

# Quality and Safety Walk-rounds

A Co-designed Approach

Toolkit and Case Study Report



Féidhmeannacht na Seirbhíse Sláinte  
Health Service Executive  
Quality Improvement Division



This Toolkit and Case Study replaces the previously published Quality and Safety Walk-rounds Toolkit (May 2013). It forms part of a series of resources being developed to support services in using the Framework for Improving Quality in our Health Service (2016):


- Quality and Patient Safety: Clinical Governance Information Leaflet (February 2012)
- Quality and Patient Safety: Clinical Governance Development: An assurance check for Health Service Providers (February 2012)
- Quality and Safety Prompts for Multidisciplinary Teams (February 2012)
- Quality and Safety Committee: Guidance and Sample Terms of Reference (May 2013)
- Safety Pause: Information Sheet (May 2013)
- Quality and Safety Clinical Governance Development Initiative: Sharing our Learning (March 2014)
- National Clinical Programmes Model of Care Development: Checklist Governance for Quality and Safety (October 2014)
- Report of the Quality and Safety Clinical Governance Development Initiative Primary Care: Sharing our Learning (April 2015)
- Board on Board with Quality of Clinical Care: Quality Improvement Project: Case Study Report (June 2015)
- Framework for Improving Quality in our Health Service: Part 1 Introducing the Framework (April 2016)


Copies of the documents can be located at [www.qualityimprovement.ie](http://www.qualityimprovement.ie).


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Quality Improvement Division  
Health Service Executive  
Dr Steevens' Hospital  
Dublin D08 W2A8  
Ireland

 +353 1 6352344

 [nationalqid@hse.ie](mailto:nationalqid@hse.ie)

 @hseqi

 [www.hse.ie](http://www.hse.ie)

## Foreword

We are delighted to present this Guidance and Toolkit which includes a Case Study from Beaumont Hospital of our Quality and Safety Walk-rounds programme provided in conjunction with the HSE Quality Improvement Division and the Royal College of Physicians of Ireland.

One of the aims of a Quality and Safety Walk-round initiative is to move towards a reflective rather than inspection focused programme, creating the space and time for conversations between staff and senior managers.

At the heart of the process is deference to the expertise and experience of frontline staff. We expected to hear about environmental challenges and staffing issues and whilst we heard about some of these issues we also heard about the many innovative work practices, staff passion and pride in their areas of work.

Beaumont Hospital has strengthened the Quality and Safety Walk-rounds Toolkit by sharing their experience on implementing this programme. Some of the key learning and contribution is:

- A tailored education programme co-designed to support the Quality and Safety Walk-rounds team;
- Using a quality improvement method builds in measurement to demonstrate improvement;
- Measuring the culture of safety is an important part of the process;
- Building an infrastructure to support the programme is essential;
- Quality and Safety Walk-rounds highlight good practice as well as areas for improvement; and
- After Action Review (AAR) is an effective tool to evaluate each walk-round.

"The Quality and Safety Walk-rounds programme has proven to be a key enabler for promoting culture change and for strengthening our quality and safety structure. As a CEO, this year I have had cause to personally use the services in our hospital. Seeing first-hand the compassion and commitment that our staff show, through the eyes of a patient for me has been an enlightening and heart-warming experience. Consistent with the ambitions of our Hospital Strategy I see the Quality and Safety Walk-rounds programme as a catalyst for mobilising the whole hospital to act together to deliver high quality care. I look forward to supporting the future development of the programme through the involvement of patients as an extension of our 'Beaumont Listening' series."

*Mr. Liam Duffy*

"This approach will support the implementation of the *Framework for Improving Quality in our Health Service*. A key factor for the Quality Improvement Division was encountering such a strong and committed Leadership Team in Beaumont Hospital. The Quality Improvement Division brought a clear structure and training to the process and locally the Hospital committed to following up and acting on staff ideas."

*Dr. Philip Crowley*

We both would like to thank the staff of Beaumont Hospital and the Quality Improvement Division Governance for Quality team for the considerable commitment and support they have given to sharing our learning. We very much appreciate Dr Peter Lachman's leadership and expertise throughout the process.

We recommend Quality and Safety Walk-rounds in promoting an open quality and safety focused culture.



**Dr. Philip Crowley**  
National Director  
Quality Improvement Division



**Mr. Liam Duffy**  
Chief Executive Officer  
Beaumont Hospital





## Step by Step Guide to Quality and Safety Walk-rounds

### AIM:

- Demonstrate senior managers' commitment to quality and safety for service users, staff and the public;
- Increase staff engagement and develop a culture of open communication;
- Identify, acknowledge and share good practice;
- Support a proactive approach to minimising risk, timely reporting and feedback; and
- Strengthen commitment and accountability for quality and safety.

### Step 1 Establish Teams

- Set up Steering Group/Project Group
- Identify coordinator
- Identify leadership team (Visiting)
- Identify unit teams (Participating)

Terms of Reference Steering Group (Resource 1)  
Contact Information (Resource 2)

### Step 2 Develop Training Programme / Refine Tools

- Identify training needs
- Develop training programme / workshops
- Review available tools and templates
- Customise and test tools
- Agree measures of improvement

Walk-rounds Process (Resource 3)  
Opening and Closing Statements (Resource 4)  
Customised Questions (Resource 5)  
Transcription Template (Resources 6)

### Step 3 Communicate Schedule

- Develop a communication plan
- Create schedule for year
- Notify staff
- Remind leadership and unit teams

Notification E-mail (Resource 7)  
Notice (Resource 8)  
Leaflet (Resource 9)  
Schedule (Resource 2)

### Step 4 Undertake Walk-rounds

- Meet unit team
- Meet service users/family
- Discuss quality and safety topics

Transcription Template (Resource 6)

### Step 5 Agree Action Plans

- Record agreed actions
- Circulate to team in draft
- Confirm actions

Transcription Template (Resource 6) or  
Action Plan (Resource 10)  
Communication After Walk-round (Resource 11 & 12)

### Step 6 Track and Report on Trends

- Update central records/database
- Identify trends
- Report on progress to relevant committees
- Close the loop on actions

Transcription Template (Resource 6)  
Action Plan Template (Resource 10)  
Database (Resource 13)

### Step 7 Evaluate, Spread and Sustain

- Review effectiveness of process
- Analyse outcomes and measures of improvement
- Identify further training needs
- Share learning with staff and service users locally and nationally

Database (Resource 13)  
After Action Review (Resource 14)





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# Part 1

## Quality and Safety Walk-rounds Guidance

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## Part 1: Quality and Safety Walk-rounds Guidance

### 1.1 Introduction

This document provides a guide, case study and toolkit aimed at helping organisations start out on this important initiative. This toolkit builds on the previously published version in *Quality and Safety Walk-rounds Toolkit May 2013* by incorporating a Case Study by Beaumont Hospital who implemented Quality and Safety Walk-rounds using quality improvement methods between 2014 and 2016.

Safety walk-rounds have helped many organisations make a significant impact on their safety culture (Feitelberg, 2006; Morello, *et al.*, 2012; and Singer and Tucker, 2014). Quality and Safety Walk-rounds allow executive/senior management team members to have a structured conversation around safety with frontline staff and service users. The walk-round can be focused on any location or service that may affect care and safety of the organisation.

As a more formalised framework, patient safety walk-rounds were initially introduced by Allan Frankel, MD (Frankel, *et al.*, 2003), have since been developed by the Institute of Healthcare Improvement (2004), Governments (Healthcare Improvement Scotland, 2011) and hospitals (Feitelberg, 2006) as a tool to engage senior managers and frontline staff in a meaningful discussion of patient safety concerns with agreed actions (O' Connor, 2011).

Central to the success of walk-rounds is a collaborative open approach. Visits are intended to be helpful opportunities to share ideas and provide immediate feedback without taking responsibility away from line managers and frontline teams.

Strong effective leadership is essential to build a safety-orientated organisational culture, as evidence suggests, that without this, many other interventions are likely to fail. Senior managers have a lead role in:

**Creating a culture where quality and safety is everybody's primary goal**

Quality and Safety Walk-rounds are a way of ensuring that senior managers can build relationships and trust so they are informed and can exchange views, regarding the safety concerns of units/teams. They provide an opportunity for frontline staff to identify and discuss their safety concerns. They are also a way of demonstrating visible commitment by listening to and supporting staff when issues of safety are raised. Walk-rounds can be instrumental in developing an open culture where the safety of service users is seen as the priority of the organisation.

### **Quality and Safety Walk-rounds**

**Structured process to bring senior managers and frontline staff together to have quality and safety conversations with a purpose to prevent detect and mitigate service user/ staff harm**

Quality and Safety Walk-rounds can be conducted in any setting such as wards, departments, operating theatres, clinics, general practice and community settings, but are not limited to these. They are also useful in services such as pathology and portering or other areas that may affect care or the safety of the organisation such as information communication technology and finance. They provide a formal process for members of the executive/senior management team/members of the board to talk with staff about safety issues in their unit or team and show their support of staff for reporting errors/near misses.

The clinical governance development initiative (HSE, 2014) identified the single most important obligation for any health system is service safety and improving the quality of care.

The report of the initiative recommended that health service providers:

- Develop a mechanism for the board or community healthcare organisation to hear directly about service users and staff experiences.
- Value, listen and engage with service users in identifying and acting on suggestions to improve their experience of care as well as overall service improvements.
- Value, listen and engage with staff in identifying and acting on suggestions for quality improvement including improving their work experience.

“I would like to see this implemented across all areas of healthcare”  
Patient Council Member



Quality and Safety Walk-rounds provide a practical means for acting on the recommendations. *The Framework for Improving Quality in Our Health Service* (HSE, 2016) provides six drivers for improving quality:



Figure 1.1: Framework for Improving Quality in Our Health Service

Introducing Quality and Safety Walk-rounds provides a mechanism to address the key components of the drivers and in particular the Governance for Quality driver, which include:

- **Knowledge and Skills:** management teams have the knowledge and skills to achieve their role in driving quality care.
- **Leadership and Accountability:** management teams are clear about leadership and accountability for quality and safety.
- **Information:** intelligent use of information to measure, monitor and oversee quality and safety of care.
- **Culture:** a culture of learning focused on quality of care is promoted throughout the organisation.
- **Relationships:** the organisation promotes strong relationships that partner with service users and staff to facilitate the alignment of the entire organisation around the quality of care.
- **Quality Improvement:** there is a quality improvement plan in place which has been developed in line with the *Framework for Improving Quality in Our Health Service* (HSE, 2016) and aligned with national and organisational priorities.

It is the combined force of drivers working together that creates the environment and acceleration for improvement.



## 1.2 Approach to Quality and Safety Walk-rounds

Being clear on the why, who, when, where and how is central to the success of Quality and Safety Walk-rounds. Consideration of the context and culture will inform the decision on the best approach and level of organisation. Using a recognised quality improvement methodology to implement this initiative will result in a planned, outcome focused approach to walk-rounds.

### *Aims*

The aims in introducing Quality and Safety Walk-rounds are:

- Demonstrate senior managers' commitment to quality and safety for service users, staff and the public;
- Increase staff engagement and develop a culture of open communication making it 'safer to ask';
- Identify, acknowledge and share good practice;
- Support a proactive approach to minimising risk, timely reporting and feedback; and
- Strengthen commitment and accountability for quality and safety.

### *Setting the Scene*

It is helpful to clarify ground rules in advance and reconfirm this at the start of the walk-round.

The key components for successful walk-rounds are:

- Understanding that the walk-round is an opportunity for an open discussion on quality and safety;
- Deference to the expertise of the frontline;
- It is not an assessment or inspection and can provide the opportunity for staff to express concerns on behalf of service users;
- Receiving feedback from the senior management team with follow up;
- Actively listening and a proactive approach to identifying and minimising risk;
- Respecting the confidentiality of information discussed in a walk-round and service user safety disclosure requirements;
- Agreeing times and location of walk-rounds an agreed period in advance; and
- Sharing key learning from walk-rounds with other units/teams.

