

Welcome!

Quality and Safety Walk-rounds

A Co-designed Approach

Toolkit and Case Study Report

Launch and Learn 8th June 2016



Féidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division



hello my name is...



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. Steevens' Hospital, Dublin 8

Date: Wednesday 8th June 2016

Time: 16.00-18.00

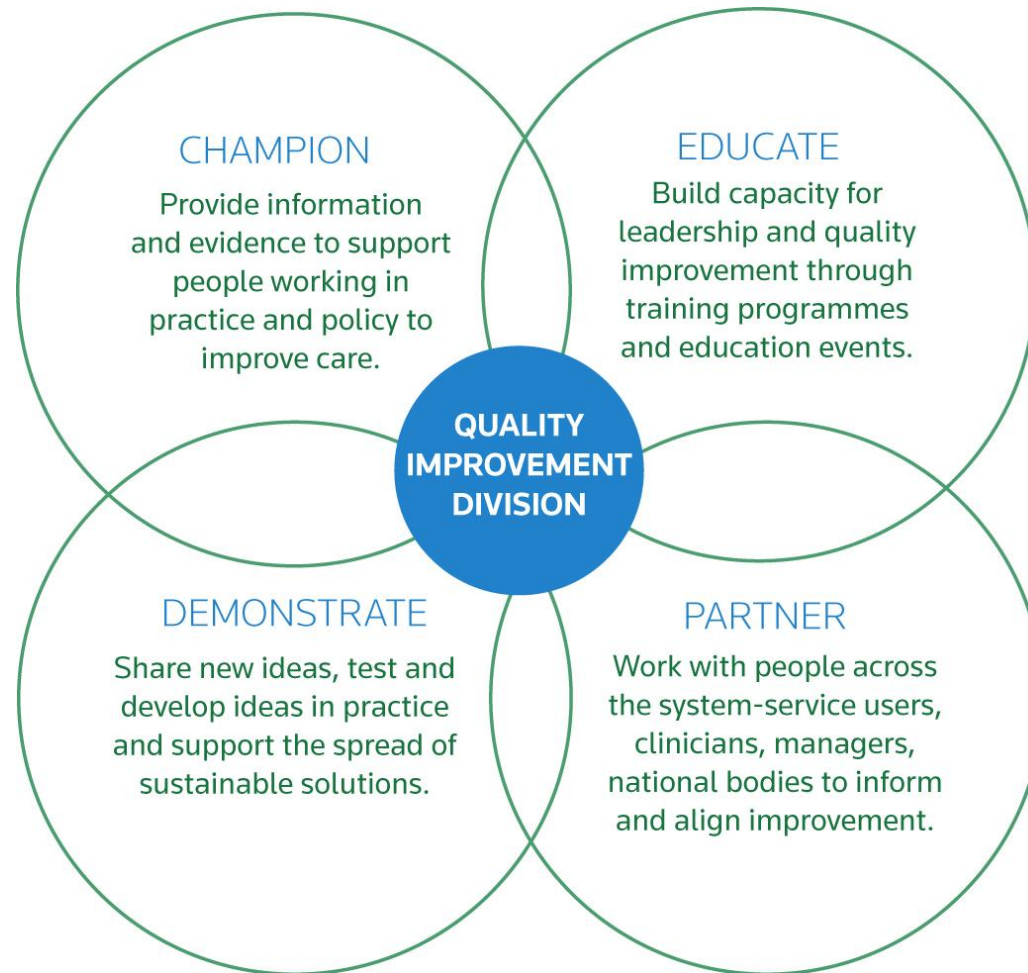
“Launch and Learn”

PROGRAMME

16.00	<p>Welcome to the launch of <i>'Quality and Safety Walk-rounds – Guidance and Beaumont Hospital Case Study'</i></p>	<p>Dr. Philip Crowley National Director, HSE Quality Improvement Division</p>
16.15	<p>Introducing Beaumont Hospital: <i>Quality and Safety Walk-rounds Improvement (QI) Project A CEO's Perspective'</i></p>	<p>Mr. Liam Duffy CEO, Beaumont Hospital</p>
16.30	<p>Reflections of a Quality and Safety Walk-rounds Team Member: <i>'How this QI project changed our way of working'</i></p>	<p>Prof. Edmond Smyth Consultant Microbiologist and Director of Clinical Governance, Beaumont Hospital</p>
16.45	<p><i>'How this QI project can help other organisations'</i></p>	<p>Ms. Kate Costello Head of Education, Learning and Development, Beaumont Hospital</p> <p>Ms. Petrina Donnelly Deputy Director of Nursing, Beaumont Hospital</p>
17.00	<p>Video for Sharing: <i>'Standing up in the work together'</i> Dr. Philip Crowley and Mr. Liam Duffy in conversation</p>	<p>Ms. Barbara Keogh Dunne Patient Flow Manager, Beaumont Hospital</p>
17.05	<p>Questions to the Panel</p>	<p>Chaired by Dr. Fidelma Fitzpatrick Consultant Microbiologist, Senior lecturer in RCSI</p> <p>Panel Members: 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 Ms. Maureen Flynn Director of Nursing ONMSD, HSE Quality Improvement Division</p>
17.30	<p>Reflection and Close of Session</p>	<p>Ms. Angela Fitzgerald Deputy National Director, Acute Hospital Division</p>



