Patient Safety Executive Walkarounds

Suzanne Graham, John Brookey, Catherine Steadman

Abstract

Since the release of the IOM report *To Err Is Human* in 1999, significant progress has been made in patient safety. One of the remaining challenges is the need to continually improve the culture of safety. This is a long-term proposition, and one that must be driven foremost by our leaders. In a consensus statement from the National Quality Forum, Dr. Kenneth Kizer pointed out, "There simply is nothing more important in overseeing a hospital or other health care facility than ensuring it is as safe as possible for patients." Improving patient safety should be among the highest priorities of health care leaders and managers. To lead patient safety improvements, executives must be visible and must take an active role in patient safety. To this end, Kaiser Permanente has designed and implemented Patient Safety Executive Walkarounds as a tool for leaders to (1) visibly demonstrate patient safety as a high organizational priority, and (2) learn from direct care staff and physicians about near misses, errors, and hazards that jeopardize patient safety. This paper will discuss our experience with Patient Safety Executive Walkarounds, including:

- Program design.
- Tool development.
- Outcome metrics.
- Leaders, manager and staff education.
- Analysis and categorization of information received.
- Key success factors.
- Outcomes and improvements to date.

Introduction

Since the release of the Institute of Medicine Report *To Err Is Human*[1] in 1999, significant progress has been made in patient safety. One of the remaining challenges is the need to continually improve the culture of safety. This is a long-term proposition, and one that is driven foremost by our leaders. In a consensus statement from the National Quality Forum, Dr. Kenneth Kizer stated, "There simply is nothing more important in overseeing a hospital or other health care facility than ensuring it is as safe as possible for the patients."[2] Improving patient safety should be among the highest priorities of health care leaders and managers.

To lead patient safety improvements, medical leadership must give patient safety the attention and focus that is given to areas such as budgeting, utilization,

and access.[3] To enable this level of involvement, Kaiser Permanente (KP) has launched a Patient Safety Executive Walkarounds program that visibly demonstrates that patient safety is a high priority. During walkarounds, leaders make an hour-long announced visit to a department/unit to talk with staff and physicians in a nonthreatening environment about the issues that have caused or could cause harm. Concerns that are raised during these conversations are recorded, entered into a database, and addressed according to their level of severity, with results reported back to staff.

The face-to-face safety conversations between clinical staff and senior leaders during walkarounds are an essential catalyst for change, and they enable KP to learn more about errors and hazards, improve our reporting systems, and enhance our knowledge about how to ensure a safe environment.

The objectives of the walkarounds are to:

- Show clinicians and staff the commitment of leadership to patient safety.
- Clearly articulate leadership commitment to developing the infrastructure necessary to ensure responsible reporting.
- Identify opportunities for improvement based on issues identified during the walkarounds.
- Implement changes based on systems issues identified.

Creating a culture of patient safety

At KP, internal analysis, conducted through interviews and collaborative focus groups, revealed that our culture must evolve if we are to reach our vision of becoming a national leader in patient safety. This culture must not only address strong accountability, but also must clinicians to report errors freely out of genuine personal commitment and without fear of retribution. It is abundantly clear from the literature that without the visible support and commitment of leadership, this culture change will be fragmented and uncoordinated and will have only minor effects.[4] Only by direct and regular contact with real care delivery is it possible for leaders to understand the problems that direct-care staff and physicians have in delivering safe care.

General business publications on organizational behavior and culture suggest that the leadership strategy of Management by Walking Around can improve morale, productivity, organization communication and culture, safety, and customer service.[5–7] Studies that assess the efficacy of walkarounds in health care have recently been initiated, with little information published to date.

In personal communication, Bryan Sexton of Johns Hopkins University explained that current research ties safety climate and perceptions of management to clinical and operational outcomes. Furthermore, research is already underway to measure improvement in caregiver attitudes as a result of executive walkarounds.

In a study of executive walkarounds initiated at Brigham and Women's Hospital in Boston,[8] Dr. Allen Frankel further found, "…comments of frontline clinicians and executives suggested that [walkarounds] help educate leadership and frontline staff in patient safety concepts and will lead to cultural changes, as manifested in more open discussion of adverse events and an improved rate of safety-based change."

