

LEADERSHIP WALK ROUNDS

At the end of the walk round, key actions will be agreed and a suggested timeframe set where possible for resolution. A log of all patient safety issues notified will be kept by Waikato DHB Quality and Risk Unit so that completed actions can be documented.

After the walk round, a response will be sent to the ward or unit within 48 hours to highlight the main area discussed and the agreed actions to be undertaken. These will be followed up one month later, to ensure that issues raised are completed and resolved to a satisfactory level. It is acknowledged that some issues will take longer to resolve and a log of these actions and ongoing activity will be kept by the Quality and Risk Unit, with regular reports presented to EG.

Conclusion

Health Waikato leadership walk rounds will be a key partnership activity by Health Waikato and Waikato DHB executives, as they both focus on improving quality and safety across the organisation. It presents an excellent opportunity for executives to visit areas they would usually not see and understand the key concerns that staff may have and to agree tangible action points that takes joint ownership of the issues and develops processes to resolve them.



Jan Bulteel-Adams
Chief Operating Officer
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HEALTH WAIKATO
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Introduction

Executive or leadership walk rounds are used world wide to improve the safety culture in hospitals. The walk round concept was developed by Dr Allan Frenkel¹ (USA), a member of the Faculty at the Institute of Healthcare Improvement. At Health Waikato* we have introduced the Health Waikato Quality and Safety Agenda and it is timely to introduce the walk round concept here. The Governance Review undertaken last year by Waikato District Health Board (DHB) recommended a system of leadership that reflected safety as a strategic priority. Walk rounds are an essential component of this.

* Health Waikato is Waikato DHB's hospital and health services provider arm.

The aim of the leadership walk rounds:

To:-

- Create a culture that puts patient/ client safety at the centre
- Make safety a priority for senior leaders by spending dedicated time to focus issues and to promote a safety culture
- Increase the awareness of safety issues among clinical and management staff
- Educate staff about patient safety concepts and, in particular, incident reporting
- Obtain and act on information gathered that identifies opportunities for improvement
- Build communication and relationships with clinical staff
- Ensure all performance reporting to the Waikato DHB board has a focus on improving quality and safety.

Who will be involved?

The Health Waikato Chief Operating Officer (COO) will be the lead for the walk rounds and executive leaders across the Waikato DHB are invited to attend. It is anticipated that the leadership walk rounds will generally involve three members of the Executive Group (EG) or their nominated representatives. The walk rounds will occur at a set time every week, with a different ward or unit being visited each time and will include mental health and addiction services, the four T hospitals plus the continuing care facilities. It is expected that a discussion with clinical staff in those areas will occur. The discussions can be held in any area that suits the ward or unit.

The leadership walk round process

The COO will introduce the group and explain the process to be used including the rules for confidentiality, anonymity and patient safety disclosures. It should be noted that patient safety is not just about hazards to patients e.g. patient falls but includes any treatment or system failures that a patient may have been subject to.

Members of the visiting walk round team will ask a series of structured questions and all staff are encouraged to participate. Staff will be encouraged to bring a patient safety scenario they have experienced to the meeting, to share with the walk round team.

The questions will focus on:-

- The key patient safety concerns
- How does the ward / unit team identify patient safety concerns
- Who are they elevated to
- How do the team use / view the incident management reporting system in resolving the issues
- What could be done to improve them
- How can we work together in resolving the issues

¹Frankel,A.,Graydon-Baker,E et al: (2003). Patient safety leadership walk rounds. Joint Commission journal on Quality and Safety 29 (1):16-26