

Patient Safety Leadership WalkRounds™ and Patient Focused Methodology collaborate to creating a culture of safety.

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INTRODUCTION

We have practiced Patient Safety Leadership WalkRounds™ (PSLW) We have been implementing Patient Safety Leadership WalkRounds™ (PSLW) at Taipei Medical University Hospital since 2021. To ensure frontline staff understand, in conjunction with managers' participation to create a safety culture and encouraged clinical numbers to participate to report all adverse events.

Although the reporting of overall adverse events has made progress over the past few years, front-line healthcare workers' (HCW) participation in the reporting of near-miss events has been unsatisfactory.

The Department of Quality Management established the PSLW 2.0 in October 2023 by adding anonymous pre-surveys on staff's knowledge of patient safety reporting and conducting 15-minute internal audits using the Patient Focus Method(PFM), to improve the reporting rate of near-miss events and to re-emphasis the importance of patient safety and to enhance a safety culture.

METHOD

Participants: A total of 15 units were selected, which included 455 HCWs from 11 paraclinical units, and 4 clinical wards which had the least and highest adverse-event reporting rate. Unit managers, safety and quality officers and various key stakeholders responsible for medical quality were required to attend the interviews, whilst other HCWs were encouraged to attend.

Measure: Between January to August 2023, the adverse event reporting rate for all 15 units were collected. We also conducted pre and post PSLW surveys, which investigated the adverse-event-reporting awareness (AER) & the patient-safety culture awareness (PSC) of the unit. We assessed work norms, with a collection of subscale measures of awareness of adverse event reporting and the degree of patient-safety culture in the unit. Example question included information about what events needed reporting (e.g., no matter the incidents have harm incidents yet, I should report the event. etc.)" PSLW 2.0 typically lasts 1 hour, and incorporated a tracer process (e.g., Patient Focused Methodology, PFM), which emphasized the value of “direct observation of the clinical environment” and the “chatting” with a wide range of stakeholders including both the frontline staffs and managers.