Although considerable attention is now paid to this improvement strategy in health care, there is little discussion of walkarounds in the literature. While the Patient Safety Executive Walkarounds program expands at KP, several metrics are being tracked in order to build an evidence base.

Identifying and resolving safety issues

Multiple mechanisms currently exist within the medical community to identify errors and close calls (e.g., unusual event reports, hot lines, medical malpractice information, complaints, focused chart reviews). Despite these efforts, clinicians historically are often hesitant to report errors and close calls for fear of disciplinary action. Dr. Lucian Leape reported that only 2–3 percent of major errors are reported through hospital incident reporting systems.[9]

The 2001 standards of the Joint Commission on Accreditation of Healthcare Organizations indicate that effective reduction of medical health care errors and other factors that contribute to unintended adverse patient outcomes in health care organizations requires an environment in which patients, their families, organization staff, and leaders can identify and manage actual and potential risks to patient safety.

The walkarounds promote a "just culture" environment. The barriers of shame and punishment related to error-reporting are removed, and actionable information related to patient safety hazards is collected. This information-to-action feedback loop is designed to lead to a decrease in adverse events and patient harm.

A supplement, not a replacement

While the overarching goal of the Patient Safety Executive Walkarounds is to correct and prevent medical errors, the work is integrated with other ongoing safety initiatives in order to support and complement the overall organizational effort to transform the safety culture.

Error reduction initiatives. The walkarounds have increased the reporting of actual errors and "near misses," which has provided input into existing and planned error-reduction strategies related to the identification, assessment, and development of appropriate programs.

Knowledge transfer. Information about walkarounds and successful interventions is shared on the Patient Safety Intranet site and other communication vehicles to promote similar efforts in other areas.

Human factors. Action plans from walkaround findings in several cases have been linked to human factors work, which is focused on advancing communications and teamwork to prevent error. For example, in cases where a patient safety concern is related to communication breakdowns within a department, a human factors intervention might include the initiation of staff briefings.

High performance on internal and external patient safety measures. Patient Safety Executive Walkarounds have helped support both internal and external standards related to patient safety (e.g., obtaining input from staff/physicians regarding patient safety, developing a culture of safety, etc.).

Environment of care. The information gathered through the walkarounds helps identify environmental, equipment-related, or product-related hazards and corresponding solutions.

Methods

Site

Kaiser Permanente is the largest nonprofit, integrated health care system in the United States, with 8.2 million members in nine states and the District of Columbia. There are 30 hospitals and 431 medical centers within the system.

The Patient Safety Executive Walkarounds were launched as a pilot project at two KP medical centers in May 2002 and April 2003, respectively. Since the pilot programs were launched, 15 other KP medical centers have initiated walkarounds.

Interest in the walkarounds program first began at a KP human factors workshop attended by Dr. Frankel, who discussed the work he was doing in the area of Patient Safety Leadership WalkRounds™ at Brigham and Women's Hospital in Boston. In developing the proposal for KP's walkarounds program, KP patient safety leaders worked closely with Dr. Frankel to transfer his work, while aligning it with KP's organizational needs and environment.

Tools

Prior to recruiting local sponsorship for the walkarounds program, KP's patient safety leaders developed customizable tools and templates to assist the medical centers in understanding, planning for, conducting, and measuring the success of the walkarounds.

Orientation materials. Presentation templates introduce the concept and principles behind the walkarounds, explain the expected results, outline the necessary steps, and list the required resources.

Communications plan. The plan outlines the tactics, dates, and responsibilities for informing and involving targeted stakeholders, including executives, managers, and frontline staff.

Talking points for executives. A list of key messages for executives who conduct walkarounds provides guidelines for initiating conversations, explaining the purpose of the visit, and talking to staff about how the information provided will be used.

Questions for walkarounds. As a second preparation tool for executives, the questions prompt discussion that focuses on systems-based patient safety concerns.

