



Patient Safety Rounds

This is brief overview of how to conduct Patient Safety Rounds. The attached description outlines what should happen on the rounds themselves and afterwards. There are a few critical pieces. They are:

1. Performing the Safety Rounds every other week
2. Collecting specific information during the rounds that includes
 - a. the comments made during the rounds
 - b. who made them (voluntary)
 - c. date, location, participants, individuals to contact, etc
3. Analyzing the information with a specific intent to:
 - a. Identify the system-based contributing factors to events discussed during the rounds. A patient safety person may need to do further research on the contributing factors - not always necessary though.
 - b. Categorize the contributing factors (NOT the events) based on severity and frequency, or using FMEA (failure mode effects analysis.) Example: medication overdose secondary to miscommunication between RN and MD should be classified under miscommunication between RN and MD, not under medication overdose. There may be multiple contributing factors to this event - perhaps in addition to miscommunication, there was poor lighting in the med room. So "Environment" might be another contributing factor to the same event. The event would be classified under two contributing factors. (Categorizing by event has its place - but the goal is to make effective change, and the contributing factors are better for that much of the time)
 - c. Using the categorization to identify issues to work on - "actions" to be taken.
 - d. Make a grid of information obtained and from whom, and the actions to be taken
4. Identifying a locus of responsibility for the actions.
5. Setting up a feedback loop
 - a. The individuals who reported information are specifically contacted about the actions taken
 - b. This is probably the most important part, and always the one given the least resources.
6. Realizing that there will be too much information to act on it all. That's OK.

Below is the template used in the initial pilots of our Patient Safety Rounds.

Patient Safety Rounds
Changing Culture through Interaction with Frontline Staff
and Actions to Address Harm

WHO: Chief of Staff, Chief of Nursing, Executive Director Forum Member, Medical Safety Coordinator

- WHY:**
1. Demonstrate commitment to safety through symbolism
 2. Fuel culture for change pertaining to Patient Safety
 3. Educate employees about Patient Safety concepts
 4. Identify opportunities for improving safety
 5. Start the development of a patient safety feedback loop:
employees → executives → managers → employees
 6. Establish a framework for safety based rapid cycle improvements.

(Include examples of interventions, articles on safety)

WHEN: Biweekly

WHERE: Patient Care Units including Inpatient, Ambulatory Care, Operating Rooms, Emergency Department, Radiology Department, Interventional Suites, Pharmacy, Laboratories

FORMAT: Conversation with 3 to 5 employees
Conference room discussions, Random employee type, random locations

- AIMS:**
1. 100% of employees will believe that a non-punitive policy regarding medical adverse events is in effect and working.
 2. There will be an increase in spontaneous reporting of adverse events.
 3. Four safety-based changes will be made by each manager per year based on information obtained in part through the Patient Safety Rounds.
 4. 80% of managers will respond that their attitudes toward adverse events have changed as a result of the Patient Safety Rounds in a manner that improves the delivery of care

MEASURES:

1. Response to cultural survey (process measure)
 - survey of front line workers
 - survey of managers
2. # of spontaneous reports/month (outcome measure)
3. # of Changes made by managers per year

Guiding Principle

1. Each of us plays an essential role in patient safety.
2. We are interested in systems problems, not in blaming individuals.
3. All information is strictly confidential and peer review protected.

Suggested opening statements

As you know, we're trying to move as an organization to more open communication and we're trying to develop a blame free environment. We're doing this because we think this is the only and best way to make the environment safer for everyone who works here and for all of our patients. First, we're interested in focusing on our systems, not on individuals. In keeping with this, please know that everything you say is confidential and peer review protected. There is a sign-in sheet for anybody who would like to know what comes of comments made here, because we'd like to let you know what we do with what you tell us, but if you don't want your name on anything, that's fine. We will be writing notes, but will write them without identifiers as to who is speaking or who were any patients involved. If you have any concerns, please let us know. These are designed to get the conversation going. As we discuss patient safety, please keep in mind the many areas to which these questions might apply including medication errors, miscommunication between individuals (including arguments), distractions, inefficiencies, invasive treatments, protocol violations, and any others you can think of."

Questions to be asked

- **Can you think of any events in the past day or few days that have resulted in prolonged hospitalization for a patient?**
Examples: Appointments made but missed
Miscommunications
Mis-timed or omitted medications
Delay in inserting a PICC line
- **Have there been any "near misses" that almost caused patient harm but didn't?**
Examples: Taking a drug to give to a patient and then realizing it's incorrect.
Misprogramming a pump, but having an alert warn you.
Incorrect orders by physicians or others caught by RN's or other staff
- **Have we harmed any patients recently that you can think of?**
Examples: Infections
Surgical complications
Complications secondary to drugs
Side effects secondary to drugs
- **What aspects of the environment is likely to lead to the next patient harm?**
Examples: Consider all aspects of admission, hospital stay and discharge
Consider movement within the hospital
Consider communication
Consider Informatics/Computer issues

- **Is there anything we could do to prevent the next adverse event?**
Examples: What information would be helpful to you
Consider alterations in the interaction between clinicians
Consider teamwork
Consider environment, workflow
- **Can you think of a way in which the system or your environment fails you on a consistent basis?**
Examples: Not enough information available.
Requirements that don't make sense.
Requirements that are unnecessarily time consuming.
- **Can you think of a time when your intervention stopped a patient from being harmed who would otherwise have been because of a system flaw?**
Examples: Finding a medication error.
Eliciting assistance from someone outside the normal purview because you knew they would be responsive.
- **What specific intervention from leadership would make the work you do safer for patients?**
Examples: Organizing interdisciplinary groups to evaluate a specific problem.
Assist in changing the attitude of a particular group.
Facilitating interaction between two specific groups.
- **What would make the Patient Safety Rounds more effective?**
Examples: Hallway vs. organized conversations
Individual vs. group discussions
Managers ensure you have free time to discuss issues
- **Are you aware that we are actively promoting a blame free culture and working on the development of a blame free reporting policy.**
Examples: Separation of performance improvement plans and inadvertent errors
The institution will grant immunity to individuals who report adverse events in a timely fashion (where criminal behavior is not an issue).

Last Comment

- What is the accident waiting to happen? What do you worry about, what keeps you awake at night? What went wrong yesterday? If you could change one thing to improve patient safety, what would it be?
- We're going to work on the information you've given us. In return we'd like you to tell two other people you work with about the concepts we've discussed in this conversation.

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