Infection prevention and control (IPC) walk rounds

Te ārai me te whakahaere pokenga ngā hīkoi āmio (IPC)

Toolkit and implementation guide

Te kete taputapu me te pukapuka tātaki mō te whakamahi

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Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

New Zealand Government

Contents | Rārangi take

About this document | Mō tēnei pukapuka

This document is a resource guide for implementing an infection prevention and control (IPC) walk round programme.

It is designed to help hospital staff plan and engage executive and senior leaders in IPC walk rounds, capture problems, opportunities and suggestions, and develop and implement improvements.

The document includes guidance on process, roles and responsibilities, actions and reporting, and templates to support planning and implementation. The suggested process and tools will encourage open communication and support agreed actions across all levels of staff, including senior leaders, frontline staff, infection prevention team members and ward and department clinical and operational leaders.

We welcome your questions, feedback and success stories. Please contact the IPC senior advisor at the Health Quality & Safety Commission (IPC@hqsc.govt.nz).

Introduction | Kupu arataki

Improved patient care is an integral part of an organisation's focus on infection prevention and control (IPC). Increasing an organisation's commitment to IPC includes activities such as:

- sharing healthcare associated infection (HAI) surveillance results
- highlighting the consequences of increasing antimicrobial resistance
- empowering frontline staff to optimise processes, tools and measures.

Good communication between all levels of the health care system is critical for making IPC an organisational priority and consistently following best practice. Two-way communication between health care executives and frontline staff can quickly identify, document and solve problems for continuous and rapid improvement.

IPC walk rounds are an effective way to improve open communication and problem-solving of issues related to infection prevention. Recommendations arising from walk rounds can inform quality improvement projects (Blackburn 2013) and support evidence for delivering mandatory standards.[1]

The role of senior leaders

Senior leaders (clinical leaders, executives and suchlike) must understand the effect they can have on a ward's learning environment. Their interactions with frontline staff provide an opportunity to foster psychological safety, which can result in collaborative problem-solving to reduce barriers to implementation (Knobloch 2018).

Senior leaders can help create a culture where IPC concerns and problems are openly discussed and resolved. Staff appreciate the time senior leaders spend at the ward level. An effective partnership between senior leaders and frontline staff is essential for gaining an understanding of staff concerns and for engaging with frontline workers and managers to resolve obstacles (Tucker and Singer 2015).

Direct conversations between senior leaders and frontline staff also encourages all staff to feel they can speak up and contribute to improving the services they provide. 'Flat' organisations tend to be more nimble at quality improvement.

The 'flat' theme helps to describe the core objectives of IPC walk rounds:

- **F**eedback
- **L**istening
- **A**ction
- **T**imeliness.

1 For example, the NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards (Standards New Zealand 2008).

The benefits of IPC walk rounds | Ngā hua o ngā hīkoi āmio IPC

The main purpose of IPC walk rounds is to improve an organisation's health care outcomes through the identification, prevention and mitigation of patient and staff harm. The informal discussions that occur in walk rounds highlight opportunities and solutions and, ultimately, create a culture where IPC is everyone's priority.

IPC walk rounds also have clear benefits for senior leaders, frontline staff and IPC teams. They ensure problems are identified and resolved, and establish lines of communication between everyone involved. This creates transparency and continuous improvement and allows the collection of actionable data. Discussing opportunities for improving IPC helps promote a culture for change.

Other benefits include:

- increased IPC issue awareness by all clinicians
- prioritisation of IPC by senior leadership
- collection of staff information about barriers to effective and consistent IPC practices
- action on information obtained from staff
- sharing of IPC best practices across an organisation
- generation of ongoing continuous feedback between frontline providers and senior leadership, including actions implemented by the organisation as a result of past feedback.

The outcome of IPC walk rounds is engaged staff who are open to discussing challenges on the ward and willing to problem-solve with top leaders (Edmondson 1999). Overall communication and collaboration among all levels of a health care organisation will increase and improve the safety culture and IPC practices.

The walk rounds concept | Te ariā o te hīkoi āmio

Management by walking around

'Management by walking around' is effective for engaging staff because it is an active form of management, as opposed to the open-door policy, which is more passive and typically ineffective (Advisory Board 2011). By visiting staff on their ward, senior leaders send a clear message of their interest and desire to be actively engaged in IPC initiatives that improve health care outcomes. Leaders may need first-hand feedback on problems and obstacles, required resources and more effective measures to help implement the organisational change from the current state to the desired state of infection prevention.

Patient safety walk rounds: a process used internationally

Patient safety walk rounds have been performed by senior leaders within health care organisations for many years. The concept was developed in 1999 by the Institute for Healthcare Improvement and gained momentum with the work of Frankel et al (2003, 2005). The structured process brings senior leaders and frontline staff together via informal hallway or individual conversations that discuss patient safety topics and propose solutions (Advisory Board 2011).

Walk rounds help to identify safety opportunities and support a culture of safety (Frankel et al 2005). Typically, senior leaders (executives) make rounds on assigned wards and/or departments and discuss safety problems with ward staff. The senior leader then helps the ward staff and clinical and operational leader prioritise and resource needed improvements, based on the opportunities raised by staff. Action plans are developed and implemented. Questions or topics related to infection prevention may be included in these informal discussions but are not usually the main focus of the walk rounds. It is important for the discussions between senior leaders and frontline staff to be targeted so problems and potential solutions about IPC can be identified and discussed.