### *Step 1: Establish Steering Group, Coordinator and Walk-round Teams*

#### *Quality and Safety Walk-rounds Steering Group*

In larger organisations, a short life local working group / steering group may be established to provide overall direction and leadership (Resource 1). This group can:

- Approve all stages and implementation of the walk-rounds programme;
- Support a standardised approach across the organisation to quality and safety walk-rounds;
- Oversee the selection and training of the walk-round team;
- Ensure a consistent approach to all communication in relation to walk-rounds;
- Monitor the implementation is on target and achieves its objectives; and
- Provide reports on progress and findings.

Alternatively, a local quality and safety committee can provide overall direction for the implementation of the quality and safety walk-rounds programme.

*Quality and Safety Walk-rounds Coordinator*

To ensure continuity, it is advised that a named person be identified by the CEO/ General Manager/ Chief Officer / Service Manager to coordinate all Quality and Safety Walk-rounds. It is important for the individual to have appropriate authority, resources and time to effectively manage the process. To assist with planning, it is advised that a list of contacts for each participating executive/ senior management team member and the relevant unit/ team be maintained. A non- executive Director (Board Member) may accompany the walk-round team. This can be arranged through the CEO /Chief Officer / General Manager/ Service Manager's office (Resource 2).

*Unit Team*

For each walk-round, a lead is identified from the ward/team being visited, usually the senior accountable person responsible for the area visited (Resource 2). The unit/team manager and medical leads are each invited to attend. On the day, there may be a number of other staff present such as junior doctors, consultants, health and social care professionals, clerical, catering, nurses/midwives and health care assistants. The priority is to have an opportunity to talk to both service users and staff.

*Senior Management Walk-round Team*

The senior most accountable person (Chief Executive Officer/General Manager/Service Manager) leads each walk-round. Other members of the executive/senior management team may be involved, for example:

- Lead/Executive/Clinical Director/Director Quality and Safety;
- Director of Nursing/Midwifery;
- Chief Operating Officer;
- Health and Social Care Professional Lead; or
- Head of Finance /Human Resources / Information and Communications Technology.

The walk-round lead may be accompanied by (where possible):

- A service user representative/advocate or liaison officer; or
- Non-Executive Director (member of the Board) – arranged through the CEO/General Manager/ Service Manager's office.

A nominated note taker (normally from the executive/senior management teams administrative staff) also attends. The note taker should not be a member of the walk-round team as this can impede active participation in the discussion.

Advice may be sought from quality improvement, risk management, health and safety, healthcare records manager, or technical services/estates/facilities staff prior to, or following on from, the visit. To support dialogue and positive relationships it is important that the Quality and Safety Walk-round numbers are kept small and never outnumber the frontline team. The maximum number visiting an area should be agreed. Members of the walk-round team may be identified, based on their experience and personal strengths, as being prepared to provide further development and support to other team members.

*Step 2 : Develop Training Programme and Refine Tools*

Some members of the executive/ senior management team may feel apprehensive about leading quality and safety oriented discussions and a shadowing system among the executive/senior management team may be useful at the initial stages. A bespoke training programme to support staff in preparing for the commencement of walk-rounds may be used to increase understanding and build confidence in the process. Equal attention may be given to preparing the ward/ service / unit team for the visit of the walk-round group to their area. Using quality improvement methods, the available tools may be customised and tested for local use (Resources 1-14).



It is important to build a process to demonstrate the impact of the Quality and Safety Walk-rounds.

One targeted measure might be considered. Some examples are:

- Number of safety-based changes made by staff by units/teams per year;
- Number of actions closed / opened;
- Changes in overall surveillance data (for example, infection rates);
- Changes in the number of compliments/complaints received per month (outcome measure);
- Increase in reporting of incidents / complaints;
- Results of ongoing safety culture survey (process measure); and
- Number of suggestions made by staff which are addressed within a certain time period.

### Step 3 : Communicate the Walk-rounds Schedule

A strong communication plan is essential to the success of any Quality and Safety Walk-round initiative. This is informed by the approach adopted by the organisation. Briefing staff so they know about the initiative and understand the aims is really important. General staff briefings, newsletters, notice boards, team meetings, and intranet communication may be used to promote the initiative (Resources 7, 8 and 9).

#### When

The walk-rounds occur at an agreed frequency (at least monthly or as designated by the executive/senior management team). Dates and times (most suitable for staff and the service) are arranged and communicated by the named Quality and Safety Walk-round person, who will schedule all dates and areas to be visited for the year (Resource 2).

#### Where

It is useful for the walk-round to start with a tour of the unit/team and meeting with service users and staff (where possible). A meeting area as close to the service area (as possible) such as an office or seminar room can be used for the discussion. It is best to agree a time limit (for example maximum one hour).

#### How

The nominated Quality and Safety Walk-rounds person arranges all communication and follow up as follows by:

##### At the start

- Creating the schedule for Quality and Safety Walk-rounds for the year; and
- Distributing the schedule to all executive/senior management team members, heads of departments, relevant others and unit/team being visited with requests for the dates to be confirmed in relevant diaries (Resource 2).

##### Before the Walk-round

- Issuing email reminder to the unit/team (the week before the scheduled visit) (Resource 7).
- Issuing email reminder to walk-round team (four days before the visit). It can be useful to include prompts of the information to be reviewed in preparation for the visit. These may include (but are not limited to):
  - Relevant quality and performance indicators;
  - Unit/team risk register;
  - Infection prevention and control reports;
  - Service user feedback about their experience compliments/complaints;
  - Incidents/near misses;
  - Quality improvements;
  - Staffing complements/absenteeism;
  - Health and safety reports; and
  - Copy of the previous walk-round visit.
- Prepare material for the note-taker (Resource 6)

#### Step 4 : Undertake Walk-rounds

The team in the area being visited is asked to describe what is working well or a change that was brought in at local level that might also work in other locations. They may also be asked to think of a recent example of a risk or service user safety incident they have experienced. The quality improvement plan or any challenges can be shared with the walk-round team. It can be helpful to ask probing questions and all members of staff and service users are actively encouraged to participate. The aim is to use an open conversational approach based on reflection rather than inspection.

#### Sample Guide for Discussion with Service Users

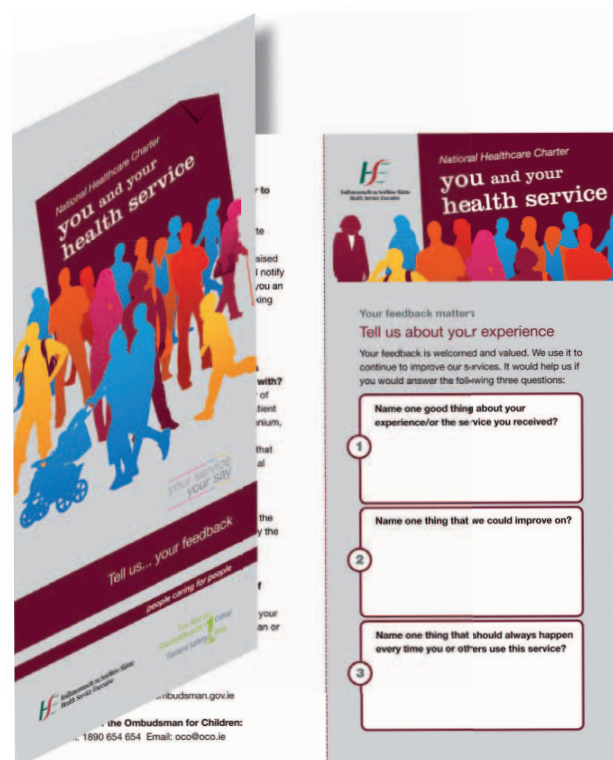
The prompts below are examples that may be used in the walk-round conversation with service users (see Table 1.1). The principles of the National Healthcare Charter (HSE, 2012) 'You and your health service' may be of assistance in preparing for the discussion. These are: access, dignity and respect, safe and effective service, communication and information, participation, privacy, improving health and accountability. The questions can be designed to promote constructive feedback. People often feel concerned about making a complaint, therefore, if they are invited to make a positive statement it is easier to suggest improvements.

Table 1.1: Sample Questions for Discussion with Service Users

#### Suggested Questions

- How are you feeling today?
- Is there anything I can do to make your stay with us better / more comfortable?
- If you were in my shoes is there anything you would do different that would make your stay here better?
- Have you any suggestions to make to help us improve things here?

During the discussion, there may be a chance to highlight some of the opportunities for service users to provide further feedback, for example using the leaflet 'You and your health service: tell us...your feedback'.



Sample Guide for Discussions with Staff

The categories below are examples that may be used to guide the discussion. Not all areas can be covered at each visit. It is helpful for the walk-round members to meet in advance to prepare for the specific walk-round (Resource 4). The walk-round leader in consultation with the group makes a decision based on engagement with the unit/team on which areas to focus on (Resource 5). The aim is to take a discursive rather than a formulaic approach. Organisations can identify a sample list of key questions (Table 1.2) that can be used by the Quality and Safety Walk-rounds teams.

Table 1.2 : Sample Questions for Discussion with Staff

CATEGORY		SUGGESTED QUESTIONS
1.	Identifying and Acknowledging Good practice	<ul style="list-style-type: none"> <li>● What do you do well – what are you most proud of here? Could this practice be of benefit elsewhere?</li> <li>● Can you tell us one thing you are happy with and one that might cause you concern?</li> <li>● Would you be happy for yourself or a member of your family to be treated in this area?</li> </ul>
2.	Communication	<ul style="list-style-type: none"> <li>● Can you describe how communication among staff either enhances or inhibits safe care on your unit/team? shift handovers between teams e.g., doctors, nurses, health and social care professionals support staff (clerical, catering, cleaning, portering)</li> <li>● Have you discussed safety issues with service users or their families?</li> <li>● Do service users and families raise any safety concerns?</li> <li>● How legible are the patients’/ service users healthcare records?</li> <li>● Have you any problems accessing patients’ healthcare records?</li> </ul>
3.	Teamwork	<ul style="list-style-type: none"> <li>● Can you tell us how your team works?</li> <li>● Can you tell us how the team works with other teams?</li> <li>● What is staff morale like?</li> </ul>
4.	Risk Management	<ul style="list-style-type: none"> <li>● Tell us about the last time a service user was harmed here/about the most recent near miss? What happened? (good starting question to get the discussion going)</li> <li>● What service user or staff safety issues keep you awake at night?</li> <li>● Is there anything we could do to help you and your staff to further minimise risk?</li> <li>● When you make a mistake, do you report it? What makes you do that?</li> <li>● If you prevent/intercept a mistake, do you report it?</li> <li>● If you make or report an error, are you concerned about personal consequences?</li> <li>● Do you know what happens to the information that you report?</li> </ul>
5.	Prevention and Control of Health Care Associated Infection	<ul style="list-style-type: none"> <li>● How did you get on in your last hand hygiene audit? Were there areas to be improved and what are you doing to improve them?</li> <li>● What are your arrangements for cleaning?</li> <li>● Do you use care bundles?</li> <li>● How do you monitor the use of antibiotics?</li> </ul>
6.	Environment	<ul style="list-style-type: none"> <li>● What aspects of the environment are likely to lead to the next service user harm? Examples: Broken sinks, taps, bedpan washers, scales, ligature points, or not enough information available (e.g. building works affecting care)</li> </ul>
7.	Equipment	<ul style="list-style-type: none"> <li>● Do you have regular maintenance of your equipment? Do you have service notices on your equipment?</li> <li>● Do you have access to all the equipment you need to care for your service users safely?</li> </ul>



CATEGORY		SUGGESTED QUESTIONS
8.	Process	<ul style="list-style-type: none"> <li>● What audits (both clinical and non clinical) does your area undertake or lead?</li> <li>● Today, are you able to care for your service users as safely as possible? If not, why not?</li> <li>● Have there been any near misses that nearly caused harm but didn't? Examples:               <ul style="list-style-type: none"> <li>○ Taking a drug to give to a service user and then realising it is incorrect</li> <li>○ Mis-programming a pump, but having an alert that warns you</li> <li>○ Incorrect prescriptions/orders caught by nurses/midwives or other staff</li> </ul> </li> </ul>
9.	Continuing Professional Development	<ul style="list-style-type: none"> <li>● What incident, risk management, quality improvement and clinical governance training have you had?</li> <li>● What infection prevention and control and medication management training have you had?</li> <li>● Are your team up to date with mandatory training, for example, Basic Life Support, Moving and Handling, Fire Training, Hand Hygiene? Have you had any training specific to your unit?</li> </ul>
10.	Leadership	<ul style="list-style-type: none"> <li>● Do you feel supported when you make a mistake or when things go wrong?</li> <li>● Who leads your team?</li> <li>● What specific intervention from senior management would make the work you do safer for service users and staff? Examples:               <ul style="list-style-type: none"> <li>○ Organise multi-disciplinary groups to evaluate a specific problem</li> <li>○ Facilitate in changing the attitude of a particular group</li> <li>○ Facilitating interaction between two specific groups</li> <li>○ What would make these Quality and Safety Walk-rounds more effective?</li> <li>○ Have you found participation in these Quality and Safety Walk-rounds beneficial?</li> </ul> </li> </ul>

#### Step 5: Agree on Action Plans

At the end of the walk-round, everyone agrees the safety issues identified, if any. The aim is for the safety issues to be dealt with at a local level with the support of the executive/senior management team. If the ward/area is a 'productive ward' site, this is an opportunity to discuss progress with other improvement initiatives and update the 'visit pyramid' (Resource 6 and 10).

