King Khalid University Hospital

Patient Safety Plan
(2009-2010)
INTRODUCTION

People are becoming more and more aware about the harms that are happening in healthcare institutions. And in the advent of Healthcare Quality, these medical errors are now being monitored and mitigated by addressing reports through education, trainings and constant follow-up.

And the effort of minimizing medical errors increases upon the introduction of Patient Safety. It intensifies the prevention and mitigation of unsafe practices of the staff within the institution by reducing healthcare risk as well as by promoting safer care to their patients.

This Patient Safety Plan has been developed to provide a roadmap to guide the staff in the accomplishment of its goal in minimizing the chance of the occurrences of untoward outcomes consequent in providing medical care.

This handbook will also guide the staff in implementing the Required Organizational Practices (ROPs) mandated by the Accreditation Canada for institutions like King Khalid University Hospital that undergoes accreditation. It is stipulated in Patient Safety Advisory that, not having these ROPs in place will put a healthcare organization at significant risk. Therefore, non-compliance with any of these ROPs will be considered a situation requiring urgent action.

This handbook also introduces the Patient Safety Programs that will standardize the practices of the staff using evidence-based guidelines that is accepted internationally. Multi-Disciplinary Teams will be created eventually to work on each program. These teams will come from different disciplines and will be group together to assess their practices. They will be the role model; in quality management we call them “Champions” of each department.

And most importantly, the Culture of Safety and the culture of no blame have been welcomed by the top management and all efforts have been initiated to ensure the full implementation of patient safety initiatives and programs. The top management is fully committed in fostering the culture of safety through quality. Patient Safety First!
Purpose

1. The organizational Patient Safety Plan of King Khalid University Hospital is to incorporate safety to all practices and to foster culture of safety by delivering quality care and services as well as to reduce risk to patients. This encourages:

   - The integration of safety priorities into all relevant organization process, functions and services,
   - The recognition and acknowledgement of risks to patient safety as well as medical/healthcare errors,
   - The initiation of actions to reduce these risks,
   - Focus on process and systems, and the reduction of system failures through the use of Failure Mode and Effect Analysis (FMEA),
   - Minimization of individual blame or retribution for involvement in a medical/healthcare error by fostering the culture of no blame (Open Culture),
   - Organizational learning from medical/healthcare errors,
   - And to encourage sharing of information that affects behavioral changes.

2. The Patient Safety Plan provides a systematic, coordinated and continuous approach for the improvement of safety throughout King Khalid University Hospital by establishing mechanisms that support effective responses to actual occurrences, proactively reduce medical/healthcare errors and the integration of patient safety priorities by designing and redesigning organizational processes, functions and services.

3. By improving patient safety the hospital staff are required to coordinate and collaborate most of the time with their co-staff to establish the spirit of teamwork. In pursuit of improving patient safety will involve multiple department and disciplines in establishing the plan, processes and mechanisms that comprises all the safety activities in King Khalid University Hospital. There will be numerous Multi-Disciplinary Teams to be organized that will coordinate and collaborate with each other. Each one of the will act as a Patient Safety Champion in each of their own field.

4. And through accreditation, all processes will be evaluated by external body. They see to it that all the Required Organizational Practices (ROPs) are being met. So this Patient Safety Plan of King Khalid University Hospital will work as a road map for each and every staff of the hospital to quality and safe care.
Benefits

By following the Patient Safety Plan, the entire staff of King Khalid University Hospital will have the benefit of working on a safer environment.

1. Increase awareness on Patient Safety among staff of King Khalid University Hospital.
2. Reduction of healthcare risk through Total Quality Management.
3. Strong commitment from the senior leadership in fostering Patient Safety.
4. They are assured that they are working in accordance to evidence-based standards.
5. In times of adverse events, staff are aware that the situation will be handled fairly. And No-Blame Policy is always in effect.
6. Inter-Departmental Communication will be improved as they will meet more often and discuss more about patient safety.