Using frontline staff knowledge

Frontline staff in a clinical area understand better than anyone current system inefficiencies and failures that could potentially harm patients. They can also suggest ways to resolve or mitigate those inefficiencies and failures, and improve processes. The strategy for IPC walk rounds puts the people who experience the obstacles in front of the people who can remove barriers (Washington State Hospital Association 2013).

The idea for IPC walk rounds is to engage in open discussion and not carry out an assessment or inspection. Information discussed during IPC walk rounds should be anonymous unless there is immediate risk to a patient or possible staff harm that would require action and reporting. The IPC walk rounds should focus on exploring and discussing the frontline staff's understandings about systems failures related to IPC processes and the opportunity to learn and improve, not on individuals or blame.

Many infection prevention programmes in hospitals involve the IPC practitioner or specialist liaising between frontline staff and senior leadership. Conducting regular IPC walk rounds, led by a senior leader, provides a direct communication link between leaders and staff working in the area where rounds are occurring. This connection helps to clarify perceptions and mitigate potential miscommunications about problems.

Actions for improvement

During a walk round, staff are encouraged to highlight issues relating to process inefficiencies or weak points where potential improvements in practice could be implemented. The information gathered through these insights can help to identify where to allocate resources to improve IPC processes. The aim is for IPC problems to be dealt with at a local level with support from the senior leadership team.

Actions resulting from walk rounds will vary from small to large. The perception may be that small interventions are less effective, but any improvements show that leadership is listening to staff. This increases their willingness to participate and offer suggestions in future walk rounds.

Sometimes optimising processes through small improvements requires a multidisciplinary effort that is beyond the capacity of an individual or ward but is achievable through help from leadership (Tucker et al 2002; Tucker 2004). While addressing small actions may seem to have little effect, the alliance formed between frontline staff and senior leadership may eventually make it easier to accomplish major improvements.

Roles and responsibilities | Ngā tūranga me ngā kawenga

Each member of the walk round team has a specific role (see Table 1) to ensure walk rounds are successful (World Health Organization 2016). To achieve the intended objectives, it is important that each team member actively participates in the walk round process.

IPC walk rounds should include employees with specific functions or jobs (eg, nursing, doctors, housekeeping, pharmacy, respiratory therapy) because this establishes a multidisciplinary approach to problem-solving.

Table 1: IPC walk round team member roles

Team member	Role(s)
Senior clinical and operational leaders: CEO, COO, CMO, DON or other senior leader delegates (executive directors or general managers)	Clearly and publicly promote communication and understanding with frontline staff about IPC risks and priorities.
	Commit to the IPC walk round process by leading the discussion and taking accountability for the implementation of shared actions from an IPC walk round.
	Promote the active participation of frontline staff in improving their IPC-related work processes and environment.
	Enable and support the team to deliver safe, high-quality care through continuous improvement.
	Quietly listen and encourage staff to share concerns and state ideas. The types of topics discussed will be influenced by the specific senior leader's participation and their background and experience. Successful walk rounds occur, regardless of whether leaders have clinical or non-clinical backgrounds.
IPC practitioner	Coordinate and manage the walk round process.
	An individual (eg, IPC practitioner or lead) should participate in all IPC walk rounds.
	Supply, in advance of the walk round, a summary to the senior leader and ward/department clinical leader of any HAI surveillance results or IPC process measures monitored for the ward or area where the walk round will take place, if this is not already available to these individuals.
	Supply a list of sample questions to the senior leader and ward/department clinical leader manager.
Clinical and operational team leaders of wards and departments (middle management)	Advise the IPC practitioner of best days/times for walk rounds, then communicate and promote the walk rounds with frontline staff once scheduled.
	Review ward HAIs, IPC process measures data and sample questions with staff who plan to participate in walk rounds.
	Work with frontline staff to determine which of the actions that have been discussed among senior leadership and their direct reports will be implemented within a specific timeframe.
	Communicate completed and ongoing actions and initiatives with the IPC practitioner and senior leader.
Scribe (could be IPC practitioner colleague or other staff member)	Document IPC walk rounds, including location, participants, topics discussed (including problems and proposed actions) and any other factors that may be pertinent to the context when reviewing comments.
Frontline staff	Actively identify the problems, opportunities and solutions.
Patients, families and whānau	May participate in the conversation and provide feedback.

Notes:

- Senior leaders with a clinical background are important participants but other executives, such as the chief financial officer and chief information officer, would also benefit from these walk rounds.
- All possible personnel (from doctors to domestic/cleaning staff) should be included in walk rounds. They should be encouraged to think about potential problems, opportunities and solutions.
- In some cases, patients, families and whānau can be considered to participate in the walk rounds. This will depend on the patient clinical situation, and family/whānau availability and interest in joining the conversation and providing feedback.
- CEO = chief executive officer; COO = chief operating officer; CMO = chief medical officer; DON = director of nursing; HAI = healthcare associated infection.

