Executive walk rounds open gates to communication with staff

Each year, diagnostic errors result in the deaths of an estimated 44,000 to 80,000 patients, and many thousands die because of teamwork and communication errors affecting their care or because they do not receive necessary evidence-based interventions,” according to an article published online last year in JAMA.

No one would argue that errors have disappeared or even decreased all that much since that article was published. But certainly it’s not for lack of effort, and some success has been achieved through a variety of patient safety initiatives.

Connecting C-suite leaders with all levels of OR staff through executive walk rounds (EWRs) at Johns Hopkins Hospital in Baltimore and New York-Presbyterian Hospital in New York City has opened communication channels between leaders and staff, inspiring process improvements and increasing patient safety.

Rounding with a purpose

“The purpose of executive walk rounds is to get the higher-level leadership together with frontline staff who can articulate concerns they have while taking care of patients every day,” Laurie A. Saletnik, DNP, RN, director of nursing for perioperative services at Johns Hopkins, told OR Manager. The 1,059-bed system includes 6 academic and community hospitals as well as 4 suburban healthcare and surgery centers and has 33 new ORs thanks to one of the largest-ever US hospital renovations.

Frontline staff can best identify where the risks are, and having executives round to meet informally with the staff can help remove barriers to solving problems. EWRs give frontline staff “face time” with executives and senior leaders. The rounds “help in forming relationships between the two groups, so you’re instilling a culture of willingness to speak up when there are things that are concerning,” Saletnik says.

Before EWRs were established at Hopkins, each unit held safety meetings with clinicians, but that forum was ineffective because the same individuals tended to participate each time. EWRs broaden the base of staff with whom the leaders interact.

A multidisciplinary team of executives representing surgery, anesthesia, nursing, facilities, environmental services, and epidemiology and infection control visits frontline staff weekly, according to Saletnik. They divide into 2 teams and round for 1 hour. One team puts on scrubs and rounds in the OR while the other team visits the preparatory and postanesthesia care units (PACUs) that serve that OR. Other areas where rounding occurs are intensive care units and central sterile and supply departments. They spend 30 minutes talking to people and asking about safety concerns.

Questions that they ask during their rounds include:

• How do you think the next patient might be harmed?
• What can be done to prevent it?
• What do you worry about?
• What is the 1 thing you would change to improve patient safety?
• What is 1 intervention from leadership that would make your work safer for patients?
During the next 30 minutes, the 2 groups come together along with anyone who participated during rounds to discuss what they learned.

**Getting a fresh perspective**

“When executives do the walk rounds, they often see something that the staff see every day but don’t question,” says Anthony P. Dawson, MSN, RN, vice president, operations, at New York-Presbyterian Hospital, a 6-hospital system with 2,478 beds and more than 4,500 attending physicians.

EWRs at New York-Presbyterian began in 2008 as part of the hospital’s “Patient Safety Fridays” program. The initial purpose of Patient Safety Fridays was to prepare for surveys, but the program has evolved into a patient safety initiative dedicated to providing better care for patients, Dawson told OR Manager.

“We do a combination of clinical and environmental activity. Our goal is to spend 20% of our week focused on patient and employee safety,” he says. A clinical education activity might be a presentation on look-alike/sound-alike drugs and how best to store them, whereas an environmental activity might focus on something like fire safety or corridor clutter.

Every manager, supervisor, director, vice president, and senior vice president across the organization participates in a Friday morning round focused on education and a tracer activity that takes place on some other day of the week, Dawson explains. Participants include clinical plus environmental services and engineering staff.

A tracer activity is an interactive experience between the person doing the tracer and 1 staff member at a time. The tracer tours the entire unit and may interview staff at any level, from support service staff to managers and physicians, he says. The interviews are brief, and leaders seek out different staff each time in an effort to get feedback from as many people as possible. The tracer also reviews the patient’s medical record with the staff and, when possible, may also interview the patient and the patient’s family.

Once a month, EWRs are done on nights and weekends (typically very early Monday morning). Reports are generated and disseminated to staff on a monthly basis, he says.

“The manager doesn’t round on his or her own unit; for example, the OR manager may round in the endoscopy suite or the cath lab, and those managers may round in the OR. This allows for a fresher perspective,” Dawson says.

