Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

QI TALK TIME

Building an Irish Network of Quality Improvers

Leadership for Quality
Quality and Safety Walk Rounds

1pm Thursday Oct 16th 2018

Connect **Improve** **Innovate**

Speaker

Dr John Fitzsimons:

is a Consultant Paediatrician at Our Lady of Lourdes Hospital, Drogheda and Clinical Director with the Quality Improvement Division (QID) in the HSE.

He trained as a Patient Safety Officer with the Institute of Healthcare Improvement (IHI) in 2009 and became a fellow of the Faculty at the NHS Institute for Improvement & Innovation for two years.

He is Clinical Director for Quality Improvement with QID. He is a course co-director for the HSE/RCPI Diploma in Leadership and Quality in Healthcare.

Siobhan Reynolds

is a Quality Facilitator in the Quality Improvement Division of the HSE.

Siobhan is a member of the Governance for Quality team and supports services in establishing Quality and Safety Committees and applying the Framework for Improving Quality.

Instructions

- Interactive

- Sound:

<u>Computer or dial in:</u>

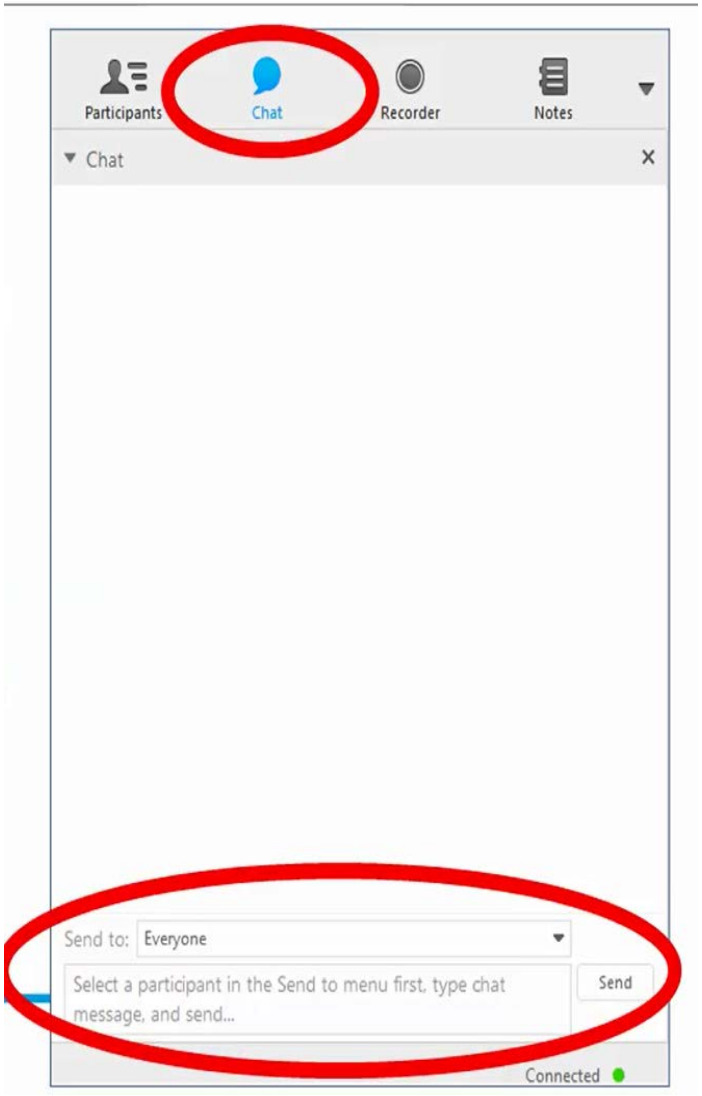
Telephone no: 01-5260058

Event number: 843984434#

- Chat box function
  - Comments/Ideas
  - Questions

- Keep the questions coming

- **Twitter: @QITalktime**



Framework for Improving Quality in our Health Service

Participants will gain an understanding of:

- Shared concepts around Quality Leadership and Culture
- Approaches to carrying out walk-rounds
- Critical success factors of Quality and Safety Walk-rounds
- How to set up a Quality and Safety Walk-round programme

Framework for Improving Quality in our Health Service

Definitions

"Structured process to bring senior managers and frontline staff together to have quality and safety conversations with a purpose to prevent, detect and mitigate patient/staff harm" (Source : HSE 2016)

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Background

- 2001 conversation at the Institute of Healthcare Improvement with Dr. Allan Frankel - *Patient Safety Leadership Walk-rounds.*
- NHS Patient Safety first Campaign - *'Patient Safety Walk-rounds'*
- Healthcare Improvement Scotland – Safe in our Hands *Leadership Walk-rounds*.

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Walk-rounds are....

- A planned discussion between frontline staff and senior management teams.
- An opportunity to identify good practice
- An agreed schedule of staff leading walk-around
- Regularly repeated
- Where frontline staff do their work – deference to expertise.
- Supported by Quality and Safety function

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Walk-rounds are not ....

- An informal meeting
- An inspection
- Only about safety concerns

Why Quality and Safety Walk-rounds?

- Demonstrate senior leaders **commitment** to quality and safety.
- Increase **staff engagement** and ensure staff ideas for change are actioned.
- Identify, acknowledge and **celebrate good practice**
- Strengthen **commitment and accountability** for quality and safety.
- Supports the development of an **open culture for safety**.
- Increasing the **in-basket of patient safety** information

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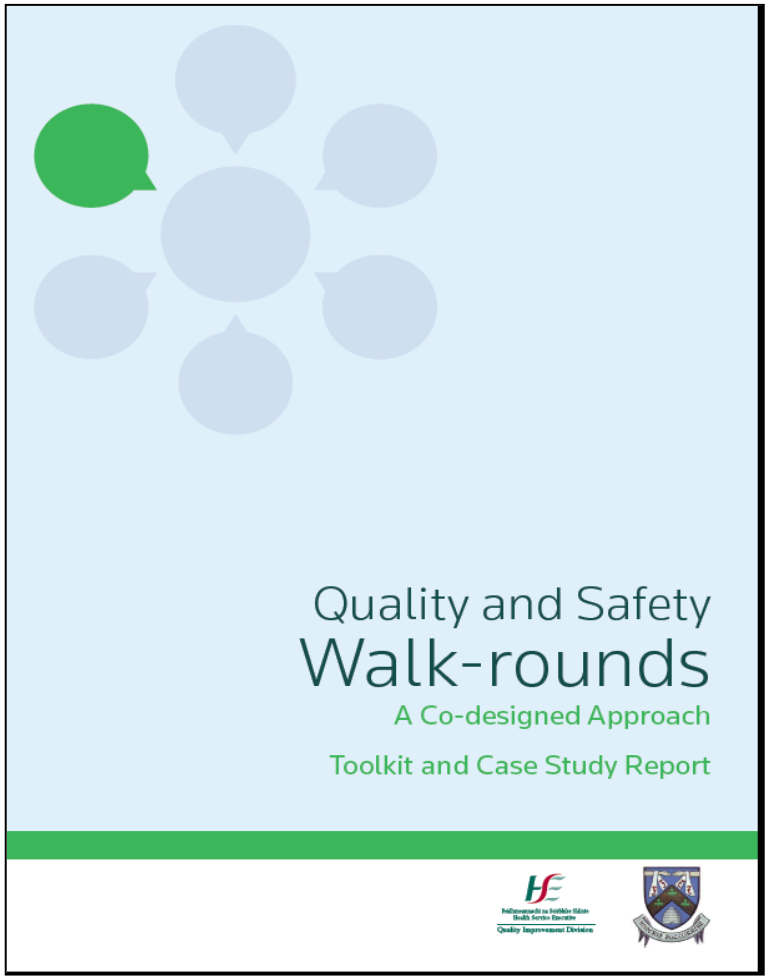
Irish Context