Evaluations. Three versions of an evaluation—one for executives, one for managers, and one for staff—ask participants to consider whether attitudes, conditions, or actions in the department have changed as a result of the walkaround.

Sponsorship

Executive sponsorship was key to advancing the walkarounds program at KP. Patient safety leaders actively recruited volunteers for the pilot program. They talked to executive leadership about their role in promoting culture change, and explained how participation in the walkarounds program could lead to improved patient safety at their respective medical centers. When the program was announced, multiple medical centers volunteered to be one of the two pilot sites. Once the sites were chosen, a process to ensure ongoing executive leadership support and resource allocation at each of the two medical centers took place.

Working closely with the executives, the patient safety leaders then outlined the logistics of the program, including a calendar that identified which leaders would attend each visit. The patient safety leaders clearly articulated that attendance at the walkarounds by the executives themselves—and not staff members serving as substitutes—was crucial to the success of the program. Before the executives went on their first walkaround, they received training on how to conduct the visit. Scripting was provided to assist the leaders in opening, conducting, and closing a visit. Executive leaders also were given an opportunity to rehearse. This was an important preparation tactic. Some executives were concerned that frontline staff might use the opportunity to voice complaints and dissatisfaction unrelated to patient safety. By rehearsing a conversation with provided talking points, they gained confidence in the process and ease with the subject matter.

How walkarounds work

At KP's participating medical centers, Patient Safety Executive Walkarounds rotate among departments/units. On average, five employees are interviewed on each hour-long round.

Each walkaround is attended by a senior executive and physician leader, the department/unit manager, the risk manager or quality director, and a scribe who records the safety concerns voiced by the employees. Staff and clinicians are informed of the purpose, date, and time of the walkaround prior to the event, and are assured that the focus is on systems issues related to patient safety rather than

on individual actions. Participation of the frontline staff is voluntary, and records of the conversations are confidential.

Prior to each walkaround, the participating executive is briefed by the unit/department manager regarding specific issues or concerns of the department that he or she may want to address with frontline staff. For example, if a department has recently experienced an unexpected adverse outcome, the executive can acknowledge the impact of the error on the patients and their families, as well as the emotional hardship the department may be experiencing.

During the walkarounds, the executive team remains in an open, public location, and staff are invited to converse with them, either one-on-one or as a group. Discussions are focused on perceptions of safety and the importance of evolving the culture to enhance the detection and reporting of errors and near misses. Leadership also uses standard questions to elicit information about dangers or episodes that caused or could have caused harm to patients. As these conversations take place, the safety issues and their actual and potential adverse outcomes are recorded by the scribe.

Following each walkaround, the executive team holds a debriefing session to enable the analysis and prioritization of any identified issues and the development of related action plans. Identified issues that can be fixed immediately are forwarded to the appropriate department or individual. Information from the debriefings also is provided to the quality department so that it can assist executives on follow-up related to improvement projects to address the issues.

Importantly, frontline staff who participate in the walkarounds also are sent "thank you" notes for their participation and are informed of any issues that are addressed as a result of the information gained on the walkarounds.

Data collection

Information about patient safety concerns or hazards collected during the walkarounds is entered into a database, which was adapted from a database developed for the walkarounds program at Brigham and Women's Hospital. Issues are categorized by contributing factor according to the Vincent Model[10] (team factors, work environment, organization and management, task factors, individual staff factors, patient factors) and assigned a severity code on a scale from 5–100.

Coding the issues enables a systems-based analysis of contributing factors, as well as the ability to prioritize urgent interventions. Patient safety leaders are able to produce reports from the database that focus on unit-specific issues, factor-specific issues, tracking, and follow-up. The database also is used to track the number and type of issues reported through the walkarounds. These issues are compared to the total issues reported through other channels as well as the number of issues resolved and/or addressed.

