Welcome!

Quality and Safety Walk-rounds
A Co-designed Approach
Toolkit and Case Study Report

Launch and Learn 8th June 2016
Dr Philip Crowley
National Director
Quality Improvement Division
Live-tweeting

- @HSEQI
- Launch and Learn event hashtag...

#GovernanceQ&S
## Programme

### Governance for Quality
**Sharing the Learning from Beaumont Hospital**
**Quality Improvement Project: Quality and Safety Walk-rounds**

- **Location:** Board Room, Dr. Steeven's Hospital, Dublin 8
- **Date:** Wednesday 8th June 2016
- **Time:** 16.00-18.00

#### “Launch and Learn”

**PROGRAMME**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter/Contributor</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.00</td>
<td>Welcome to the launch of 'Quality and Safety Walk-rounds - Guidance and Beaumont Hospital Case Study'</td>
<td>Dr. Philip Crowley, National Director, HSE Quality Improvement Division</td>
</tr>
<tr>
<td>16.15</td>
<td>Introducing Beaumont Hospitals Quality and Safety Walk-rounds Improvement (QI) Project: A CEO’s Perspectives</td>
<td>Ms. Liam Duffy, CEO, Beaumont Hospital</td>
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<tr>
<td>16.30</td>
<td>Reflections of a Quality and Safety Walk-rounds Team Member: 'How this QI project changed our way of working'</td>
<td>Prof. Edmond Smyth, Consultant Microbiologist and Director of Clinical Governance, Beaumont Hospital</td>
</tr>
<tr>
<td>16.45</td>
<td>'How this QI project can help other organisations'</td>
<td>Ms. Kate Costello, Head of Education, Learning and Development, Beaumont Hospital</td>
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<tr>
<td>16.45</td>
<td>Video Sharing: 'Standing up in the work together'</td>
<td>Ms. Petrina Donnelly, Deputy Director of Nursing, Beaumont Hospital</td>
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<tr>
<td>17.00</td>
<td>Video for Sharing: 'Standing up in the work together'</td>
<td>Ms. Barbara Keogh Dunne, Patient Flow Manager, Beaumont Hospital</td>
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<tr>
<td>17.05</td>
<td>Questions to the Panel</td>
<td>Chaired by Dr. Fidelma Fitzpatrick, Consultant Microbiologist, Senior Lecturer in RCSI</td>
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<td>+ Panel Members: Ms. Karen Greene, Director of Nursing, Beaumont Hospital</td>
<td>Dr. Philip Crowley, National Director, HSE Quality Improvement Division</td>
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<td>+ Dr. Philip Crowley, National Director, HSE Quality Improvement Division</td>
<td>Dr. Peter Lachman, CEC, International Society for Quality in Healthcare</td>
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<td>+ Ms. Maureen Flynn, Director of Nursing ONMSO, HSE Quality Improvement Division</td>
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<tr>
<td>17.30</td>
<td>Reflection and Close of Session</td>
<td>Ms. Angela Fitzgerald, Deputy National Director, Acute Hospital Division</td>
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Quality Improvement Division Role

CHAMPION
Provide information and evidence to support people working in practice and policy to improve care.

EDUCATE
Build capacity for leadership and quality improvement through training programmes and education events.

DEMONSTRATE
Share new ideas, test and develop ideas in practice and support the spread of sustainable solutions.

PARTNER
Work with people across the system-service users, clinicians, managers, national bodies to inform and align improvement.
Framework for Improving Quality

A CULTURE OF PERSON CENTRED QUALITY CARE THAT CONTINUOUSLY IMPROVES

- Leadership for Quality
- Person and Family Engagement
- Staff Engagement
- Use of Improvement Methods
- Measurement for Quality
- Governance for Quality
Governance for Quality.....

Executive and Board
- Your role, knowledge and skill in driving QI
- Your accountability for quality and safety
- Your use of information
- Promote a culture of learning
- Build relationships with staff and patients
- Seek a quality improvement plan
Why Quality and Safety Walk-rounds?

- Demonstrate **senior managers’ commitment** to quality and safety for service users, staff and the public
- Increase **staff engagement** and ensure staff ideas for change are actioned
- Identify, acknowledge and **celebrate good practice**
- Opportunity for the leadership to truly **understand front line work**
- Strengthen **commitment** and **accountability** for quality and safety
2013 ........to 2016.....

