ORGANIZATIONAL FACTORS

Walk rounds

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Walk rounds on hospital wards were set up as part of the leadership work stream of the Scottish Patient Safety Programme (SPSP). Essentially, a walk round involves the executive team members taking part in weekly walk rounds to clinical areas to explore patient safety issues. An effective walk round aims to: increase awareness, make safety a priority, educate staff about patient safety concepts, obtain and act on information, close the gap between frontline staff and management level, as well as share learning across the organisation. The aim of this project was to evaluate the walk round service in order to refine the process of walk rounds and enhance their effectiveness.

Patient safety leadership walk rounds: an evaluation study

The research project encompassed three stages of data collection. First, a staff survey was designed and sent to the 18 hospital areas to capture staff views on the effect of walk rounds for themselves, their staff, and their work environment. Secondly, a semi-structured interview was designed and conducted with the members of stakeholders directly involved in the walk rounds (i.e., executives, ward staff and the public representative) to gain insight into their thoughts around the effectiveness of the walk round process. Thirdly, walk round reports filed in 2010 were systematically analysed to summarise the issues discussed and actions completed.

The results indicated that the walk round process was considered to be both valid and an acceptable way of producing continual improvement. The involvement of executives was reported as important to increase patient safety visibility and close the gap between senior and frontline staff. Finally, the walk round reports identified 89 issues which were grouped into 6 themes: Environment (e.g., storage, equipment, drug cupboards), infection (e.g., cleanliness, bed spacing), SPSP work (e.g., hand hygiene, patient care bundles), staffing (staffing level, training), patient (e.g., patient flow/transfer), and incident reporting on DATIX.

Publications

In preparation