Evaluations

Because transformation of the patient safety culture is a main goal of the walkarounds program, qualitative data also is collected to track attitudinal changes among leadership, management, and frontline staff. KP uses the following tools to collect this data:

Safety attitudes questionnaire (SAQ*).* A survey instrument developed by the University of Texas that measures attitudes toward teamwork climate, safety climate, job satisfaction, perceptions of management, stress recognition, and work environment. The SAQ has been given to multiple disciplines (e.g., physicians, nurses, respiratory therapists, pharmacists, etc.) throughout both medical centers prior to the initiation of the walkarounds. A followup SAQ is in process to determine if there has been a positive change in attitude among those units that have participated in the walkarounds.

Staff, manager, and leader evaluations. Surveys, adapted to job role, are distributed to the walkarounds participants at 6- and 12-month intervals following the walkarounds.

People pulse survey. This internal survey is distributed annually to all KP employees and physicians in order to measure attitudes toward the workplace. One question on the survey asks if the participant agrees or disagrees with the statement, "In my department or work unit, everyone works together to ensure we make this the safest possible place to work." Scores by medical center on this measure are evaluated for improvements following the walkarounds.

Results

Participation

As of April 2004, data are available from KP's two pilot sites. From September 2002 to April 2004, there have been 29 walkarounds at Pilot Site A—24 in the day shift and 5 in the evening shift. In total, 15 executives and 24 managers have participated. Comments from 85 frontline staff who discussed their concerns during the walkarounds have been recorded in the database. (Employees who talked with leadership but did not express concerns are not included in this count.) At Pilot Site B, there have been 11 walkarounds that have involved 10 managers and 57 members of frontline staff.

Walkarounds have been conducted in the following units: medical/surgical, ante/postpartum, neonatal intensive care, pediatrics, emergency, perioperative areas, inpatient and outpatient pharmacies, ancillary services (laboratory/radiology) and the transitional care unit. In addition to executives and department managers, participants have included nurses, patient care assistants, physicians, technicians, and clerks.

Issue identification and resolution

To date, 271 safety concerns have been identified through the walkarounds at the two pilot sites—138 at Pilot Site A and 133 at Pilot Site B. At Pilot Site A, 98 issues have been resolved (120 actions were taken to resolve 98 issues; some issues required more than one action and/or action from more than one department for meaningful resolution). Thirty-one issues are still pending, and nine issues are considered "non-priority/non-response" issues and will probably remain without action. Of note is the fact that many of the issues identified have not been identified through other reporting mechanisms, such as unusual event reports, hot lines, etc.

Among the issues identified at the two pilot sites, the majority (56 percent) fell under the category of "work environment." Within this category, the most common subcategory was "equipment/supplies unavailability." Following "work environment," "team factors" was the second most common issue category, accounting for 17.3 percent of the issues identified.

An example of a response to concerns expressed during the walkarounds was a change in the storage of medicine in the transitional care unit of Pilot Site B. When a staff nurse pointed out to an executive that several similar-looking sets of medicine vials were stored in one narrow drawer, posing a risk for a medication error, the drawer system was replaced and look-alike drugs were clearly separated.

In an example from another unit, nurses expressed concern that their computer charting experienced system crashes, potentially affecting patient flow and the transfer of information between shifts. After the issue was identified, the computers were upgraded to fully support the needs of the charting software.

Survey/evaluation responses

Safety attitude questionnaire

In the preproject survey in 2002, Pilot Site A nurses ranked within the *bottom* 30 percent in teamwork climate benchmarked across 101 clinical areas taking the Safety Attitudes Questionnaire. In a shortened 2004 postproject survey of a subset of the original cohort, respondents ranked within the *top* 30 percent of organizations on the same benchmarking scale in teamwork climate.

Evaluations

An evaluation survey is sent to participants 6 months following their participation in a walkaround. To date, Pilot Site A has received 40 survey responses in return—28 from frontline staff, 7 from managers and 5 from executives.

Of the responses received from frontline staff:

- 86 percent responded that they have a better understanding of patient safety and the KP patient safety program as a result of the walkarounds.
- 64 percent said that something has been done differently in their area related to patient safety.
- 29 percent indicated that reporting or discussion of errors and near misses has increased since the walkarounds.
- 68 percent said that they have had conversations with coworkers or managers regarding the patient safety walkarounds.