“Often what happens in the prep area becomes an issue when it hits the OR, or

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**Resources for conducting executive walk rounds**


**Source:** Laurie A. Saletnik, DNP, RN, and Anthony P. Dawson, MSN, RN
what starts in the OR comes to a head in the PACU. [Rounding] gives us the whole sequence of care so we can have a robust conversation about the entire process,“ Saletnik notes.

Over a 17-month period at Hopkins, EWRs identified 204 issues of concern. Most were related to policies—for example, noncompliance, such as not following isolation protocols, or lack of clarification about policies. In an unusual instance, a patient reached the OR before staff realized a consent form was lacking. The problem, which stemmed from a miscommunication between the OR and the ICU team members, led to the development of a more formal handoff process with additional interventions to prevent a recurrence.

Sharing the data
Hopkins uses a SharePoint site, which lists all of the issues, persons responsible for addressing them, and the intervention. “We have a perioperative safety nurse who rounds with us, and it’s her responsibility to add the issues to the list after we’ve completed rounds,” Saletnik explains. Any staff member can then access the list, and there’s a good visual cue to see the status. When a line turns green, that particular issue has been resolved; yellow means it’s still being addressed.

New York-Presbyterian uses SurveyMonkey and Sentact to show which unit was surveyed and items that were found to be either in compliance or noncompliant. If there’s an engineering problem, a request is routed to engineering directly, Dawson says. Similarly, information is routed to the manager of the unit that was surveyed.

“When we report at the didactic session on Friday morning, the staff see overall results by area and by campus—we do this on all 6 of our campuses. When the Joint Commission comes and asks us to show how we’re trending safety data, we have a lot to show them,” he notes.

In addition, if an error occurs at any of the New York-Presbyterian hospitals, everyone across the system is informed so they can avoid making that error again. In the same way, solutions to problems are shared across units.

Seeing the progress
Over time, staff have gotten used to “the suits” being on the floor, Dawson says, and there has been an increasing willingness to share information with the leadership. At Hopkins, if an adverse event occurs, there’s a discussion about ways to prevent it from happening again, and staff are comfortable with that type of discussion, Saletnik says.

When someone identifies an issue that could potentially lead to a significant error, the person who has brought the issue to everyone’s attention is recognized, she adds. At New York-Presbyterian, a “best practices” presentation puts staff in the limelight for process improvements. For example, Dawson says, recently a manager from the neuro ICU presented on a decluttering initiative in her unit, which inspired others to follow her lead.

“We will soon roll out rounds on our inpatient units, and I’ll be participating in those,” Saletnik says. “We’ve found it helpful, in terms of identifying issues on a unit that might have been generated in the OR, to have the OR perspective on rounds that are outside of perioperative services.”

Building on success
For organizations that want to begin EWRs or improve their existing rounds process, Saletnik advises them to start small. “Don’t try to take on the whole organization at one time,” she says. “Not every organization will look the same. If you’re concerned
about how to begin, you can find standard questions in the literature so you can prepare a script for the leaders. If you’re going to take a group of individuals to the OR who’ve never done anything like this, you might start with 5 questions they can use to get the answers they’re looking for.” (See sidebar for list of resources.)

Saletnik says she did this initially at Hopkins, but after the first week or two, a script was no longer needed.

“Never underestimate the trust you have to build,” Dawson says. It’s important to educate the leaders so that they don’t alienate the staff by criticizing them.

Saletnik agrees, and she says follow-up is crucial. If staff identify problems and nothing is done to fix them, they’ll be less willing to talk next time rounds are done.

“This doesn’t take a huge amount of effort. It takes time. And the benefits on the back end far outweigh the amount of effort you have to put in on the front end. It doesn’t take a lot of resources. It takes a commitment from the leadership to take time to talk to the staff,” Saletnik says.

“It’s not just the big sentinel events that get reported, it’s also the near misses that occur, and when you do executive walk rounds, you need to think about those,” Dawson says. “We’ve been doing this for 5 years, and we’re still finding things every day. You’re never perfect.”

—Elizabeth Wood

References