#### Step 6: Track and Report on Trends

The findings of the walk-round can be circulated and discussed at the appropriate line management forum. By exception they may be circulated also to the executive/senior management team. Responsibility is delegated to address issues arising.

The Quality and Safety Walk-round Coordinator will be responsible for:

- Preparing and circulating to all those present at the walk-round the draft action plan for comment and approval (within an agreed timeframe of the visit where possible Resource 11);
- Circulating the final action plan within an agreed timeframe (Resource 12);
- Updating the Quality and Safety Walk-rounds database (Resource 13); and
- Following up progress on the issues being actioned by the executive/senior management team.

This will also provide evidence, for assurance. The aim is to complete these actions within an agreed timeframe. This does not prevent all staff from addressing the risks identified and recording these on the unit/team risk register, where appropriate.



### Step 7: Evaluate, Spread and Sustain Walk-rounds

For effective use and follow up, the executive/senior management team normally commits to maintaining a record of the process. A tracking mechanism (electronic) can then be used to monitor progress while at the same time providing reports on issues identified, actioned, escalated and resolved (Resource 13). The nominated Quality and Safety Walk-round Coordinator will be responsible for maintaining the record and ongoing communication such as;

- Creating the schedule for Quality and Safety Walk-rounds for each subsequent year;
- Updating the Quality and Safety Walk-round Database on an on-going basis;
- Preparing reports as required; and
- Evaluating the walk-rounds through After Action Reviews (AARs) to establish that structures and processes are effective and meet the overall objectives (Resource 14).

### 1.3 Summary

In summary, walk-rounds can:

- Demonstrate commitment to improving safety and quality of care;
- Provide opportunity for direct engagement and communication with service users about safety and their experience;
- Establish open communication about service user safety among frontline staff and managers;
- Provide opportunities for staff to raise concerns and suggest improvements;
- Encourage reporting of issues, errors, and near misses;
- Promote a culture focused on quality and safety;
- Support local solutions in minimising risk ; and
- Demonstrate accountability.

A further development of Quality and Safety Walk-rounds are the introduction of 'Immersion Days' for board members and executives to have the opportunity to see and experience the complexities of care delivered (Bock and Paulus, 2016).

# Part 2

## A Co-designed Approach Beaumont Hospital Case Study Report

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## Part 2: Beaumont Case Study

### 2.1 Executive Summary

Over a period of eighteen months, Beaumont Hospital formalised a Quality and Safety Walk-rounds (QSWRs) programme aimed at promoting and enhancing the safety culture. Using the *Model for Improvement* (Langley, Mone *et al.*, 2009) and a phased implementation approach, a total of 12 Quality and Safety Walk-rounds took place in clinical and clinical support sites across the hospital. The walk-rounds were carried out by a Quality and Safety Walk-round Leadership Team which was made up of senior managers and clinicians from across the hospital. All members of the team completed a modularised, accredited leadership development programme co-designed between Beaumont Hospital and the National Quality Improvement Programme (HSE QID/RCPI) to support and enable the initiative. There was a growing realisation that implementing Quality and Safety Walk-rounds for sustainable impact was more about culture change and not a case of "let's just do it". A deliberate decision was made to focus on co-designing the programme with staff to ensure that Quality and Safety Walk-rounds enhanced the culture of the organisation. A suite of promotional material and a customised toolkit was developed by the Quality and Safety Walk-round Leadership Team to clearly outline and define the processes involved. The Quality and Safety Walk-rounds initiative has exceeded the leadership team's expectations with regard to predicted outcomes and has contributed to the development of an enhanced, more open, reflective model of engagement between senior management and frontline staff in contrast to an inspection focused approach. Quality and Safety Walk-rounds have proven to be a very useful way of generating a shared understanding of quality and safety across clinical and clinical support services; a mechanism for sharing good practice, and for acknowledging staff; a proactive approach to addressing safety priorities and a way of enhancing a culture of continuous improvement in the hospital.

### 2.2 Introduction

Beaumont Hospital is a level 4 hospital in the recently established RCSI Hospital Group. It is an 820 bedded acute facility with national and regional specialties and has approximately 3,000 employees. Patient safety is a strategic priority for the hospital with strong clinical and corporate governance, supporting the delivery of high quality safe care. Quality and Safety Walk-rounds are a mechanism for building a culture of open communication and dialogue about quality and safety in a proactive way and for creating the conditions for acknowledging and sharing good practice across the organisation. In keeping with many international patient safety recommendations, Quality and Safety Walk-rounds are an opportunity to increase visibility of senior leaders at the frontline.

### 2.3 Context for Initiative

The organisation had moved from a traditional hierarchical culture to one of a shared leadership model in the form of a clinical directorate structure where accountability and decision-making are held closer to the point of care delivery. The Hospital's Organisation Development Programme included a renewed focus on staff engagement and leadership development to support and enable structural and cultural changes. Whilst local walk-rounds were in existence as part of the traditional structures, the programme was in need of remodelling to fit the new shared leadership structures.

There was a renewed focus on patient safety following the publication of various high profile national and international reports. Feedback from the *National Patient Safety Culture Survey* (2014) at Beaumont Hospital and from staff engagement sessions considering how services work towards meeting the *Safer Better Healthcare Standards* (HIQA, 2012) highlighted the opportunity to create a mechanism for greater visibility of senior leadership to enable a deeper understanding and appreciation of frontline quality and safety issues.

The new shared leadership model was embedding well and clinical directorates provided a good foundation for building on and enhancing the quality and safety agenda across clinician-management boundaries.

## 2.4 Aim

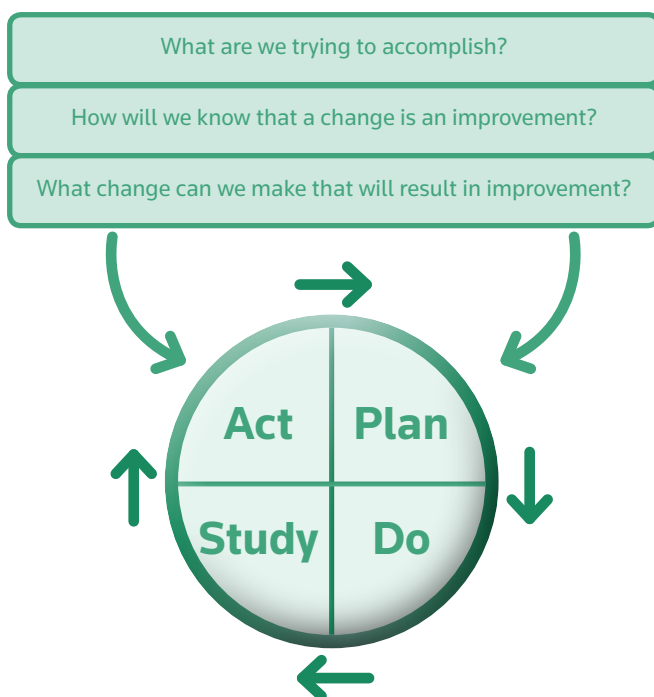
The overarching aim of the Quality and Safety Walk-round initiative is to enhance the patient safety culture in Beaumont Hospital by:

- Providing a mechanism for regular open dialogue and engagement between senior management and frontline staff;
- Inviting patient feedback on their experience of service quality and safety;
- Enabling visibility of Senior Management at the frontline creating a deeper understanding of frontline quality and safety issues by senior leadership;
- Strengthening existing quality and risk structures;
- Providing a platform for sharing learning across boundaries; and
- Creating two-way opportunities for sharing the good stories and experiences of quality and safety.

## 2.5 Methods

The quality improvement method used was based on the *Model for Improvement* (Langley, Mone *et al.*, 2009) Developed by Associates in Process Improvement, it is a simple yet powerful tool for accelerating improvement. The model has two parts:

1. Three fundamental questions.
2. The Plan Do Study Act (PDSA) cycle to test changes in real work settings.



**Figure 2.1 Model for Improvement**  
Adapted from Model for Improvement from Associates in Process Improvement Langley, Mone *et al.*, (2009)

The factors or components that influence the achievement of the aim are called 'drivers'. A driver diagram was created outlining the primary and secondary drivers for the Quality and Safety Walk-rounds Project (See Figure 2.2 ).

### What is a PDSA?

A change or a new procedure, process or system to be introduced is developed (plan), implemented for a specific timeframe on a small scale with a minimal cohort of stakeholders (do), evaluated (study) and adjusted (act), with repeated PDSA cycles, until it is fit for purpose and wholesale implementation

### What is a Driver Diagram?

A driver diagram is used to plan improvement project activities. It provides a way of systematically laying out aspects of an improvement project so they can be discussed and agreed on. It organises information on proposed activities so the relationships between the aim of the improvement project and the changes to be tested and implemented are made clear. The diagram has three columns - Outcome, Primary Drivers and Secondary Drivers.

