

Conducting Patient Safety Rounds with Staff

First Steps

- Set the stage
 - Unit and Hospital Leadership Support
 - Identify a “champion(s)” for each unit where rounds will be conducted
 - “Go to” person and liaison between person conducting Patient Safety Rounds and staff on unit
 - Provide “systems and human factors” education
 - Develop a schedule – frequency and time of day of Patient Safety Rounds
 - Provide inservice education to staff about the rounding program – purpose, process, roles

First Steps

- Develop basic questions to ask staff
- Develop a plan to assure follow-up to issues reported during rounds
 - Review, action, monitoring, reporting, feedback
- Create a database to file reports
- Determine a program administrator (i.e. Risk Manager, Patient Safety Officer...)

Key Question

Has anything happened today, yesterday or recently that you think is an obstacle in providing safe care to your patients?

Questions to Further Probe for Information During Rounds

- Do you have any standard work-arounds?
- Do you routinely take any short-cuts?
- Are there any policies/procedures that are difficult to follow because you do not have the right resources, such as equipment or information?
- What keeps you awake at night?
- Do you have everything you need when you need it?

Probing Questions

- When your patient arrives, has everything been done that should have been done prior to the appointment?
- Where do you feel vulnerable in your practice?
- What was your most recent mistake?
- What do you think will be your next mistake? What can be done to prevent this?

Probing Questions

- Have there been any “near misses” recently that could have caused patient harm?
- What are the sources of interruptions in your practice? Are they avoidable?
- What are 3 major problem areas for you in your practice?
- Do patients express safety concerns to you? What are they?

Probing Questions

- Has anything happened that you think has caused a patient to return to clinic/be re-admitted for an otherwise unscheduled appointment?
- Can you describe an intervention you have made that prevented an error or patient harm/protocol violation?

Probing Questions

- Are there any aspects of the environment that could lead to patient harm?
- Is everything you work with labeled correctly (medications, equipment, lab specimens)?

On The Unit

- Approach staff that are available
- Include quotes in notes taken
- Ask for patient specific examples when possible
- Keep a notebook or log of patient safety rounds with staff to refer back to if necessary

Data Base Management

- Create a database to file reports
- Consider what information you want to capture before creating database
- Include fields within database to track corrective actions and recommendations

Suggested Database Fields

- Unit location
- Date, day of week, time of day
- Staff interviewed by role type
- General category of event
- Free text description
- Staff recommendations
- Actions
- Incident report filed – yes/no
- Event reached patient – yes/no
- Patient harm – yes/no, space for description

Suggested Data Categories

- Medication: ordering, dispensing, administration, monitoring
- Communications
- Laboratory related
- Environment
- Equipment: Medication related and non-medication related
- Computer related
- Scheduling
- Choose categories relevant to your facility

Reports

- Customize to own needs
- Suggestions
 - Monthly reports by location to area managers
 - Periodic reports by category
 - Periodic reports of resolved issues
 - Periodic reports to clinical/administrative leadership

Review Suggestions

- Build into an existing review mechanism
 - i.e. structure that reviews incident reports
- Distribute reports in advance of review meeting
- Create a project grid to track activities and responsibility for actions
- Triage issues to appropriate individuals or committees for actions

Sample Project Grid

<u>Topic</u>	<u>Owner</u>	<u>Status</u>	<u>Action</u>	<u>Next step</u>	<u>Next Report</u>
Turn around time (TAT) of INR tests	S. Smith	2	Collected data for 6 weeks – TAT trended to 70 min from 62 min	Discuss with Lab Director	Nov 2005
VS recorded in wrong section of flow sheet	B. Days	6	Investigation revealed new flow sheet inverted the temp and weight boxes	Flow sheet design changed – no more occurrences	Completed Sept 2005

Status key: 1. Discussion 2. Planning 3. Implementation 4. Evaluation 5. Ongoing 6. Complete

Essential Success Factors

- Be flexible with scheduled rounds times – if the unit is very busy, reschedule
- Do not create more work for the staff to make reports
- Think of yourself as an educator – encourage people to “think outside the box” about the broad aspects of patient safety

Essential Success Factors

- Record everything
- Do not minimize staff annoyances
- Listen
- Ask for suggestions for improvement
- Provide follow-up to staff who report incidents or concerns