

Patient Safety Leadership Walkrounds: Promoting a Safety Culture in Developing Countries

Mohammad Saadati^{1*} (PhD Candidate); Mehdi Nouri² (MSc); Robert McSherry³ (PhD)

¹ Iranian Center of Excellence in Health Management, Student Research Committee. Department of Health Service Management, School of Health Services Management and Medical Informatics, Tabriz University of Medical Sciences, Tabriz, Iran.

² Road Traffic Injury Research Center- Shahid Mahallati Hospital, Quality Improvement Office.

³ Professor of Nursing and Practice Development, University of Teesside, Middlesbrough, England, United Kingdom.

Article history: Received: 02-May-2016, Accepted: 23-June-2016

Patient safety is the cornerstone of health care quality and governance(1).

Globally the emergence of what could be regarded as a 'patient safety movement' can be attributed to the following: firstly, health care organizations were trailing to develop and promote a positive attitude and safety culture(2). Secondly, a positive patient safety culture is one in which every individual, providing the care, should have the necessary knowledge, understanding and is competent in skills of risk evaluation and reduction.

Thirdly, where safety is a potential issue individuals should be encouraged and supported to promote changes through education and training(3). Fourthly, promotion patient safety culture interventions need to be rooted in the principles of teamwork, hospital leadership and behavioural change(4).

Finally, an effective way to translate clinical leadership into health care quality improvement and patient safety is to focus on promoting the principles aligned to a duty of candour into frontline practice (5).

Various interventions and strategies are available to improve safety culture(3). For example, Patient Safety

Leadership Walkrounds (PSLW) is a strategy engaging directly hospital leadership with frontline staff(4, 6).

A multidisciplinary team of hospital executives visit the patient care areas in hospital to observe and identify the current and potential risks and discuss with the frontline care providers to eliminate them. In a walkround, the team and staff discuss about safety issues only and they plan to improve safety issues (such as safety culture, equipment, patient safety, building safety and etc). Walkrounds show the commitment of hospital leadership and foster trust and psychological support for frontline staff(7).

The way forward for hospitals, especially in developing countries with restricted resources, where urgent interventions are required like patient safety leadership walkrounds. The aim of this initiative is to improve safety culture, care effectiveness and patients' outcomes. It brings leadership commitment to the frontline efforts to improve patient safety.

Keywords

Health care quality, Patient Safety Culture, Patient Safety Leadership Walkround

References

- 1- Currie L, Hughes R. Patient safety and quality: An evidence-based handbook for nurses. chapter. 2008;10:08-0043.
- 2- Vincent C, Amalberti R. Safer healthcare: Strategies for the Real World: Springer Open, Oxford; 2016.
- 3- Weaver SJ, Lubomksi LH, Wilson RF, Pfoh ER, Martinez KA, Dy SM. Promoting a culture of safety as a patient safety strategy: a systematic review. *Annals of internal medicine*. 2013;158(5_Part_2):369-74.
- 4- Frankel A, Graydon-Baker E, Nepl C, Simmonds T, Gustafson M, Gandhi TK. Patient safety leadership walkrounds. *The Joint Commission Journal on Quality and Patient Safety*. 2003;29(1):16-26.
- 5- McSherry R, Pearce P. What are the effective ways to translate clinical leadership into health care quality improvement? . *Journal of Healthcare Leadership* 2016;February 2016(11-17).
- 6- Janati A, Farid MSM, Saadati M, Yahyaie SM, Asadi P, Narimani MR, et al. An Evaluation of Patient Safety Leadership Walk-Rounds, Shahid Mahallati Hospital. *Depiction of Health*. 2013;4(4):20-5.
- 7- Frankel A, Grillo SP, Baker EG, Huber CN, Abookire S, Grenham M, et al. Patient safety leadership WalkRounds™ at Partners HealthCare: Learning from implementation. *The Joint Commission Journal on Quality and Patient Safety*. 2005;31(8):423-37.