**OUTCOMES**

**PRIMARY DRIVERS**

**SECONDARY DRIVERS**

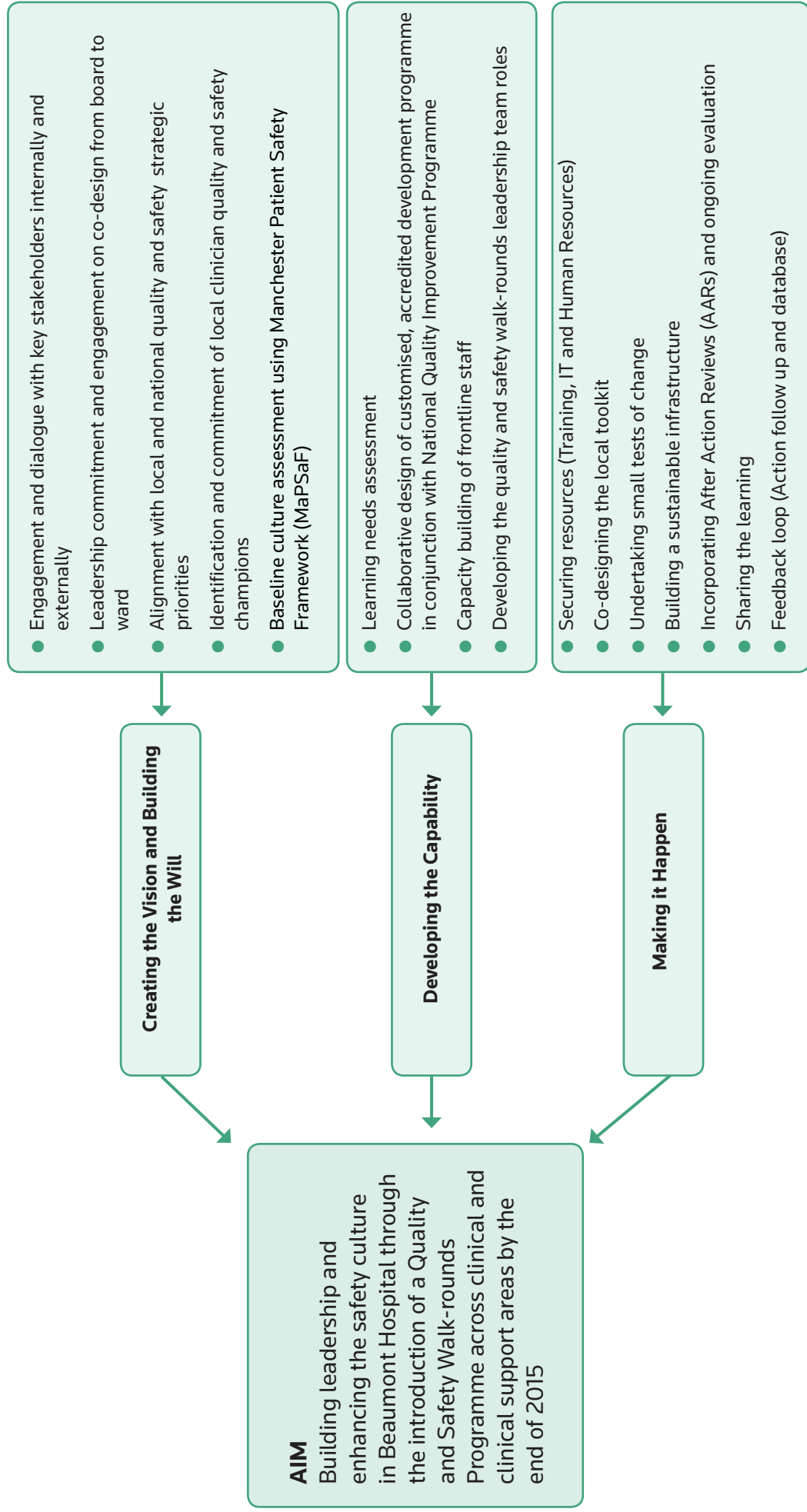


Figure 2.2: Quality and Safety Walk-rounds Driver Diagram

The process of implementing the quality and safety walk-round initiative is described using the *High Impact Leadership Framework* (Institute for Healthcare Improvement, 2013) as follows:

- Creating the Vision and Building the Will;
- Developing the Capability; and
- Making it Happen.

A process timeline was developed identifying key milestones for the initiative (see Figure 2.3).

### Step 1: Creating the Vision and Building the Will

The decision by three senior managers to adopt the Quality and Safety Walk-round initiative as a strategic change project in part fulfilment of the Hospital's Masters in Organisational Change and Leadership Development Programme was welcomed with enthusiasm and support from the Senior Management Team, Clinical Governance, Clinicians and Directorate Management Teams. It was felt that the timing was right in terms of a renewed energy with the appointment of the new Hospital Board, several clinicians involvement in national and local quality improvement programmes and the will to build on enhancing the existing quality and safety culture.

The Quality and Safety Walk-rounds project leads set about creating the vision and building the will by engaging with local, national and international experts. At a strategic level this involved early dialogue and engagement with the Hospital Board and the Senior Management Team to gain sponsorship and support for the walk-rounds initiative. Some of the early preparation and planning activities involved the following:

- Carrying out desktop research and incorporating best practice models;
- Undertaking site visits in healthcare and industry (Great Ormond Street, Pfizer, Aer Lingus);
- Assessment of local patient safety culture and reviewing findings from engagement sessions with frontline staff regarding Safer Better Healthcare Standards (HIQA, 2012) and feedback from National Patient Safety Culture survey, (July, 2014);
- Collaborating with the HSE Quality Improvement Division;
- Collaborating with internationally recognised Quality and Safety Walk-rounds clinician leader; Dr Peter Lachman;
- Presentations on Quality and Safety Walk-rounds to the Hospital Board, Senior Management Team and Heads of Department;
- Securing CEO sponsorship and commitment;
- Securing sponsorship and support from the chair of clinical governance;
- Engagement and enlisting support of senior clinician champions;
- Development of local implementation structure to support the initiative i.e. Steering Group made up of members of the Senior Management Team, Hospital Board, clinician champions, Quality Improvement Division, Directorate Management Team, Facilities Management, Organisational Development etc.(Figure 2.4) and Project Team Members (Senior nursing, Education, Learning and Development and Integrated Quality and Safety colleagues). (Appendix 2.9); and
- Regular engagement with directorate management teams and frontline staff : visiting wards and departments, inputting into existing structures and meetings.

“*Maybe I was a little bit sceptical about this at first, but I enjoyed the meeting and felt it was very positive. It was great to have the chance to show members of the Senior Executive Team the work we are doing in the unit, and I like the fact that this process is proactive rather than reactive. There should be more of this type of interaction in the hospital*”

Consultant



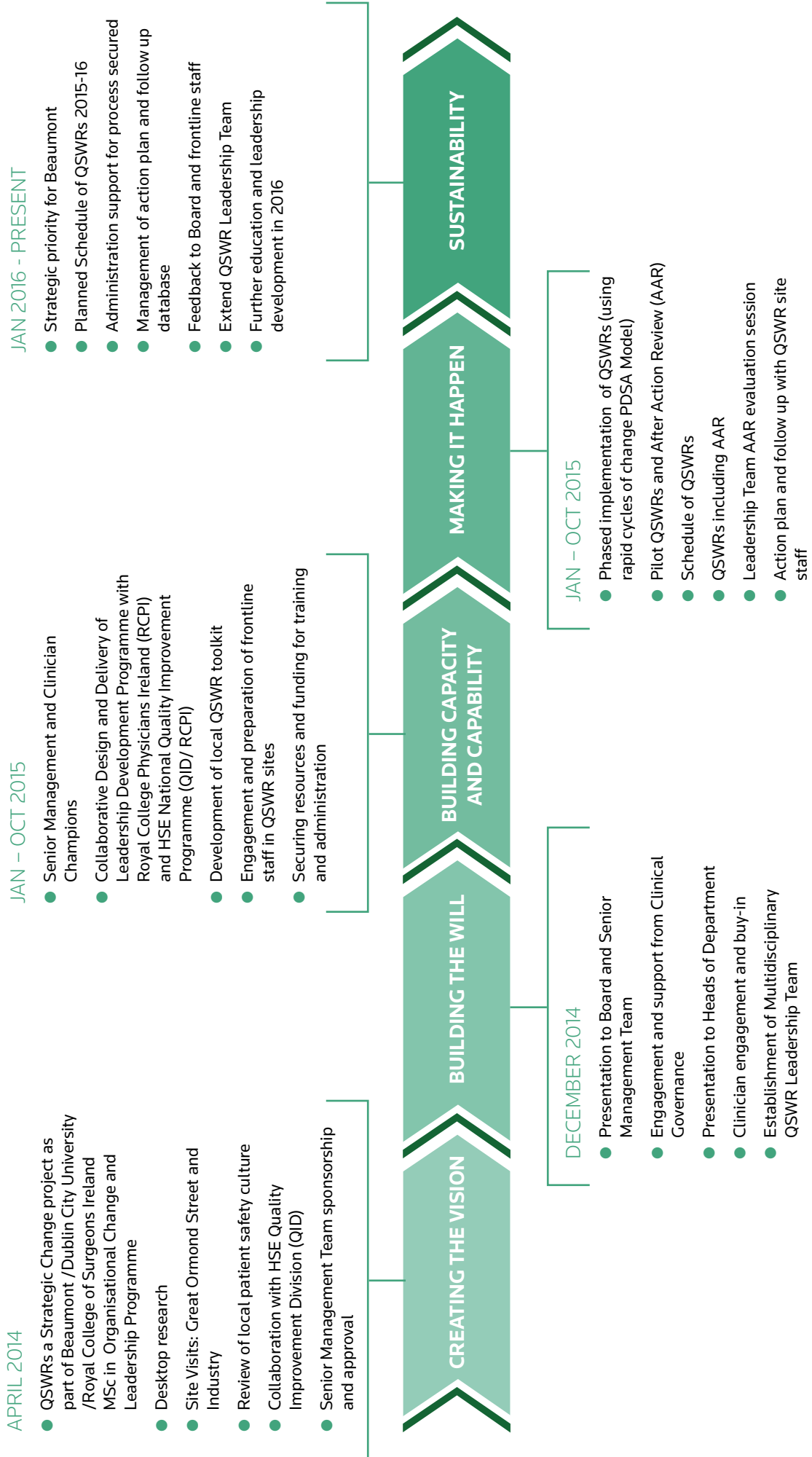


Figure 2.3: Quality and Safety Walk-rounds Implementation Timeline



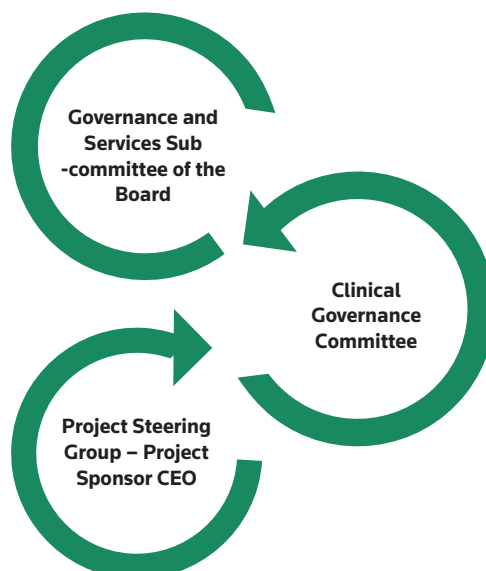


Figure 2.4 : Project Governance Structure

### Step 2 : Developing the Capability

At one of the early Steering Group Meetings the need to create a shared understanding of Quality and Safety Walk-rounds and educational support to build competence and confidence for conducting Quality and Safety Walk-rounds was highlighted by clinician and non-clinician colleagues. A submission was made to National Quality Improvement Programme (HSEQID/RCPI) seeking hospital-specific funding to support the training programme. Having researched best practice models the project team invited Dr Peter Lachman, National Quality Improvement Programme and Royal College of Physicians Ireland (RCPI) colleagues to collaborate on the co-design of a customised, flexible leadership development programme to support the Quality and Safety Walk-rounds initiative. A modularised, accredited programme (awarded 18 CME points) was developed jointly and delivered by Dr Peter Lachman, RCPI.

An expression of interest was sent out to the Senior Management Team inviting them to become part of the Quality and Safety Walk-rounds Leadership Team and the team were requested to commit to participating in four rounds per year. The Quality and Safety Walk-rounds Leadership Team who attended the training over a nine month period was made up of members of the Senior Management Team, Integrated Quality and Safety Division, clinician champions, Facilities and Hygiene Management, Education Learning and Development and Organisation Development (Appendix 2.9).

The following objectives were agreed for the Quality and Safety Walk-rounds leadership development training programme:

- To explore and enhance the safety culture;
- To develop the leadership capacity for introducing Quality and Safety Walk-rounds as a component of a quality and safety programme;
- To co-design the methodology for Quality and Safety Walk-rounds; and
- To test practice and evaluate Quality and Safety Walk-rounds in a clinical and clinical support area initially.

The programme which consisted of five modules was delivered on-site at Beaumont Hospital to facilitate attendance and work commitments (Table 2.1). Each module of the training programme was evaluated and participants reported very high levels of satisfaction with the programme provider, the approach, the content and the ability to apply the learning to support the Quality and Safety Walk-round initiative. Over the nine month period of the training programme there was 90% attendance and all clinicians attended the five modules thus prioritising a three-hour commitment to each session. Of attendees, 100% agreed that they could relate to the course concepts and apply the learning. In addition the programme also incorporated a facilitated After Action Review process to gather the learning and to identify any opportunities for improvement (Resource 14).

