Washington State Hospital Association

Executive Rounds for Safety

Building a Safe Culture: Bringing Board Members, Executive Leaders, and Frontline Staff Together

Contents

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Introduction

Build Safe Culture Using Executive Rounds for Safety

Executive Rounds for Safety is one of the few patient safety tools that addresses transforming culture while visibly demonstrating that patient safety is a top priority.[i] Executive rounds for safety take away the *assumption* of a safe culture and provide evidence of a *verified* safe culture.[ii] These types of rounds have been used to improve culture in institutions of all sizes both nationally and internationally. The concept is ideal because it is simple, creates a mechanism to promote change, build trust and establish meaningful relationships between frontline staff and executive leaders.

The executive rounds for safety process does not dictate change but rather creates an environment for board members, executives and frontline staff to come together and mutually agree on problems and action steps. As one step leads to another, it often produces a fundamental shift in how the organization responds to safety, and an overall change in organizational culture. Creating a discipline involving board members and executive leaders who elicit and listen to concerns regarding safety delivers a strong message to the organization: it is important to create a safer environment for both patients and employees.[iii]

Who Should Conduct Executive Rounds for Safety?

Organizations that have successfully implemented executive rounds for safety include executive leaders such as: the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO) and Board Members in their rounds teams.

The focus of this tool is related to the process of executive rounds for safety. However, there are many different types of rounds that occur at every level of the organization. The table below provides an overview of several types of rounds.

Type	Lead	Participants	Objective
Executive rounds	Senior executives (the CEO/ "C" suite)	Front line staff, students (also consider Board members, patient advisors)	• Enhance climate of trust • Discuss progress on key performance metrics • Surface/address issues identified by staff • Recognize accomplishments and progress • Remove barriers to communication and process improvement • Strengthen accountability processes
Rounds w/ direct reports	All leaders w/ direct reports	Direct reports	• Further strengthen relationship between managers and those who report to them • Identify and recognize what is going well • Identify opportunities to support staff
Leader rounds with internal customers	Support staff leaders who provide services to other departments	Staff in units receiving service from support departments	• Build relationships with internal customers • Learn what is working well and what could be further improved • Improve level of service provided to internal customers
Nurse executive rounds	Nurse leaders (e.g. CNO, nursing directors/managers and charge RNs)	Patients and families	• Assess quality of care and service from patient/family perspective • Identify what is going well • Identify what could/needs to be improved • Provide any needed service recovery • Increase patient/family confidence in care
Physician rounds	Physicians w/active patients	Patients and families	• Assess status of patient's care • Discuss key care issues with patient and family

Organizations should develop a structured process for scheduling and carrying out executive rounds. The actual conversations will vary to ensure the comfort level of the participants and to encourage the sharing of information. Each organization will need to determine what departments will begin the process and at what frequency executive rounds should occur. For example, an organization may choose to pilot the process in a select number of units or they may want to prioritize certain units based on their data or identified risks. Ideally, each department would be involved in executive rounds on a regular basis.

Staff should be encouraged to report errors as a vehicle for improving patient safety. Executive rounds should support the current safety agenda, but can also have a special focus to influence new or problematic topics; for example, focusing on catheter associated urinary tract infections (CAUTI) if the hospital's CAUTI rate is especially high **(see Attachment B)**. In such an instance, the executive who performs rounds would be provided with effective questions for identifying barriers to reducing CAUTI. This strategy puts the people who experience the obstacles in front of the people who can help remove barriers.[ii]

A critical component in the rounds process is the feedback loop. A feedback loop is a process in which executives circle back on issues that were brought up during rounds to check in or provide updates. This provides a visible demonstration that staff were heard and that their input is important. This encourages them to continue sharing their safety concerns which promotes safe culture.

Basic Components of Executive Rounds

The basic components of Executive Rounds Include:

1. **Planning**
2. **Scheduling**
3. **Rounds Sessions**
4. **Documentation and Reporting**
5. **Closing the Loop**
6. **Measuring Effectiveness**

1. Planning

In order for executive rounds to be successful, a strong commitment and active involvement from board and executive leadership is essential.

Examples of this include:

- Being actively involved and highly visible in the organization, modeling rounds as a top priority
- Chairing monthly meetings to review feedback and data from rounds
- Ensuring timely follow through as issues rise to the executive or operations level.
- Participating in the feedback to staff and departments
- Ensure executives have the correct training and resources to conduct effective rounds

In order to create a positive environment for rounds, it is important to inform staff of the purpose and process. This will help encourage staff to share information comfortably with executives. Ideally, a point person would be assigned to oversee the rounds. This individual would be in charge of planning the rounds schedule, data collection and analysis and ensure there is a process for follow-up and feedback. The person designated to be in charge of the rounds program should have enough global knowledge of the different departments to recognize when feedback affects multiple clinical areas and disciplines. A scribe is also recommended to help facilitate consistent documentation of issues.

2. Scheduling

It is recommended that executive rounds for safety sessions be scheduled as far in advance as six months to ensure they are completed on a consistent basis. Cancelling scheduled rounds sends a message to the frontline staff that safety is not a priority. The composition of the rounds team can vary depending on the size of facility, but at a minimum should have a senior executive, department director and/or manager and designated scribe.

