

We celebrate the efforts of the organization as they develop noteworthy activities, practices, or processes that are innovative and tied to CCHSA's Quality Standards

## Patient Safety Rounds

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### ■ Patient Safety Rounds – Alignment with ROPs

- **Communication** – improve the effectiveness and coordination among service providers (inform and educate)
- **Worklife/Workforce** – create an environment that supports safe delivery of care (develop and implement a plan and process to assess patient safety issues)
- **Worklife/Workforce** – deliver education on patient safety to staff

### ■ Patient Safety Rounds - Background

**Patient safety culture** includes a blame free environment, a high awareness of safety issues at all levels, leaders encouraging the reporting of safety problems, and accountability for ensuring safety problems are addressed (Frankel, 2005)

**Patient safety culture elements:** leadership commitment to safety; organizational resources for patient safety; priority of safety versus production; effectiveness and openness of communication; openness about problems and errors; organizational learning; and frequency of unsafe acts

**Patient Safety Rounds provide a forum for front line staff** to share safety issues with leaders and receive feedback on progress of issues

### ■ Patient Safety Rounds -Demonstrating Successful Results

- Process:**
- Define
  - Align
  - Prioritize
  - Measure
  - Report
  - Communicate

### ■ Innovative and Creative Components

- Regular safety rounds
- Conducted by senior leaders
- Database management
- Program operations (scheduling and issues management)
- Communications and feedback
- Training about safety principles

### ■ Patient Safety Rounds

**Overall Goal:**  
To improve safety in the hospital

- Objectives:**
- To demonstrate to staff senior leadership **commitment to patient safety**
  - To create an **awareness of safety issues** by multidisciplinary staff within the hospital
  - To create an environment where staff **freely share information** about safety issues **without fear of reprisal**
  - To provide opportunities to **educate staff** about patient safety concepts
  - To identify and **take action** on patient safety issues and improve the reliability of care and support processes

### ■ This Practice Can be Adapted by Other Organizations

- Lessons learned:**
- Development of trust
  - 'Iron clad' process
  - Senior leadership buy-in
  - Advance schedule
  - Start small and build on success
  - Timely follow up
  - Accountability for action plan