Table 2.1 Outline of Training Programme

<p><b>High Impact Leadership</b> Session 1 (4 Hours)</p> <ol style="list-style-type: none"> <li>1. High Impact Leadership</li> <li>2. Introduction to culture for safety</li> <li>3. Rationale for walk-rounds</li> <li>4. MaPSaF focus group discussion and assessment of the safety culture</li> </ol>	<p><b>Developing the Method for Walk-rounds</b> Session 2 (2 Hours)</p> <ol style="list-style-type: none"> <li>1. Process map of walk-round</li> <li>2. Question development</li> <li>3. Feedback loop</li> <li>4. Assessment</li> <li>5. Support required</li> </ol>
<p><b>Culture for Safety</b> Session 3 (3 Hours)</p> <ol style="list-style-type: none"> <li>1. Culture for safety</li> <li>2. Walk-round feedback</li> <li>3. Lessons learned and changes needed</li> <li>4. Role play</li> </ol>	<p><b>Developing the Safety Leadership Team</b> Session 4 (3 Hours)</p> <ol style="list-style-type: none"> <li>1. Developing the safety leadership team</li> <li>2. Walk-round feedback</li> <li>3. Lessons learned and changes needed</li> <li>4. Role play</li> </ol>
<p><b>After Action Review</b> Session 5 ( 2.5 Hours)</p> <ol style="list-style-type: none"> <li>1. What did we expect?</li> <li>2. What actually happened?</li> <li>3. Why was there a difference?</li> <li>4. What have we learned?</li> <li>5. Sustainability of Quality and Safety Walk-rounds Programme in Beaumont Hospital</li> </ol>	

**Step 3 -7 : Making it Happen**

Whilst external reports and toolkits were available nationally through the HSE Quality Improvement Division, members of the Steering Group identified the need to engage with staff locally to create the vision and build the internal will and momentum in order to develop and sustain a Beaumont Hospital specific walk-rounds programme and toolkit.

During the delivery of the training programme and up to January 2016 the Quality and Safety Walk-rounds Leadership Team adapted and tested the national toolkit with the overall aim of creating a customised toolkit for the hospital. Mixed methodologies have been incorporated into the training programme, for example use of video simulations, desk top reviews, classroom role play, rapid testing in the classroom and in real time.

A baseline for the safety culture was established by using the Manchester Patient Safety Framework (MaPSaF) (Parker, 2006) tool for focus group discussions during module 1 of the education programme. The culture of safety for the organisation was assessed under ten dimensions of patient safety.

*MaPSaF Survey Results Summary*

The MaPSaF safety culture exercise generated a lively conversation among the Quality and Safety walk-round

**What is the Manchester Patient Safety Framework (MaPSaF)?**

It is a tool to help organisations and healthcare teams assess their progress in developing a safety culture

**What are the dimensions of MaPSaF?**

1. Commitment to overall continuous improvement
2. Priority given to safety
3. System errors and individual responsibility
4. Recording incidents and best practice
5. Evaluating incidents and best practice
6. Learning and effecting change
7. Communication about safety issues
8. Personnel management and safety issues
9. Staff education and training
10. Team working

Leadership Team highlighting an openness to debating the strengths and weaknesses of the safety culture whilst acknowledging the complex multi-dimensional aspects of patient safety. There was a spectrum of views but the overall result revealed that as a team and as an organisation patient safety is a high priority. In terms of levels of safety culture maturity the results indicate movement in the right direction away from a bureaucratic culture towards a proactive culture. The results provide a useful baseline from which to measure improvement as the Quality and Safety Walk-rounds programme becomes embedded in the hospital.

Table 2.2 Quality and Safety Walk-rounds Toolkit

Standard Operating Procedure	Transcription Template (Resource 6)
Scheduling Template (Resource 2)	Notification E-mail (Resource 7)
Process (Resource 3)	Notice (Resource 8)
Opening and Closing Statement (Resource 4)	Information Leaflet (Resource 9)
Customised Questions (Resource 5)	Actions Database (Resource 13)

The following national tools were tested and amended:

- **Poster and Information Leaflet** – a Beaumont Hospital notice and an accompanying information leaflet was designed to inform staff of the scheduled walk-round.
- **Notification of Quality and Safety Walk-rounds** – this letter/e-mail is sent to the visiting area one week in advance of the walk-round. It highlights the date/time and outlines what the areas should expect from the visit and also outlines the need for the area to prepare in advance and ensure the appropriate staff is present.

Additional tools were developed by the Leadership Team to support the process:

- **Opening Statement** – this sets the context of the Quality and Safety Walk-rounds and provides an opportunity to explain the process and outline everyone's role.
- **Customised Questions** – a bank of questions was developed and tested during the training programme. The questions were based on the Charles Vincent (Vincent, 1998) Factors categories: Organisation, Management, Environmental, Equipment, People (Staff and Patients) and Task factors. These questions can be used at any time throughout the visit to assist with open communication as needed. It is not imperative that the team stick to these questions but rather use them as a guide for engagement with staff and service users.
- **Transcription Template** – this action orientation template allows for the scribe to capture three actions and identify who is responsible for follow up.
- **Closing Statement** – this was designed to allow the Quality and Safety Walk-rounds team feedback what has been heard and observed during the walk-round. The closing statement will also encourage staff to identify good practices that can be shared.
- **Actions Database** – a specific Quality and Safety Walk-rounds Database scheduling ownership and trend analysis for issues and actions identified.



Plan Do Study Act Cycles

A phased implementation plan was used to carry out a total of twelve Quality and Safety Walk-rounds across clinical and clinical support sites using the Plan Do Study Act (PDSA) rapid cycles of tests of change. The Project Team carried out 14 small tests of change as outlined in Table 2.3:

Table 2.3: Tests of Change

<p><b>PDSA 1 &amp; 2</b> Opening and Closing Statements</p>	<p>2 teams carried out 2 walk-rounds in the same site Tested the opening and closing statements and questions <b>Revised both statements and questions incorporating feedback from Quality and Safety Walk-round team and local site staff</b></p>
<p><b>PDSA 3</b> Developing and testing of a customised Question Bank</p>	<p>Desktop research on Quality and Safety Walk-round questions Class room testing and role play of questions <b>Revised questions tested in real time</b></p>
<p><b>PDSA 4-6</b> Testing and applying the methodology</p>	<p>4 teams undertook 15 minute walk-rounds across 2 sites Tested the revised opening, closing statements and questions and the overall safety walk-round process <b>Approved both statements and question bank</b></p>
<p><b>PDSA 7-10</b> Refining skills</p>	<p>Video recorded 4x15 minute walk-rounds in 2 sites (clinical and clinical support). After Action Review (AAR) using the video material to ascertain what worked well and what needed improving and lessons learned <b>Quality and Safety Walk-rounds team standardised the approach</b></p>
<p><b>PDSA 11</b> Conduct After Action Review (AAR)</p>	<p>AAR conducted and attended by 20 participants (QSWR Leadership Team members, leadership programme director and local site participants) Reviewed QSWR roles and processes Concerns about sustainability highlighted for attention <b>Validation and sign off of roles and processes</b> <b>Sustainability measures addressed locally and incorporated into the agenda for the final leadership development training module</b></p>
<p><b>PDSA 12</b> Test the scribe action plan template</p>	<p>Incorporate the scribe action plan template changes completed as part of a planned Quality and Safety Walk-round Review the feedback on use of the new scribe action plan template <b>Standardisation and sign off of the scribe action plan template and inclusion of free text for discussions on walk-rounds</b></p>
<p><b>PDSA 13</b> Test the AAR tool for evaluating each walk-round</p>	<p>AAR incorporated into 4 walk-rounds Use of AAR validated as a positive addition to methodology <b>AAR incorporated into standardised process</b></p>
<p><b>PDSA 14</b> Test the duration of the walk-round</p>	<p>Reviewed the prescribed time allocated against the real time experience Analysed the time allocated and the feedback over 10 Quality and Safety Walk-rounds <b>No change made to allocated time (remained 1 hour)</b></p>

*Establishing the Infrastructure for Walk-rounds*

The process for carrying out walk-rounds was documented in the form of a standard operating procedure and a process map (Resource 3). Planning and coordinating Quality and Safety Walk-rounds is key to success. It was agreed that in order for the walk-round to commence, four key people need to be available to participate on the Quality and Safety Walk-round Team; (i) Clinical Lead, (ii) Senior Management Team Lead, (iii) Safety representative and (iv) a scribe. Where possible, it is advised that scheduled walk-rounds should not be cancelled. Walk-rounds should be scheduled on a day and time that suits the area being visited. For local site Quality and Safety Work-rounds it was recommended that (i) the site Clinical Lead for the area, (ii) Area Manager, (iii) Staff from each discipline appropriate to the area (e.g. nursing, medical, support staff, admin, health and social care professional), and (iv) Directorate management and team representative may be in attendance for the visit.

*Using After Action Review (AAR) as a tool for evaluating each walk-round*

The Quality and Safety Walk-rounds were evaluated using the After Action Review (AAR) approach. This aimed at extracting the learning, identifying any opportunities for improvement and the critical success factors (Resource 14). Ongoing evaluation of quality and safety walk-rounds using the After Action Review approach has been incorporated into the process.

*Creating a system for tracking walk-rounds*

The Quality and Safety Walk-rounds Actions Database (Resource 13) developed enables the allocation of ownership and trend analysis for issues and actions identified. These actions have been linked to Directorate Management and clinical governance structures to ensure follow through at local and organisational levels. Issues identified on the walk-rounds are categorised using the "Vincent Model" contributing factors as follows: Organisation/Management, Environmental, People (staff and patients), Equipment and Task factors.

Table 2.4 shows examples of issues arising under the various categories and also includes shared learning/innovative practice opportunities.

Actions identified as a result of walk-rounds were discussed with the local units and were addressed at local and directorate team level where appropriate. If an action/ issue identified could not be addressed at this level, these were escalated to the Senior Management Team if required. The results were reviewed for trends and an analysis of issues was sent to the Clinical Governance Committee and the Senior Management Team.

A total of twelve safety walk-rounds took place across clinical and clinical support sites during the study period. The programme involved forty four frontline staff across disciplines and professions. A small number of conversations took place with patients on the walk-rounds (Table 2.5).

“The safety walk-round gave all members of the ward team an opportunity to ‘show off’ our achievements, and also to raise areas of concern. The meeting was relaxed and interactive, with all participants being involved, and the team doing the walk-round were really interested in what was going on at ground level. Staff commented afterwards how important this was, and they would like to see more of this”.

