

Leader Rounding: Creating a Safety Culture for Patients and Workers

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LEARNING OBJECTIVES

1. Discuss how intentional rounding embodies principles of high-reliability organizations.
2. Explain how to prioritize, escalate and resolve healthcare worker concerns with loop closure using visual dashboards.
3. Apply key principles of restoring joy to existing or new leader rounding programs.

Target Audience: CEOs, CMOs, CNOs, CQOs, Hospital Executives, Directors, Managers, Supervisors, Quality & Performance Improvement, and Patient Safety.

BACKGROUND & PURPOSE

- **Problem:** UMMC saw reductions in the **Teamwork** and **Hospital Management Support for Patient Safety** domains on the Agency for Healthcare Research and Quality (AHRQ) Culture of Safety Survey
- Burnout impacts >50% of U.S. healthcare workers and **causes reduced professional efficacy** and negatively influences patient, nurse, and organizational outcomes.^{4,9}
- Leader rounding with concern resolution and positive encouragement is associated with lower rates of healthcare workforce burnout and improved safety cultures.
- **Proposed Solution:** Create a **leader rounding** program to improve domains.

METHODS

- We **flipped the script** to find out what matters to our team members tracking both their **concerns** and **bright spots**.
 - Create **talking points** for leader and project managers
 - Ask team members **what matters to them**
 - Design **form** to document feedback
- We collected feedback from frontline team members by:
 - Partnering a **Leader** and a **Project Manager** for every round
 - Documented feedback using **form**
- Concerns resolutions were prioritized using a **Pick Chart**
- Display feedback on a **dashboard** tracking feedback themes and existing concern resolution process.
- **Loop closure** was provided to the unit or team member responsible for reporting concern.

RESULTS

- During **16 week** pilot, **22 Rounds** were completed, **111 Feedback** items were collected. (59% Concerns, 41% Bright Spots)
- **50% of concerns had themes of patient safety.**
- 26% of concerns led to organization change
- 30% of concerns under consideration for additional change