- 2015 - Beaumont Hospital in partnership with Quality Improvement Division and Royal College of Physicians
- 2016 - Toolkit and Resources (Beaumont) published Launch and Learn Event
- 2017 - Social Care - Older Persons services commenced training
- 2018 – Cavan and Mayo Hospitals



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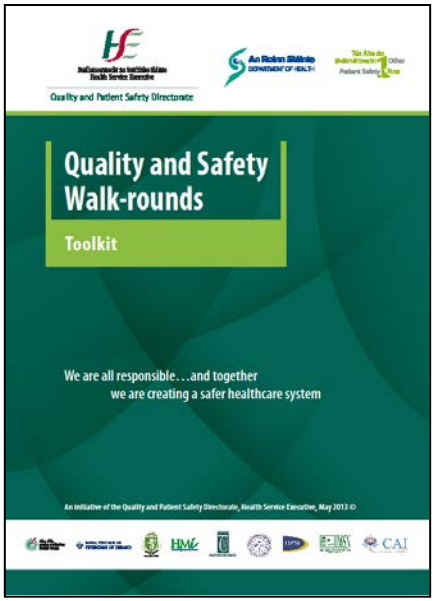
Guidance

2013



Step by Step Guide to Quality and Safety Walk-rounds

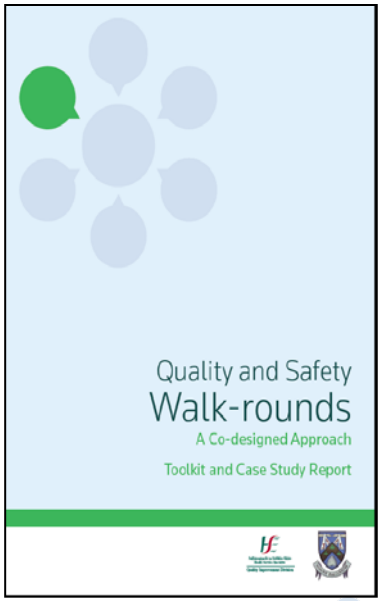
AIM:

- Demonstrate senior managers' commitment to quality and safety for service users, staff and the public;
- Increase staff engagement and develop a culture of open communication;
- Identify, acknowledge and share good practice;
- Support a proactive approach to minimising risk, timely reporting and feedback; and
- Strengthen commitment and accountability for quality and safety.

Step 1 Establish Teams	• Set up Steering Group/Project Group • Identify coordinator • Identify leadership team (Visiting) • Identify unit teams (Participating)	Terms of Reference Steering Group (Resource 1) Contact Information (Resource 2)
Step 2 DevelopTraining Programme /Refine Tools	• Identify training needs • Develop training programme / workshops • Review available tools and templates • Customise and test tools • Agree measures of improvement	Walk-rounds Process (Resource 3) Opening and Closing Statements (Resource 4) Customised Questions (Resource 5) Transcription Template (Resources 6)
Step 3 Communicate Schedule	• Develop a communication plan • Create schedule for year • Notify staff • Remind leadership and unit teams	Notification E-mail (Resource 7) Notice (Resource 8) Leaflet (Resource 9) Schedule (Resource 2)
Step 4 Undertake Walk-rounds	• Meet unit team • Meet service uers/family • Discuss quality and safety topics	Transcription Template (Resource 6)
Step 5 Agree Action Plans	• Record agreed actions • Circulate to team in draft • Confirm actions	Transcription Template (Resource 6) or Action Plan (Resource 10) Communication After Walk-round (Resource 11 & 12)
Step 6 Track and Report on Trends	• Update central records/database • Identify trends • Report on progress to relevant committees • Close the loop on actions	Transcription Template (Resource 6) Action Plan Template (Resource 10) Database (Resource 13)
Step 7 Evaluate, Spread and Sustain	• Review effectiveness of process • Analyse outcomes and measures of improvement • Identify further training needs • Share learning with staff and service users locally and nationally	Database (Resource 13) After Action Review (Resource 14)

2017

2016



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Setting up a Walk-round Programme

QSWRs - Key Tasks

1. Annual schedule
2. Confirmation of walk-round teams
3. Information to staff prior to the visit
4. Ground rules – ways of working agreed
5. Reporting of actions
6. Measuring effectiveness

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Safety Culture Assessments

They address a variety of issues including:

- senior management visibility and commitment to safety.
- communication between staff and managers.
- attitudes to incident reporting, learning from incidents and reviews.