Quality Improvement Division Role



Framework for Improving 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



Step by Step: Guidance

Step by Step Guide to Quality and Safety Walk-rounds		
<p>AIM:</p> <ul style="list-style-type: none"> ● 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. 		
<p>Step 1 Establish Teams</p>	<ul style="list-style-type: none"> ● Set up Steering Group/Project Group ● Identify coordinator ● Identify leadership team (Visiting) ● Identify unit teams (Participating) 	<p>Terms of Reference Steering Group (Resource 1) Contact Information (Resource 2)</p>
<p>Step 2 Develop Training Programme / Refine Tools</p>	<ul style="list-style-type: none"> ● Identify training needs ● Develop training programme / workshops ● Review available tools and templates ● Customise and test tools ● Agree measures of improvement 	<p>Walk-rounds Process (Resource 3) Opening and Closing Statements (Resource 4) Customised Questions (Resource 5) Transcription Template (Resources 6)</p>
<p>Step 3 Communicate Schedule</p>	<ul style="list-style-type: none"> ● Develop a communication plan ● Create schedule for year ● Notify staff ● Remind leadership and unit teams 	<p>Notification E-mail (Resource 7) Notice (Resource 8) Leaflet (Resource 9) Schedule (Resource 2)</p>
<p>Step 4 Undertake Walk-rounds</p>	<ul style="list-style-type: none"> ● Meet unit team ● Meet service users/family ● Discuss quality and safety topics 	<p>Transcription Template (Resource 6)</p>
<p>Step 5 Agree Action Plans</p>	<ul style="list-style-type: none"> ● Record agreed actions ● Circulate to team in draft ● Confirm actions 	<p>Transcription Template (Resource 6) or Action Plan (Resource 10) Communication After Walk-round (Resource 11 & 12)</p>
<p>Step 6 Track and Report on Trends</p>	<ul style="list-style-type: none"> ● Update central records/database ● Identify trends ● Report on progress to relevant committees ● Close the loop on actions 	<p>Transcription Template (Resource 6) Action Plan Template (Resource 10) Database (Resource 13)</p>
<p>Step 7 Evaluate, Spread and Sustain</p>	<ul style="list-style-type: none"> ● Review effectiveness of process ● Analyse outcomes and measures of improvement ● Identify further training needs ● Share learning with staff and service users locally and nationally 	<p>Database (Resource 13) After Action Review (Resource 14)</p>



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



A decorative graphic on the left side of the slide consists of seven speech bubbles. One bubble is a solid green color, while the other six are a light blue color. They are arranged in a cluster, with the green bubble on the left and the others surrounding it.

*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

hello my name is...



