Patient safety walkrounds enable staff to raise concerns with senior executives. Their use in one mental health trust led to improvements in safety and care.

Leadership walkrounds in mental health care

In this article...

- Why patient safety walkrounds are valuable
- How they can be used in mental health
- Their role in staff empowerment

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Patient safety leadership walkrounds are designed to assist healthcare leaders to improve patient safety. At 2gether Foundation Trust, walkrounds have been developed in mental health settings. They ensure that executives are informed first-hand about the safety concerns of frontline staff, while ensuring staff are listened to and supported when issues of safety are raised. Patient safety and quality improvements have been implemented over time through this process.

Too many people are harmed by things going wrong while they are receiving healthcare, and the NHS has been given an urgent challenge to systematically tackle the causes of patient safety incidents and so continuously reduce harm (NHS England, 2013). The 2gether Foundation Trust, walkrounds have been developed in mental health settings. They ensure that executives are informed first-hand about the safety concerns of frontline staff, while ensuring staff are listened to and supported when issues of safety are raised. Patient safety and quality improvements have been implemented over time through this process.

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Walkrounds are a management tool to help hospital leaders to implement effective safety solutions by listening to the concerns of frontline staff, supporting appropriate accountability and allocating resources to areas of greatest risk (Frankel et al, 2006). They also demonstrate visible commitment by listening to and supporting staff when issues of safety are raised, and can help to develop an open culture where patient safety is seen as the organisation’s priority (Patient Safety First, 2009).

The Patient Safety First campaign advocated walkrounds as a vehicle to take directors back to the floor (National Patient Safety Agency, 2011). Davies (2013) identified a focused exercise such as a structured patient safety walkround as a “back to the floor” activity, critical for changing culture.

5 key points

1. NHS England says the causes of patient harm need to be tackled urgently and systematically.
2. Patient safety walkrounds allow staff to raise safety concerns with senior executives before incidents occur.
3. In mental health settings, a “talkaround” may sometimes be more appropriate than a walkround.
4. Walkrounds empower teams to tackle or escalate patient safety issues.
5. Walkrounds are a way to spread good practice in organisations.

Reduce avoidable harm to users of mental health services, and this has offered opportunities to be proactive and identify gaps in safety. Trusts have historically collected data on what works well and what has not gone to plan, but this is done after an incident has happened and is therefore a reactive approach to patient safety.

A need for cultural change has been identified in the light of the Francis report (Francis, 2013), and Berwick (2013) strongly identified that leaders have a crucial role to play in shaping a positive culture.

Why walkrounds are useful

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Staff “talkarounds” are valuable for learning about patient safety.
Bringing in walkrounds
Unlike acute general hospital walkrounds, ours are opportunities for discussion – “talkarounds” – with more talking and less walking.

Sometimes it is not appropriate to walk around as it can affect the stability of a carefully managed clinical mental health area but, if there are environmental safety concerns, it is useful to see the clinical environment. Walkrounds have developed into conversations that are structured yet open and informal in style; they are planned in advance so staff know when to expect them.

The walkround procedure was developed from resources available via the Patient Safety First initiative (Patient Safety First, 2009). During 2011, the first walkround was trialled then refined, based on feedback gathered from both the ward team and the executives involved.

The original aim in 2012 was to have four walkrounds each month, but this arrangement was challenging to achieve. The schedule was reviewed because of concerns that if executives failed to make the walkround it would compromise the message to clinical teams that patient safety remained a priority. The target was reduced to two walkrounds per month in 2013 and the executive team achieved this consistently and continue to do so. Walkrounds have been extended to include high-risk community teams such as crisis resolution and home treatment teams, assertive outreach teams and early intervention teams.

The trust’s executive lead for the Patient Safety Programme had been involved in walkrounds in a previous role, so was able to build on experiences to use the visits to reinforce high quality and patient safety as a priority for the organisation. Our process for walkrounds was tested, developed and refined through “plan, do, study, act” methodology.

Walkround organisation and outcomes
The clinical lead for continuous improvement provides overall coordination and administration of the walkround visit schedule, along with planning and documentation before and after the visit, with some administration support. Scheduling, scripting, feedback and reporting are covered under this arrangement.

The visits are planned and scheduled so that each area receives one visit a year, and are triangulated with other executive visits, such as board visits, to avoid frequent visiting or duplication in a short time frame.

Each walkround visit to a clinical team generates a set of actions to improve patient safety. This is drafted as an action plan for the team to agree, and identified actions are owned by the team manager, the executive, an identified team member or middle management within a time frame towards resolution. Actions are reported and followed up. Themes from visits are captured and fed back to the executive and clinical teams.

Planning
Planning for the visit is helpful and walkround visit information packs support clinical teams to engage in the process and focus the discussion on safety as well as educating executives who may not have a clinical background. Clinical teams need to understand the purpose of the visit (especially that it is not an inspection) and that being open and transparent is essential (Davies, 2013).

Unplanned visits can be viewed as exerting hierarchical power to catch people out. Walkrounds are planned to improve engagement with teams, so staff are told when they will take place.

Coordination is needed to ensure that clinical areas are not burdened by too many visits, and a coordinator has an overview of the whole organisation. This is essential in multi-site organisations in which smaller units, both inpatient and community, exist within larger hospitals.