Senior leaders and ward/department clinical leaders

Well-respected senior leaders, who are able to engage frontline staff, share specific personality characteristics (Frankel et al 2003). They:

- exhibit fallibility (allow frontline staff to be the experts in their day-to-day work)
- model curiosity by continuing to ask questions
- are active listeners
- are approachable and genuine
- use supportive language (how they as leaders can potentially help in overcoming the barriers raised by staff)
- support a learning environment and culture that facilitates psychological safety, which promotes situations where employees share ideas and information and offer support to each other with the goal of quality improvement (Edmondson 1999; Aranzanmendez et al 2015)
- engage in reflection and evaluation for further process improvement.

Some ward/department clinical leaders might feel challenged that senior leaders are leading rounds and engaging with frontline workers directly. This risk is lessened if IPC walk rounds engage clinical leaders as hosts and guides for senior leaders. These clinical leaders can also act as leaders in the development and implementation of strategies that address IPC obstacles. Including clinical leaders in both the education and process reduces the chances of their feeling excluded or thinking the walk rounds are a mechanism for senior leaders to find fault with them (Rotteau et al 2014).

Frequency and timing of IPC walk rounds | Te auau me te wā o ngā hīkoi āmio IPC

Ideally, IPC walk rounds will be scheduled regularly. The frequency of walk rounds for each organisation will need to reflect the size and complexity of services that it delivers. For large organisations, they may take place a minimum of 12 times per year. Smaller organisations will need to adapt the frequency to work with lesser departments and number of staff. They should also:

- be scheduled well in advance and allow for rotation of the senior leadership team for easier scheduling (Flynn 2014)
- allow for adequate allowance of time for conversations with staff from all disciplines (Montgomery 2008). This may take 45–60 minutes per walk round
- vary in frequency, depending on organisation size. It is preferable to schedule IPC walk rounds regularly with rotating senior leaders
- occur as scheduled and not be cancelled. Regularly scheduled walk rounds ensure staff at all levels recognise that IPC is an organisational priority and focus on quality improvement. Senior leaders can be rotated in order for walk rounds to go ahead as scheduled; for example, if an urgent meeting comes up and conflicts with a particular leader's attendance at the walk round, another senior leader can attend in their place at the agreed walk round time (Rotteau et al 2014). Maintaining the walk round schedule will further engage frontline staff because they will see it is the organisation's priority.

Scheduling

Times scheduled for IPC walk rounds should be dependent on frontline staff availability, with careful thought given to nursing shifts, lulls in activity and when doctors perform clinical rounds. Avoid peak times so staff can participate without compromising patient care.

In addition to walk rounds being scheduled during the day, early morning, late evening or weekend walk rounds are a good way for senior leaders to interact with staff from night and weekend shifts. Because these shifts are usually less staffed, walk rounds could occur consecutively on two different wards during one event, so leaders can maximise their exposure to staff.

Several days before the scheduled walk rounds, staff in the ward should be made aware of the purpose and given a list of sample questions.

Location of IPC walk rounds | Te wāhi o ngā hīkoi āmio IPC

Walk rounds should be performed in all areas that affect both clinical care and IPC processes (particularly high-risk areas). For example, in a secondary care organisation, the areas include:

- patient care wards
- operating theatres
- emergency departments
- day stay and other outpatient areas
- laboratories.

Organisations will need to determine which wards or departments will start the process. Certain wards may be prioritised, based on their IPC data or identified IPC risks. Eventually, and ideally, each ward would be involved in IPC walk rounds on a regular basis.

Staff should choose the specific location of IPC walk rounds, which may be based on the number of attendees. Central areas within a department such as nursing stations, patient care corridors/hallways or next to the ward quality board are good public places that help to increase the visibility and importance of IPC walk rounds and the senior leadership prioritisation and investment in infection prevention. They also allow the senior leader to see the high amount of activity in the ward. Other, less public, options could be an empty patient room, nearby meeting room or break room to limit distractions (Frankel et al 2003).

The IPC walk round process | Te hātepe mō te hīkoi āmio IPC

Starting out

Starting an IPC walk round initiative in your organisation will take planning and communication with individuals on the rounding team. A strong communication plan is essential for the success of any walk round initiative and should be informed by each organisation's typical communication approach. IPC practitioners must initiate communication of the IPC walk round idea with senior leaders and clinical and operational leaders.

Planning, discussion and follow-up are important steps for ensuring that IPC walk rounds are successful and seen as a meaningful and worthwhile activity. An environment where staff are able to hold open conversations will help them feel psychologically safe and lead to acknowledgement and problem-solving (Edmondson 1999). This disclosure and problem-solving will then guide the adoption of sustainable evidence-based best practice that reduces the incidence of HAIs (Frankel et al 2003).

Some organisations may already have patient safety walk rounds. If patient safety walk rounds are already regularly conducted in your organisation, it may be necessary to clarify the purpose and expectations of both patient safety and IPC walk rounds. Because IPC walk rounds may overlap on location and be in close time proximity to patient safety walk rounds, it will be important to reduce confusion among staff (Edmondson 1999). Once an agreed plan is developed, brief staff so they understand the initiative's objectives and their importance. Staff briefings, newsletters, notice boards, team meetings and intranet communication can be used to promote the IPC initiative.

If IPC walk rounds with senior leaders have not been performed in your organisation, it may be worthwhile completing a 'pilot' to test and improve the concept and process. Informal conversations, documentation of topics and action identification, along with feedback to both senior leaders and frontline staff, should be trialled. Once the process has been tested, communication should be sent organisation-wide to introduce the plan for implementing IPC walk rounds.

