Patient and Worker Safety

It’s a Two Way Street
September 27, 2016

International Forum on Quality and Safety in Healthcare
Plan for the Session

- Patient Safety
- Worker Safety
- Global Research
- Interventions on the Two Way Street
- Discussion
Section 1

PATIENT SAFETY FOR THE NEXT 15 YEARS
Patient Safety is a Public Health Issue

It’s been 15 years since the Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Health System* estimated that 44,000-98,000 lives were lost every year due to medical errors in hospitals at an annual cost of $17 Billion - $29 Billion.
Patient Safety: The Beginning

The first report of its kind, *To Err is Human* led to widespread recognition of patient safety, highlighting the human toll and social impact of medical errors on both patients and healthcare professionals.

*To Err is Human* proposed a four-tiered approach to improve patient safety:

1. **Establish Leadership and Knowledge**
2. **Identify Learning Opportunities / Best Practices**
3. **Set Performance Standards and Safety Expectations**
4. **The Implementation of Safety Systems Across Health Care Organizations**
TO ERR IS HUMAN FRAMED PATIENT SAFETY AS A SERIOUS PUBLIC HEALTH ISSUE (1999 ESTIMATES)

44,000 - 98,000
Annual deaths from medical error among hospitalized patients

43,458
Annual deaths from breast cancer

16,516
Annual deaths from AIDS

TO UNDERSTAND THE FULL IMPACT OF PATIENT SAFETY PROBLEMS, WE MUST LOOK AT BOTH MORTALITY AND MORBIDITY

1 in 10
1 in 10 patients develops a health care acquired condition (such as infection, pressure ulcer, fall, adverse drug event) during hospitalization.

BY SOME MEASURES, HEALTH CARE HAS GOTTEN SAFER SINCE TO ERR IS HUMAN

1.3 Million
Estimated reduction in hospital-acquired conditions (2011-2013) as a result of the federal Partnership for Patients initiative.

BUT WE MUST LOOK BEYOND HOSPITALS TO THE FULL CARE CONTINUUM

1 Billion
Roughly 1 billion ambulatory visits occur in the US each year.

35m
About 35 million hospital admissions occur annually.
Total Systems Approach to Safety

A project by project approach has not lead to widespread, holistic change. Initiatives only succeed when **teamwork, culture, and patient engagement** are a key focus.

**What Does a Total Systems Approach Look Like?**

- **Constant prioritization of safety culture by leadership**
- **Considers safety across the entire care continuum**
- **Addresses both mortality and morbidity**
- **Includes prioritization of well-being and safety of workforce**
- **Avoids adding disjointed initiatives to a stressed delivery system and workforce**
Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.

1. ENSURE THAT LEADERS ESTABLISH AND SUSTAIN A SAFETY CULTURE

Optimization of patient safety efforts requires the involvement, coordination, and oversight of national governing bodies and other safety organizations.

2. CREATE CENTRALIZED AND COORDINATED OVERSIGHT OF PATIENT SAFETY

Measurement is foundational to advancing improvement. To advance safety, we need to establish standard metrics across the care continuum and create ways to identify and measure risks and hazards proactively.

3. CREATE A COMMON SET OF SAFETY METRICS THAT REFLECT MEANINGFUL OUTCOMES

To make substantial advances in patient safety, both safety science and implementation science should be advanced, to more completely understand safety hazards and the best ways to prevent them.

4. INCREASE FUNDING FOR RESEARCH IN PATIENT SAFETY AND IMPLEMENTATION SCIENCE
Safety Culture

- Reporting – Learning – Just
  - Staff are held accountable for behavioral choices
  - Staff are not punished for human errors
  - Errors and near misses are identified and mitigated
  - Staff learn from previous errors through strong feedback loop

- Foundation to achieving total systems safety
  - For patients
  - For staff
  - For caregivers
### Recommendation 1

**Ensure that leaders establish and sustain a safety culture**

### TACTICS

| 1.1 | Refocus the boards of organizations to guide and be accountable for patient safety through governance, goal setting, and ensuring that executives and all levels of management value and prioritize safety (e.g., ensure that safety data and stories are presented at every board meeting). |
| 1.2 | Ensure that leadership and governance bodies develop and implement robust processes to initiate and sustain transformation to a culture of safety and respect, specifically one that encourages honesty, fosters learning, and balances individual and organizational accountability. |
| 1.3 | Develop and implement operational culture change “playbooks,” based on existing practices and operational experience with successful culture change efforts. |
| 1.4 | Create a new norm that every trustee, leader, and regulator completes a foundational program in patient safety science (e.g., just culture, systems). |

### RATIONALE

| 1.1 | A culture of safety is fundamental to driving improvements in patient safety, and more attention is needed for improvement. |
| 1.2 | Leaders need practical, tactical strategies to actually change culture. |
| 1.3 | Boards, leaders, and regulators (e.g., state agencies) need sufficient education in the fundamentals of safety science to foster culture efforts. |

**IMPROVED CULTURE IS NOT THE MEANS TO AN END BUT AN END ITSELF. IT CANNOT BE TREATED AS ONE AMONG OTHER SAFETY ACTIVITIES.**
Eight Recommendations for Achieving Total Systems Safety

5. ADDRESS SAFETY ACROSS THE ENTIRE CARE CONTINUUM
Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to evaluate the safety of care in various settings.

6. SUPPORT THE HEALTH CARE WORKFORCE
Workforce safety, morale, and wellness are absolutely necessary to providing safe care. Nurses, physicians, medical assistants, pharmacists, technicians, and others need support to fulfill their highest potential as healers.

