



INSTITUTE FOR
HEALTHCARE
IMPROVEMENT

Rounding to Influence

Leadership method helps executives answer the “hows” in patient safety initiatives.

At the monthly meeting of a multi-hospital system’s executive team, the CEO asked each chief administrator, “Are the infection control bundles for ventilator-associated pneumonia, central line bloodstream infection and catheter-associated urinary tract infections fully implemented in your hospital?” After an uncertain glance at a nurse executive in attendance, each administrator answered, “Yes, the bundles are all in place.” The CEO looked puzzled and said, “I’m wondering how you know that because infections in our system aren’t dropping.”

How *did* they know? In the conversation that followed, the hospital administrators said “they knew” because nurse leaders had briefed unit managers, held some in-service education events, asked one unit or another to pilot the bundles and then checked off “Bundles Implemented” on their to-do lists. The focus of the executive team meeting conversation then shifted to whether the system for measuring infections was accurate, why the definition of “hospital-acquired infection” wasn’t quite fair and how coding needed to be improved.

The quality staff members who were sitting around the periphery of the meeting room were distressed by this

conversation. They had visited several ICUs that same week and knew the bundles being discussed were *not* reliably in place anywhere in the system. They also knew that the same gap between the realities at the front line and executive-level conversations also applied to other ongoing quality and safety efforts such as implementation of surgical checklists, safety behaviors and evidence-based medical practices.

It’s not just about leaders being seen—it’s about what leaders are seen doing and asking.

So, how could this story be different? Well, for one thing, if each hospital’s executives and operational managers had been systematically *rounding to influence* using a specific, script-driven plan, they would have been able to give a reality-based answer to the CEO’s question “how do you know?” And, more importantly, *rounding to influence* would have been helping operational leaders remove obstacles to implementing the bundles while also building accountability for safety behaviors. In addition, the bundles would more likely have really been in use and hospital-acquired infections would probably have been decreasing.

Rounding to Influence

Rounding to influence is one element of an evidence-based bundle of leadership methods used in highly reliable organizations. *Rounding to influence* is not quite the same thing as leadership safety walkrounds, in which leaders go to hospital units and visit with staff to send a signal that they care about the hospital’s improvement agenda, want to gain better awareness of safety issues and want to build relationships with frontline staff. While these are all desirable outcomes, they don’t drive the successful execution of specific safety or infection control practices. *Rounding to influence* is much more focused. It’s not just about leaders being seen—it’s about what leaders are seen doing and asking.

What might *rounding to influence* look like in practice? Let’s consider a hospital whose primary aim is to reduce hospital-acquired infections. For the first 12 weeks of its improvement efforts, the hospital decides to focus specifically on reducing catheter-associated urinary tract infections (CA-UTIs), the most frequent type of infections, by implementing a bundle of evidence-based interventions. Frontline staff is educated about the specific care elements in the CA-UTI bundle. Using *rounding to influence*, managers round on each unit regularly—perhaps daily for unit managers, weekly for directors and

monthly for COOs—to assess the effect of the CA-UTI bundle on reducing infections. The rounding process involves brief, five- to 10-minute engagements with frontline staff that are focused and scripted.

The following is an example of a script an executive might follow during a rounding engagement with frontline staff:

