CME

clinical contributions

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Patient Safety Executive Walkarounds

By Steven P Feitelberg, MD

Abstract

The KP Patient Safety Executive Walkarounds Program in the KP San Diego Service Area was developed to provide routine opportunities for senior KP leaders, staff, and clinicians to discuss patient safety concerns proactively, working closely with our labor partners to foster a culture of safety that supports our staff and physicians. Throughout the KP San Diego Service Area, the Walkarounds program plays a major part in promoting responsible identification and reporting of patient safety issues. Because each staff member has an equal voice in discussing patient safety concerns, the program enables all employees—union and nonunion alike—to engage directly in discussions about improving patient safety. The KPSC leadership has recognized this program as a major demonstration that the leadership supports patient safety and promotes reporting of safety issues in a "just culture."

Introduction

Since publication of the Institute of Medicine Report, *To Err Is Human: Building a Safer Health System*,[1] increased attention has been focused on patient safety in health care settings. The challenge for health care organizations is to foster a culture of safety and to continually identify opportunities to improve and assure the safety of patients being treated at health care facilities. At Kaiser Permanente (KP), this ongoing process is driven fundamentally by the organization's leaders. As stated by Kenneth Kizer, MD, MPH, President and Chief Executive Officer of the National Quality Forum (NQF) in an NQF consensus statement, "There simply is nothing more important in overseeing a hospital or other health care facility than to ensure that it is as safe as possible for patients."[2] (The NQF—of which KP is a member—is a private, not-for-profit membership organization created to develop and implement a national strategy for measuring and reporting on the quality of health care.) The medical profession has realized that improving patient safety must be among the highest priorities of health care leaders and managers. Nonetheless, only by direct and regular contact with real care delivery can leaders understand the problems of staff and clinicians in delivering safe care. To facilitate this level of involvement, the KP San Diego Service Area launched the Patient Safety Executive Walkarounds Program. This program gives top KP leaders the tools to show KP staff and clinicians that the KP leadership is committed to patient safety and to developing the infrastructure necessary to ensure responsible reporting of safety-related errors and hazards. By walking through hospital units to conduct face-to-face conversations with any staff member or physician with a safety concern, leaders can learn more about errors or hazards that could or did cause harm; and on the basis of issues identified during the Walkarounds, the leadership can identify opportunities for improving patient safety. These informal discussions are thus an essential catalyst for change because they enable the organization to improve our reporting systems and enhance our knowledge about how to ensure a safe environment.

Program Origin and Components

Recognizing that the Patient Safety Executive Walkarounds program could help the KP San Diego Service Area to become a leader in patient safety (a top-priority strategic goal identified by the Service Area), the KP San Diego Service Area manager encouraged the KP San Diego Medical Center to become the Southern California pilot site for implementing the Walkarounds program. The program subsequently began as a nine-month, day-shift pilot program in San Diego in September 2002. From the beginning, the Medical Service Area Administrative Team (MSAAT) and the KP San Diego Leadership Team

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Table 1. Sample questions asked by the MSAAT representative during Patient Safety Executive Walkarounds at the KP San Diego Medical Center

- Can you think of any events in the past day (or few days) that have resulted in harm to a patient?
- Can you think of any "near misses" that almost caused a patient harm but did not?
- What aspect of the environment is likely to lead to the next patient harm?
- What do you think this unit (or area) could do on a regular basis to improve safety?
- How are you involved in patient safety on this unit?
- When you make an error, do you always report it?
- If you prevent or intercept an error, do you always report it?
- If you make or report an error, are you concerned about personal consequences?
- Do you know what happens with information that you report?
- Are you aware that we are actively promoting a "just" ("blame-free") culture?
- Have you discussed patient safety issues with your patients or with their families?
- Can you think of a time when your intervention prevented harm to a patient who would otherwise have been harmed by a system flaw?
- What specific intervention could leadership direct to make safer the work you do for patients?
- What would make Patient Safety Executive Walkarounds more effective?

(SDLT) gave their strong support and sponsorship to the program.