(Clinical Nurse Manager 3)



Table 2.4 Quality and Safety Walk-rounds: Data Analysis

Categories of Issues Identified	Number of Issues Identified	Some examples of issues identified and resolved	Sharing Learning/Innovative Practice
<b>Organisation / Management</b>	9	<ul style="list-style-type: none"> <li>Continuing to streamline patient pathways and reduction in delays through national Outpatients project</li> </ul>	<ul style="list-style-type: none"> <li>Laboratory accreditation supported by Qpulse system</li> <li>Implementation of national Emed ICT system for renal patients</li> </ul>
<b>Environmental</b>	7	<ul style="list-style-type: none"> <li>Inadequate Waste Management in Outpatients – facilities increased waste management collection.</li> <li>Poor patient experience due to lack of snacks in Outpatients – Vending machines now available with healthy snacks.</li> <li>Poor workflow processes resulting in staff stress – Office Equipment reorganised to improve flow.</li> <li>Introduction of resilience training to support frontline staff for handling conflict and maintaining resilience</li> </ul>	<ul style="list-style-type: none"> <li>Experience of ward re-organisation using the Productive Ward model</li> <li>Lowering of wall hangings in residential units to facilitate patients in wheelchairs – Community Nursing Unit</li> </ul>
<b>People (Staff and Patients )</b>	9	<ul style="list-style-type: none"> <li>Introduction of delirium and behaviours that challenge training programme to support staff and patient safety</li> <li>Proactively engaging with patients in the outpatient setting by introducing local patient engagement training</li> </ul>	<ul style="list-style-type: none"> <li>Design and display of graphics from Staff-patient engagement “Beaumont Listening” series.</li> </ul>
<b>Equipment</b>	2	<ul style="list-style-type: none"> <li>Infusomat and patient trolleys approved and supplied for patient safety and comfort on wards</li> </ul>	<ul style="list-style-type: none"> <li>Tutorial Room on first floor fitted with video-conferencing equipment</li> </ul>
<b>Task</b>	5	<ul style="list-style-type: none"> <li>Review of Outpatients batch appointments leading to overcrowding was undertaken</li> <li>Review of critical incidents relating to staff safety in high risk areas and implemented relevant health and safety training</li> </ul>	<ul style="list-style-type: none"> <li>Multi-disciplinary approach to providing holistic care in ambulatory care setting</li> <li>Upskilling of Clinical Nurse Specialist to insert peripherally inserted central catheter (PICC) lines to improve the patient experience and improve flow</li> </ul>

Table 2.5 : Analysis of Quality Safety Walk-rounds 2015

No. of walk-rounds	12
No. of staff involved local sites	44
No. of unit Physicians involved	13
No. of Nursing staff involved	17
No. of Health and Social Care Professionals involved	6
No. of support staff involved	8
No. of patients involved	5

## 2.6 Lessons Learned

A number of critical success factors were identified with this initiative:

- Executive sponsorship and engagement is key;
- Clinician involvement and engagement is vital;
- The value of education and leadership development for the team cannot be overstated;
- Trusting the Quality and Safety Walk-round process but not being constrained by it;
- An administration resource for the programme e.g. scheduling, managing write up, follow-up activities is essential for sustainability;
- Keeping in mind from the outset, the importance of not undermining existing local and corporate structures and management processes;
- Feedback on closing out of actions with units/ services visited is really important;
- Sharing the balance of follow-up between local directorate management teams and departments with Senior Management; and
- Quality and Safety Walk-rounds are a very useful means of promoting the good work happening across the hospital as well as highlighting the opportunities for improvement.

The Beaumont Quality and Safety Walk-round Project Team established a number of guiding principles when working on this initiative, they are:

- Ensuring that preparation was in place and that motivation and sustainability were key driving forces;
- Supporting engagement from all involved;
- Having a person focused approach by supporting the walk-round team, sites visited and engaging with patients and family members;
- Keeping mutual values and respect/trust to the forefront;
- Fostering a culture of openness – a 'Just Culture' where freedom to voice concerns is encouraged;
- Sharing responsibility for quality and safety matters in a non-hierarchical way (role modelling);
- Cultivating a Positive Deviance mindset to improvement and change initiatives;
- Working across functional /boundary/ inter -professional teams;
- Ensuring visibility;
- Bringing to the forefront pride and passion; and
- Learning and reflection on methods for quality improvement (PDSA and AAR).

“Being part of the Quality and Safety Walk-rounds was an excellent opportunity to demonstrate and collaborate with the Senior Management Team to develop clearly structured solutions that we can undertake to ensure high quality care for patients and a safe environment for staff. I would highly recommend any Clinical Nurse Manager (CNM) to become involved.” CNM1



## 2.7 Sustainability and Next Steps

Quality and Safety Walk-rounds is a key strategic priority for the Beaumont Hospital Board and Senior Management Team. The initiative is incorporated into existing quality and safety structures. The hospital put in place a number of steps to support sustainability, to embed the process and to build on existing capacity:

- Quality and Safety Walk-round administration was created by building capacity into an existing role to support the programme;
- Results are reported to the Hospital Clinical Governance Committee and embedded in the clinical directorate structure;
- Findings are reported to the Senior Management Team and Heads of Departments;
- Quality and Safety Walk-rounds are now scheduled one year ahead;
- Sharing the learning hospital wide and at a national level by attending national conferences, contributing to the revision of HSE Quality and Safety Walk-rounds Toolkit (2013);
- Increase the pool of Quality and Safety Walk-rounds Leadership Team by linking with quality improvement champions in the organisation;
- Repeat the MaPSaF survey when a critical mass of walk-rounds have been completed in order to track progress;
- Further training for additional Quality and Safety Walk-round Leadership Team members and refresher training for the current Leadership Team to maintain competency going forward; and
- Sharing the learning from this case study with the patient engagement initiative 'Beaumont Listening' to strengthen patient participation in the Quality and Safety Walk-rounds programme.

## 2.8 Conclusion

The Quality and Safety Walk-rounds initiative has generated a renewed energy and enthusiasm among frontline colleagues and senior leadership for working together to enhance the quality and safety culture in Beaumont Hospital.

The initiative has created a platform for senior management to hear first-hand about frontline challenges to delivering safer better care but this has also revealed the innovative practices and good news stories that all too often never make it to the Boardroom or across the organisation. As well as hearing from staff the Quality and Safety Walk-rounds have also contributed to strengthening the hospital's patient engagement approach by inviting feedback from patients as appropriate exploring additional ways of having conversations with patients on suggestions for improving services and care delivery.

The walk-rounds have become formalised within the organisation and they contribute to the Hospital's continuous improvement drive and support sharing of learning and practice across traditional boundaries. Reports were provided to the Hospital Board meeting, CEO and Clinical Governance Committee. The Senior Management Team and Directorate Team received updates via the Hospital newsletter, local patient safety meeting and national and academic conferences. The Quality and Safety Walk-rounds leadership development programme created a very safe and motivated learning environment for clinicians and managers to explore and design together a customised, sustainable methodology for testing and implementing walk-rounds.

The Quality and Safety Walk-round initiative has been really positive from the perspective of increasing visibility of the Senior Management Team at the frontline. Quality and Safety Walk-rounds have served to enhance the Senior Management Team's experience and understanding of quality and safety issues at the frontline. It has created the opportunity to enhance staff engagement and staff acknowledgement. Quality and Safety Walk-rounds have empowered staff for solving local quality and safety issues with the support of other key stakeholders across the hospital e.g. facilities management and senior management. This initiative has improved clinician – management relations and has given an alternative approach to patient involvement.



## 2.9 Appendices

### Quality and Safety Walk-rounds Steering Group Members

Mr Liam Duffy	CEO
Ms Karen Greene*	Director of Nursing
Ms Petrina Donnelly*	Deputy Director of Nursing
Mr John Walsh*	Directorate Nurse Manager, Medical Directorate
Dr Raphaela Kane	Board Member (until June 2015)
Ms. Maureen Flynn	HSE Quality Improvement Division
Prof. Edmond Smyth	Director of Clinical Governance
Dr Fidelma Fitzpatrick	Consultant Microbiologist
Ms Patricia Owens	Director of HR
Mr Donal O'Rourke	Business Manager, Radiology Directorate
Ms Judy McEntee	Directorate Nurse Manager, Critical Care Directorate
Ms Ann Marie Cushen	Medication Safety Officer
Ms Helen Ryan	Clinical Governance Manager
Ms Kate Costello*	Head of Education Learning & Development
Ms Pauline Fordyce	Head of Integrated Quality & Safety Department
Mr Des O'Toole	Business Manager, Surgical Directorate
Ms Marie Kelly	Directorate Nurse Manager, Surgical Directorate
Mr Peter O'Leary	Laboratory Manager
Ms Sharon Dwyer	Head of General Services (until September 2015)
Ms Marie Keane	Director of Capital Campus Development and Facilities Management (until September 2014)
Ms Helen Shortt	Chief Operations Manager (until October 2015)
Ms Sheila McGuinness	Director of Nursing (until April 2015)
Ms Susan Moloney	Quality Manager (until September 2015)
Ms Aileen Kileen	Business Manager, Neurocent Directorate (until February 2015)

\*Project Team Members



**Quality and Safety Walk-rounds Leadership Development Programme Attendees**

Mr. Liam Duffy	CEO
Ms. Mary Farrelly	Finance Director, Senior Management Team
Ms. Anne McNeely	Head of Organisational Development, Executive Management Team
Mr. John Walsh	Directorate Nurse Manager Medical Directorate
Ms. Petrina Donnelly	Deputy Director of Nursing
Ms. Karen Greene	Director of Nursing
Ms. Kate Costelloe	Head of Education, Learning & Development
Ms. Helen Ryan	Clinical Governance Manager
Ms. Pauline Fordyce	Head of Integrated Quality & Safety
Prof. Edmond Smyth	Director, Clinical Governance Committee
Ms. Mary Keoghan	Consultant Immunologist
Mr. Colm Magee	Consultant Nephrologist
Ms. Sharon Dwyer	Facilities Manager, Senior Management Team (until September 2015)
Ms. Dorothy Costello	General Services and Hygiene Manager
Mr. Stephen Toomey	Facilities, Technical Services
Mr. Mark Graham	Director of ICT
Ms. Sheila McGuinness	Director of Nursing, Senior Management Team (until April 2015)
Ms. Helen Shortt	Previous Head of Operations, Senior Management Team, (until October 2015)
Ms. Ann Marie O'Grady	Head of Clinical Services & Business Planning, Senior Management Team (until January 2015)
Ms. Susan Moloney	Quality and Accreditation Manager (until September 2015)
Mr. Alan Byrne	Business Manager, Laboratory Directorate (until April 2015)

# Part 3

## Toolkit Resources

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## Resource 1 : Terms of Reference Quality and Safety Walk-round Steering Group

### *Role and Responsibilities*

- Agree on membership and invite new members as required
- Approve the selection of new walk-round leadership team members
- Develop and implement a Communication Plan
- Identify training requirements and approve and develop new programmes
- Provide overall direction and leadership for the delivery and implementation of the project
- Approve all stages and plans, commit resources and resolve issues as required
- Oversee the implementation of quality and safety walk-rounds in clinical and non-clinical areas and to agree pace of rollout
- Ensure that the programme receives local and national recognition
- Ensure that the programme is on target and meets its approved objectives
- Sign-off on key programmes milestones/ deliverables
- Approve the use of external walk-round methodologies/toolkits within the organisation
- Evaluate and regularly review the effectiveness of the programme
- Support the sustainability of the programme

### *Reporting Relationship*

- Provide reports to Clinical Governance /Quality and Safety Committee / Board /Executive Management Team

### *Membership*

- CEO Project Sponsor
- Representatives from Senior Management Team / Executive
- Director of Nursing
- Hospital Board Nominee
- Chair of Clinical Governance
- Director of Human Resources
- Director of Finance
- Representative from each Directorate Management Team
- Quality and Safety Manager
- Facilities Manager
- Learning and Development
- Medication Safety Lead