Scope

The scope of Patient Safety Plan includes an on-going assessment and re-assessment using internal and external knowledge and experiences in prevention of error occurrences to promote and improve patient safety within the hospital. Information coming from aggregated data (ex. Incident reports) will be reviewed and presented to Patient Safety Committee. The committee will then act according to the severity of the incident and will give recommendation and solution.

Types of medical/ healthcare errors that are included in data analysis are as follows:

- No Harm Errors
  - Any unintended acts, either through omission of commission, or acts that do not achieved their intended outcome but did not result in physical or psychological negative outcome to patients.

- Mild-Moderate Adverse Outcome Errors
  - Those unintended acts, either of omission or commission, or acts that do not achieve their intend outcome, that result in an identified mild to moderate physical or psychological adverse outcome for the patient.
- **Medication Errors** - the staff member identifying a medication error (no harm and mild-moderate harm) will notify the Physician and the Pharmacy Department of the event.

- **Adverse Drug Reaction** – the staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then preserve any physical evidence as appropriate, notify his/her immediate supervisor, document facts appropriately in the medical record and on an occurrence report, submitting the report to the Performance Improvement Committee per organizational policy. Staff will also notify the Physician and the Pharmacy Department.

- **Transfusion Reaction** – the staff will perform any necessary clinical interventions to support and protect the patient and notify the physician staff responsible for the patient, carrying out any necessary physician orders. Staff will then follow the Blood/Blood Component Transfusion Reaction Policy and Procedure.

- **Hazardous Condition/Patient Safety Issue** - as appropriate, and if possible, staff will contain the hazardous condition or patient safety issue. Staff identifying a hazardous condition or potential patient safety issue will immediately notify his or her supervisor and document the findings on an occurrence report. The occurrence report will be submitted to the Performance Improvement Committee per organizational policy.

- **Sentinel Event**

  It is an unexpected event or occurrence involving death or serious physical or psychological injury or the risk thereof - including any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Serious injury specifically includes loss of limb or function. Sentinel event criteria includes:

  - The event has resulted in an unexpected death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition, or
• Any event (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):
  
  • Suicide of any patient in a setting where the patient receives around-the-clock care, or suicide of a patient within 72 hours of discharge,
  • Unanticipated death of full term infant,
  • Abduction of any patient receiving care,
  • Infant abduction or discharge to the wrong family,
  • Rape (by another patient, visitor or staff),
  • Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities,
  • Surgery or invasive procedure performed on the incorrect patient or incorrect body part,
  • The unintentional retention of a foreign object, i.e., sponge, instrument, in a postoperative or post invasive procedure patient,
  • All identified cases of unanticipated death or major permanent loss of function associated with a health care associated infection,
  • Severe neonatal hyperbilirubinemia; bilirubin that is greater than 30 milligrams per deciliter (30mg/dl),
  • Prolonged fluoroscopy with cumulative dose greater than 1,500 rads to a single field, or any delivery of radiotherapy to the wrong Committee region or greater than 25% above the prescribed radiotherapy dose.

• Near Miss
  🟢 Any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

The scope of the Patient Safety encompasses the patient population, visitors, volunteers and staff (including medical staff). The program addresses the improvement in patient safety issues
in every department throughout the facility. There will be an emphasis on important hospital functions on:

- Leadership
- Ethics, Rights and Responsibilities
- Provision of Care, Treatment and Services
- Medication Management
- Surveillance, Prevention and Control of Infection
- Improving Organization Performance
- Human Resources Management
- Information Management, etc.

**Methodology**

The Interdisciplinary Risk Management and Patient Safety Committee is responsible for the oversight of the Patient Safety Programs and the RM and PS Committee Chairperson will have administrative responsibility with its sub-committees like medication safety, Morbidity and Mortality, CPR, Critical Care and Code Status, Pharmaceutical and Therapeutics, Environmental Safety and Emergency management & Fire Plan. These sub-committees may assign the task to other members to form the Patient Safety Teams.