- Champion (2013) Quality and Safety Walk-rounds published
- Educate (2014) Tailored education programme through NQIP
- Partner (2014 to 2016) Beaumont Hospital and Quality Improvement Division
- Demonstrate (2016) Launch and Learn toolkit published
# Step by Step: Guidance

## 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)

### Step 2: Develop Training Programme/Refine Tools
- Identify training needs
- Develop training programme/workshops
- Review available tools and templates
- Customise text tools
- Agree measures of improvement

### Step 3: Communicate Schedule
- Develop a communication plan
- Create schedule for year
- Notify staff
- Remind leadership and unit teams

### Step 4: Undertake Walk-rounds
- Meet unit team
- Meet service users/family
- Discuss quality and safety topics

### Step 5: Agree Action Plans
- Record agreed actions
- Circulate to team in draft
- Confirm actions

### Step 6: Track and Report on Trends
- Update central records/database
- Identify trends
- Report on progress to relevant committees
- Close the loop on actions

### Step 7: Evaluate, Spread and Seal the
- Review effectiveness of process
- Analyse outcomes and measures of improvement
- Identify further training needs
- Share learning with staff and service users locally and nationally

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### Resources
- Terms of Reference Steering Group (Resource 1)
- Contact Information (Resource 2)
- Walk-rounds Process (Resource 3)
- Opening and Closing Statements (Resource 4)
- Customised Questions (Resource 5)
- Transcription Template (Resource 6)
- Notification E-mail (Resource 7)
- Notice (Resource 8)
- Leaflet (Resource 9)
- Schedule (Resource 10)
- Transcription Template (Resource 11)
- Transcription Template (Resource 12)
- Action Plan Template (Resource 13)
- Database (Resource 14)
What have we learned?

- Adapt international models locally
- Leadership from senior staff and management
- Respect for frontline expertise
- Careful planning - takes time, plan sustainability
- Tailored education programme
- Several tests of change
- Build into existing governance structures
Acknowledgements
And
Thank You
Launch of

Quality and Safety Walk-rounds
A Co-designed Approach
Toolkit and Case Study Report

Dr Philip Crowley and Mr Liam Duffy
Prof. Edmond Smyth
Consultant Microbiologist and Director of Clinical Governance, Beaumont Hospital

Reflections of a Quality and Safety Walk-rounds team member

How this QI Project Changed our Way of Working
Clinical Governance

- Audit & quality improvement
- Serious incident reviews
- Learning from complaints, serious incidents etc
- Responding to external reports
- Implementing national guidelines
- Reacting to inspections by regulators
- Education & training
THE PATIENT SAFETY CULTURE LADDER

- **Predictive**: That is how we do business round here
- **Proactive**: Safety leadership and values drive continuous improvement
- **Calculative**: We have systems in place to manage risks
- **Reactive**: Safety is important, we do a lot every time we have an accident
- **Pathological**: Who cares as long as we’re not caught

Increasingly Informed → Increasing Trust and Accountability
Walk Rounds in Action
‘A different conversation’
Walk Rounds in Action
‘A different conversation’
Quality and Safety Walk-rounds

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.
Philosophy

- Demonstrating management’s commitment
- Using standardised but not constrained approach
- Involving senior staff
  - CEO etc, clinician, IQS, scribe
- Having an open discussion
- Showing deference & respect
- Actively listening
- Providing feedback and listing ‘actions’
- Sharing good practice
Training and Planning for QSWRs in Beaumont Hospital

- Clinician engagement: bringing clinicians and managers together to design the initiative
- Commitment to undertake education/leadership development for walk rounds
- Being part of the BH QSWR toolkit design team
- Training & teamwork
- Role play and simulation to test the toolkit
Preparation for QSWRs

- Scheduling & respecting clinicians’ time
- Preparation for the clinical staff
- Encouraging broad representation
- Meeting with QSWR team members prior to visit
  - Briefing
  - Ascribing roles
- Setting timelines
  - For the visit
  - For the report
  - For the actions

Consider opening questions
The QSWR

- The opening statement
- Walk round!
- The first question
- Be inclusive
- Involve a patient if possible
- Listen, interact, comment, feedback
- Agree an action plan with all present
Post-Walk Round

- Post-walk round evaluation by team members.
- Scribe completes action plan
- Database populated
- Links to local Directorate Clinical Governance Structures
- Reporting to Hospital Clinical Governance Committee
Diversity of QSWR Sites visited

- Out patients
- Renal
- Cardiology
- Renal Out Patients
- Immunology Service
- Critical Care
- Neurology
- Residential Care Unit
- Haematology
- Renal Home Therapies
- Cardiology Diagnostics & Intervention
‘The safety walk-round gave all members of the ward team an opportunity to ‘show off’ our achievements, and also to raise areas of concern.

The meeting was relaxed and interactive, with all participants being involved, and the team doing the walk-round were really interested in what was going on at ground level. Staff commented afterwards how important this was, and they would like to see more of this’.
Feedback: Clinical Nurse Manager 1

‘Being part of the Quality and Safety Walk-rounds was an excellent opportunity to demonstrate and collaborate with the Senior Management Team to develop clearly structured solutions that we can undertake to ensure high quality care for patients and a safe environment for staff. I would highly recommend any CNM to become involved.’
Feedback: Consultant

‘Maybe I was a little bit sceptical about this at first, but I enjoyed the meeting and felt it was very positive. It was great to have the chance to show members of the Senior Executive Team the work we are doing in the unit, and I like the fact that this process is proactive rather than reactive. There should be more of this type of interaction in the hospital’
Personal Reflections

- Fascinating
- Awe & pride
- Empowering for staff
- Multi-disciplinary team work
- Responsibility but not overly so
- Effective
- Expensive
- Logistically challenging
# hello my name is...