In the Walkarounds program, two senior leaders are scheduled to visit each nursing unit, hospital clinical department, and several medical office buildings at least once per year to speak with frontline staff about patient safety concerns, which must be assigned a priority level according to which the concerns will be resolved. The Walkarounds team must include at least one representative from either the MSAAT or the SDLT (these entities participate on a rotating basis), a representative from either the Quality Resource or Risk Management/Patient Safety Department (or a representative from each department), and a scribe. The Walkarounds team must conduct rounds for at least one hour each month and interview at least three persons.

All members of the staff—members of labor unions as well as nonrepresented staff—are encouraged to participate fully in these discussions, which must focus exclusively on patient safety issues and may not be combined with any other type of unit rounds. In addition to verbalizing the organization's commitment to improving patient safety, the leaders obtain feedback from staff and physicians regarding perceptions of a "just culture." A culture that does not blame people who make mistakes but looks at the root cause of the errors and promotes system improvements that result in a safer environment for the patients and staff.

During the Walkarounds, the team informally approaches the patient care area to meet with available staff and physicians. The MSAAT Representative may take the lead in the discussions, asking questions to solicit information regarding perceptions of safety as well as safety issues that did or could cause harm to patients. An interview tool was developed to assist leaders in facilitating the discussions (Table 1). As these conversations take place, a representative from Risk Management/Patient Safety noted the issues verbalized by staff and physicians and subsequently entered these issues into a database.

Data Analysis

To assess the effectiveness of the Program, three types of outcomes from the Walkarounds Program were measured:

- *Improvement in patient safety (Vincent Factors):*[3] This measure used a quantitative (Vincent Model) approach to "counting" the patient safety issues identified and resolved (Table 2). Components for the Vincent Factors (Table 3) were derived from medical publications on error, adverse outcomes, and risk management.[3-7] This framework incorporated factors which influence clinical practice and which are used to categorize, analyze, and prioritize patient safety issues. During each walkaround, issues were entered into a database

Table 2. Total weighted scores of patient safety issues identified or resolved

	Total score		
Vincent category	**Identified**	**Resolved**	**% of total**
Organization/Management	150	115	77
Work Environment	1020	895	88
Team	200	165	83
Individual	50	35	70
Task	170	120	71
Patient	15	15	100

and categorized using the Vincent Model.

- *Effects on the organization's culture of safety (a Just Culture):* This outcome measured physicians' and staff's perception of the safety culture in the service area. The People Pulse survey was distributed for recipients to assess how everyone worked together to ensure the safest possible workplace.
- *Perceptions expressed by staff about the power of the Walkarounds (Program Survey responses):* This measure consisted of survey results from Walkarounds participants in various health care delivery and support disciplines, from their immediate supervisors, and from the leadership representatives who conducted the rounds.

The data analysis included type, severity (actual or potential outcome to patient), and frequency (number of participants reporting the safety issue during rounds). When reports were generated, the frequency of each issue identified was multiplied by the severity outcomes to provide a weighted value for each issue. This score was designed to help the organization to prioritize safety concerns according to either the number of individuals concerned about it or the extent of its harmful impact (actual or potential) for patients.

Data collection was identified as critical for determining the success of the program. To record, monitor, and analyze safety issues identified by the Walkarounds program and to identify trends, the program uses a database developed specifically for it by staff at Brigham and Women's Hospital. The database assigns a severity code to each issue after categorizing it as one of the Vincent Model's "contributing factors": team factors, work environment factors, organization/management factors, task factors, individual staff factors, and patient factors.[3] The database enables systems-based analysis of these contributing factors, prioritization of urgent interventions, and initiation of special projects. Quantitatively, this analysis enabled KP leaders to routinely track the categories, frequency, and severity of safety issues identified and the percentage of issues resolved. This procedure served as a safeguard against prolongation or neglect of safety concerns. Because participants could present any patient safety concern, data collection was not limited by amount or category of data.