**All departments** of King Khalid University Hospital are responsible to report patient safety occurrences and potential occurrences to the Quality Management Department. These aggregated occurrences will be presented as report to the Risk Management and Patient Safety Committee on a quarterly basis. The report will contain aggregated information related to type of occurrence, severity of occurrence, number/type of occurrences per department, occurrence impact on the patient, remedial actions taken, and patient outcome. And finally the Risk Management and Patient Safety Committee will analyze the reported information and determine further patient safety activities as appropriate.

The aggregated data will be reviewed according to severity or through the use of prioritization matrix grid (High Risk, High Cost, High Volume and Highly Problematic). Then the Patient Safety Steering Committee will select at least one process in the hospital that needs proactive risk assessment or popularly known as Failure Modes.
and Effect Analysis (FMEA). And through the use of these quality tool like (Flowchart, cause and effect diagram, etc), we will identify the root cause of this high risk process. The proactive risk assessment will include:

- Identification of the ways in which the process could break down or fail to perform. This will be done through assessment of the intended and actual implementation of the process by identifying the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient.
- Prioritizing the potential processes breakdowns or failures
- For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur
- Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation
- Test and implement the redesigned process
- Identify and implement measures of the effectiveness of the redesigned process
- Implement a strategy for maintaining the effectiveness of the redesigned process over time
- Description of mechanisms to ensure that all components of the healthcare organization are integrated into and participate in the organization wide program.
- Upon identification of a process or system failure and/or medical/health care error, the patient care provider will immediately:
  - Perform necessary healthcare interventions to protect and support the patient’s clinical condition.
  - As appropriate to the occurrence, perform necessary healthcare interventions to contain the risk to others - example: immediate removal of contaminated IV fluids from floor stock should it be discovered a contaminated lot of fluid solutions was delivered and stocked.
  - Contact the patient’s attending physician and other physicians, as appropriate, to report the error, carrying out any physician orders as necessary.
  - Preserve any information related to the error (including physical information). Examples of preservation of physical information are: Removal and preservation of blood unit for a suspected transfusion reaction;
preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from IV medication; preservation of medication label for medications administered to the incorrect patient. Preservation of information includes documenting the facts regarding the error on an occurrence report, and in the medical record as appropriate to organizational policy and procedure.

Report the process/system failure or medical/health care error to the staff member’s immediate supervisor.

Submit the occurrence or incident report (IR) to the Quality Management Department per organizational policy.

Any staff that identified a process/system failure and/or potential patient safety issue will immediately notify his or her supervisor and afterwards document the findings on an OVR or incident report.

Staff response to process/system failures and/or medical/health care errors is dependent upon the type of error identified (No Harm Failures or Errors, Mild-Moderate Adverse Outcome Failures or Errors, Hazardous Condition/Patient Safety Issue, Sentinel Event and Near Miss.)

All sentinel events and near miss occurrences will have a root cause analysis conducted. The determination of the Patient Safety Steering Committee members, based on internal and external data analysis and prioritizing of patient safety criticality, will determine:

- Further remedial action activities necessary for identified occurrences
- Proactive occurrence reduction activities
- Necessity and benefit of root cause analysis performance for identified occurrences or proactive reduction activities

An effective Patient Safety Plan will not exist without optimal reporting of process/system failures and medical/health safety errors and occurrences. Therefore, it is the intent of this organization to adopt a non-punitive approach or popularly known as No Blame Policy in its management of failures, errors and occurrences. All personnel are required to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those responsible for
errors and occurrences. A focus will be placed on remedial actions to assist rather than punish staff members, with the Patient Safety Steering Committee and the individual staff member’s department supervisor.

Staff that are involved in a sentinel event will receive support from the Risk Management and Patient Safety Committee through counseling. The Committee encourages the staff member’s involvement in the Root-Cause Analysis (RCA) and action plan processes, to allow the staff member an active role in process resolution. Additionally, any staff member involved in a sentinel event or other medical/health care error may request and receive supportive personal counseling from the Performance Improvement Committee, Human Resources Department and/or his or her department supervisor.