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

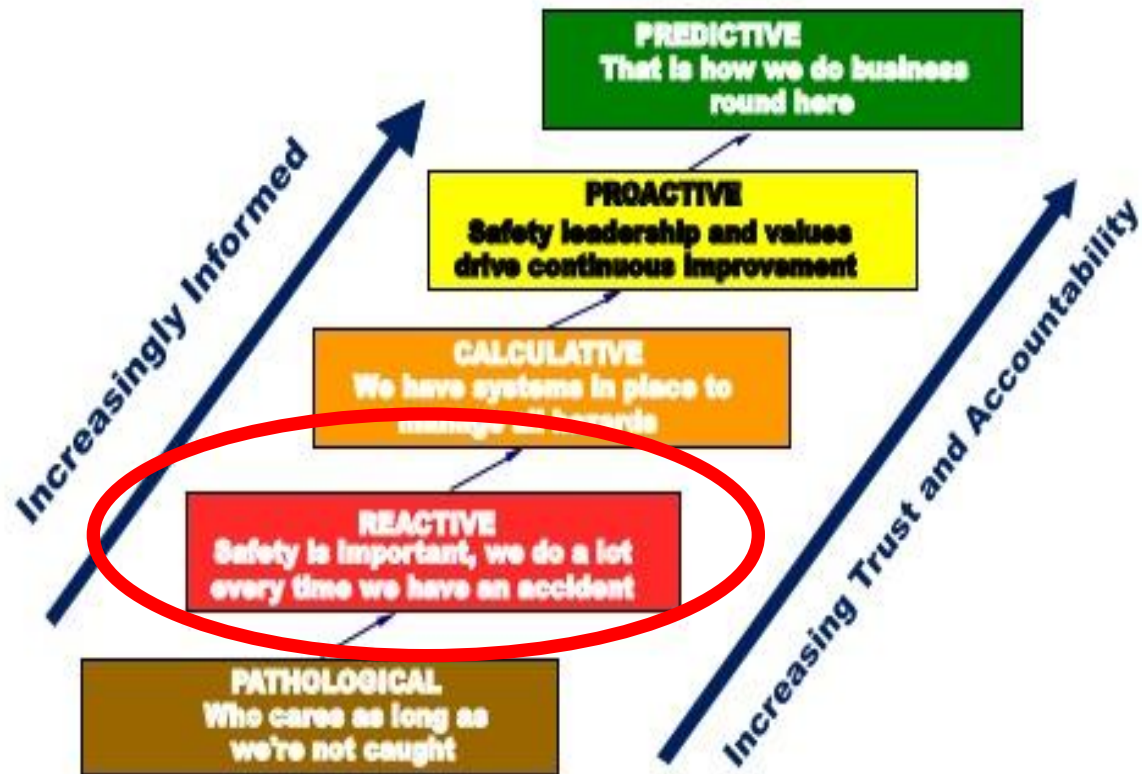


Clinical Governance

- 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



Walk Rounds in Action

'A different conversation'



Walk Rounds in Action

'A different conversation'

INSPECTION

Passed

Failed



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

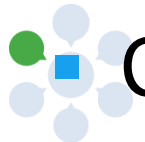
Training and Planning for QSWRs in Beaumont Hospital

- 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

Feedback: Clinical Nurse Manager 3

'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>

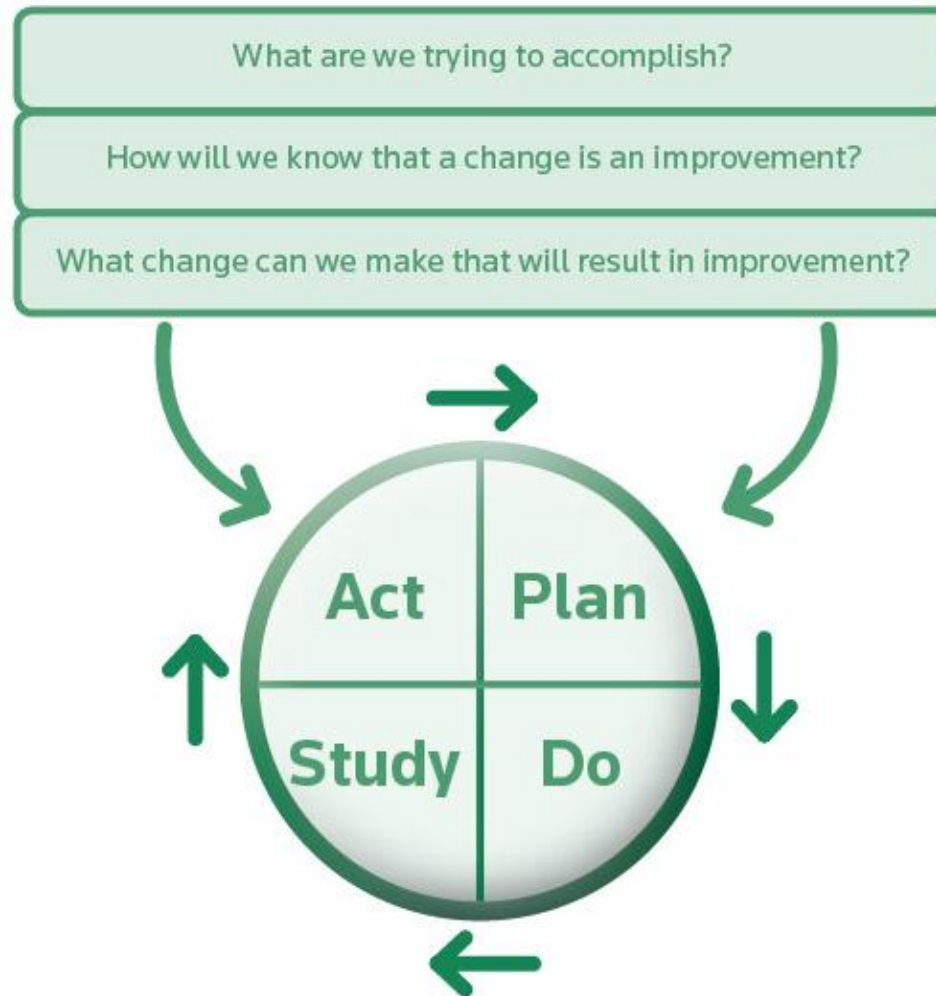


What worked....