Ref: NPSA : 7 Steps to Patient Safety

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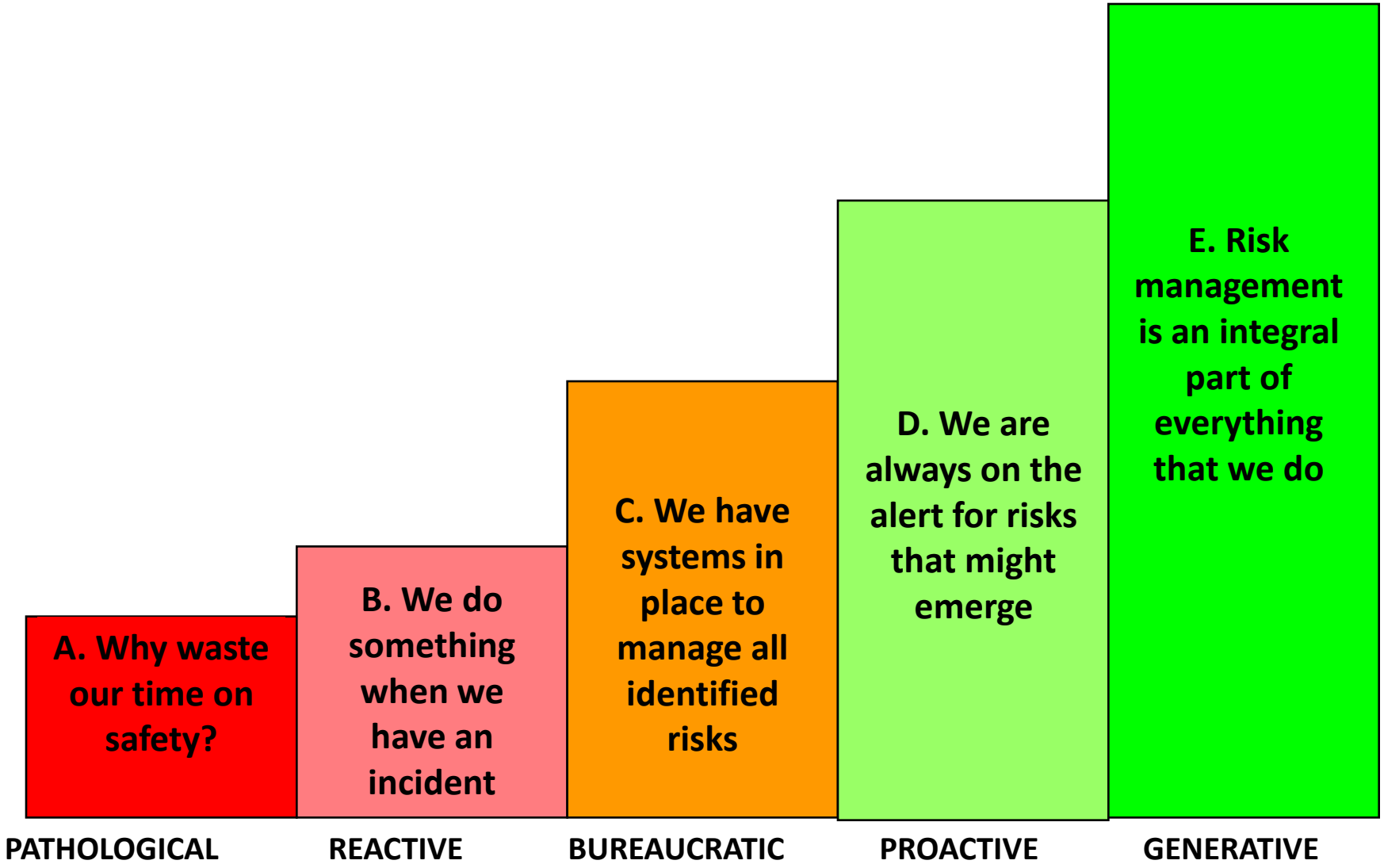
Levels of Maturity with respect to a Safety Culture



Source: NPSA MAPsaf Slides

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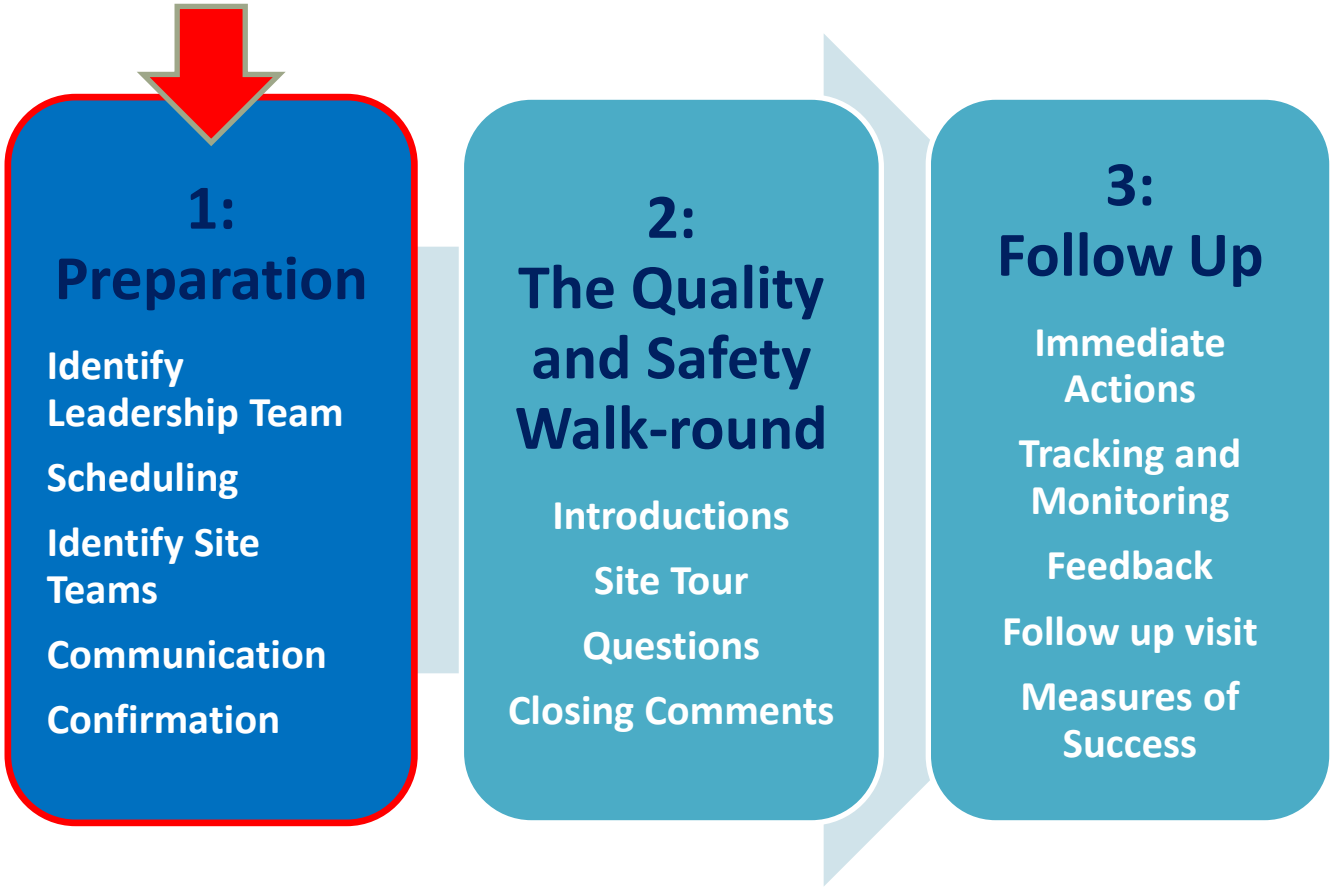
3 Phases



Source : www.patientsafety first. nhs.uk

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1. Who ? How Many ?...