Of the responses received from managers:

- 86 percent said that they have had conversations with staff or physicians regarding the patient safety walkarounds.
- 86 percent responded that new patient safety initiatives or other changes have been made as a result of the input from staff and physicians related to patient safety issues identified during the patient safety walkarounds.
- 14 percent responded that, as a result of the walkarounds, they have changed their approach toward how they handle staff who make a mistake.

Of the responses received from executives:

- 100 percent responded that they gained information from the walkarounds.
- 80 percent reported that they have taken actions as a result of feedback received on patient safety walkarounds.

The evaluations also include an opportunity for participants to write in additional comments. These responses reflected a consensus among all groups that the walkarounds advanced understanding of patient safety and effected change within their facility/unit. “We are identifying issues that have not come up through any other reporting mechanism,” said one manager.

There are two key factors related to walkarounds that managers credit with the increase in reporting and/or issue identification. The first is that the walkarounds provide an opportunity for leadership to actively engage frontline staff in a discussion around the concept of a “just culture,” where reporting does not lead to retribution. When staff are told by leaders at the highest level that their reports will not lead to disciplinary action, and when they observe this in practice following walkarounds, they gain confidence in systems-based reporting.

Secondly, managers have found that, on some occasions, staff do not report potential causes of harm simply because they are so accustomed to their work environment that they fail to notice some work patterns and environments as risks. However, executive walkarounds provide another point of view that

recognizes these risks. For example, in one unit the nurses were periodically experiencing difficulties with the patients' electronic buzzing systems, so they brought in backup dinner bells for patients' use. Upon hearing about the problem, the executive made sure that the electronic system was immediately repaired.

People Pulse Survey

On KP's People Pulse Survey question, "In my department or work unit, everyone works together to ensure we make this the safest possible place to work," there was an increase of 5 percent in staff who agreed with the statement in 2003 over 2002, and a 9 percent increase in the favorable responses of physicians. Based on the number of survey respondents, this represents a significant difference.

Discussion

> *"The interesting thing is the culture change. People will now come up to us, not on the rounds, and bring up some things that are an issue. People are very comfortable saying 'Oh, I almost made this mistake.'" –KP medical center executive*

> *"I see incredible changes in this medical center. It is dramatically different than a year and a half ago when we started the walkarounds. The morale, safety, and confidence of our frontline staff are superb. The management support of our frontline staff is superb." –KP physician*

In the 2 years since since the Patient Safety Executive Walkarounds were launched at the first pilot site, a remarkable change in the patient safety culture at the participating medical centers has been observed. Though many participants were initially skeptical, both executives and frontline staff have expressed a high level of enthusiasm regarding the program now that they have seen actual changes in the culture and safety levels of their areas. In particular, frontline staff and physicians noted a new understanding about patient safety: that it is not enough to simply avoid errors; it also is important to identify and report potential causes of errors before they occur.

During work with the pilot sites as well as the other medical centers that are now implementing walkarounds, several factors that are critical to the success of the walkarounds were identified. These success factors are not unique to this project and should be considered as preconditions for the success of other patient safety initiatives:

Leadership. Unless leadership fully supports the project, the project will not be successful.

Physician involvement. The importance of having a physician champion cannot be overemphasized. In both of the pilot sites, we identified physicians who were champions of patient safety and felt the walkarounds were an important part

of our culture change. These physicians solicited the necessary support of other members of the medical staff.

Provision of tools. Staff and physicians at medical centers are immersed in the care of patients and the running of the medical center. They do not have time to research and develop tools for projects. Time and again, pilot sites said that if KP regional staff had not done the research, provided the tools, and assisted in the implementation, the walkarounds would never have taken place.

Test small before going big. When we began the project at the two pilot sites, many issues were identified that in a less controlled environment could have sounded the death knell for the project. The issues identified were addressed, including how to inform frontline staff about walkaround results and how later to present interested medical centers with a superior package of tools.

Remember that this is part of a culture change. In addition to establishing why this project is important to the organization, it is important to answer the question, "What's in it for me?" It also is important to identify how to improve patient care and the work life of staff and physicians.