On at least an annual basis, staff will be queried regarding their willingness to report medical/health care errors.

The Patient Safety Plan includes implementation of the recommendations set forth by Accreditation Canada (formerly known as Canadian Council for Healthcare Service Accreditation- CCHSA), or other identified alternative recommendations defined by this institution, to achieve compliance with the Required Organizational Practices (ROPs). The selected recommendations will be monitored on a routine basis to evaluate the organization’s effectiveness of the processes as well as achieving compliance with the Accreditation Canada’s Patient Safety Goals.

The Patient Safety Plan includes quarterly audits on each clinical area to ensure compliance and to recommend solutions and provides suggestions for improving patient safety practices here in our institution.

The patients, as well as their families will be informed about the outcomes of Safety, including unanticipated outcomes, or when the outcomes differ significantly from the anticipated outcomes. The Risk Management and Patient Safety Committee will request a report from the Information Management Committee on a quarterly basis consisting of random record review to ensure staff compliance. After that the committee will then analyze reported data and give recommendations.

The staff will educate the patients and their families about their role in helping to facilitate the safe delivery of care. The Risk Management and Patient Safety Committee will also request a report from the Information Management Committee.
on a regular basis consisting of random record review verifying compliance with this educational process.

 krij Staff will receive education and training during their initial orientation process and also on a regular basis with regards to job-related aspects of patient safety. It includes the methods on how to report medical/health care errors. Education will include the staff member’s right to report any concerns about safety or quality of care to the Quality Management Department. And, because the optimal provision of healthcare is provided in an interdisciplinary manner, the staff will be educated and trained on the provision of an interdisciplinary approach to patient safety.

 krij Medical/healthcare errors and occurrences, as well as sentinel events, will be reported internally as per hospital policy through the proper channel of communication. Issues will be handled fairly and there will be no reprisal as long as it is not intentional and no gross negligence.

 krij The Risk Management and Patient Safety Committee will submit the final report on a regular basis to the Quality Management Department, whose job is to oversight the activities of the committees. The Department will guide them along the way using the quality management process.

 krij A quarterly patient safety report will be forwarded to the Quality Council on the occurrence of medical/health safety errors and actions taken to improve patient safety, both in response to actual occurrences as well as the progress of patient safety initiatives.

Patient Safety Initiatives

1. Implementation of Safety Culture and the Culture of No Blame

The first essential step in the process of developing Patient Safety is to improve the organizational culture by assessing the current status. And one way of doing it is by conducting Patient Safety Survey to all the staff. This will give a clear picture on how safety is being implemented inside the institution.

An institution can develop a patient safety culture by:
• Declaring Patient Safety as a no. 1 priority
• The senior leadership will establish responsibilities for patient safety
• Embrace a new knowledge and skill that are evidence-based
• Install a blameless reporting system vs. openness about errors and problems
• Develop accountability
• Reform education and develop organizational learning
• Unity, loyalty and teamwork among staff
• Non-punitive environment.

2. **Total compliance on Require Organizational Practices (ROPs)**

King Khalid University Hospital is undergoing accreditation with the guidance of Accreditation Canada. And it is essential for all the organization under them to follow the Required Organizational Practices (ROPs). According to them, these ROPs should be in place to enhance patient/ client safety and to minimize risk.

The Accreditation Canada is requiring all international healthcare organization like us to comply on all nine (9) ROPs. They are requiring our organization to meet the entire test for compliance as a proof of having the ROPs in place as well as achieving the stated goals.

The nine ROPs required for international client organizations are:

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3. Implementation of Patient Safety Programs and the Bundles of Care

These are the list of suggested Patient Safety programs that were designed to proactively reduce medical errors and hazardous conditions by utilizing a systematic, coordinated and continuous approach of quality improvement. This approach centers on safety of the patient by establishing mechanisms that supports effective response to actual occurrences and hazardous condition by designing and redesigning all relevant organizational processes, functions and services.