- CEO /General Manager
- Lead clinicians
- All executive management team
- Pair clinical and non-clinical
- Non executives and patient representatives
- Scribe

Numbers are small…. Never outnumber frontline team

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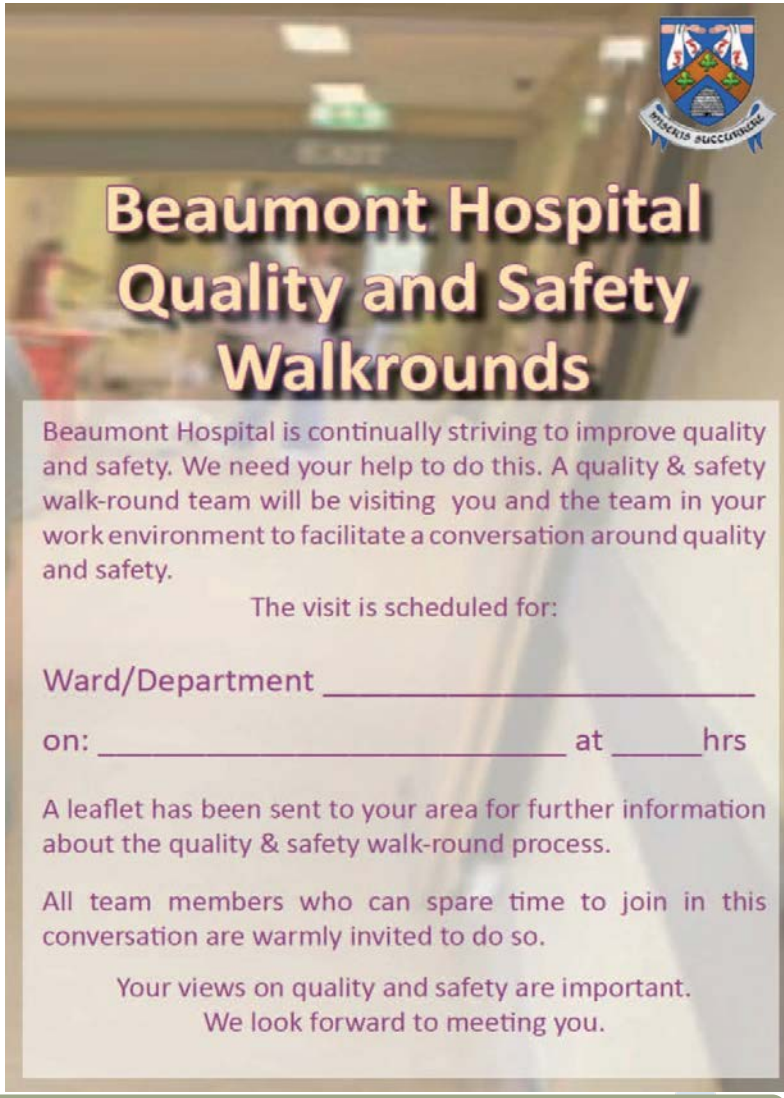
1. The Site Team

- Lead Clinicians
- Mixed group of staff
- Location that is suitable nearby the clinical area

1. Communicate the Plan

- Communication Plan
- Create Schedule for Year
- Inform Staff
- Coordinate the visits



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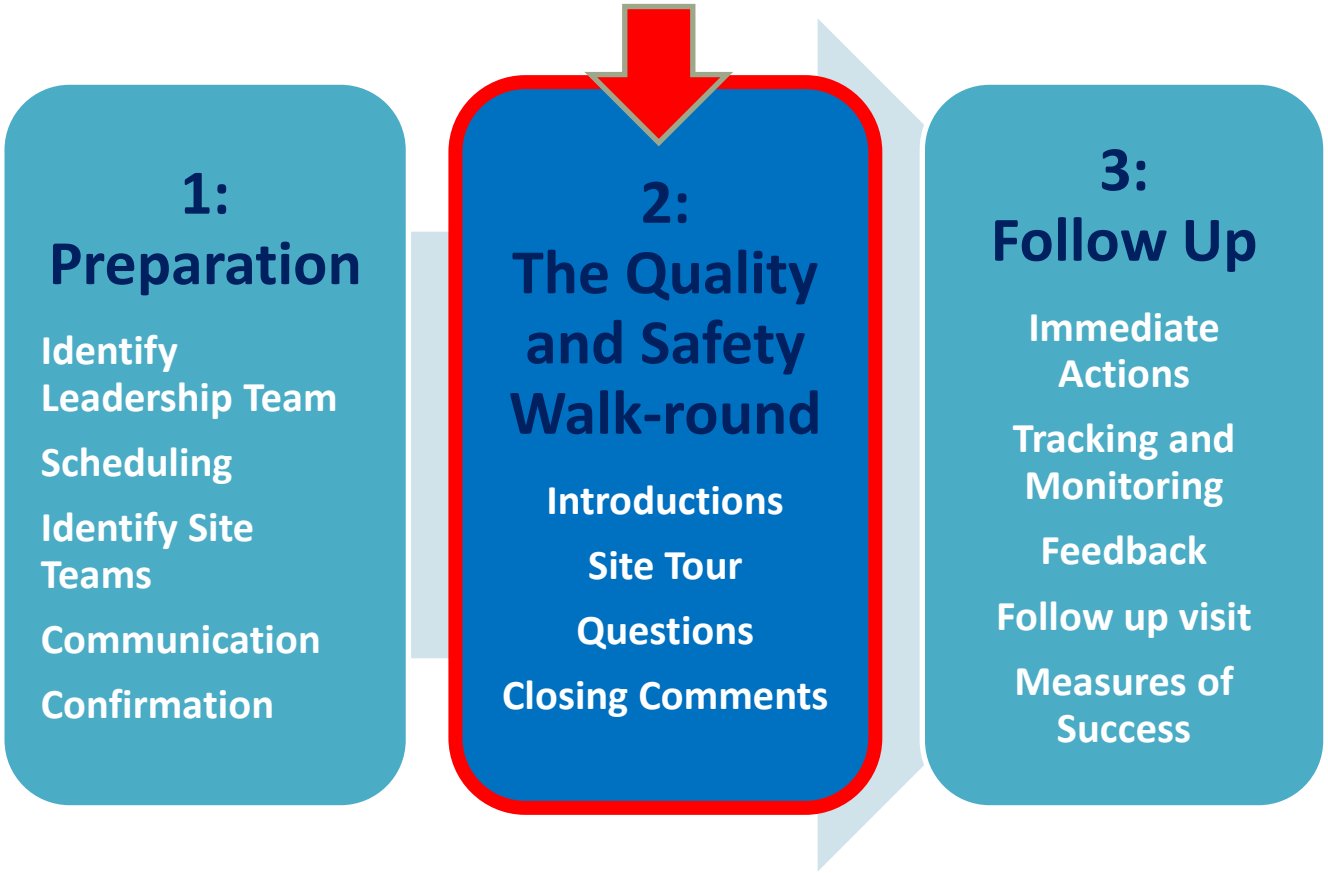
What happens during a walk-round ?

Framework for Improving Quality in our Health Service

3 Phases....



Source : www.patientsafety first. nhs.uk

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2. The QSWR

- Team meet to discuss approach
- Agree roles
- Visit area /Site Tour
- Introductions & Opening Statement
- Questions
- Facilitation skills
- Actions agreed
- Closing statement

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What happens after a walk-round ?