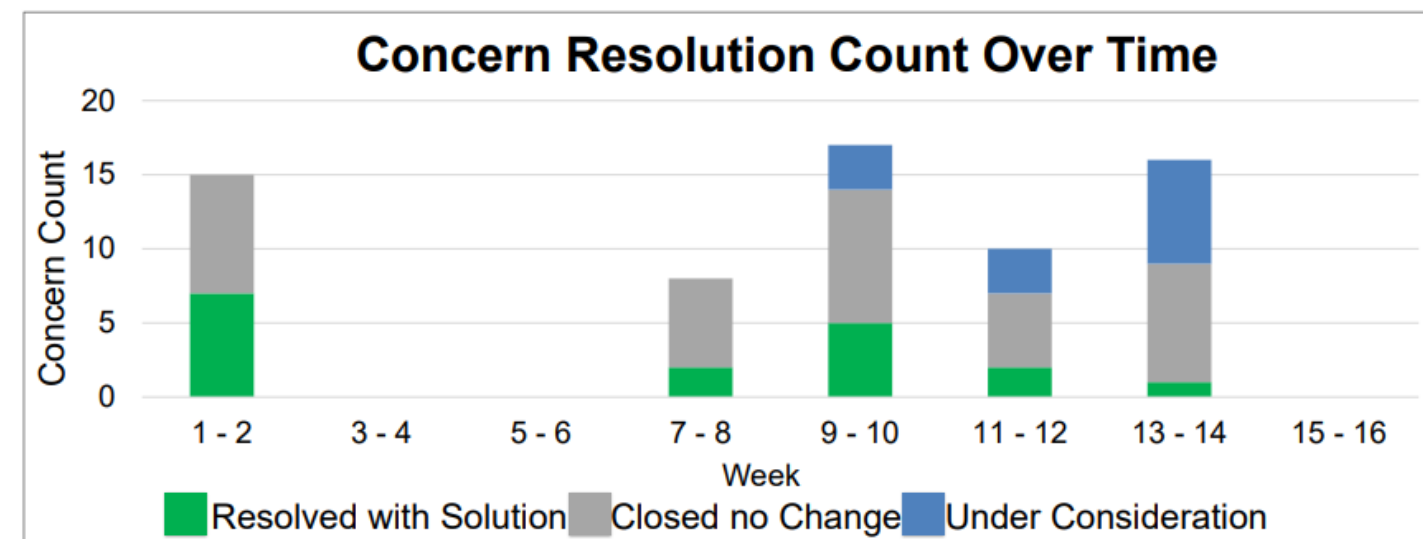
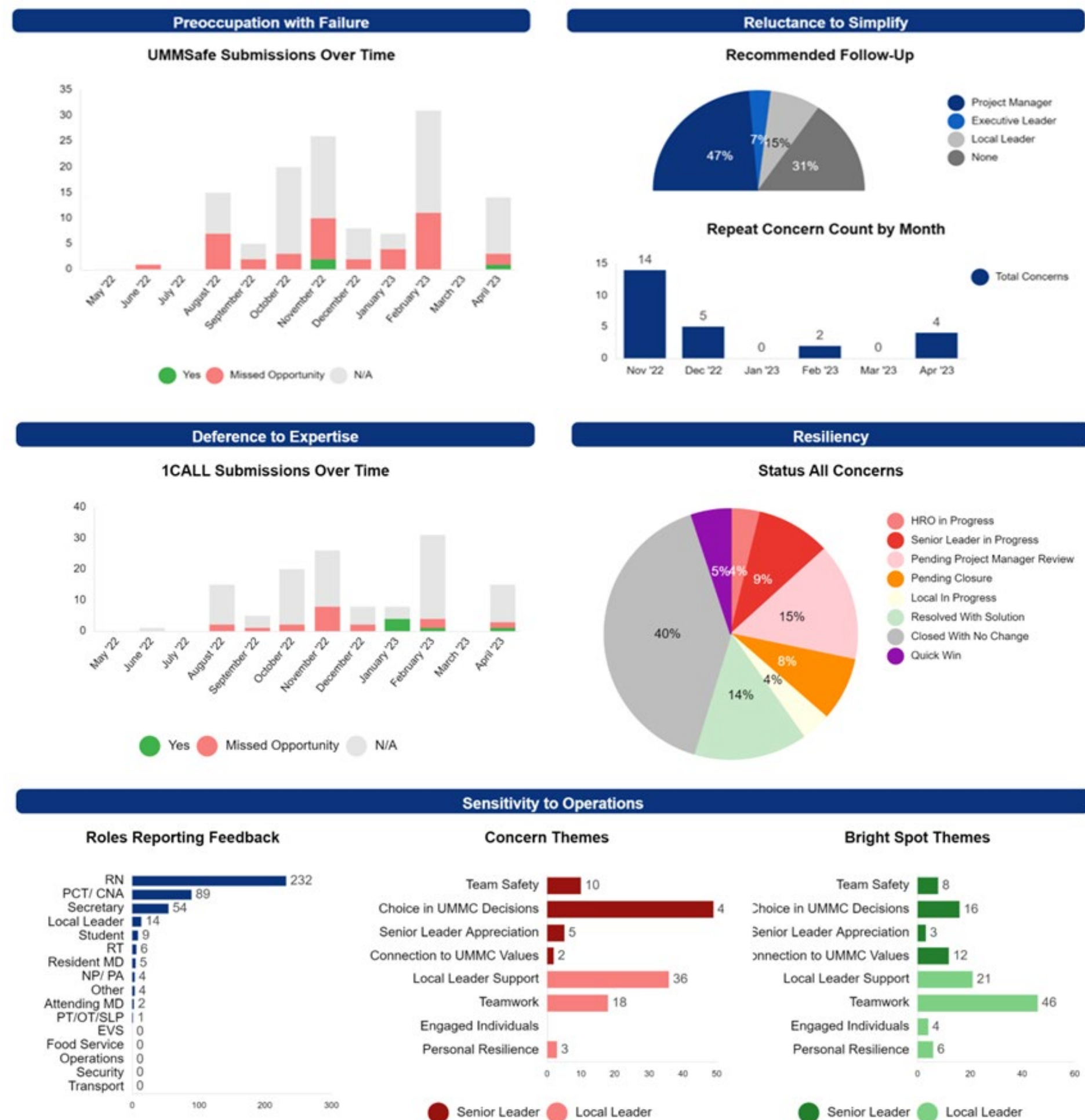
High Reliability Rounding: HRO Steering