Alternative times for walkrounds have been offered to enable staff engagement. These visits are entirely different from board visits and they should be kept separate. Teams report that, because different types of visits are expected and are growing in number, knowing that the walkround will happen once a year is useful.

BOX 1. EXAMPLES OF IMPROVEMENTS

<table>
<thead>
<tr>
<th>Inpatient environments</th>
<th>Workforce</th>
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<tbody>
<tr>
<td>● Removal of potential ligature points</td>
<td>● More permanently employed staff</td>
</tr>
<tr>
<td>● Funding and fitting of handrails</td>
<td>● The electronic healthcare record system is better, with less downtime</td>
</tr>
<tr>
<td>● Repairs to internal and external doors</td>
<td>● Staffing is closer to the required establishment than it was one year ago</td>
</tr>
<tr>
<td>● Improved signs to promote safety</td>
<td>● Teams have active plans in place to maintain patient safety</td>
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BOX 2. EXAMPLES OF SAFER CARE

- Improved ability to admit from assertive outreach team to inpatient areas
- Better recording of carer communication in some teams
- Physical healthcare for inpatients has been improved
- Missed doses (blank boxes on prescription cards) reducing in 14 inpatient areas trust-wide
- Fewer absconders across all inpatient areas
- Less harm from falls
- Timelier transfer/transitions for some teams
- Handover processes in high-risk community teams are robust

Our “talkaround” style
We use an open discussion style that is effective and is highly valued by clinical teams.

It is recognised that staff voices are among the most valuable for learning about patient safety, alongside those of patients and carers (Berwick, 2013). Structured informality is effective in facilitating conversations and team members are able to speak freely without fear of reprisal about their patient safety concerns.

Empowerment and ownership
Clinical teams continue to be proactive in identifying their patient safety concerns and actions that they have already taken. Responsibility for actions are “owned” through the development of the patient safety action plan.

The walkrounds actively support frontline ownership and empowerment to resolve issues that are within the scope of the clinical team; other actions needed are referred to middle management or executive directors.

The walkrounds ensure that issues are captured in context. They are also a vehicle for sharing patient safety improvements from other clinical areas and for implementing and continuously improving these.

Matrons continue to be increasingly engaged in taking action based on issues raised, which supports teams.

Clinical teams report satisfaction with the process and regard it as a positive intervention, as they feel listened to and heard as well as being able to align the focus on patients and patient safety.
BOX 3. TEAM COMMENTS

“It’s good to have executive interest – it feels genuine and is useful to have the discussion”

“The visits help us to refocus on patient safety”

“After a visit, as a ward manager, I feel more able to go back to the team and push improvements forward”

“I know I am expected to sort out patient safety issues at team level, but I know that the executives will support me if needed”

Improvements to clinical care
Of the actions identified through the visits, 90% have been completed to date.

Boxes 1 and 2 show examples from more than 200 issues that have been identified and actioned to improve the environment and the workforce (Box 1) and to provide safer care (Box 2).

What we have learnt
The walkrounds have been instrumental in making teams feel more empowered to take action to address patient safety concerns as they arise. This is attributed to the consistent message that patient safety remains a priority for the organisation.

Clinicians demonstrate courage in identifying and raising patient safety concerns for discussion with the leadership team, connecting with the 6Cs of the NHS nursing vision and strategy (Cummings and Bennett, 2012).

We have found that some teams, for example the recovery units, initially reported that little change would be likely within six months, and that their safety concerns could be reviewed over a longer time frame. As visits have continued and issues have resolved, more teams have reported this.

Frequent rescheduling of walkrounds dilutes the message that patient safety is a priority. We have found it is better to schedule fewer visits but give them a high priority than schedule more than can be managed then have to rearrange them.

A completed action does not always equate to a resolved issue, but may be a stepping stone towards resolution. Issues raised by high-risk community teams are different from those in inpatient areas.

As the visit process has matured, it has been apparent that walkrounds are invaluable in identifying good practice that can be spread across the trust.

Themes emerging from visits include:
» Increasingly, teams are proactively addressing patient safety concerns as they arise, and robust risk assessment is in place;
» Good practice is evident, and teams are keen to share their achievements;
» There is a need for volunteers to play a supportive role in patient safety;
» CQUIN requirements are known and teams understand their role in achieving these as well as the impact on patient care, carers and families.

Box 3 provides examples of comments from clinical teams about the walkrounds.

Conclusion
The trust has introduced patient safety walkrounds and amended them so they can be used effectively in mental health settings. Walkrounds focus on inpatient and priority community areas. They have enabled the executive team to engage frontline staff in an open dialogue about patient safety concerns.

The evidence in the literature reflects our experience in terms of walkrounds promoting a culture that is mindful of avoidable harm to inpatients.

The executive team achieved two walkrounds per month throughout 2013 and is maintaining this rate. This shows continued commitment, which is valued by staff. Teams receive a consistent message through avoiding cancellations and reducing rescheduling, and their feedback on visit frequency is taken into account.

Leadership requires presence and visibility, and staff voices are valuable in learning about patient safety (Berwick, 2013). We have used walkround visits as a part of wider organisational development to build a culture that prioritises patient safety and quality. Both clinical teams and executives value the opportunity to have an open and honest “talkaround”, and the visits continue to produce improvements to patient safety.

References