Set the ground rules

There are important ground rules to be followed in an IPC walk round (Quality Improvement Division, Health Service Executive 2016).

- It is an open discussion related to IPC and not an assessment or inspection.
- It is an opportunity for staff to express concerns on behalf of patients and themselves.
- Everyone is allowed to voice concerns.
- IPC concerns should be acknowledged by senior leaders during walk rounds.
- Senior leaders actively listen and foster a proactive approach to identifying and minimising risk for potential harm.
- Senior leaders communicate and ensure the anonymity of information discussed in walk rounds.
- Senior leaders and IPC practitioner share key learnings from walk rounds with other wards/departments and teams.
- IPC practitioner ensures prompt closed-loop feedback with the senior leader, clinical and operational leader and staff.

Staff concerns and leadership feedback

Although all concerns expressed by staff should be heard compassionately, an effort should be made to lead conversations to focus specifically on IPC-related problems, resource constraints and process improvements. To share the concepts discussed during walk rounds, participating staff should be asked to share the purpose of IPC walk rounds and their experience with colleagues who they work with. These casual discussions help with socialising the concept and purpose of walk rounds.

Once prioritised, actions should be monitored. Regular updates should be provided to the leadership team on where and when walk rounds took place, the topics discussed, and actions planned and implemented.

A fundamental component of the walk round process is the feedback loop. This involves senior leaders making sure the opportunities highlighted during the walk round remain a priority and to check in or provide updates directly to staff or through the clinical and operational leader (Washington State Hospital Association 2013). Actions are only complete if they have been communicated back to frontline staff. These updates can be provided through various forums, such as staff meetings and/or departmental communications.

It is important that feedback is acknowledged and actively addressed (or ongoing discussions are occurring), for staff to continue to voice open and honest problems and potential solutions. While many different opportunities and actions will be identified during walk rounds, some will not be suited to immediate or short-term fixes, such as staff-shortage complaints or significant architectural changes. Even though some problems may not be resolved because of the lack of simple solutions they should still be documented.

Findings

Findings from walk rounds should be disseminated and discussed at appropriate management, leadership committee or team meetings (Montgomery 2008). An existing clinical governance committee/group led by a senior leader should be identified to review and track actions resulting from IPC walk rounds. IPC walk rounds should be a standing agenda item for this committee.

Discussions related to IPC walk rounds will help to advertise their benefits and highlight opportunities for process implementation in other wards. The IPC committee should also review the walk round data to determine opportunities for transferring best practices across the organisation.

IPC walk rounds can be modified over time, based on evaluation and process optimisation (Frankel et al 2003).

Socialising IPC walk rounds

Some of the difficulties associated with walk rounds such as scheduling and open communication can be avoided by socialising the concept and gaining buy-in from all staff involved. Keeping the logistics of the activity simple and informal will create open and relaxed conversation. It is important to consider the patient care workflow and to perform walk rounds during off-peak hours or when staffing is at the appropriate level. Asking specific and appropriate questions helps to avoid vague responses.

Communicating success

Communicating the results of IPC walk rounds encourages leaders and staff to continue participating. Potential success measures may be tracked to determine how well IPC walk rounds are working in your organisation. The number of IPC-based changes made by department clinical leaders or wards per year is a process measure that can be easily collected and reported. Outcome or process measures specific to IPC, such as HAI surveillance rates, hand hygiene or bundle compliance, can also be correlated with IPC walk rounds, especially if completed actions are associated with those measures.

Your organisation can share its success stories with the Health Quality & Safety Commission for further sharing with other health care organisations. Success stories might be a one-page document that discusses:

- the specific IPC situation the ward or facility faced
- the problems identified
- the implications of the problems
- how the need was identified, communicated and resourced or solved through the IPC walk round
- the measure of improvement that resulted from the actions taken to address the initial problem.

Successful examples could also be made into short videos that highlight best practice and the benefits of IPC walk rounds.