Resource 2 : Quality and Safety Walk-round – Contact information and Schedule

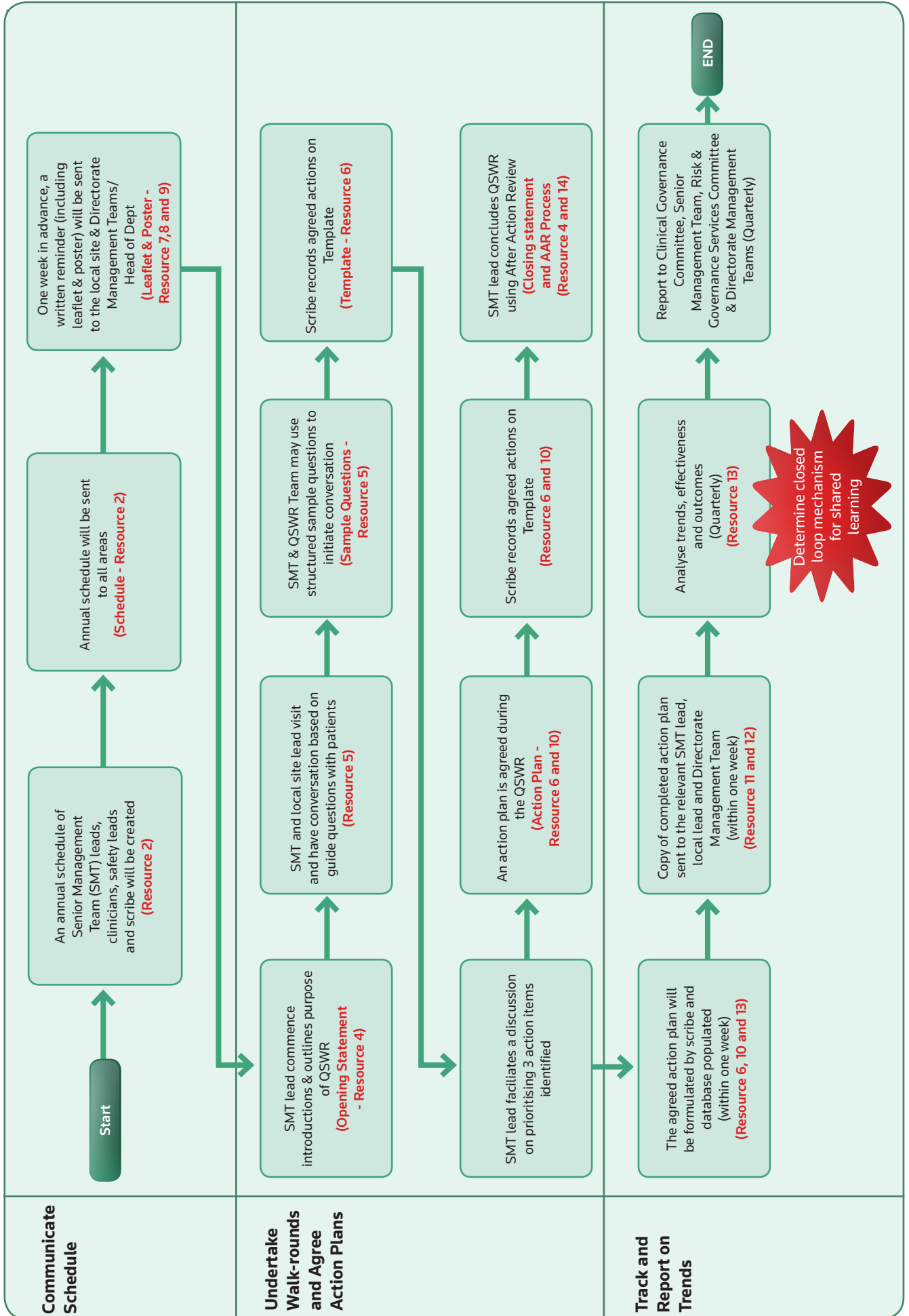
**Quality and Safety Walk-round Contact Information**

	Ward/Department/ Unit	Directorate/ Division	Nurse/Midwife Lead	Medical Lead	Phone	Email

**Quality and Safety Walk-round Schedule**

Department/ Directorate	Unit/Team	Date	Day of Week	Time	REPRESENTATIVE			
					Senior Manager	Clinical Lead	Safety Lead / Other	Scribe

Resource 3 : Quality and Safety Walk-round Process



## Resource 4 : Quality and Safety Walk-round Opening and Closing Statements

**Opening Statement**

This sets the context of the QSWR and provides an opportunity to explain the process and outline everyone's role.

*We are here on a Quality and Safety Walk-round today and the team is made up of a senior management representative (Name & Role), a member of our safety team (Name & Role), a clinical lead (Name & Role) and (Name & Role) will assist us with note keeping today.*

*So could you introduce yourselves and tell us your roles.*

*We are interested in focusing on systems and processes and not individuals. Each of us has an important role to play in patient safety so your views are very valuable. We must highlight that this is not an inspection or an audit.*

*We are here to listen to you as we want to work together to improve patient care and safety. Our aim is to discuss good safety practice and concerns and work with you to improve the environment and overall delivery of care. During our visit today we would like to meet with 1 or 2 patients (if appropriate for the area being visited) to seek their views on safety also.*

*Where would be a good place to have our discussions today?*

**Closing Statement**

This allows the Quality and Safety Walk-round team feedback what has been heard and observed during the walk round, it also allows for all parties to recap on the agreed actions timeframes and responsible persons. The closing statement will also remind staff to identify good practices that can be shared.

*Thank you for taking the time to meet with us today. We appreciate how busy you are and hope you have found some benefit from the conversation. We are very glad that we have come here today as this has been very beneficial. There are some actions that we have agreed can be managed by yourselves or that you need to discuss with your directorate management team. You have also highlighted some issues that the directorate management team and ourselves will need to discuss further to follow up.*

*From here the actions we have agreed together to prioritise will be sent within xxxxx (agree a timeframe) to you (Unit Manager) and to your directorate management team to support you with follow up.*

*One of the things today that we have been so impressed with is how proactive you and your team have been with .... (give an example of a quality initiative that has been discussed). We would like you to think about how you can share this great initiative with other similar areas in the hospital.*

*Following today, we would like you to inform your team about today's walk-round so that all staff members are aware of the agreed actions.*

## Resource 5 : Quality and Safety Walk-round Customised Questions

The questions can be used at any time throughout the visit to assist with open communication as needed. It is not imperative that the team stick to these questions but rather use them to get engagement. There are also patient questions if deemed appropriate.

### **Beaumont Hospital Questions Bank**

#### **Introduction Questions**

1. *What do you do well – what are you most proud of here?*
2. *What patient or staff issues cause you concern in relation to quality and safety?*

#### **People patient/staff**

1. *Can you describe how communication either enhances or inhibits safe care on your unit in the following areas - Handover, multidisciplinary team, patients or relatives?*
2. *How can patients/relatives raise safety concerns?*
3. *Have any concerns been raised by staff members with regard to quality or safety?*

#### **Equipment**

1. *Do you have any safety concerns about the equipment in your area?*

#### **Task**

1. *Today are you able to care for your patients as safely as possible? If not, what is prohibiting you?*
2. *Do you feel you have the ability and support to perform the tasks which are expected of you?*

#### **Environment**

1. *Can you think of a way in which the environment fails you or your patients on a regular basis?*
2. *Are there opportunities for improving the environment that you think are feasible?*

#### **Organisational**

1. *What specific action could the leadership team take to make the work you do safer for patients and staff?*
2. *What could you and your team do on a regular basis to improve quality and safety for patients and staff?*
3. *Can you highlight an example of good practice that could be shared with other areas?*

#### **Patient Engagement**

1. *Is there anything that we could do better with regard to quality and safety?*



Resource 6 : Quality and Safety Walk-round Transcription Template



### Quality and Safety Walk-round Transcription Template

<b>Date:</b>		<b>Time:</b>	
<b>SMT Lead:</b>		<b>Location:</b>	
<b>Clinical Lead:</b>		<b>Scribe:</b>	
<b>Other:</b>		<b>IQS:</b>	

Did the area receive letter of (i) Notification of QSWR?  (ii) QSWR Leaflet?

Present	Grade/Role	Present	Grade/Role

### Action Plan

*\*Pick 3 key areas for Local Action and Corporate Action*

<b>1</b>	Description:	
	Work to Date:	
	Action Req:	
	Action Owner:	Review Date:

<b>2</b>	Description:	
	Work to Date:	
	Action Req:	
	Action Owner:	Review Date:

<b>3</b>	Description:	
	Work to Date:	
	Action Req:	
	Action Owner:	Review Date:

Discussion Notes:

## Resource 7: Quality and Safety Walk-round Notification E-mail

This letter/e-mail is sent to the visiting area one week in advance of the walk round. It highlights the date/time and outlines what the areas should expect from the visit and also outlines the need for the area to prepare in advance and ensure the appropriate staff is present. Walk-rounds should be scheduled on a day and time that suits the area being visited.

[insert date]

Dear XXX,

XXXX ward/unit has been scheduled for a Quality and Safety Walk-round (QSWR) on the dd/mm/yyyy from XX:XX am to XX:XX am.

These walk-rounds are part of our commitment to patient safety and improving patient care.

The aim of the Quality Safety Walk-round is to provide an opportunity for a member of the senior management team to meet with a consultant / clinical director, the local manager and multidisciplinary team members to showcase good practices and highlight any concerns. To make the most of this opportunity, it would be useful for you and the team to reflect on what you would like to discuss. Prior to the walk-round you are asked to ensure that both yourself or representative and a clinical lead is available to participate on the Quality and Safety Walk-round.

All staff have an important role to play in improving safety, therefore the walk-round team would like to use the visit as an opportunity to speak to key staff of any grade or profession. Please inform staff members of the quality and safety walk-round and their opportunity to engage in the process. The walk-round team would also welcome the opportunity to speak with patients if possible and this can be discussed on the day.

Attached is a leaflet on the Quality and Safety Walk-round process which provides more detail for your team to help them understand the purpose of the visit. A Quality and Safety Walk-round notice is also attached and we would appreciate it if you could display this in a visible area.

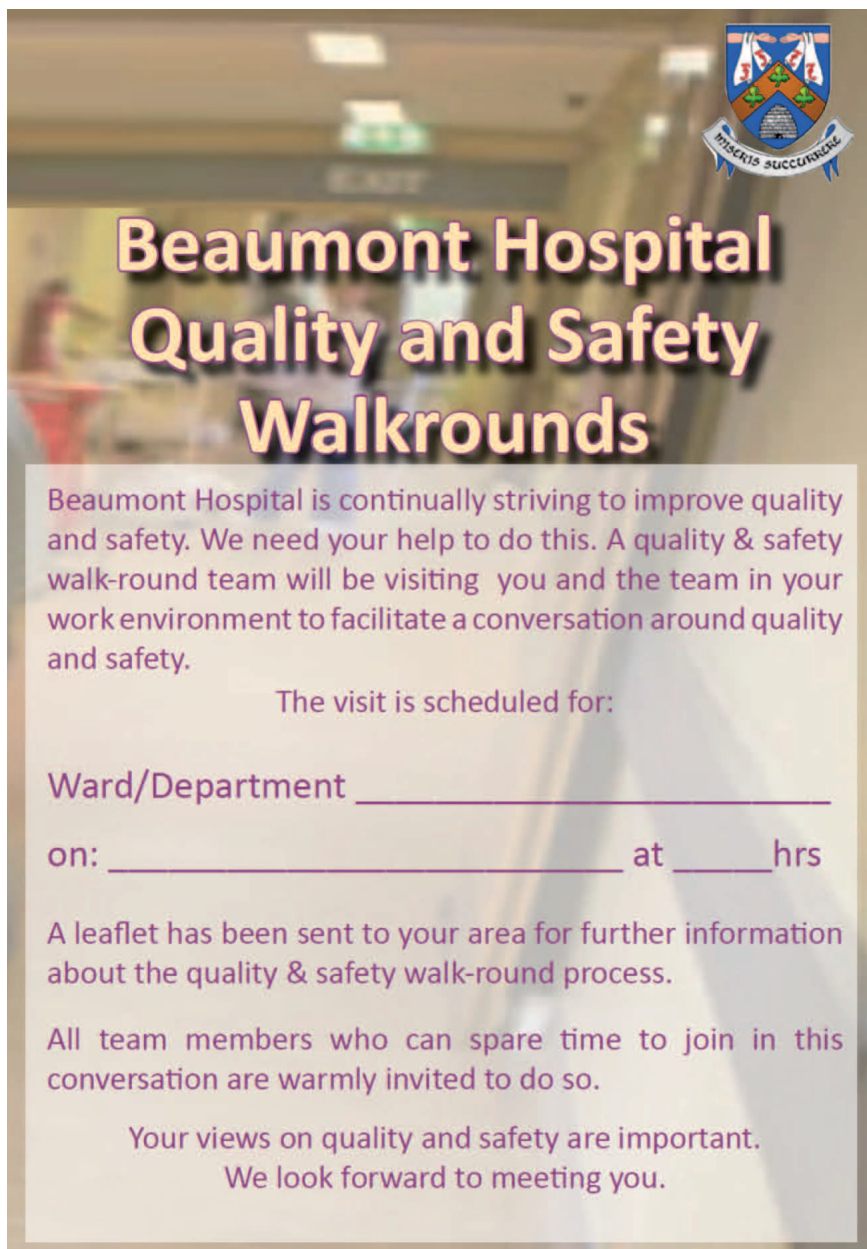
We look forward to meeting with you and your team.