Bundle of Care

These are group of evidence-based interventions for the patients that, when implemented together will result in better outcome than when applied individually.

1) Hand Hygiene Program

This is a Patient Safety program that will significantly reduce the incidence of hand associated infection by strictly adhering to hand hygiene policy.

Hand Hygiene Intervention Bundle
   a. Clinical staff, including new hires and trainees, understand key elements of hand hygiene practices (demonstrate knowledge)
   b. Clinical staff, including new hires and trainees, use appropriate technique when cleansing their hands (demonstrate competence)
   c. Alcohol-based hand rub and gloves are available at the point of care (enable staff)
   d. Hand hygiene is performed at the right time and in the right way and gloves are used appropriately as recommended by CDC’s Standard Precaution (verify competency, monitor compliance, and provide feedback)

2) Reducing MRSA Program

This is a Patient Safety program that will significantly reduce Methicillin-Resistant Staphylococcus Aureus (MRSA) transmission and infection by reliably implementing the five components of care.
Five (5) components of care:
   a. Hand Hygiene
   b. Decontamination of the environment and equipment
   c. Active surveillance
   d. Contact precautions for infected and colonized patients
   e. Device bundles (Central Line Bundle and Ventilator Bundle)

3) **Prevent Central-Line Associated Bloodstream Infection (CLAB) Infection**

This is a Patient Safety program that concentrates on catheter-related nosocomial infection and the impact that will incur to patient. It is a group of evidence-based intervention to patients with intravascular central catheter that, when implemented together will result in better outcome than when applied individually. The central line bundle has five key components:

The central line bundle has five key components:
   a. Hand Hygiene
   b. Maximal barrier precautions
   c. Chlorhexidine plus alcohol skin antisepsis
   d. Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters
   e. Daily review of line necessity, with prompt removal of unnecessary lines

4) **Prevent Ventilator-Associated Pneumonia (VAP) Infection**

This is a Patient Safety program that addresses the serious complication caused by ventilator-associated pneumonia that presents a greater risk to patients. It is an evidence-based program that will make use of 4 components of care called the Ventilator-Bundle.

Four elements of care:
   a. Elevation of the head of the bed (HOB) to between 30 and 45 degrees
   b. Daily “sedative interruption” and daily assessment of readiness to extubate.
   c. Peptic ulcer disease (PUD) prophylaxis
   d. Deep venous thrombosis (DVT) prophylaxis (unless contraindicated)
5. **Prevent Adverse Drug Events (ADE) - Medication Reconciliation**

One of the Patient Safety programs that prevents or limit medication/prescribing errors and/or adverse events by implementing processes which includes verification, clarification and standardization that will lead to reconciliation. This strategy can prevent prescribing errors of omissions, wrong dosage or frequency of medications, duplication of orders as well as same classification of orders.

The medication reconciliation process involves three steps:

- **Verification** (collection of the medication history);
- **Clarification** (ensuring that the medications and doses are appropriate); and
- **Reconciliation** (documentation of changes in the orders).

6. **Prevent Harm on High Alert Medications**

One of the Patient Safety programs that classify some medications that are most likely to cause significant harm to the patient, even when used as intended. The program will demonstrate that these medications when used improperly can cause harm, these medications cause harm more commonly and the harm they produce is likely to be more serious. Although mistakes may not be more common in the use of these medications, when errors occur the impact on the patient can be significant.

**General Principles for Reducing Harm from High-Alert Medications**

- **Design processes to prevent errors and harm.**
- **Design methods to identify errors and harm when they occur.**
- **Design methods to mitigate the harm that may result from the error.**

**Key Components of Appropriate Management of High-Alert Medications for each category of high-alert medications:**

- **Anticoagulants**
- **Narcotics**
- **Insulin**
- **Sedatives**
7. Deploy Rapid Response Team (RRT)

One of the patient safety programs that will make use of evidence-based guidelines on rendering care to patients with deteriorating condition. This will not replace the work CPR Team in times of emergency but by rendering proactive care before the condition worsen.