Table 3. Categories of Vincent Factors

Organizational and management factors	Financial resources and constraints Organizational structure Policy standards and goals Safety culture and priorities
Work environment	Staffing levels and skills mix Workload and shift patterns Design, availability, and maintenance of equipment Administrative and managerial support
Team factors	Verbal communication Written communication Supervision and seeking help Team structure
Individual (staff) factors	Knowledge and skills Motivation physical and mental health
Task factors	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results
Patient characteristics	Condition (complexity and seriousness) Language and communication Personality and social factors

A post-Walkarounds survey was sent to each participant six months after the Walkaround, and responses were collected and analyzed. These evaluations provided participants an opportunity to give open responses that could clarify survey results.

Results of the Walkarounds Program

The Walkarounds Program enabled the KP San Diego Service Area to identify and resolve patient safety vulnerabilities more effectively and to address staff perceptions of the local service area's safety culture. Compared with responses to the 2002 KP People Pulse Survey question, "In my department or work unit, everyone works together to ensure we make this the safest possible place to work and be a patient," responses collected in 2003 showed a 5% increase in the number of staff who agreed with the statement and a 9% increase in the number of physicians responding favorably. This response indicates a substantial strengthening of our safety culture. In addition, more than 85% of the program participants and managers surveyed reported a better understanding of the KP Safety Program, and all noted that new safety initiatives had been implemented in their area as a direct result of the Walkarounds.

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The Walkarounds Program proved to be a unique vehicle for facilitating discussion among staff and physicians about personal safety concerns that might otherwise not be reported. As the only such systematic mechanism available to any staff member or physician available on the unit, the Executive Walkarounds

Table 4. Vincent Factor weighted scores of items identified during Patient Safety Executive Walkarounds with weighted scores of items resolved

Vincent category	No. of issues	Total weighted score	% of total
Organization/Management	20	150	9
Work Environment	118	1020	64
Team	19	200	12
Individual	4	50	3
Task	17	170	11
Patient	3	15	1

Nearly all the issues identified would never have been identified through other existing reporting mechanisms …

Program provided an opportunity for face-to-face expression of patient safety concerns and tracking of these issues. For example, nurses might typically never report their concern about the potential for an unstable intravenous pole causing injury to a patient, whereas during the first three months of the Executive Walkarounds Program in San Diego, nine nurses from three different units—Labor and Delivery, DUO, Dialysis, and Orthopedics—individually reported concern about the instability of the intravenous poles holding more than one solution simultaneously. As a direct result of receiving these reports during the Walkarounds, the KP San Diego Service Area replaced all its intravenous poles with newer, sturdier versions.

By the end of 2005, 181 safety concerns had been identified through the Walkarounds in the KP San Diego Service Area. To date, 84% of these concerns have been resolved. Nearly all the issues identified would never have been identified through other existing reporting mechanisms, such as Unusual Event Reports and hotlines, which staff currently use to report actual occurrences. During the Walkarounds, physicians and staff shared with leaders concerns about near-misses or the potential for an adverse event.

The following list gives brief highlights of actions taken on issues identified during the Walkarounds:

- *Equipment:* Hospitalwide replacement of intravenous poles; additional oxygen tanks, table straps, portable monitor gait belts, and blood pressure monitors; new wheelchairs; repair of Labor & Delivery Department ultrasound machine; and hospitalwide replacement of brakes on older beds.
- *Process changes:* Abnormal results reporting process (added to Cardiology); SBAR; virtual hallway bed area created in the emergency department; budgeting for bed replacements; improved system for diagnosing proper placement of nasogastric tubes.
- *Services:* Creation of lift teams (and subsequent extension of lift team hours of operations), wheelchair valet service.
- *Environment:* Widening of doorways in the radiology department; no-slip mats purchased for area near ice machines to prevent falls by patients and employees; increased storage area created in Dialysis Unit.