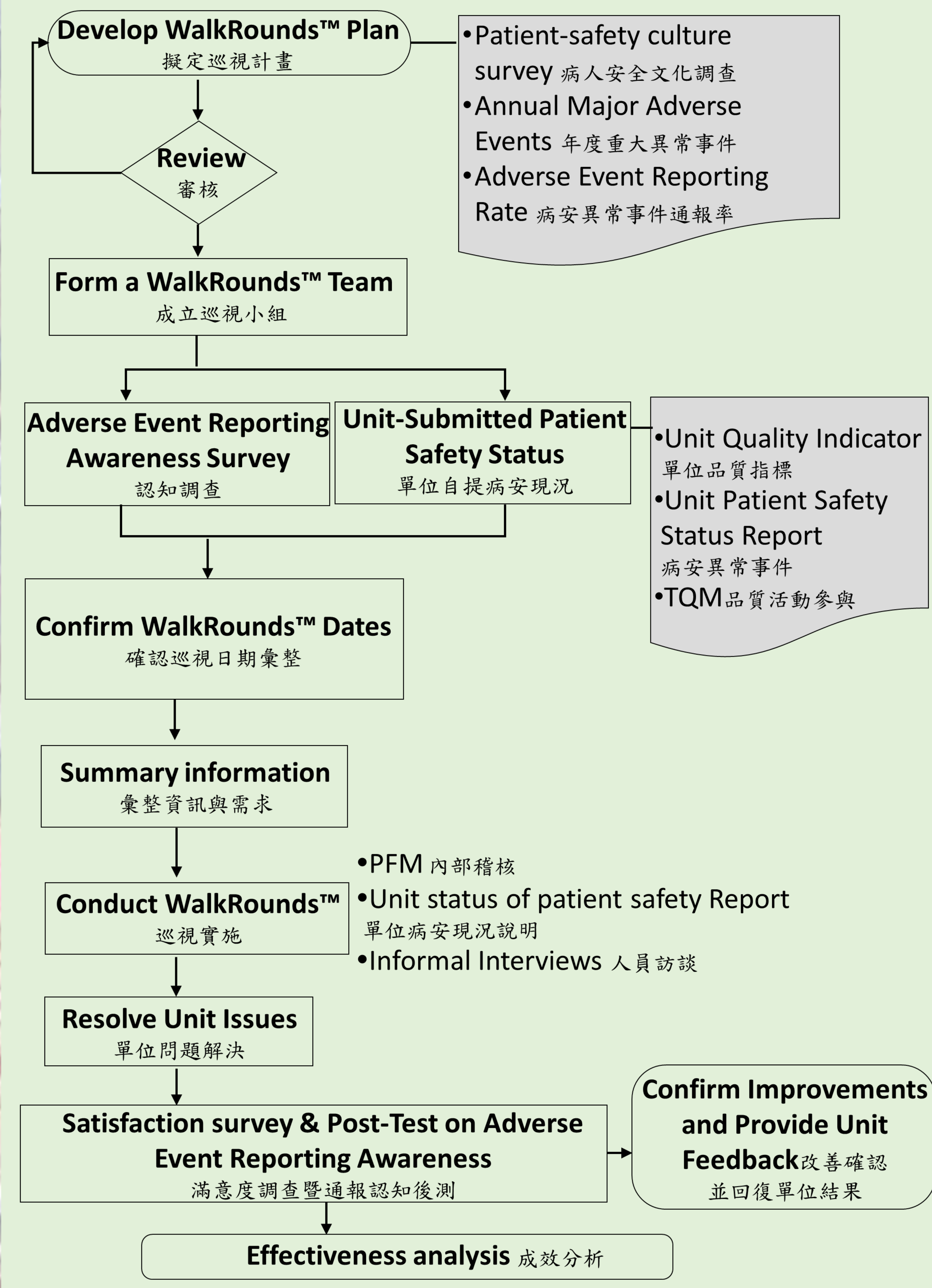
RESULTS

The PSLW 2.0 took place between October 20th and November 23rd 2023. There were 136 staff members who participated in the PSLW, with a 89.9 percent response rate for the adverse-event-reporting (AER) awareness survey. The most positively perceived dimensions in the AER survey were 「Hospital management will pay attention to responds and take action to address patient safety concerns」, which is at 64.3 percent. Followed by 「managers support for the reporting member when patient has an adverse event」, which is at 60 percent. The following dimensions showed significant improvement (p<0.001) after the PSLW2.0. These were “have an award after the report”, ”need to implement the notification for adverse event“ and “No harm incidents don’t need reporting”.

The adverse-event reporting rates also showed improvement from 0.13 % to 0.14% across 4 clinical wards. At the clinical support departments, the adverse-event reporting was showing improvement from 104 to 138 every month, the near miss reporting average increase 21 every month.

The Safety Climate in the (PSC) survey, clinical wards had is fall 0.86 point and the clinical support departments had is rising 2 point. The other side, ”The manager of this departments won’t omitted the patient safety” showed shrunk between the pre & post PSLW2.0 surveys.

Additionally, all issues identified during the rounds were addressed within a month, and feedback was provided to the departments. This made the frontline staff feel valued and supported by the hospital, effectively enhancing their willingness and timeliness in reporting.



	The clinical wards			The clinical support departments		
	2022 (N=59)	2023 (N=58)		2022 (N=226)	2023 (N=247)	
The Safety Climate	74.8	73.94	-0.86	78.44	80.44	+2
The manager of this departments won't omitted the patient safety	79.2	77.2	-2	81.7	80.3	-1.4

CONCLUSIONS

At Taipei Medical University Hospital, we combined WalkRounds with PFM in PSLW 2.0. We demonstrated that through this method, the adverse-event reporting rate and the patient-safety related awareness were improved in all the participating units. Positive response from frontline workers was also obtained via the facilitated resolutions of important clinical problems which further enhanced mutual trust across clinical units in our hospital.