"Just culture" environment. Assure staff and physicians that leadership supports a nonpunitive environment and that issues brought up during the walkarounds are not going to be used for future discipline.

Align with organizational priorities. Make certain that walkarounds are seen as part of the bigger organizational goal to ensure patient safety and not as a separate initiative.

Communicate and celebrate. In addition to fear of discipline, some staff and physicians said they never receive feedback when they do report patient safety concerns. Staff members sometimes feel that reports about errors or near misses go in a "black hole," and they see no value in reporting if nothing appears to have been done with the information. The walkarounds program leaders not only report back to staff what is being done with the information that they have provided, but also celebrate when this information has resulted in a major change. News is shared through newsletters, staff meeting announcements, or other communication vehicles.

Conclusion

Since launching the Patient Safety Executive Walkarounds program at KP, we have observed a groundswell of interest, both within our own organization and among external organizations. Because the program tools are easily replicated and modified to meet local needs, the opportunities for transfer are evident.

We believe that one of the reasons for the tremendous interest in the program is that there are comparatively few patient safety practices in the literature that directly address transforming the patient safety culture. The walkarounds program is unique in its dual focus on issue identification and cultural change. The visible support of executive leadership demonstrates patient safety as an organizational

priority in a way that traditional communications campaigns—newsletters, staff meetings, posters—cannot.

Looking forward, suggestions for improving the walkarounds include doing them on all shifts (Pilot Site A is currently expanding the program to evening shifts) and surveying frontline staff shortly before the walkarounds so that leaders can be more informed about departmental concerns before arriving.

A second future opportunity is the involvement of patients in the walkarounds program, acknowledging that they may have insight into patient safety based on their experience. As one frontline staff member wrote in an evaluation, "If we addressed service-related complaints, we would recognize hidden safety problems as well as liability risks."

Currently at KP, we are focused on maintaining momentum by continuing to transfer the program to more of our medical facilities. As we are able to collect data from more medical centers to build our evidence base, we expect that the unique value of walkarounds will become evident to more medical center executives.

Acknowledgments

This project was supported in part by Kaiser Permanente's Garfield Memorial Fund.

Author affiliations

All authors are affiliated with Kaiser Permanente, Oakland, CA.

Address correspondence to: Suzanne Graham, RN, Ph.D., Director of Patient Safety, Kaiser Permanente, 1950 Franklin Street, Oakland, CA 94612; phone: 510-987-4651; fax: 510-873-5444; e-mail: suzanne.graham@kp.org.

References

1. Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human: building a safer health system. A report of the Committee on Quality Health Care in America, Institute of Medicine. Washington DC: National Academy Press; 2000.
2. Kizer K. Patient safety: a call to action. A consensus statement from the National Quality Forum (NQF). MedGenMed 2001 Mar 21;3(2):10.
3. Conway J. Strategies for leadership: hospital executives and their role in patient safety. Chicago: AHA; 2000.
4. Leape L. Can we make health care safe? In: Reducing medical errors and improving patient safety. A report of the National Coalition on Health Care and the Institute for Healthcare Improvement. Available at: http://www.qualityhealthcare.org/ihi/uploads/medical_errorsACT.pdf. Boston: ACT: 2000 Feb.
5. Hopkins-Doerr M. Getting more out of MBWA—management by walking around. Superv Manage 1989 Feb;34(4);17–20.
6. Peters T, Waterman M. In search of excellence: lessons from America's best-run companies. New York: Harper and Row; 1982.

7. Schein E. The corporate culture survival guide. San Francisco: Jossey-Boss; 1999.

8. Frankel A, Graydon-Baker E, Neppi C, et al. Patient Safety Leadership WalkRounds™. Jt Comm J Qual Saf 2003 Jan; 29(1):16–26.

9. Leape L. Testimony before the U.S. Congress, House Committee on Veterans' Affairs, 1997 Oct 12.

10. Vincent C. Framework for analyzing risk and safety in clinical medicine. BMJ 1998;316:1154–7.