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TAPPING FRONT-LINE KNOWLEDGE: Identifying problems as they occur helps enhance patient safety

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This article describes a methodology developed/tested by the United States-based Institute of Healthcare Improvement (IHI) and Cedars-Sinai Medical Centre to assist front-line staff to identify areas within their work processes which may impact negatively on patient safety. It utilises an approach that seeks to "unearth" issues rather than emphasise designing "perfect" systems. The method is based around informal visit/s to a hospital unit with a format centred on conversations about safety issues with its employees rather than an inspection/evaluation of the unit and its processes.

The Methodology in Action

Step 1: Organise a Visit to the Unit Beforehand

- Choose a location with minimal disruptions;
- Select a mix of six to eight front-line staff so that a cross-section of those working in the unit are involved in the conversation;
- Select a small leadership team who will ask questions; and
- Set aside at least 60 minutes of conversation time so that all staff can discuss their work.

Step 2 – Arrange for All Participants to Describe their Jobs

- This segment of the conversation should take place within the first 10 or 15 minutes of the visit;
- Establish that the discussion is not an assessment of their work performance so as to create a non-threatening environment that will leave them more open to talking about their work, how it is done, and the value they add to their patients and the organisation; and
- Focus this segment about understanding the staff's work and their environment.

Step 3 – Assess the Work Environment Using "Anchoring Questions"

- Use specific situations (clinical/non-clinical) that have been problems and anchor subsequent questions on them (i.e., "When was the last time a case was delayed?", "What makes some diabetics more difficult to manage?");
- Establish a non-threatening and non-blaming tone for the discussion to maximise information sharing;
- During a 60 minute conversation like this, 10-15 issues can be easily surfaced, note these down; and
- Steer the discussion away from solutions.

Step 4 – Debrief

- Get the buy-in from both the front-line and questioning team on possible actions/the need for actions based on the list of issues that have surfaced.

A key success factor for this method is focusing the wording of the questions on the unit's specific work and the individual employee's role. For instance, instead of asking general questions (e.g., "What safety concerns do you have?"), questions are specific (e.g., "When was the last time you were missing a critical medication? Describe the incident."). By doing this, it helps staff reframe their mindset and see incidents, often viewed as "normal" occurrences (e.g., frequent interruptions, unclear instructions, etc.), as safety issues. When this is acknowledged, it allows and triggers responses such as, "How can we change our work to enhance the safety of our patients?"

Conclusion

This method has unleashed an impactful way for front-line staff to potentially eliminate many of the daily interruptions that risk patients' safety. What is crucial about the method is involving staff in seeing the problems rather than simply accepting them as "part of the job". With this new perspective and the use of "anchoring" questions, it offers opportunities for issues to surface and gives staff permission to solve them and share their learning with others.

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