Ms. Kate Costello  
Head of Education, Learning and Development

Ms. Petrina Donnelly  
Deputy Director of Nursing

How this QI Project can Help other Organisations
How This QI Project Can help Other Organisations

- What worked
- Challenges along the way
- Critical success factors
Inspiring Others........

https://www.youtube.com/watch?v=c47otcg13Z8
What worked....

- Leadership & strategic alignment
- Motivation & commitment
- Collaborative with HSE-NQID & RCPI
- Co-designing the approach - tapping into local staff potential, diversity & expertise
- Planning & use of QI methodology
- Keeping mutual values & respect to the forefront
- On-going evaluation and learning
Method: Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?
**AIM**
Building leadership and enhancing the safety culture in Beaumont Hospital through the introduction of a Quality and Safety Walk-rounds Programme across clinical and clinical support areas by the end of 2015.

**OUTCOMES**

- Creating the Vision and Building the Will
- Developing the Capability
- Making it Happen

**PRIMARY DRIVERS**

- Engagement and dialogue with key stakeholders internally and externally
- Leadership commitment and engagement on co-design from board to ward
- Alignment with local and national quality and safety strategic priorities
- Identification and commitment of local clinician quality and safety champions
- Baseline culture assessment using Manchester Patient Safety Framework (MaPSaF)

**SECONDARY DRIVERS**

- Learning needs assessment
- Collaborative design of customised, accredited development programme in conjunction with National Quality Improvement Programme
- Capacity building of frontline staff
- Developing the quality and safety walk-rounds leadership team roles

- Securing resources (Training, IT and Human Resources)
- Co-designing the local toolkit
- Undertaking small tests of change
- Building a sustainable infrastructure
- Incorporating After Action Reviews (AARs) and ongoing evaluation
- Sharing the learning
- Feedback loop (Action follow up and database)
Challenges along the way

- Competing demands – strategic & operational
- Building capacity and capability
- Securing and sustaining Clinician engagement
- Sign up and commitment to training programme
- Building the Infrastructure to ensure sustainability
Critical Success Factors

- Executive sponsorship
- Clinician engagement
- Co-designed approach
- Deference to the frontline
- Education and training
- Customised QSWR toolkit
- Infrastructure to support sustainability
- Follow-up and links to existing governance structures
- Shared learning
# QSWR Implementation Timeline

<table>
<thead>
<tr>
<th>APRIL 2014</th>
<th>JAN - OCT 2015</th>
<th>JAN 2016 - PRESENT</th>
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| - QSWRs a Strategic Change project as part of Beaumont/Dublin City University/Royal College of Surgeons Ireland MSc in Organisational Change and Leadership Programme | - Senior Management and Clinician Champions  
- Collaborative Design and Delivery of Leadership Development Programme with Royal College Physicians Ireland (RCPI) and HSE National Quality Improvement Programme (QID/RCPI)  
- Development of local QSWR toolkit  
- Engagement and preparation of frontline staff in QSWR sites  
- Securing resources and funding for training and administration | - Strategic priority for Beaumont  
- Planned Schedule of QSWRs 2015-16  
- Administration support for process secured  
- Management of action plan and follow up database  
- Feedback to Board and frontline staff  
- Extend QSWR Leadership Team  
- Further education and leadership development in 2016 |
| - Desktop research  
- Site Visits: Great Ormond Street and Industry  
- Review of local patient safety culture  
- Collaboration with HSE Quality Improvement Division (QID)  
- Senior Management Team sponsorship and approval | | |

## Creating the Vision

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<th>DECEMBER 2014</th>
<th>JAN - OCT 2015</th>
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| - Presentation to Board and Senior Management Team  
- Engagement and support from Clinical Governance  
- Presentation to Heads of Department  
- Clinician engagement and buy-in  
- Establishment of Multidisciplinary QSWR Leadership Team | - Phased Implementation of QSWRs (using rapid cycles of change PDSA Model)  
- Pilot QSWRs and After Action Review (AAR)  
- Schedule of QSWRs  
- QSWRs including AAR  
- Leadership Team AAR evaluation session  
- Action plan and follow up with QSWR site staff |
Ms. Barbara Keogh Dunne
Patient Flow Manager, Beaumont Hospital

Introducing video conversation

*Standing up in the Work Together*

https://vimeo.com/169731002
Dr. Fidelma Fitzpatrick
Consultant Microbiologist, Senior Lecturer RCSI

Introducing the Panel and Your Questions

Ms. Karen Greene, Director of Nursing Beaumont Hospital
Dr. Philip Crowley, National Director, HSE Quality Improvement Division
Dr. Peter Lachman, CEO, International Society for Quality in Health Care (ISQua)
Ms. Maureen Flynn, Director of Nursing, ONMSD, HSE Quality Improvement Division
Where to find the resources

Twitter: @HSEQI
Web: www.qualityimprovement.ie
Email: nationalqid@hse.ie