The Program's improvements in safety culture and patient safety remained consistent even after the pilot program. The Walkarounds continue along with ongoing analysis of the quantitative and qualitative data. Indeed, after analysis of the data, the entire MSAAT and SDLT gave their full support to continuing the Walkarounds program, expanding it to the afternoon shift and eventually to the evening shift. Since the program started, program participation has included all levels of the organization, including executives, department administrators, nurses, patient care assistants, physicians, environmental services staff, technicians, and clerks—all of whom have equal opportunity to discuss safety concerns directly with the top leaders and gain their support to ensure resolution.

Most (56%) of the safety-related issues identified during the Walkarounds were categorized as "Work Environment" (Table 4). The second most common category, "Team Factors," accounted for 17.3% of the issues identified. As can be seen from the following examples, a variety of actions were taken to resolve safety concerns.

- Concerns were voiced by multiple units about intravenous poles being unsteady and tending to fall over. Monies not previously budgeted for this issue were subsequently approved, and intraveous poles throughout the hospital were replaced.
- During the Walkarounds, staff from several clinical departments and medical office buildings discussed concerns about patients who had fallen when leaving the area after receiving tests. A Special Project Team was formed to analyze the issue and implemented a centralized Wheelchair Valet Service.

- Malfunctioning brakes on patient beds were mentioned often. The Engineering Department was instructed to conduct a hospitalwide review of the brakes and subsequently determined that all older beds should be replaced. The process of budgeting was then adjusted to include replacement of all older beds.
- Concern with proper afterhours identification of radiological films was verbalized during a Walkarounds tour of the Radiology Department. As a result, an FMEA team was formed to identify these vulnerabilities and subsequently implemented appropriate preventive measures.
- As a direct result of an issue voiced during a Walkaround, architectural review and reconstruction were both approved and completed to expand several doorways in the Radiology department.

Responses to post-Walkaround surveys showed increased attention to, and awareness of, patient safety and an increase in patient safety initiatives implemented after the Walkarounds (Tables 5,6). Whereas responses to the preproject questionnaire administered in 2002 showed that the teamwork climate among nurses in the San Diego Service Area ranked in the bottom 30% of organizations for benchmark measures in 101 clinical areas, responses to a shortened 2004 postproject survey (distributed to a subset of the original cohort) showed that the teamwork climate among respondents ranked within the top 30% of organizations on the same benchmarking scale. And a 2004 survey distributed to KP leaders in the San Diego Service Area showed that 86% of respondents had personally taken actions as a result of the Walkarounds—an increase of 6% compared with survey results obtained a year earlier. The write-in responses reflected a consensus among all groups that the Walkarounds advanced understanding of patient safety and affected change within their facility or unit. "We are identifying issues that have not come up through any other reporting mechanism," said one manager.

In response to the People Pulse survey question asking how everyone worked together to ensure the safest possible place, a 6% increase in positive responses was observed among physicians and staff after implementation of the Walkarounds. The high response rate for this survey indicated that the 6% difference was meaningful.

An unexpected positive outcome of the Walkarounds Program occurred during the 2003 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey at the KP San Diego Medical Center, where the Walkarounds program was presented as the facility's performance improvement project. The Consolidated Accreditation and Licensing Survey (CALS) accreditation team gave accolades for a successful and unique process of demonstrating improvements to safety and quality.

Since initiation of the San Diego Walkarounds, the total weighted Vincent score of all the patient safety issues has been identified as 1605. The total Vincent score for resolved issues was 1345 (84%). Survey responses showed overwhelming support for the Walkarounds Program in regard to effective communication of patient safety issues and perception of actions taken to resolve these issues.

Discussion

The Patient Safety Executive Walkarounds Program is KP's prescribed, systematic process for facilitating regular dialogue between caregivers and senior organizational leaders to improve patient safety and for these leaders to actively show their interest and involvement with patient safety (they must "walk the talk"). The Program thus provides a proactive approach to resolving patient safety issues. As such, the Walkarounds Program has been highly successful in achieving significant sustained improvements in all its core elements. The Walkarounds Program also supports and complements other patient safety initiatives, such as Error Reduction Initiatives, Knowledge Transfer Initiatives, Human Factors Initiatives, and Environment of Care