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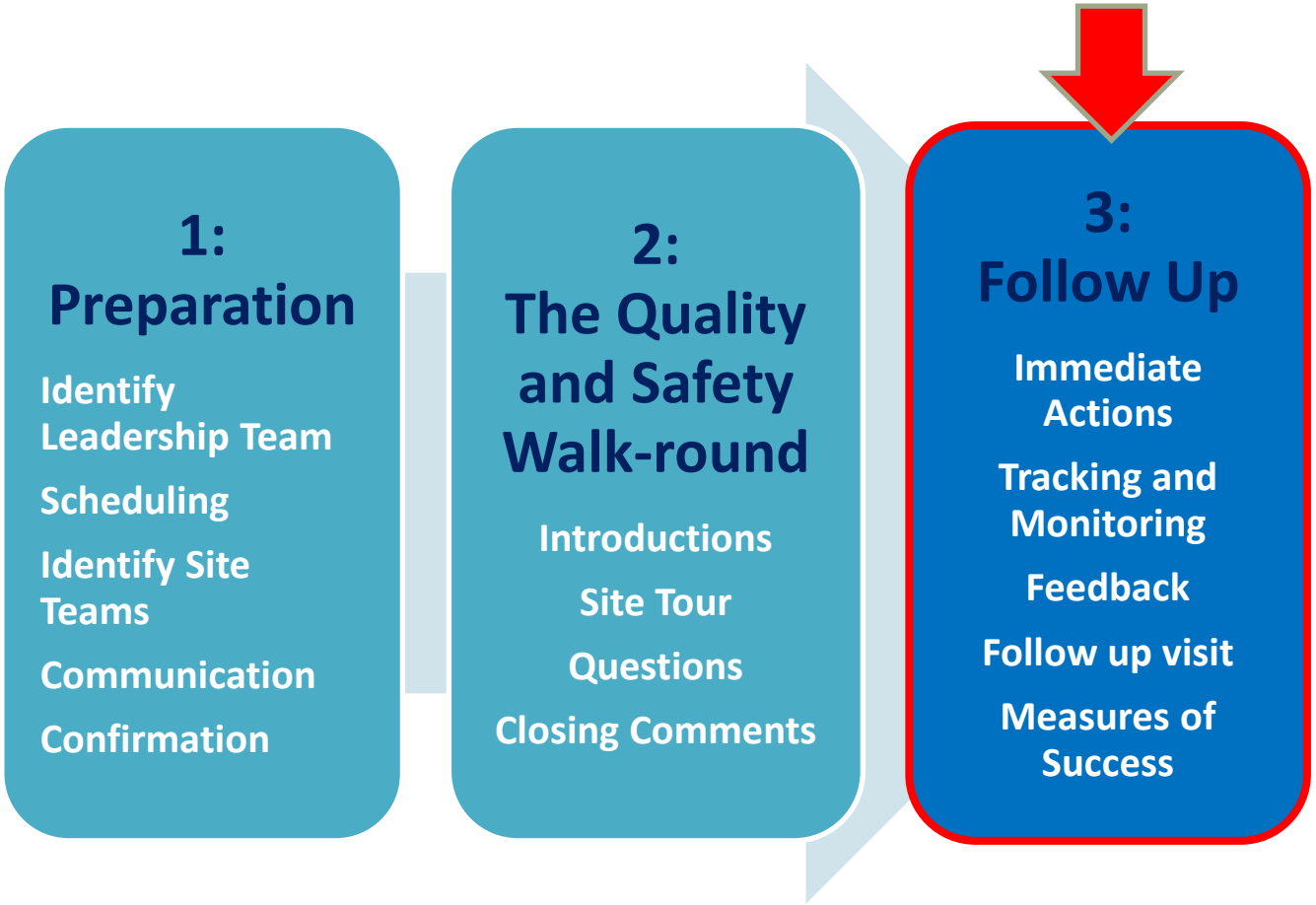
3 Phases....



Source : www.patientsafety first. nhs.uk

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3. Follow up

- Within an agreed number of days
  - Write up the notes
  - Send back to team
  - Update database
- Standing item on management team agenda
- Closing actions
- Monitoring trends

3. Actions

Quality and Safety Walk-round Transcription Template

Date:		**Time:**	
SMT Lead:		**Location:**	
Clinical Lead:		**Scribe:**	
Other:		**IQS:**	

Did the area receive letter of (i) Notification of QSWR? ☐ (ii) QSWR Leaflet? ☐

Present	Grade/Role	Present	Grade/Role

Action Plan

Pick 3 key areas for Local Action and Corporate Action

1	Description:	
	Work to Date:	
	Action Req:	
	Action Owner:	Review Date:
2	Description:	
	Work to Date:	
	Action Req:	
	Action Owner:	Review Date:
3	Description:	
	Work to Date:	
	Action Req:	
	Action Owner:	Review Date:

Discussion Notes:

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3. Follow up -Trends

- Communication
- Environment
- Training
- Teamwork
- Incident reporting
- Equipment
- Staffing

3. After Action Review

1. **What was expected ? What did we set out to do?**
2. **What actually happened ?** *Explore the Facts: What you did, saw or experienced during the event ?*
3. **Was there a difference ?**