Kind regards,

*If you have any queries please contact...*

*c.c. Directorate Management Team / Department Heads / Service Manager.*

## Resource 8: Quality and Safety Walk-round Notice





## Beaumont Hospital Quality and Safety Walkrounds

Beaumont Hospital is continually striving to improve quality and safety. We need your help to do this. A quality & safety walk-round team will be visiting you and the team in your work environment to facilitate a conversation around quality and safety.

The visit is scheduled for:

Ward/Department \_\_\_\_\_  
on: \_\_\_\_\_ at \_\_\_\_\_ hrs

A leaflet has been sent to your area for further information about the quality & safety walk-round process.

All team members who can spare time to join in this conversation are warmly invited to do so.

Your views on quality and safety are important.  
We look forward to meeting you.

Resource 9: Quality and Safety Walk-round Leaflet

**Beaumont Hospital Safety Programme**

The Quality & Safety Walk-rounds process is aimed towards improving patient and staff safety in Beaumont Hospital. The safest organisations are those able to:

- create a culture that puts patient quality and safety at the centre of everything we do;
- provide guidance and support to remove barriers and develop people to improve patient safety;
- Ensure quality and safety are strategic priorities for the organisation
- Share good practices throughout the organisation and beyond.

**Quality & Safety WalkRounds**

References.

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**Beaumont Hospital**

Quality & Safety  
Walk-rounds  
(QSWRs)

Beaumont Hospital striving to continually improve quality and safety.

Date Issued: June 2014  
 Review Date: June 2016  
 Author (s) Quality & Safety Walk Rounds Group  
 Approved by: Quality & Safety Walk Rounds Group

PRINTROOM PDON PROOF 26032014U0002015

**WHY ARE WALKROUNDS IMPORTANT?**

Walk-rounds are a way to connect Senior Management with staff in clinical and clinical support areas to talk about their ideas and issues about quality and safety. The aim of the Walk-rounds is to:

- Increase staff engagement and develop a culture of open communication
- Identify, acknowledge and share good practice.
- Strengthen commitment and accountability for quality and safety.

provide an opportunity for the team to reflect on quality and safety for their area in preparation for the walk-round.

On the day of the walk-round an Executive member will explain and introduce the walk-round process, you and the team will be asked some structured questions to facilitate a conversation about quality and safety in your area and the discussions will be captured by a note taker. The discussion will be about:

- Your key patient or staff safety concerns
- How can we improve quality and safety together?
- Teamwork - how does your local team work?
- Are there any communication issues?
- What good practices are performed in your area and can we share them

**WHAT WILL HAPPEN TO THE INFORMATION WE GATHER?**

A summary and action plan will be sent to the local team following the walk-round, confirming the main issues discussed & key actions to be undertaken, including who will take responsibility for them and a time frame identified.

**WHERE DOES THE WALKROUND TAKE PLACE?**

The walk-round team and local staff can meet in any area that suits the ward or department normally close to the area of activity.

The area should allow approximately 1 hour for the walk-round to take place. This will comprise of a brief walk-round of the area followed by a discussion in a convenient meeting area with the team members

**WHAT HAPPENS AT THE WALK-ROUND?**

Prior to walk-rounds, a scheduled annual rota of QSWRs will be available to all areas which will include dates, times and locations of QSWRs. Each area will be reminded one week in advance of scheduled walk round. This reminder will

**WHO IS INVOLVED?**

We would like the whole team in your area to be involved as everyone has a valuable contribution to make. The executives visiting the clinical / clinical support area would like to meet the local manager who will attend the walkround and facilitate relevant MDT staff in the area including students, doctors, nurses, HCAs, Technicians, Catering, AHP's, Portering, Admin staff, managers working in the area and any other staff. Patients may also be involved in this process.

The walk-round team will consist of a maximum of 4 people and may include people such as the Chief Executive Officer, Chief Operations Officer, Directors of Human Resources & Nursing, Medical Director, Clinical Governance, IQS staff, General Services, & TSD. A member of the Beaumont Hospital safety team will record the issues discussed.

**KEY MESSAGE**

Quality & Safety walk-rounds are an opportunity to raise patient & staff safety issues directly with executives, whether to discuss challenges you face or good practice you would like to share. They are not an inspection. The issues raised can be for action or information.

*At Beaumont Hospital we pride ourselves in seeking to attain the highest standards in everything we do. Each one of us has a duty to know what is required of us and to play an active part in promoting Quality & Safety in the workplace.*

Resource 10: Quality and Safety Walk-round Action Plan Template

CATEGORY	ISSUE OR CONCERN RAISED	WHAT HAS ALREADY BEEN DONE TO ADDRESS ISSUE	ACTION TO BE TAKEN FOLLOWING WALK-ROUND	PERSON RESPONSIBLE	DUE DATE
Organisation/ Management					
Environmental					
People (Staff and Patients)					
Equipment					
Task					

FEEDBACK	SUGGESTIONS

## Resource 11: Quality and Safety Walk-round Communication after the Quality and Safety Walk-round

A copy of the draft Action Plan is circulated to all those present at the walk-round for comment and approval. All positive feedback and suggestions for improvements are also noted and these are included in the email sent to the team following the walk-round. In some instances, it can be useful to focus on a small number of high priority issues identified on a Quality and Safety Walk-round. A suggested email template is as below. It is good practice to distribute the draft action plan within an agreed time frame.

[insert date]

Dear XXXX,

Thank you for investing the time and participating in the Quality and Safety Walk-round to XXXX unit/team on dd/mm/yyyy.

As agreed, please find attached a draft version of the action plan that highlights safety action points that together we will take forward with the intention of resolving or raising further awareness on the issue.

In addition, we would like to note the positive feedback we received during the visit:-

- 1.
- 2.

Suggestions for unit/team to consider as part of promoting further good practice are:

- 1.
- 2.
- 3.

If you wish to make any amendments to the attached report or to the comments above, I would be grateful if you could please let me know by XXX 20XX. The final action plan will then be emailed to all concerned to ensure agreed actions are taken forward.

Kind regards,

## Resource 12: Quality and Safety Walk-round Final Communication after the Quality and Safety Walk-round

The final action plan is circulated to all participants in the walk-round within an agreed timeframe. An example email template is as below. The named person for coordinating the Quality and Safety Walk-rounds takes responsibility for following up progress on the action plans as the deadlines approach. Progress on all other issues are normally captured at the next walk-round visit for that particular area (or as agreed by the executive/senior management team).

[insert date]

Dear XXX,

Thank you for participating in the Quality and Safety Walk-round to XXXX unit/team on dd/mm/yyyy.

Further to my email (dated XXX) please find attached the final action plan that takes account of your comments and highlights the agreed priority issues that will be taken forward.

Again, we would like to note the positive feedback we received during the visit:

- 1.
- 2.

Suggestions for unit/team to consider as part of promoting further good practice are:

- 1.
- 2.
- 3.

Our agreed time scale for addressing the issues is dd/mm/yyyy. Please keep me briefed on the progress to enable me to update the Quality and Safety Walk-round database.

Kind regards,

Resource 13 : Quality and Safety Walk-round Database Fields

Clinical Unit	Area	Ward Contact	Date	Day of Week	Time	Representatives

Actions Sent	Action Deadline	Actions Followed Up	Actions Outstanding	Actions Chased	Actions Closed	Final Report Sent



## Resource 14 : After Action Review Process

### After Action Review (AAR) Process

An After Action Review (AAR) is a discussion of an event that enables the individuals involved to learn for themselves what happened, why it happened, what went well, what needs improvement and the lessons learnt. The AAR seeks to understand the expectations of all those involved and provides insight into events and behaviours in a timely way with the learning leading to personal awareness and action.

### After Action Review (AAR) The Four Steps

What was EXPECTED?	What ACTUALLY happened?
<p>Before the event, what was the objective, plan or expected outcome? What did we set out to do?</p> <p><i>It could be a shared plan, a formal agreement, a guideline, a personal expectation, or simply regular practice</i></p>	<p>After the event each participant describes what they did, saw or experienced during the event</p> <p><i>Explore the facts, while acknowledging the perspective and feelings of others</i></p>
WHY there was a difference?	What can be LEARNED?
<p>Why there was a difference between the expected outcome and the reality of the moment?</p> <p>Reflect on the successes and failures What worked well ? why ? What didn't work? What could have gone better ? why?</p> <p><i>Check if expectations were properly shared and what constraints on people, time or resources prevented expectations being realised</i></p>	<p>Learning is the prime action within an AAR. What will be different next time?</p> <p>What are the two or three key lessons you would share with others ?</p> <p><i>It may be a change in practice or policy or a change in attitude, behaviour, shared understanding or greater insight. Direct the collective wisdom to improving future performance.</i></p>

### AAR GROUND RULES

- Leave hierarchy at the door
- Everyone contributes and all contributions are respected
- The purpose of the AAR is to learn
- No BLAME – Discussing mistakes should not lead to blame
- Everyone will have a different truth to share of the same event
- Contributions should be through what people know, feel and believe
- Respect time pressures but all must be fully present
- Make no assumptions, be honest and open
- All must agree with these ground rules

Adapted from : Andrews, (2008) University College London (UCL) Hospitals NHS Foundation Trust.

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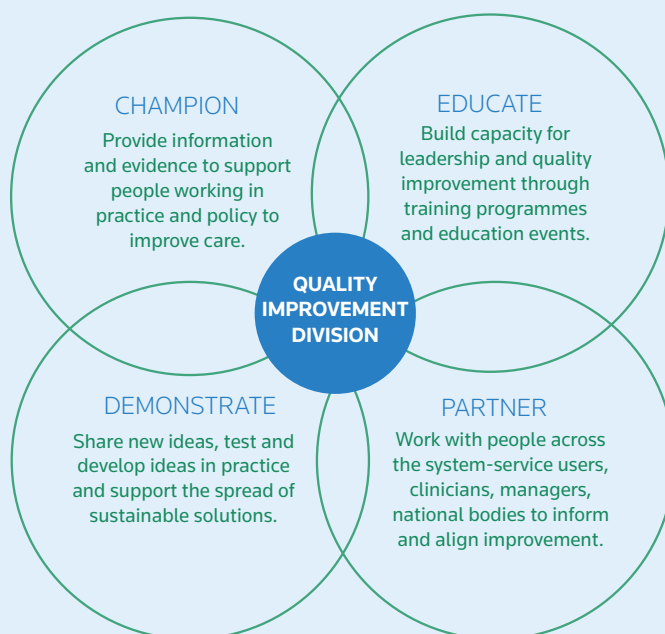
## About the Quality Improvement Division

The HSE Quality Improvement Division (QID) was established in 2015 to support the development of a culture that ensures improvement of quality of care is at the heart of all services that the HSE delivers.

The mission of the Quality Improvement Division team is to provide leadership by working in partnership with service users, families and all who work in the health system to innovate and improve quality and safety of care.

Improving quality is everyone's business, and each and every person working in the HSE has a role to play. Our purpose is to work in partnership with all healthcare stakeholders to create safety quality care.

To support a culture of service user safety the role of the Quality Improvement Division is to:



Quality Improvement Division  
Health Service Executive  
Dr Steevens' Hospital  
Dublin D08 W2A8  
Ireland

+353 1 6352344

nationalqid@hse.ie

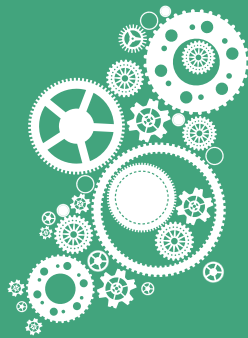
@hseqi

www.hse.ie

For further information please see [www.qualityimprovement.ie](http://www.qualityimprovement.ie)

Tús Áite do  
Shábháilteacht 1 Othar  
Patient Safety First

The HSE is a signatory to **Patient Safety First** - the initiative through which healthcare organisations declare their commitment to patient safety. Through participation in this initiative, those involved aspire to play their part in improving the safety and quality of healthcare services. This commitment is intended to create momentum for positive change towards increased patient safety.



We are all responsible ... and together we  
are creating a safer healthcare system