Table 5. Responses to evaluations distributed to staff, managers, and leaders at 6 months and at 12 months after participation in the Walkarounds

Frontline staff	•Most (85%) responded that they had a better understanding of patient safety and the KP patient safety program as a result of the Walkarounds. •Most (76%) indicated that reporting or discussion of errors and "near misses" had increased since the Executive Patient Safety Walkarounds.
Unit managers or DA	•Nearly all (91%) said that they have had conversations with staff or physicians regarding the patient safety Walkarounds. •Most (73%) responded that new patient safety initiatives or other changes had been made as a result of the input from staff/physicians related to patient safety issues identified during the Executive Patient Safety Walkarounds.
Executives	•All (100%) responded that they gained new learnings from the Walkarounds and considered them valuable. •Most (86%) reported that they had taken actions as a result of feedback received on the Executive Patient Safety Walkarounds.

Initiatives. In the San Diego Service Area, the success of the Program was enhanced by the strong support of the Program sponsors.

A strength of the Program is its broad-based participation by all departments and by staff at all levels. Most departments involved in direct patient care have been visited by the Executive Walkarounds Team, and many support departments have been involved in developing and implementing solutions to address safety concerns.

Another strength of the program is its use of a database to organize information so that systemwide problems can be readily identified. Systems-based solutions are far-reaching: They are used by many departments and therefore improve safety for patients throughout the San Diego Service Area. Nonetheless, implementation of a Walkarounds Program requires only a minimal financial expenditure, and this financial commitment is directed exclusively to resolving concerns about patient safety.

The Patient Safety Executive Walkarounds Program has the potential to strengthen KP's Labor Management Partnership by providing the opportunity for senior organizational leaders and union-represented employees to come together for focused, face-to-face discussions on a common goal: ensuring patient safety. As employees witness their concerns being addressed and resolved, these employees can feel that they are being heard and understood.

Responding to the positive feedback received and the improved outcomes accomplished by the Walkarounds Program to date, the KP San Diego Leadership Team committed itself to continuing the program, which subsequently became a required 2004-2005 goal for all KPSC medical centers and has already been transferred to nine KP medical centers in Southern California and to other KP Regions. All of the tools utilized for the Walkarounds are now available online, and a video was developed for use in conjunction with training.[8] Multiple requests have been received from outside of KP for our Walkarounds toolkit, and we have received reports that many of those requestors have started their own Walkarounds Programs. The project was presented at a 2004 plenary session of the NPSF Congress[9] and has been selected by the Agency for Healthcare Research and Quality for its compendium on best practices.[10]

Table 7 shows voluntary survey results from six other KPSC Service Areas related to their experience with the Walkarounds Program. An interesting finding in some other service areas was the expansion of the Program to include patients.

Successful program replication requires minimal fiscal support, partly because the program design has already been completed. Tools needed to introduce and implement this program have been developed and are easily available on the KP Intranet[8] and include:

- *Orientation Materials:* Presentation templates introduce the concept and principles behind the Walkarounds, explain the expected results, outline the necessary steps, and list the required resources.
- *Communication Plan:* This plan outlines the tactics, dates, and responsibilities for informing and involving targeted stakeholders (executives, managers, and frontline staff).
- *Talking Points for Executives:* This list of key messages for executives who conduct

Table 6. Selected testimonials collected from surveys
What is the greatest value that Patient Safety Executive Walkarounds brings to the organization?

Staff comments	•Improved patient care through improved patient safety •Finding out the real problem on the floor that needs to be resolved •Allowing those in leadership positions to be aware of the conditions that hinder workplace safety
Manager comments	•Visibility of the Executive Leadership Team who show true concern that they care about our staff and our members •Brings "top" and "frontline" people together, making it clear that everyone is working toward the same goals •It has given my staff an improved sense of "value for what we have to say" •It has stimulated an increased attention to safety in the workplace
Leadership Team comments	•Open communication and connection with staff •An opportunity to fix a problem before it escalates to a bad event or outcome •Demonstrating to our staff that we recognize how difficult their jobs are and how much our senior leaders value quality and safe care •An opportunity for MSAAT and the AA to discuss unit-specific issues and concerns together on the frontlines

Walkarounds learnings reported by the KP San Diego Leadership Team:

- I learned a great deal about the challenges faced by clinical staff around all the patient safety goals.
- If you "fixed" it once several years ago, you may have erosion in the process with turnover; go back and check again.
- Nursing Department staffing challenges.
- That staff doesn't always express their concerns unless given the opportunity to do so. They need to be invited to provide information and feedback.