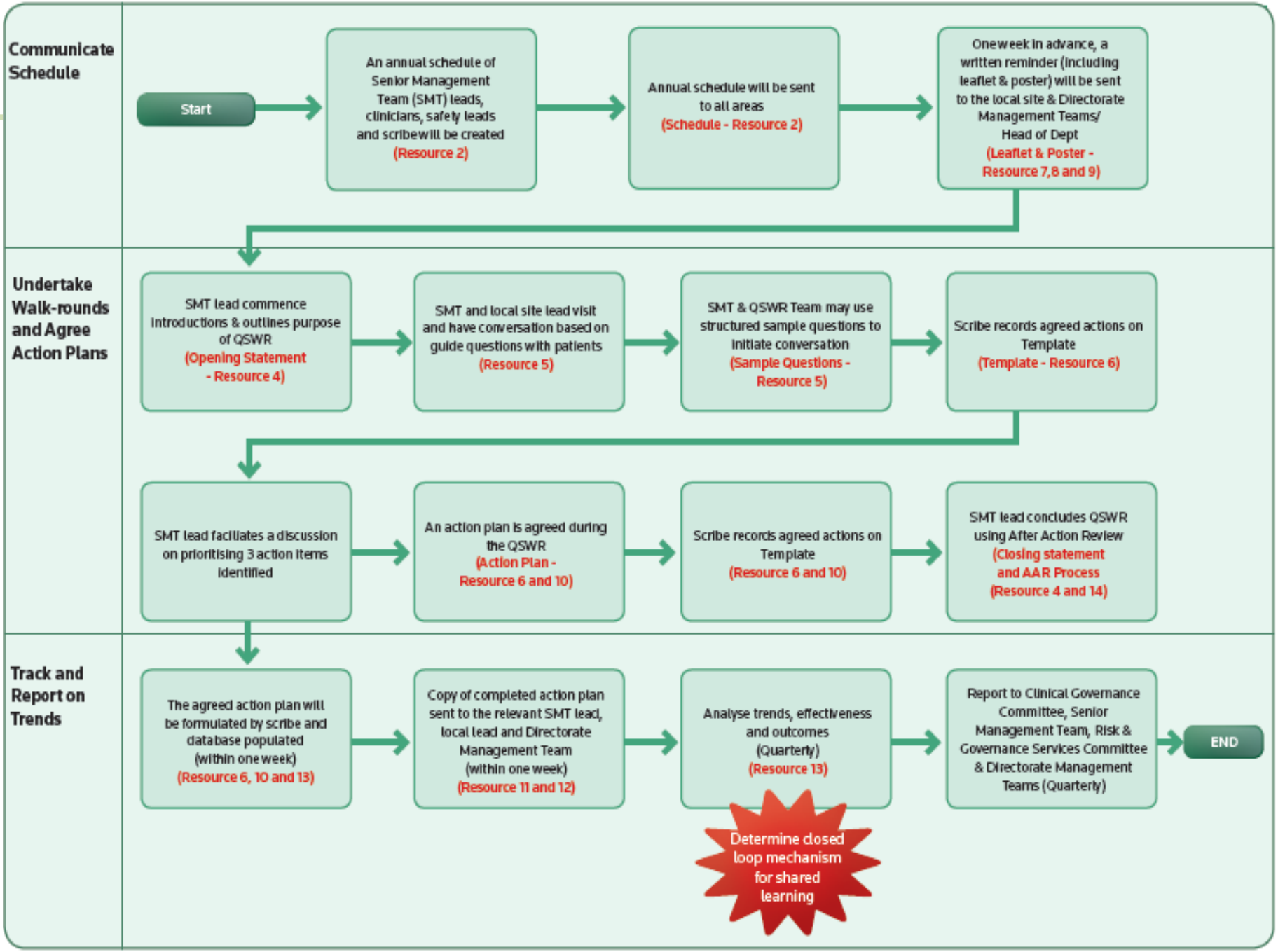
   Reflect on the successes and failure

   What worked well ? Why ? What didn't work ?

   What could have gone better and why ?
4. **What can be learned ?**

   What will be different next time ?

   What are the two or three lessons you would share with others ?


Communicate Schedule
Start
An annual schedule of Senior Management Team (SMT) leads, clinicians, safety leads and scribe will be created (Resource 2)
Annual schedule will be sent to all areas (Schedule - Resource 2)
One week in advance, a written reminder (including leaflet & poster) will be sent to the local site & Directorate Management Teams/ Head of Dept (Leaflet & Poster - Resource 7,8 and 9)
Undertake Walk-rounds and Agree Action Plans
SMT lead commence introductions & outlines purpose of QSWR (Opening Statement - Resource 4)
SMT and local site lead visit and have conversation based on guide questions with patients (Resource 5)
SMT & QSWR Team may use structured sample questions to initiate conversation (Sample Questions - Resource 5)
Scribe records agreed actions on Template (Template - Resource 6)
SMT lead facilitates a discussion on prioritising 3 action items identified
An action plan is agreed during the QSWR (Action Plan - Resource 6 and 10)
Scribe records agreed actions on Template (Resource 6 and 10)
SMT lead concludes QSWR using After Action Review (Closing statement and AAR Process (Resource 4 and 14)
Track and Report on Trends
The agreed action plan will be formulated by scribe and database populated (within one week) (Resource 6, 10 and 13)
Copy of completed action plan sent to the relevant SMT lead, local lead and Directorate Management Team (within one week) (Resource 11 and 12)
Analyse trends, effectiveness and outcomes (Quarterly) (Resource 13)
Determine closed loop mechanism for shared learning
Report to Clinical Governance Committee, Senior Management Team, Risk & Governance Services Committee & Directorate Management Teams (Quarterly)
END

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Critical Success Factors

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Critical Success Factors

- Executive sponsorship and clinician engagement
- Active listening and genuine curiosity
- Coordinated approach
- Customised toolkit
- Part of existing governance structures
- Closing the loop

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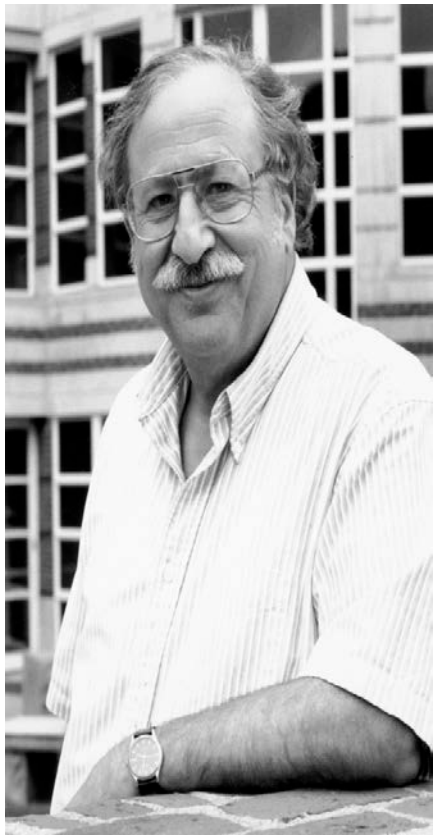
Quality, Leadership and Culture

Leadership

Marshall Ganz



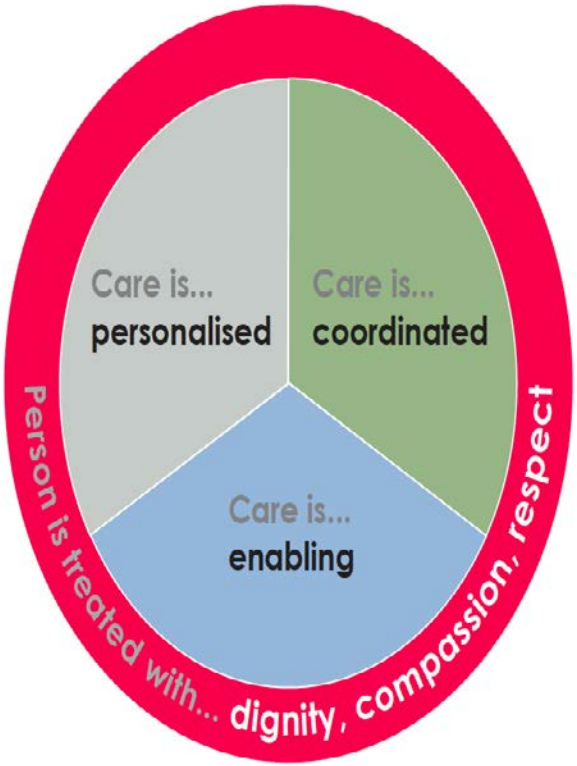
Leadership is…

Leadership is accepting responsibility to create conditions that enable others to achieve shared purpose in the face of uncertainty.