Here are sample clinical criteria for an Early Warning Scoring System:
   a. Staff member is worried about the patient
   b. Acute change in heart rate <40 or >130 bpm
   c. Acute change in systolic BP <90 mmHg
   d. Acute change in RR <8 or >28 per min or threatened airway
   e. Acute change in saturation <90% despite O2
   f. Acute change in conscious state
   g. Acute change in UO to <50 ml in 4 hours

8. Preventing Surgical Site Infection

One of the patient safety programs that will significant prevents the incidence of surgical site infection. Certain procedures should be accomplished before the patient will be placed on the operating table.

Preventing Surgical Site Infection: Four Components of Care:
   a. Appropriate Use of Prophylactic Antibiotics
   b. Appropriate Hair Removal
   c. Controlled Postoperative Serum Glucose in Surgery
   d. Immediate Postoperative Normothermia in Surgery

9. Improve Care for Acute Myocardial Infarction (AMI)

This is a Patient Safety Program that will significantly improve the care for Acute Myocardial Infarction (AMI). The patient will be assessed thoroughly and will be given emergency medication that will lessen the complications from the impending disease.
The Key Components of Reliable, Evidence-Based AMI Care:

a. Early administration of aspirin/Aspirin at discharge
b. Early administration of beta-blocker/Beta-blocker at discharge
c. ACE-inhibitor or angiotensin receptor blockers (ARB) at discharge for patients with systolic dysfunction
d. Timely initiation of reperfusion (thrombolysis or percutaneous intervention)
e. Smoking cessation counseling

10. Deliver Reliable, Evidence-Based Care for Congestive Heart Failure

One of the patient safety programs that will significantly improve care and reduce readmissions for patients with congestive heart failure by reliably implementing the components of care.

Key Components of Reliable, Evidence-Based CHF Care:

a. Left ventricular systolic (LVS) function assessment
b. ACE-inhibitor or angiotensin receptor blockers (ARB) at discharge for CHF patients with systolic dysfunction (Left Ventricular Ejection Fraction (LVEF) <40%)
c. Anticoagulant at discharge for CHF patients with chronic or recurrent atrial fibrillation (AF)
d. Smoking cessation advice and counseling
e. Discharge instructions that address all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen
f. Influenza immunization* (seasonal)
g. Pneumococcal immunization

11. Reduce Surgical Complication

One of the patient safety programs that will significantly reduce surgical complications by reliably implementing the four changes in care recommended by the Surgical Care Improvement Project (SCIP).

Reducing Surgical Complications

a. Surgical Site Infection Prevention
b. Beta Blockers for Patients on Beta Blockers Prior to Admission

c. Venous Thromboembolism (VTE) Prophylaxis

d. Ventilator-Associated Pneumonia Prevention

4. Leadership WalkRounds™

WalkRounds is a tool to connect senior leadership to patient safety and to inculcate safety ideas into the health care system. It was postulated that the information elicited during the WalkRounds, if effectively analyzed, might be used to drive safety-based changes by creating a cycle of information–analysis–action–feedback. The end result would be a self-sustaining process that would continue to engage leadership, educate clinicians and managers, and lead to continuous improvement.

The WalkRounds™ concept was created with the following objectives:

a. Increase awareness regarding patient safety issues by all clinicians;
b. Make patient safety a high priority for senior leadership;
c. Educate staff about patient safety concepts and encourage non-punitive reporting; and
d. Obtain and act on information elicited from staff about safety problems and issues.

By conducting Patient Safety Leadership WalkRounds™ bi-monthly, senior leaders of health care organizations can demonstrate to staff the organization’s commitment to building a culture of safety. WalkRounds are conducted in patient care departments (such as the Emergency Department, Radiology Department, and operating rooms), the pharmacy, and laboratories. They provide an informal method for leaders to talk with front-line staff about safety issues in the organization and show their support for reporting of errors.