the Comprehensive Unit-Based Safety Program (CUSP) on Safety Culture in a Surgical Inpatient Unit.
Joint Commission Journal on Quality and Patient Safety 2010; 36(6): 252-260
http://psnet.ahrq.gov/public/Timmel-JCJQPS-2010-18221.pdf

Pronovost P, Vohr E. Safe Patients, Smart Hospitals: How One Doctor's Checklist Can Help Us Change Health Care from the Inside Out. Hudson Street Press 2010

Lindberg L, Judd K, Snyder J. Developing a Safety Culture with Front-line Staff. Health & Hospital Networks. September 2008
http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/09SEP2008/0809HHN_FEA_QualityUpdate&domain=HHNMAG

http://www.patientsafetysolutions.com/

Home

Tip of the Week Archive

What’s New in the Patient Safety World Archive