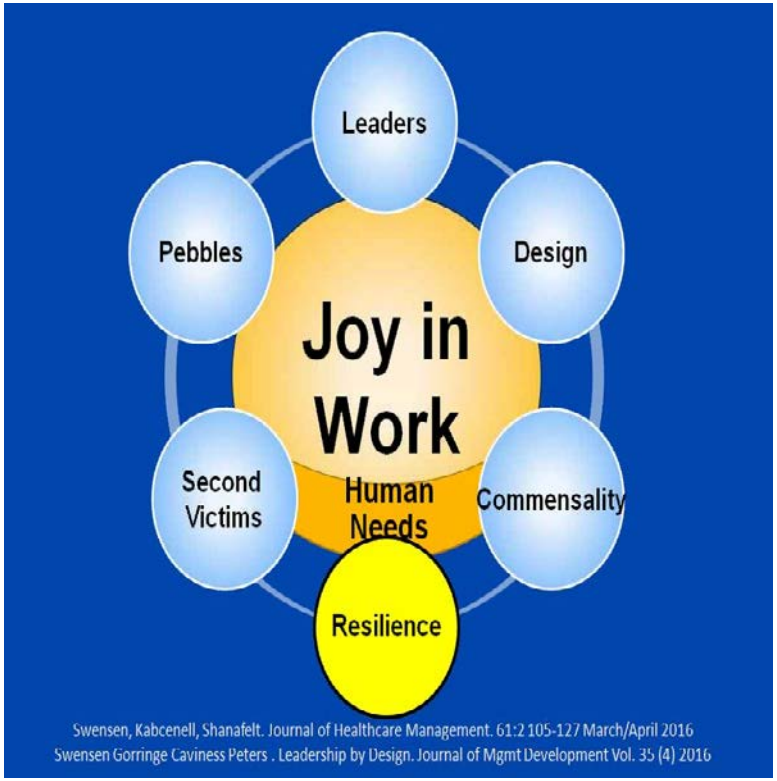
Marshall Ganz

A Person Centred View of the World

"moving from what's the matter?" to "what matters to you?"

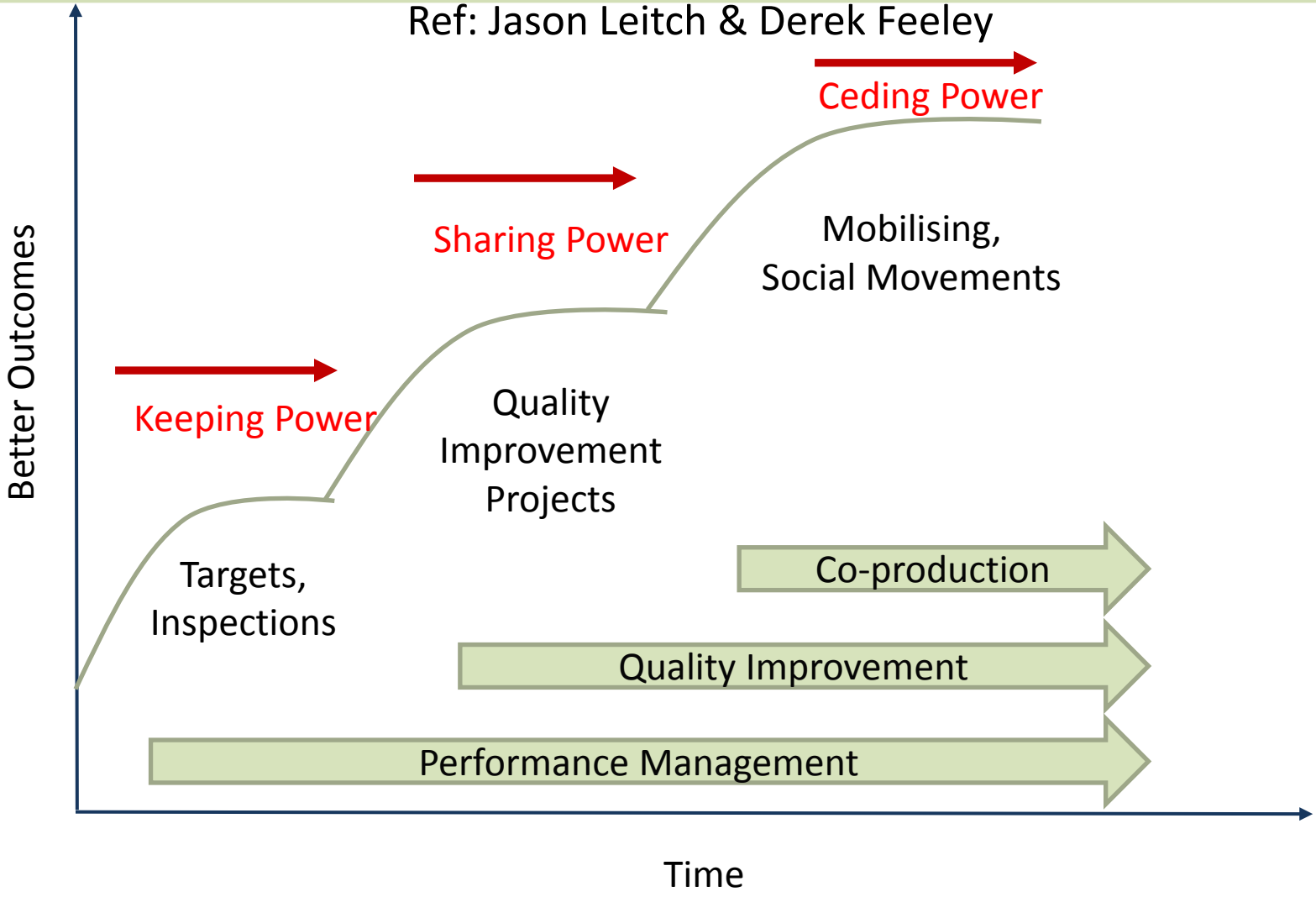


Person Centred Care Model
Health Foundation www.health.org



Joy in Work Model
Mayo Clinic, USA

Getting to the Third Wave of Improvement



Psychological Safety

Ref: Amy Edmondson

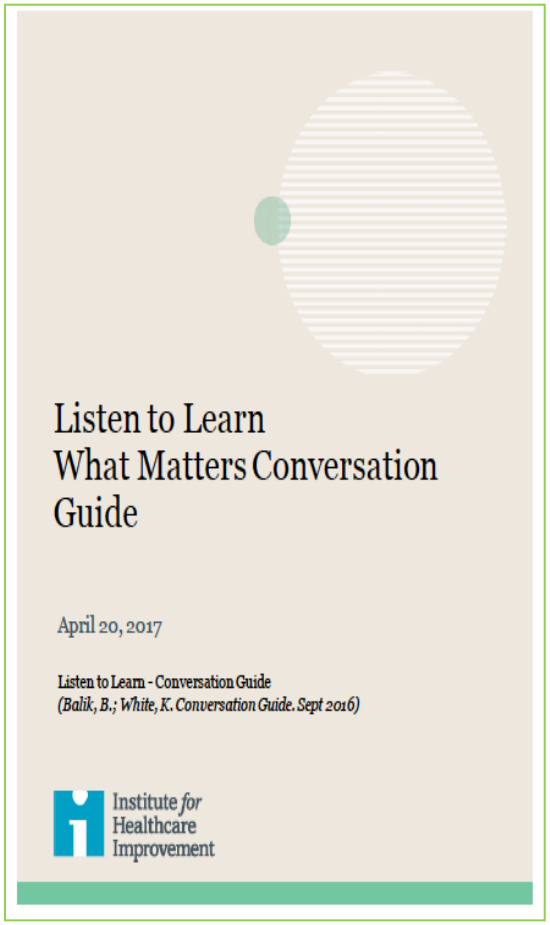
Psychological safety: the belief that you won't be punished when you make a mistake

Questions that demonstrate psychological safety:

- Can I ask questions without looking stupid?
- Can I be respectfully critical without looking negative?
- Can I seek feedback without seeming incompetent?
- Can I be innovative without looking disruptive?