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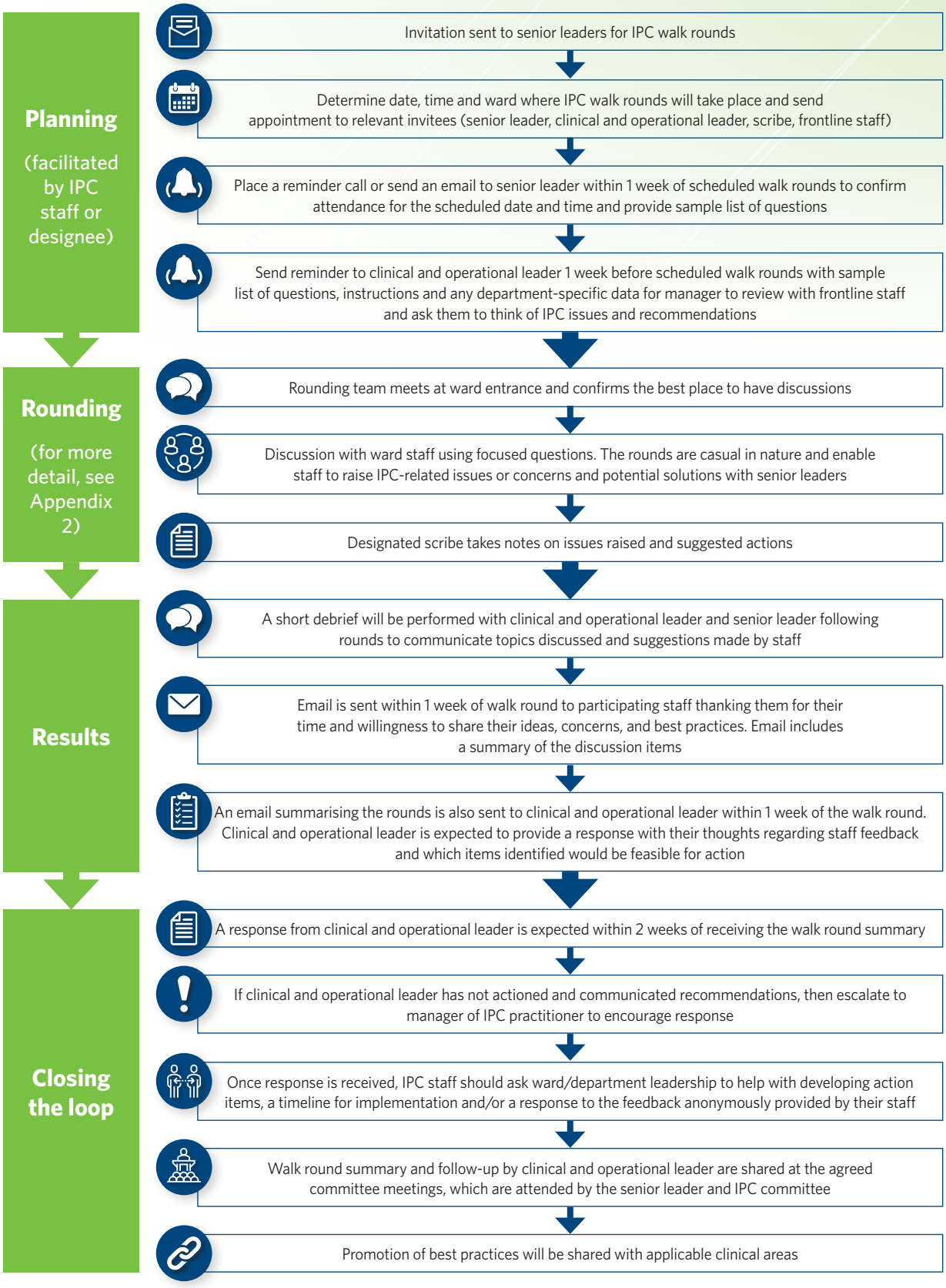
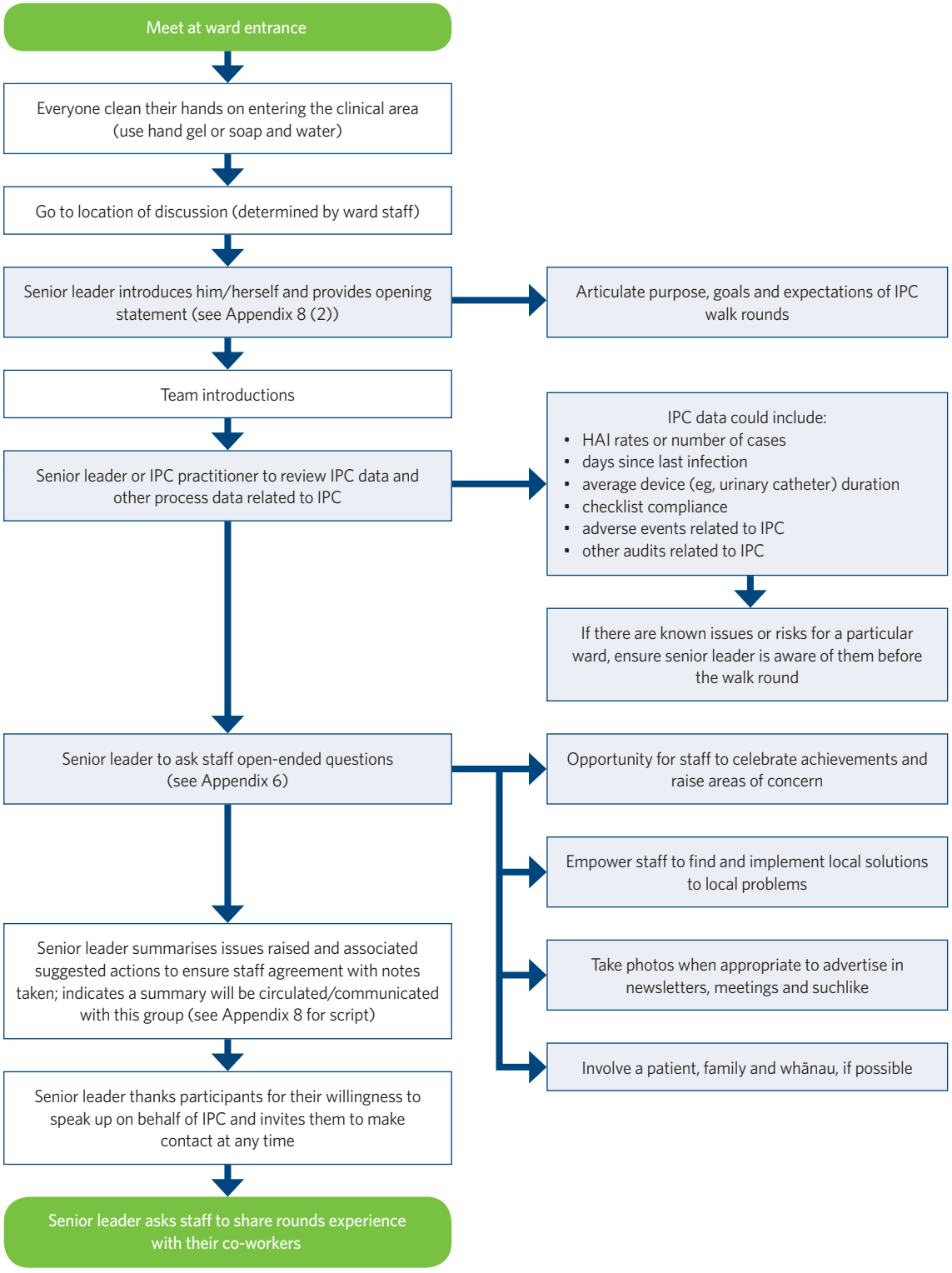
Appendix 1: Coordinating IPC walk rounds | Āpitihanga 1: Te hātepe mō te whakatū i ngā hīkoi āmio mō te ārai me te whakahaere pokenga (IPC)