- 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

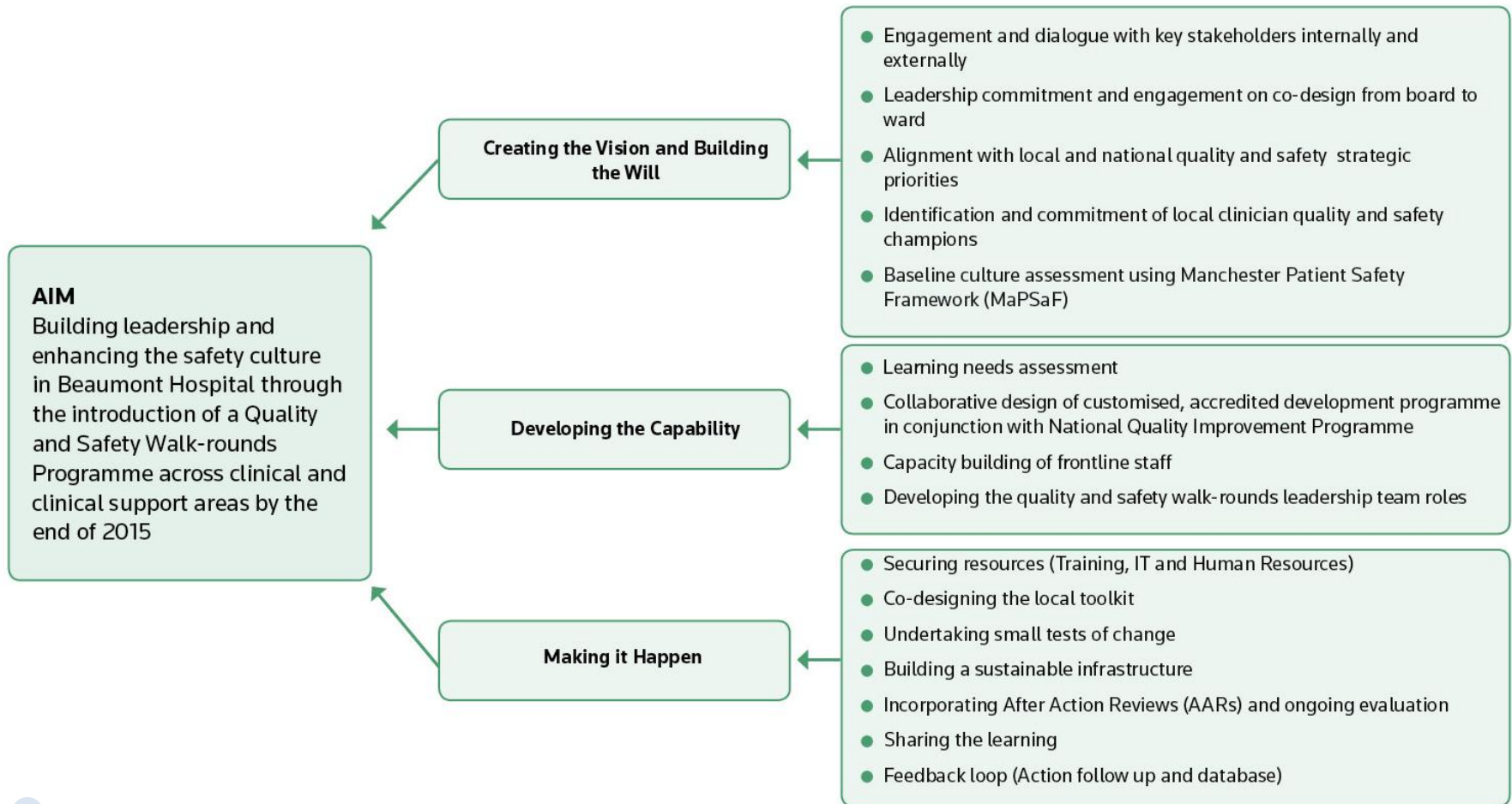


Method: Driver Diagram

OUTCOMES

PRIMARY DRIVERS

SECONDARY DRIVERS



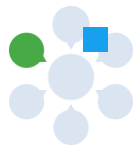
Challenges along the way

- 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

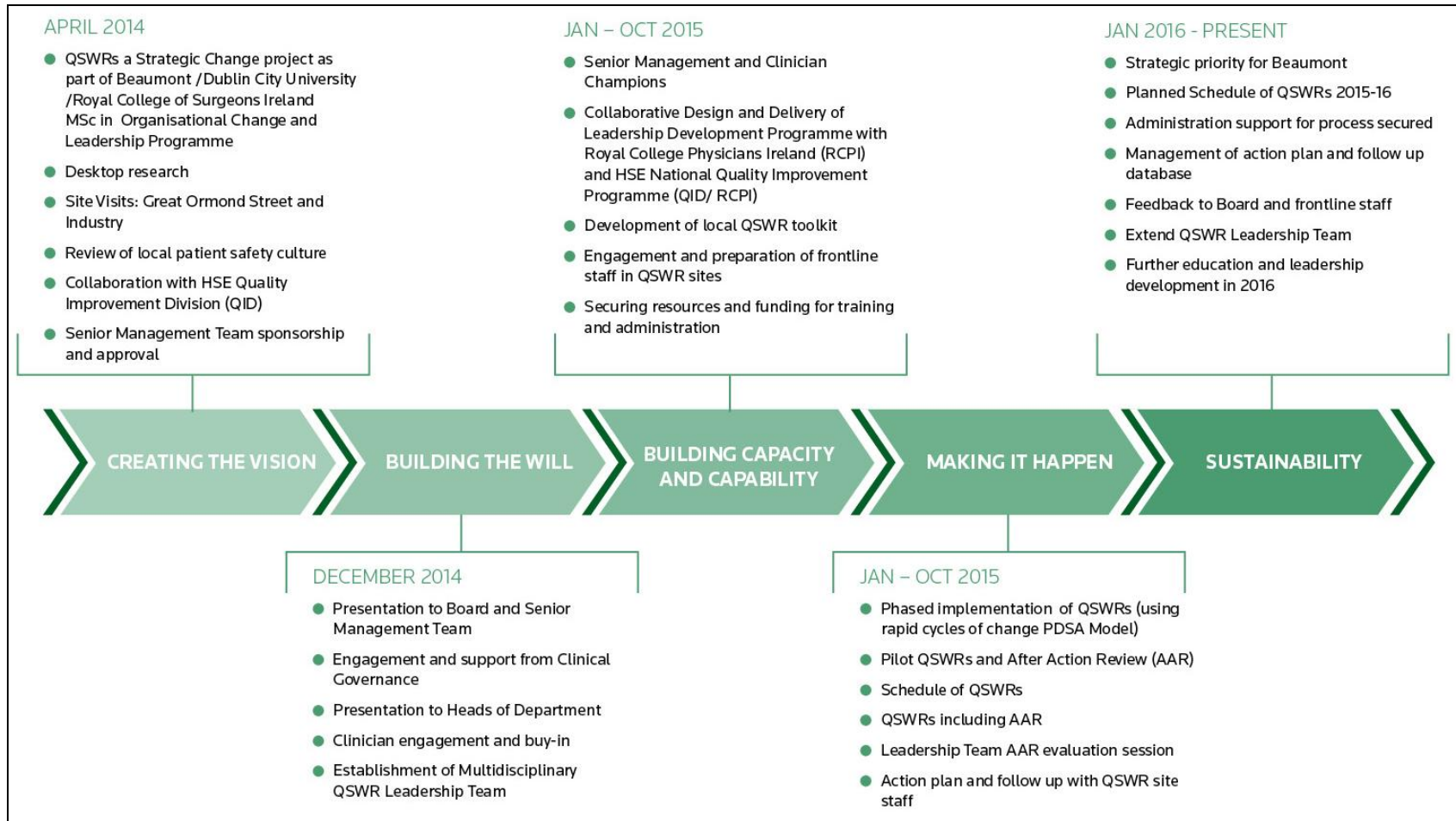


Critical Success Factors

- 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 Time Line



hello my name is...



Ms. Barbara Keogh Dunne

Patient Flow Manager, Beaumont Hospital

Introducing video conversation

Standing up in the Work Together

<https://vimeo.com/169731002>



hello my name is...



Dr. Fidelma Fitzpatrick

Consultant Microbiologist, Senior Lecturer RCSI

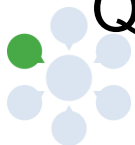
Introducing the *Panel and Your Questions*

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