What matters to you?

What Matters to You?



Do	Don't	Steps to Try
Purpose		
• Talk about the *purpose* of the conversation – why you are interested in "What matters" to them • Share a story about what matters to you, what makes a good day for you	• Assume you know what others are thinking or experiencing • Promise to fix everything • Do this as a one-time activity	• Purpose = Why; be able to say why you are talking about joy in work • Talk about your commitment to working together to make daily life better for everyone • Emphasize this is about ongoing improvement not a one-time or quick fix
Build on Assets/Bright Spots – What Matters		
Ask members to share: • Why I decided to be in healthcare? • What matters to me in my work is . . . • What is the most	• Assume all team members will get what you're talking about immediately – they are often not used to being asked • Assume all will feel	• Choose 1 question to get started then listen and engage others to comment

“I have no special talents.
I am only passionately curious.”

Albert Einstein

What's your C.Q.?

Harvard Business Review

MANAGING YOURSELF

Curiosity Is as Important as Intelligence

by Tomas Chamorro-Premuzic

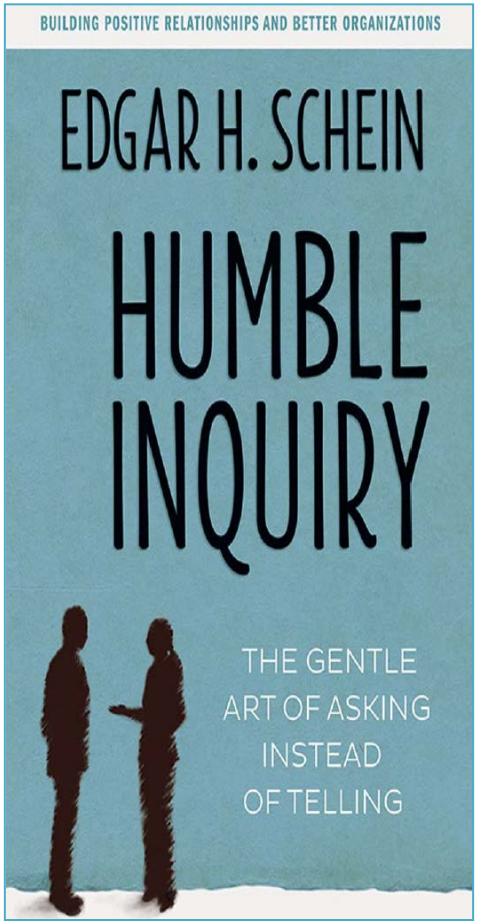
AUGUST 27, 2014

SAVE SHARE 92 COMMENT TEXT SIZE PRINT $8.95 BUY COPIES

There seems to be wide support for the idea that we are living in an "age of complexity", which implies that the world has never been more intricate. This idea is based on the rapid pace of technological changes, and the vast amount of information that we are generating (the two are related). Yet consider that philosophers like Leibniz (17th century) and Diderot (18th century) were already complaining about information overload. The "horrible mass of books" they referred to may have represented only a tiny portion of what we know today, but much of what we know today will be equally insignificant to future generations.

Humble Inquiry

The Gentle Art of Asking Instead of Telling

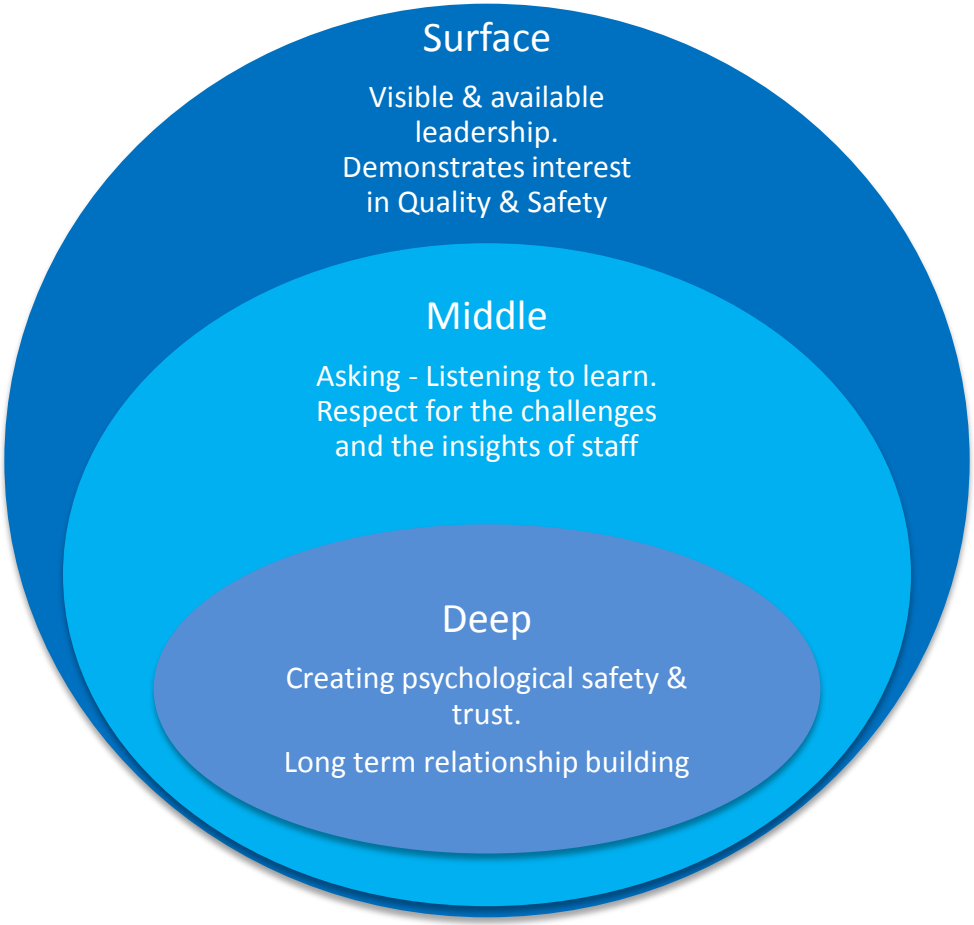


Humble Inquiry is the fine art of drawing someone out, of asking questions to which you do not already know the answer, of building a relationship based on curiosity and interest in the other person.

Edgar H. Schein

3 Levels of Quality & Safety Walk- rounds

All can happen at the same time



Helpful links

Framework for Improving quality

www.qualityimprovement.ie

Improvement Knowledge and Skills Guide

http://www.hse.ie/eng/about/Who/QID/aboutQID/

Improving Quality in our Health Service

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Next QI Talktime:

Tues Nov 6th 1pm: Building a Model line for Frailty

Speaker: Fiona Keogan – Service Improvement Lead Ireland East Hospital Group

Thank you from all the team @QITalktime
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Noemi.palacios@hse.ie

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