Communicate the concept of IPC walk rounds to all staff.



Appendix 2: Specific steps during IPC walk round | Āpitihanga 2: Ngā hātepe tautuhi mō tētahi hīkoi āmio mō te ārai me te whakahaere pokenga (IPC)



Appendix 3: Template for senior leaders – infection prevention and control (IPC) walk rounds | Āpitihanga 3: Te tātauira mā ngā kaiārahi matua – ngā hīkoi āmio mō te ārai me te whakahaere pokenga (IPC)

Senior leaders (each leads an IPC walk round)		
Name	**Title**	**Point of contact**
	CEO	
	DON	
	CMO	
	COO	

Note: This appendix is available as a separate, editable download on the Commission website at: www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/3560.

Appendix 4: Template for ward contacts – infection prevention and control (IPC) walk rounds | Āpitihanga 4: Te tātauira mā ngā kaiwhakapā takotoranga – ngā hīkoi āmio mō te ārai me te whakahaere pokenga (IPC)

Ward contact information				
Ward (department)	Nurse lead	Medical lead	Phone	Email

Note: This appendix is available as a separate, editable download on the Commission website at: www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/3561.

Appendix 5: Template for infection prevention and control (IPC) walk rounds schedule | Āpitihanga 5: Te tātauira mō te hōtaka hīkoi āmio mō te ārai me te whakahaere pokenga (IPC)

IPC walk rounds schedule								
Location (ward/ area)	Date	Day of week	Time	IPC walk round team				
				Senior leader	IPC practitioner	Clinical and operational leader	Scribe	Other

Note: This appendix is available as a separate, editable download on the Commission website at: www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/3562.

Appendix 6: Standardised list of questions | Āpitihanga 6: Te rārangi pātai aro whānui

On the following page are sample questions that can be used and/or customised to help staff prepare to discuss actual or potential patient harm that results from system complexity related to infection prevention and control (IPC). These questions can be used at any time during walk rounds to engage staff in open communication.

The questions are divided into categories based on the World Health Organization's core components for IPC (World Health Organization 2016):

- best practices
- IPC education and training
- healthcare associated infection surveillance
- multimodal strategies
- monitoring IPC practices and feedback
- environment, materials and equipment for IPC.

It is important to determine what improvements can be made and what is working well. Where applicable, processes that are working well can be shared across other areas of the hospital to add benefit.

The specific questions for each IPC walk round should be prioritised at least one week beforehand and given to the clinical and operational leader to share with staff. It is important that IPC processes and outcome data are reviewed, to determine which questions are most applicable for a specific ward. Data must be as timely as possible. Old data may be inadequate for discussion purposes, because when a case scenario is mentioned, it may be hard for staff to remember exactly what happened in that particular situation.

Consider focusing only on an individual ward's data during the walk round. Evidence shows that frontline staff may not appreciate leaders comparing their data with other wards. They may see this as an unfair comparison because of the unique circumstances of, and patient population on, each ward.[2]

2 Frankel A, Graydon-Baker E, Neppl C, et al. 2003. Patient safety leadership walkrounds. *Joint Commission Journal on Quality and Patient Safety* 29(1): 16–26.