We need to modify our routine process for capital equipment to better identify requests related to patient safety issues and prioritize them higher in our regular process.

Walkarounds provides guidelines for initiating conversations, explaining the purpose of the visit, and talking to staff about how the information provided will be used.

- *Questions for Walkarounds*: As a second preparation tool for executives, the questions prompt discussion that focuses on systems-based patient safety concerns.
- *Evaluations:* Three versions of an evaluation—one each for executive, manager, and staff—ask participants to consider whether attitudes, conditions, or actions in their department have changed as a result of the Walkarounds.
- *Database* (a replica of the database customized by the KP San Diego Service Area).

Table 7. Responses of six KP Southern California Service Areas[a] to KPSC Regional Survey on Patient Safety Executive Walkarounds

Data element	Data totals
No. of Walkarounds completed - 2004	90
No. of Walkarounds completed - 2005 Q1	15
Leadership members attending Walkarounds	Area Associate Medical Director, Department Administrator, Risk Management, Service Area Manager, Quality Service Leader, Director of Hospital Operations, Director of Quality, Service Line Leaders
No. of staff involved, 2004	268
No. of staff involved, 2005 Q1	166
No. of unit physicians involved, 2004	19
No. of unit physicians involved, 2005 Q1	4
No. of unit patients involved, 2004	63
No. of unit patients involved, 2005 Q1	7
Shifts included	days and evenings (five medical centers); days only (five medical centers); all shifts (one medical center)
No. of issues identified during 2004	342
No. of issues identified during 2005 Q1	42
No. of issues resolved 2005 Q1	15

[a] includes Panorama City, West Los Angeles, Bellflower, Baldwin Park, Orange, and Woodland Hills; excludes KP San Diego Service Area.

The KP Program Offices Director of Patient Safety has provided the support to continually update all these aforementioned tools on the KP Intranet. The San Diego Director for Risk Management/Patient Safety has already provided an overview training of the database to KPSC Risk Managers. In addition, a videotape was filmed during actual Walkarounds and is available to provide additional support for successfully introducing and implementing the program.[8]

It is advisable, but not required, to maintain a part-time (ten hours per week) project support manager to ensure follow-up with and assistance to departments handling resolution of patient safety issues identified during the Walkarounds. Reminders of the Walkarounds' functions are included in the Risk Management/Patient Safety functions.

Conclusion

Only by direct, regular contact with care delivery can our organizational leaders understand the problems of staff and physicians in delivering safe care. Multiple mechanisms currently exist to identify errors and close calls, but many clinicians have historically reported only what they could not conceal out of fear of disciplinary action. The Walkarounds Program is one tool for promoting change in our organizational culture. Implementation of any program is achieved most effectively when aligned with the organization's priorities. To sustain the momentum of the program, its achievements must be communicated and celebrated. These activities are crucial to frontline staff to assure them that their concerns are not "lost in a black hole" and that their participation can bring change.

To support safety in a just culture, the entire leadership of the San Diego Service Area remains committed to continuing and advancing the Patient Safety Executive Walkarounds Program. By promoting reporting and by improving systems, we can ensure that the right thing to do is also the easiest. ❖

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The Same Price

We don't want to save any money;
we want to give better, more comprehensive services—at the same price.

— Sidney R Garfield, MD, 1906-84, founder of the Kaiser Permanente Health Plan to Morrie Collen, MD, regarding the costs of Multiphasic examinations.
This "Moment in History" quote collected by Steve Gilford, KP Historian