STATUS DASHBOARD

"Staff are much more likely to be enthusiastic and positive about securing the best outcomes for patients when they feel supported, empowered, and respected." -D. Feeley IHI



Driving Toward Zero Harm



LESSONS LEARNED

- Engage executive leadership early for buy-in, project approval, and barrier to resolution escalation.
- Provide education and talking points for rounding leaders.
- Team members care about patient safety as shown in 50% of concerns had themes of patient safety.
- Classify progress in terms of High Reliability Organization Principles.
- Provide regular updates and loop closure with frontline.
- Use existing processes for issue resolution and escalation.
- You don't need to have all the answers, just start somewhere.

KEY TAKEAWAYS

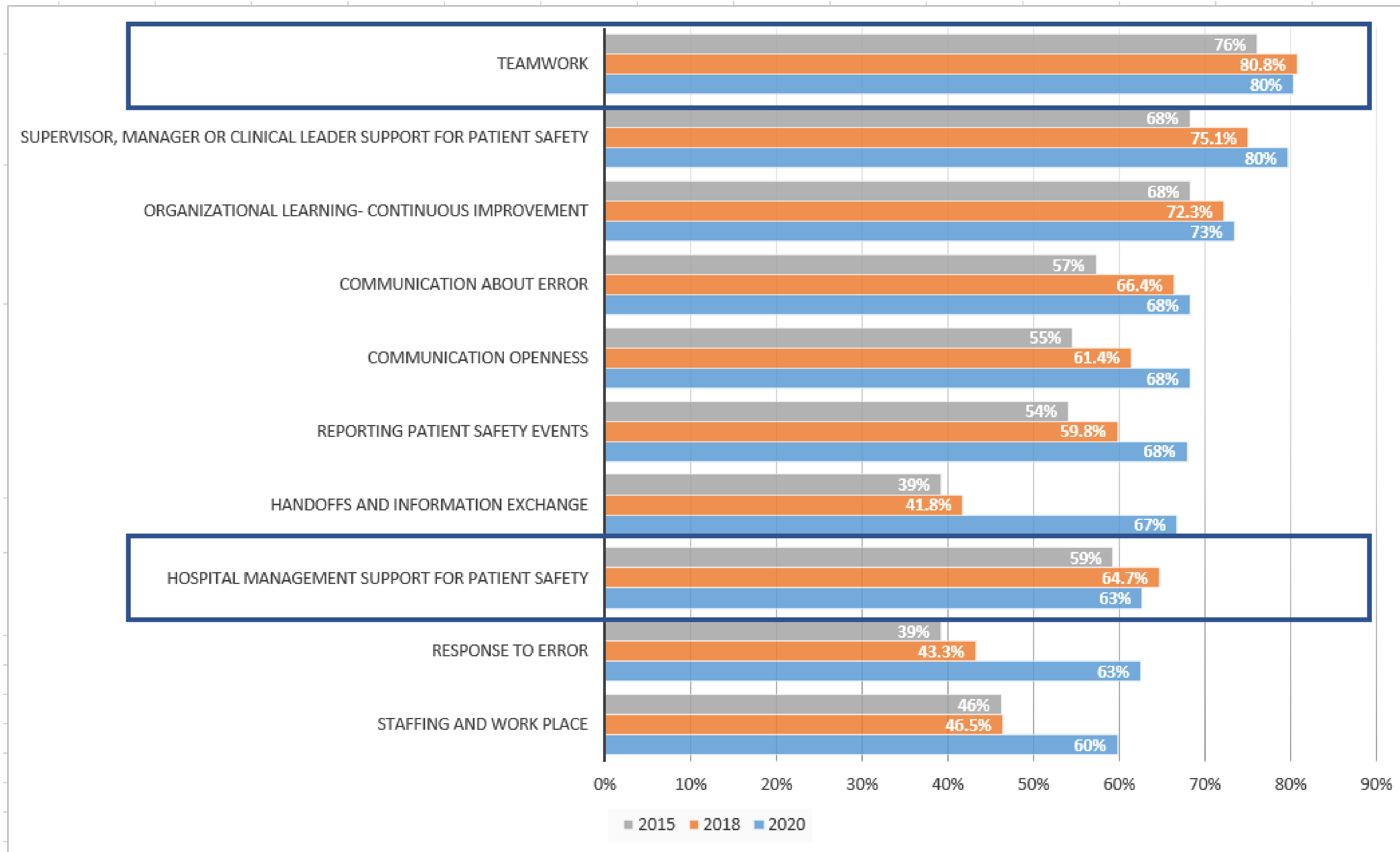
- Use purposeful **leader rounding** to improve **patient safety** and restore **joy in work**.
- Develop a **concern-resolution** system.
- Patient Safety is important to our workforce.
 - **50% of workforce concerns had themes of patient safety.**
- Workforce **burnout interventions** are **patient safety interventions**.
- The people closest to the work are the experts in their environment.
- **Finding the good** is just as important as finding the opportunities.