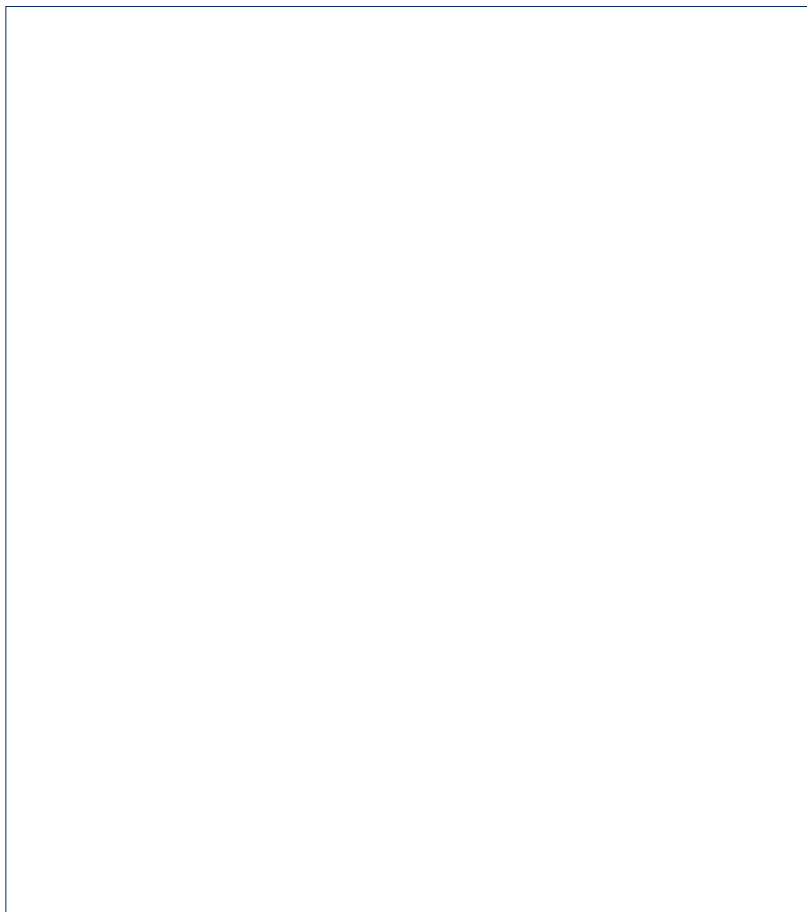
- Find a patient with a Foley catheter in place.
 - Approach the nurse caring for that patient and ask for a few minutes to talk about preventing infections—specifically CA-UTIs.
 - Briefly describe the importance of CA-UTI reduction to patient safety—perhaps cite the number of patients who get one of these infections each month in your hospital or relate a brief story about a patient who had serious complications from a CA-UTI.
- Ask the nurse to describe the bundle elements for the prevention of CA-UTI.
 - If the nurse is not familiar with the bundle or cannot describe the key elements, then you have just learned something important about how your hospital's education and training system needs to be improved. Make a note to address this issue with the management team.
 - If the nurse gives a good answer (e.g., don't put Foleys in if they're not necessary, don't place the

Foley bag above the patient and pull the Foley out ASAP), then give positive reinforcement. (Note: Executives and managers will need to be familiar with the bundle.)

- Ask the nurse which of the bundle elements is most difficult to implement. Listen to the answer. A common answer is, "On this unit, the hardest element of the bundle is getting permission to pull the Foley. Sometimes we need the doctor's order, and sometimes it's just that it's more convenient for us as nurses to keep the Foley in place."
- Have a conversation about how to address any operational barriers that are identified.

- Make a note to address these barriers with the management team and identify ways to remove them.

- Ask the nurse if there's a staff person on the unit who implements the bundle exceptionally well. Ask "Can I have your commitment to do whatever you can to implement these and other infection control bundles and to let us know if you have ideas for how we can improve our ability to do so reliably?"
- Say "thank you."
- Identify another patient with a Foley, and another nurse, and repeat the rounding process.



Rounding Results

After 12 weeks of these rounds on every unit where urinary catheters are used, chances are good that three things will have occurred:

- Operational barriers to implementation of the CA-UTI bundle will have been identified and removed.
- The staff's sense of accountability for implementation of the bundle will have dramatically increased.
- The reliability of use of the CA-UTI bundle will have improved.

As a result, the whole team can then go to the maintenance phase of the

CA-UTI reduction work and move on to the next item on the infection agenda—for example, use of the bundle to prevent central line bloodstream infections—and start a new series of rounds. Nine months later, after similar processes to implement bundles to prevent ventilator-associated pneumonia, MRSA and *C. diff*, when the system CEO asks “Are these practices in place? How do you know?” the answer is far more likely to be grounded in reality.

Other Applications

Rounding to influence can be used for any improvement practice that you wish to make reliable—it isn't limited to infection control bundles. For example, safety behaviors such as “red rules,” pre-procedure checklists and

rigorous, complete communication processes at the time of handoffs are all excellent subjects for focused, scripted rounding by operational and executive leaders. And while you'll learn about structural, process, policy and technological barriers to implementation of safety practices, the most important barrier that you will discover is cultural—in particular, cultural norms that emphasize autonomy over accountability.

Rounding to influence is also tightly connected to another excellent safety practice—the daily 15-minute briefing in which the CEO and key leaders review significant safety issues from the past 24 hours, anticipate issues for the next 24 hours and prioritize

work lists generated from the issues identified during rounds.

All too often there is a huge gap between executive-level conversations and frontline realities, especially when it comes to safety and infection control practices. *Rounding to influence* as a regular practice can be an effective tool to help close that gap. And it might be

especially useful the next time your CEO asks you, “How do you know?” ▲

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Ask the Expert

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