Facilities should determine the frequency of rounds based on their size and identified risk level for the different units. Organizations with outpatient facilities and clinics should also incorporate those departments into the rounds process as well. Various performance data sets can be used to help prioritize the focus of initial rounds. These can include, but are not be limited to:

- Employee engagement scores
- Safety culture data from the Safety Attitude Questionnaire (SAQ)
- Patient safety performance from adverse events, unusual occurrence reports, hospital -acquired conditions, sentinel events, loss costs, etc.
- Patient satisfaction ratings and/or comments
- Employee illness and injury rates
- Employee turnover rates

Another successful strategy for rounds is to organize the date and time of rounds sessions to avoid shift changes, physician rounds and any known high activity times on the unit. Careful scheduling will help to successfully engage staff.[i] Rounds at the busiest time of day will not facilitate the best conversation and staff members will not have the time to interact with the executive. Some facilities ensure executives are rounding on each other's departments versus their own. This can provide a "fresh" perspective and new insight.

3. Executive Rounds Session

Ideally all departments should participate in rounds, including, but not limited to, all inpatient floors, radiology, lab, emergency room, surgery, dietary, housekeeping, pharmacy, physician clinic offices and others depending on your facility. Using a visible area increases participation and helps all staff learn about executive rounds.[1] It is very common to open the session with a scripted statement such as:

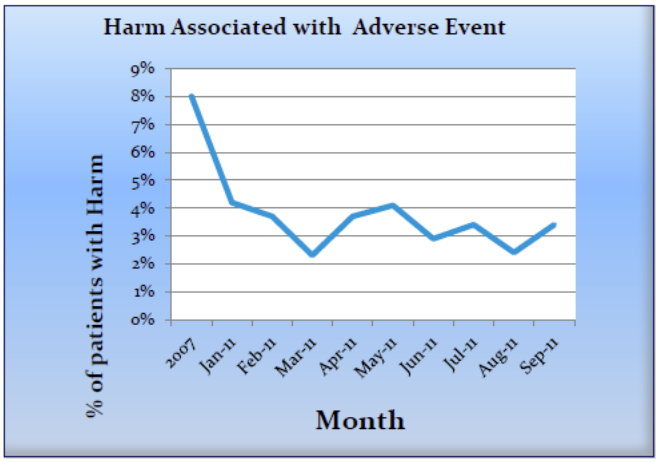
> *"It is important to the organization that we have an environment that encourages open communication and a blame-free culture. This will improve safety for our patients and staff members. Executive rounds*

are meant to be an informal, confidential discussion that is focused on patient safety and process improvement. The focus should be on the systems you work with each day and not blame of individuals. We will ask some general questions but are happy to discuss any issues of concern you may have. Our intent is to take the information given from staff and use it to improve your work and your ability to deliver excellent safe care." [1]

In order to help executives succeed, it is important to incorporate their styles of communication into the structure of the session. Some executives are more comfortable than others. Some may benefit from more specific guidance on topics and a sample list of questions to follow. If there are known issues or topics these should be brought to their attention prior to the session **(see Attachment A: Sample Questions Frankel 2004).**

Strategies to Incorporate Board Members into Executive Rounds
• Partnering the non-clinical board members with clinical executives
• Provide opportunities for observing and practicing
• Provide sample questions with the appropriate answers
• Provide some scripting to help guide the dialogue

It is recommended to end the session by thanking the staff for their time and all their efforts to improve safety in the organization. Explain the process for follow-up and feedback, which can vary from individual follow-up to multi-department follow-up. Encourage staff to report errors and patient harm and explain how this helps to improve safety.[i] Suggest staff members share with others their experience with rounds



4. Documentation and Reporting

A standard form can be very useful in documenting key issues and feedback during the interaction with staff. This information can be used to develop a database that includes the names of the participating individuals, date, time and location, feedback given by category, any contributing factors, action items and responsible party.

The database can be used for effective tracking of events, follow-up and developing useful reports for appropriate committees and department meetings. Remember, actions are only complete if they have

been communicated back to the front line. Databases for this purpose are available commercially or simple tools can be developed internally.

One suggestion for reviewing and responding to the information collected from executive rounds is to designate a multidisciplinary team to review the data and action items at scheduled intervals. The team can be its own committee or added to an already established committee. Other common follow-up includes monthly reports to executives and physician leaders, quarterly reports to safety and quality committees and biannual reports to the board.