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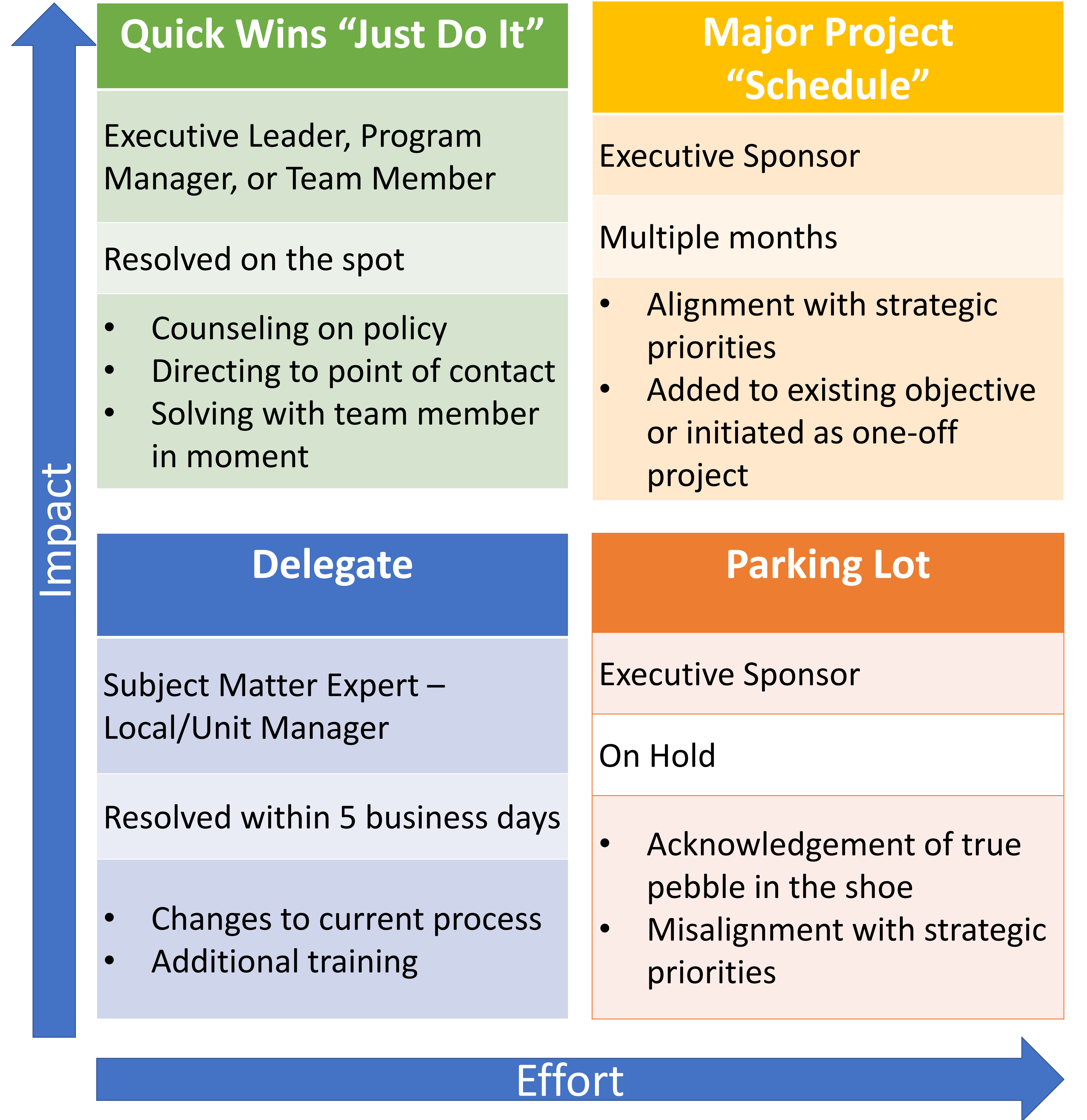
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Previous Rounding Limitations