Sample questions for IPC walk rounds*	
Core component	**Example questions**
Best practices	What do you do well and what are you most proud of here?
	Can you give an example of good practice that could be shared with other wards?
	Can you tell us one thing you are happy with and one thing that might cause you concern?
	Can you tell us how your team works on the ward?
IPC education and training	What infection prevention and control training have you had?
	Are periodic evaluations done on the effectiveness of training programmes (eg, hand hygiene audits, other checks on knowledge)?
	Is specific IPC training available for patients, families and whānau, to minimise the potential for healthcare associated infections (HAIs) (eg, immunocompromised patients, patients with invasive devices, patients with multi-drug resistant infections)?
Healthcare associated infection surveillance	What type of HAI surveillance is collected for your ward (eg, central line associated bacteraemia (CLAB), catheter associated urinary tract infection (CAUTI), *Staphylococcus aureus* bacteraemia (SAB), surgical site infection (SSI))?
	Are you regularly informed of up-to-date surveillance data for your ward?
	What type of collaboration is performed between ward staff and the IPC team to identify HAIs?
	What type of information do you receive on the HAI cases identified for your ward?
	Have incidents occurred lately that you can think of where a patient was harmed by an infection?
	Is surveillance data used to make tailored ward-based plans for the improvement of IPC practices?
Multimodal strategies (involvement of champions and link nurses, bundles, reminders, system change, awareness raising, leadership engagement)	Are additional non-IPC staff available with adequate skills to serve as trainers and mentors (eg, link nurses, champions)?
	Do you use care bundles or checklists for preventing HAIs? Which ones?
	Is a multidisciplinary team used to review IPC data and implement IPC strategies?
	What specific intervention from senior management would make the work you do safer for patients and staff? For example: • organising a multidisciplinary group to evaluate a specific problem • facilitating interaction between two specific groups.
	What IPC problems or practices do you talk about with patients, families and whānau?
	How do you communicate to patients, families and whānau on their role in their own prevention of infection?
Monitoring IPC practices and feedback	What IPC audits (both clinical and non-clinical) does your ward undertake or lead? How often are IPC audits performed?
	How are audit reports on the state of IPC activities and performance fed back to you?
	How did your most recent hand hygiene audit go? Were there areas to be improved and what are you doing to improve them?
	How do you monitor the use of antibiotics?
Environment, materials, and equipment for IPC	What aspects of the environment are likely to lead to the next patient harm?
	Can you think of a way in which the environment or equipment fails you or your patients on a regular basis?
	Is personal protective equipment (PPE) available at all times and in sufficient quantity for all uses for all health care workers?
	Are disposable items available when necessary (eg, injection safety devices, examination gloves)?
	What are your arrangements for cleaning? Are appropriate and well-maintained materials available for cleaning (eg, detergent, mops, buckets, microfibre cloths)?
	Can you think of opportunities to improve the environment that are achievable?
Closing	Can you think of anything that we can do better to prevent infection?

* Note, these questions can be customised to apply to local settings.

These questions are available as a separate, editable download on the Commission website at: www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/3563.

Appendix 7: Template for infection prevention and control (IPC) walk round issue and action list | Āpitihanga 7: Te tātauira mō te rārangi take me ngā mahi mō ngā hīkoi āmio mō te ārai me te whakahaere pokenga (IPC)

IPC walk round issue/action list			
Location (ward/area):		Date/time:	
Senior leader:		IPC staff:	
Frontline staff and role:		Scribe:	
Problem and/or issue description	**Action(s)**	**Timeline/deadline**	**Action owner**
Best practices			
IPC education and training			
Healthcare associated infection (HAI) surveillance			
Multimodal strategies (champion/link nurse involvement, bundles, reminders, system change, awareness raising, leadership engagement)			
Monitoring IPC practices and feedback			
Environment, materials and equipment for IPC			

Note: This appendix is available as a separate, editable download on the Commission website at: www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/3564.

Appendix 8: Communication templates | Āpitihanga 8: Ngā tātauira mō te whakawhiti kōrero

(1) Ward notification (*email or letter that notifies clinical and operational leader of purpose and time for IPC walk round*)

Dear *[clinical and operational leader name]*

Our organisation is committed to continuous improvement of processes related to infection prevention and control (IPC). One way of identifying opportunities to improve IPC communication and practices is to conduct IPC walk rounds. The Infection Prevention team coordinates IPC walk rounds with senior leadership.

The walk rounds focus on IPC education and training, healthcare associated infection (HAI) surveillance, multimodal strategies, monitoring of IPC practices and feedback, and environment, materials and equipment. This is part of our effort to become a global leader using the World Health Organization's Guidelines on Core Components of Infection Prevention and Control.

Your ward/department was selected for our walk round, and we greatly appreciate your staff's time and willingness to provide input.

[Ward name] has been scheduled for an IPC walk round on *[date]* from *[start time]* to *[end time]*. This walk round is part of our commitment to IPC and improving patient care.

The goal of the walk round is to provide an opportunity for a senior leadership team member to meet with staff who work in your ward, to highlight good practices and discuss any concerns. All staff members play a vital role in IPC, so the walk rounds team would like to use this visit as a chance to speak with all staff working at the time of the scheduled walk round.

These rounds are casual in nature and give staff the opportunity to identify and discuss IPC problems directly. There are no right or wrong answers to the questions the senior leader will ask. This conversation helps foster a culture of open communication and to identify ways to improve systems and share best practice.

[Attach a list of sample questions to review with your staff prior to the IPC walk round.]

To make this opportunity worthwhile, it would be valuable for you and your team to think about what you would like to discuss. Before the IPC walk round, you are asked to ensure that you are (or a delegate is) available to participate in the walk round.

Please inform staff members of the IPC walk round and their opportunity to engage in the process. The rounding team may also welcome the chance to talk with patients, if possible, and this can be decided on the walk round day.

If you have any questions or need further clarification, please contact *[IPC team]* at *[phone or email]*. We look forward to meeting with you and your team.