5. Closing the Loop

This is one of the most critical components of the rounds program, yet is often forgotten or performed inconsistently.[1] There should be an established process for ensuring timely feedback is given, not just once or to an individual, but multiple times to all areas of the organization. Some successful strategies that have been used for communicating feedback are:

- ✓ Memos or emails to individual staff members
- ✓ Thank you cards for participating in rounds
- ✓ Newsletter articles
- ✓ Monthly reports at department meetings
- ✓ Summaries and reports at various committees
- ✓ Town hall meetings
- ✓ Celebrations with treats that highlight successes from rounds

6. Measuring Effectiveness

Safety culture can be challenging to measure but there are some evidenced-based tools that focus on the climate around teamwork, perceptions of management, safety, willingness to report errors, fear of reporting and environmental stress. Examples of some well-tested and highly utilized tools are:

- Hospital Survey on Patient Safety and Culture (HSOPSC)
  https://www.ahrq.gov/professionals/quality-patient-safety/index.html

- Safety Attitudes and Safety Climate Questionnaire (SAQ)
  https://med.uth.edu/chqs/surveys/safety-attitudes-and-safety-climate-questionnaire/

Other measures that can be used to evaluate success are:

- ✓ Percent of employees who believe that a fair and just culture policy regarding medical adverse events is in effect and working.
- ✓ Increased spontaneous reporting of adverse drug events (ADEs) and other adverse events.
- ✓ Implementation by each manager of a targeted number of safety-based changes per year based on information obtained through executive rounds.
- ✓ Response to cultural survey of front-line workers and managers.
- ✓ Number of errors reported per month from voluntary reporting systems.

- ✓ Number of safety-based changes made by managers per year.
- ✓ Percent of changes in overall surveillance data (for example, infection rates).

Evaluation

The executive team should determine the method of evaluation that best aligns with the organization's goals for executive rounds. Ideally, an assessment of culture would be completed prior to the start of the executive rounds process intervention.

Attachment A

Sample Questions

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

- 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?"

- What information would be helpful to you?
- Consider alterations in the interaction between clinicians
- Consider teamwork
- Consider environment and workflow

"What specific interventions from executives would make the work you do safer for patients?"

- Organize interdisciplinary groups to evaluate a specific problem.
- Assist in changing the attitude of a particular group.
- Facilitate interaction between two specific groups.

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

- Selecting a drug dose from the medications cart or pharmacy to administer to a patient and then realizing it's incorrect.
- Incorrectly programming 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?

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

"How can we make executive rounds most effective?"

- Informal conversations in the hallway instead of organized conversations
- Individual conversations instead of group discussions
- Ensure free time to discuss issues

"What is working well?"

- A new process that was recently put in place that has made care safer, e.g. helped reduced falls, infections or medications errors.
- The system for reporting errors is accessible and easy to use.
- Executives provide a safe environment for reporting errors and promote a "just culture".

Attachment B

Focused Rounds

Brief, five-to-ten-minute engagement with frontline staff, usually scripted. Can be scheduled more frequently and is very useful to evaluate recent education or roll-out of a new project, usually after new education or new project has been released.

Topic: Reduce catheter-associated urinary tract infections (CAUTI). Post-education of the CAUTI Bundle.

Example Script:

- Find a patient with a Foley catheter in place and approach the nurse caring for that patient. Ask if you may have a few minutes to talk about preventing infections — specifically CAUTIs.
- Briefly describe the importance of CAUTI reduction to patient safety and review number of patients who get one of these infections each month in your hospital or relate a brief story about a patient who had serious complications from a CAUTI.
- Ask the nurse to describe the bundle elements for the prevention of CAUTI.
    - If the nurse is not familiar with the bundle or cannot describe the key elements, then you have just learned something important about how your hospital's education and training system needs to be improved. Make a note to address this issue with the management team.
    - If the nurse gives a good answer (e.g., don't put Foleys in if they're not necessary, don't place the Foley bag above the patient and pull the Foley out ASAP) then give positive reinforcement. (Note: Executives and managers will need to be familiar with the bundle.)
- Ask the nurse which of the bundle elements is most difficult to implement. Listen to the answer. A common answer is, "On this unit, the hardest element of the bundle is getting permission to pull the Foley. Sometimes we need the doctor's order, and sometimes it's just that it's more convenient for us as nurses to keep the Foley in place."
    - Have a conversation about how to address any operational barriers that are identified.
    - Make a note to address these barriers with the management team and identify ways to remove them.
- Ask the nurse if there's a staff person on the unit who implements the bundle exceptionally well.
- Ask, "May I have your commitment to do whatever you can to implement these and other infection control bundles and to let us know if you have ideas for how we can improve our ability to do so reliably?"
    - Say "thank you."
- Identify another patient with a Foley, and another nurse, and repeat the rounds process.

[i] Frankel, A., Grillo, S., Pittman, M., "Patient Safety Leadership Walkrounds Guide." Health Research and Educational Trust, Chicago, Illinois; Partners HealthCare, Boston, Massachusetts. 2006. Web February 2013. http://www.wsha.org/files/82/Appendix%20P_pslwalkrounds.pdf.

[ii] Reinertsen, J.L., Johnson, K.M. "Rounding to Influence: leadership method helps executives answer the "hows" in patient safety initiatives." *Healthcare Executive*. Sept/Oct; 25(5) (2010) 72-75. http://www.ihi.org/knowledge/Pages/Publications/RoundingtoInfluence.aspx

[iii] Cavanagh, et al., "Patient Safety Walkrounds." Patientsafetyfirst.nhs.uk. January 2, 2009. Web February 2013. http://www.institute.nhs.uk/images//documents/SaferCare/How-to-Guide-for-Leadership-WalkRounds-%28pdf%29.pdf.