- Concern prioritization
- Loop closure with team
- Organization between rounds



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Results

22 Rounds, 16 Weeks, 111 Feedback Items

- 59% concerns, 41% bright spots

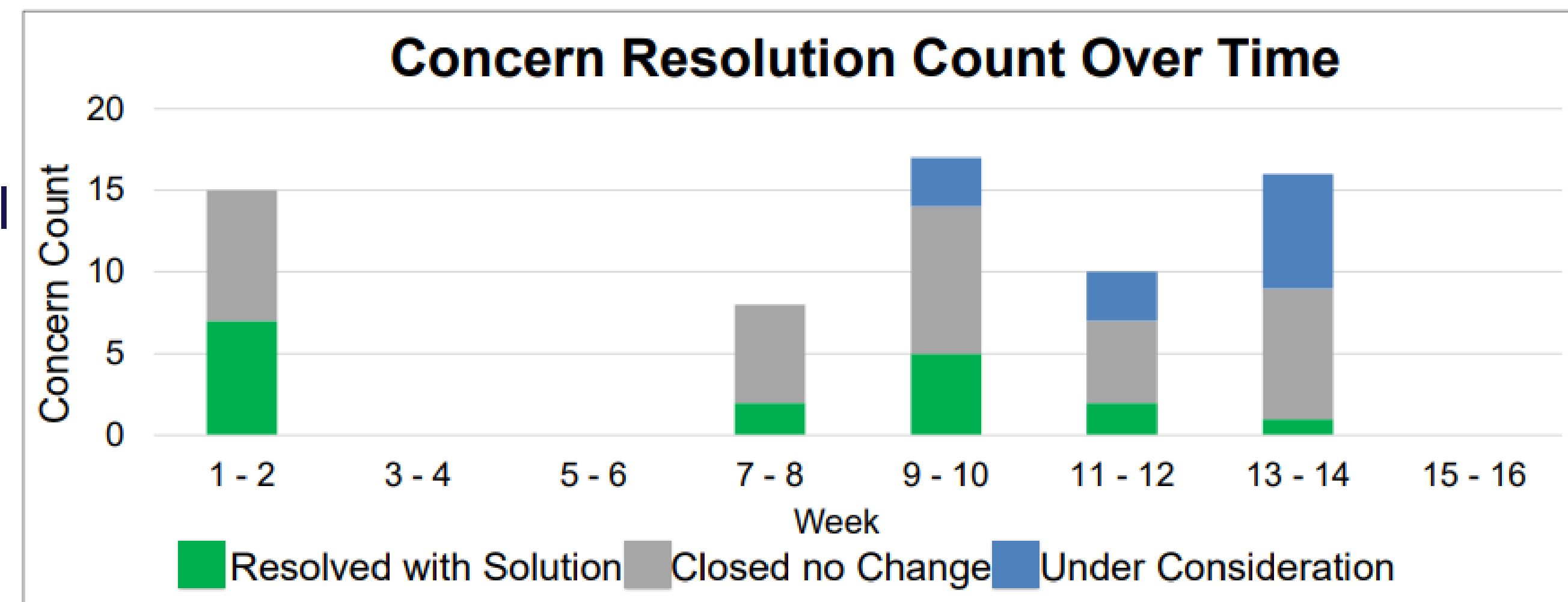
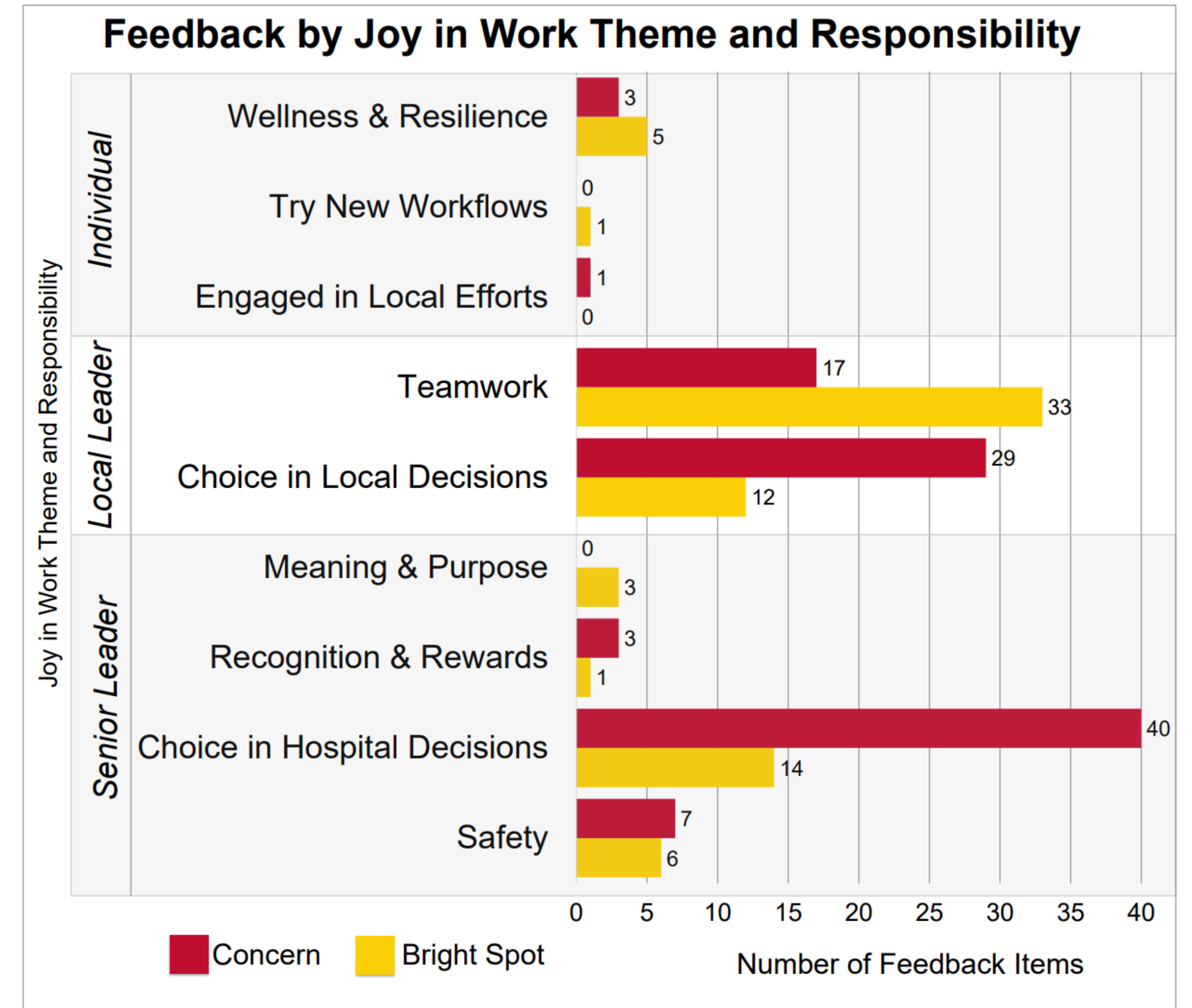
Concerns

- 61% Choice in Hospital Decisions
- 44% Choice in Local Decisions
- 26% Teamwork

Bright Spots

- 73% Teamwork
- 31% Choice in Hospital Decisions
- 27% Choice in Local Decisions

- 26% of concerns lead to organizational change
- 30% under consideration for additional change
- 50% had themes of patient safety



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