Kind regards

[IPC staff]

(2) Opening statement during IPC walk rounds (provided by senior leader)[3]

We are here on an IPC walk round today. The team is made up of a senior leader (myself, *[name and role]*), a member of our IPC team *[name]*, the clinical and operational leader *[name]*, and the scribe *[name]* who will help with taking notes of the topics we discuss and proposed actions.

We are interested in focusing on IPC systems and processes, not individuals. Each of us has an important role to play in IPC so your views are very valuable. We must highlight that this is an informal discussion and not an inspection or audit.

Problems tend to fall into a few different categories. Some problems are on a local level, which means solutions may be more readily found and implemented. Others may be clinically simple but administratively more complex to solve. Some problems require significant budgetary investments or the attention of an action team to assess the problem before attempting a solution. All of you participating in this walk round should know that your input will help prioritise opportunities.

We are here to listen to you, because we want to work together to improve practices related to IPC. Our aim is to discuss good IPC practice and concerns, and to work with you to improve the environment and overall delivery of care related to IPC.

Optional: During our visit today, we would like to meet with one or two patients (if appropriate for the area being visited) to ask them for their views on IPC also.

So, before we dive into conversation, could you please introduce yourselves and tell us your roles?

(3) Closing statement at end of IPC walk rounds (provided by senior leader)[4]

Thank you for taking the time to meet with us today and share your thoughts and ideas. We appreciate how busy you are and hope you have found value from the conversation. We are very glad we have come here today because this has been particularly beneficial for us. We have agreed that some actions can be managed by yourselves or that you need to discuss with your clinical and operational leader *[list items]*. You have also highlighted opportunities that the clinical and operational leader and myself will need to discuss further to follow up *[list items]*.

From here, the actions we have agreed together to prioritise will be sent within two weeks to you (clinical and operational leader) and to support you with follow up.

One of the things we have been so impressed with today is how proactive you and your team have been with … *[give an example of an IPC initiative that has been discussed]*. We would like to think about how you can share this great initiative with other similar areas in the hospital.

To reinforce that IPC is an organisational priority, we would appreciate if you could share with your colleagues about today's walk round and the ideas we covered so that all staff are aware of the topics and actions discussed.

3 Quality Improvement Division, Health Service Executive. 2016. *Quality and Safety Walk-rounds: A co-designed approach, toolkit and case study report.* Dublin, Ireland: Quality Improvement Division, Health Service Executive.

4 *Ibid.*

(4) Initial communications after IPC walk rounds

a. Thank you to participating frontline staff (*this could be written as an email or postcard sent to staff*)

Thank you for talking with our leaders and participating in the IPC walk rounds to improve IPC practices and safety culture. Your input is highly valued, and further follow up with your clinical and operational leader will include prioritisation and implementation of the actions discussed.

For questions or additional feedback about the IPC walk round process, please contact Infection Prevention at *[phone number or email address]*.

b. Email or letter that highlights topics discussed, recommended solutions and request for action review and prioritisation

Kia ora *[clinical and operational leader name]*

Thank you very much for committing your time and participating in the IPC walk round to *[ward]* on *[date]*. We enjoyed meeting and talking with you and your staff about IPC opportunities and found it very informative.

As agreed, please find attached a draft version of the action plan that emphasises the IPC action points we will take forward together with the intention of resolving or raising further awareness on the issue.

[Senior leader's name] who rounded in your area would like to highlight the following items provided by your staff as positive feedback:

- *[item]*
- *[item]*
- *[item].*

Below are opportunities your staff identified that they would like to see resolved:

- *[item]*
- *[item]*
- *[item].*

Please take a moment to consider these ideas and respond as to what actions, if any, are feasible for implementation. If any actions need to be clarified or amended, please feel free to do so. Please respond with the actions you prioritised and your anticipated date of completion for each item by [*date – two weeks from date of this letter].*

Once your response is received, the final action plan will be emailed to all members of the rounding team, to ensure agreed actions are completed.

[Attach summary of topics discussed and proposed solutions by staff]

We also ask for your feedback on the IPC walk round process. Do you have any recommendations as to what would make these IPC walk rounds more effective? Have you found participation in the IPC walk rounds beneficial?

Thank you for your dedication to providing the highest quality of care to our patients.

Kind regards

[IPC staff]

(5) Final communications – summary of final agreed actions to clinical and operational leader:

Kia ora *[clinical and operational leader name]*

Thank you very much for committing your time and participating in the IPC walk round to *[ward]* on *[date]*.

As agreed, please find attached the final version of the action plan that emphasises the IPC action points we will take forward together with the intention of resolving or raising further awareness on the issue.

Again, we would like to mention the positive feedback provided by your staff:

- *[item]*
- *[item]*
- *[item].*

Below are the final actions and intended deadlines to be worked on by you and your team:

- *[item]; [deadline date]*
- *[item]; [deadline date]*
- *[item]; [deadline date].*

Please keep me apprised of your progress, so I can inform the appropriate leaders and committees and keep the IPC walk rounds database up to date. Please also contact me if you have any questions or concerns related to the action implementation.

Kind regards

[IPC staff]

Note: This appendix is available as a separate, editable download on the Commission website: ww.hqsc.govt.nz/our-programmes/infection-prevention-and-control/publications-and-resources/publication/3565

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