7. PARTNER WITH PATIENTS AND FAMILIES FOR THE SAFEST CARE
Patients and families need to be actively engaged at all levels of health care. At its core, patient engagement is about the free flow of information to and from the patient.

8. ENSURE THAT TECHNOLOGY IS SAFE AND OPTIMIZED TO IMPROVE PATIENT SAFETY
Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.
Support the Healthcare Workforce

- As discussed in *Through the Eyes of the Workforce: Creating Joy and Meaning and Safer Healthcare*
  - “Workplace safety is inextricably linked to patient safety”
  - Care givers need protection, respect, and support in order to:
    - Avoid making errors
    - Adhere to safe practices
    - Work well in teams

- Workplace safety includes freedom from
  - Physical harm: physical injury, violence in the workplace, stress-related illness
  - Emotional harm: disrespectful behavior, intimidation, verbal abuse

Workplace Safety

- Psychological Safety
  - Ability of staff to speak up when they see safety violations or failures to complete tasks in safety procedures
  - Can you and your colleagues answer the following questions every day?
    1. Am I treated with dignity and respect by everyone?
    2. Do I have what I need so I can make a contribution that gives meaning to my life?
    3. Am I recognized and thanked for what I do?
Workforce Support

- Provide comprehensive training
- Address
  - Low morale
  - Professional burnout
  - Lack of engagement
- Provide support for caregivers and staff who experience psychological harm after being involved in errors
MEMBERS OF THE DEDICATED HEALTHCARE WORKFORCE NEED SUPPORT TO FULFILL THEIR HIGHEST POTENTIAL AS HEALERS.

**Recommendation 6**

**Support the healthcare workforce**

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<tr>
<th>TACTICS</th>
<th>RATIONALE</th>
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<tr>
<td><strong>6.1</strong> Organizations must adopt modern quality improvement tools and methods and train all professionals in safety culture and implementation science throughout their career trajectory.</td>
<td>Providing the knowledge and skills to improve safety may improve job satisfaction, engagement, resilience, and patient safety.</td>
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<td><strong>6.2</strong> Expand or develop resources that support the workforce, including initiatives to improve working conditions and establish an environment of respect; programs to support staff and improve resiliency; fatigue management systems; and communications, apology, and resolution programs.</td>
<td>Workforce safety is a precondition to patient safety; however, physical and psychological harm and burnout are highly prevalent in health care.</td>
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<td><strong>6.3</strong> Involve the workforce in identifying domains for measurement and creating workforce safety and wellness dashboards to be reviewed by leadership and boards.</td>
<td>Standardized measures of physical and psychological safety are not available for senior leaders to review.</td>
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Section 2

WORKER SAFETY IN HEALTHCARE
Topic Areas

1. Slips, Trips, Falls
2. Safe Patient Handling
3. Bullying
Worker Injuries in the USA

Top 10 Hazards for Slips Trips Falls (STF)

1. Contaminants on the Floor
   Food service areas, decontamination areas, soap dispensers, drinking fountains, building entrances tracking from outside
   Prevention strategies
   Keep floors clean and dry, use proper cleaning techniques, wear slip resistant shoes, prevent entrance into wet areas

2. Poor Drainage Pipes and Drains
   Kitchen and Decontamination areas
   Prevention Strategies
   Check pipe alignment, unclog drains regular especially in kitchen, redirect downspouts away from high pedestrian traffic
Top 10 Hazards for Slips Trips Falls (STF)

3. Indoor Walking Surface Irregularities
   Entrances, patient rooms, operating rooms, hallways, floor matting
   Prevention strategies
   Replace buckled carpeting, remove blistered vinyl tile, patch cracks in walkways, level elevators
   Create visual clues (yellow highlight)
   Replace smooth floors in water exposed areas with rougher flooring

4. Outdoor walking surface irregularities
   Entrances, lawns, parking garages and lots, walkways
   Prevention strategies
   No concrete wheel stops in parking areas
Top 10 Hazards for Slips Trips Falls (STF)

5. Weather Conditions: Ice and Snow
6. Inadequate Lighting
7. Stairs and handrails
8. Stepstools and ladders
9. Tripping Hazards: Clutter
10. Improper Use of Floor mats and runners
Strategies for ALL

- Know your data
- Go looking for hazards
- Employee training and involvement
Musculoskeletal Injuries – USA Data

- **Injuries**
  - Hospitals have 6.8 non-fatal occupational injuries/illness per 100 Full Time Workers (FTE)
  - All Industries = 3.5/100

- **Incidence rate with days away from work**
  - All Industries 1.2/100 FTE
  - Healthcare Industry 4.4/100 FTE
    - 50% are musculoskeletal
    - Nursing assistants #1, nurses #5

- **Cost**
  - $15,600, with $12,000 in replacement cost
  - Indirect costs: turnover, training, productivity, morale
Back and Musculoskeletal Injuries

- **US Department of Labor**
  - 35,000 back and other injuries among nursing employees severe enough to miss work
  - Nursing Assistants (NA) and orderlies = 3x more likely than construction workers
  - NA, warehouse workers, truckers, stock clerks, & nurses in that order

- **Proper Body Mechanics have been taught the same way for over 100 years**
  - Keep your back straight, bend at knees and hips
How Much Can I Safely Lift?

- Spine Research Center at The Ohio State University
  - There is no safe way to lift patients with proper body mechanics
  - Need to use a ceiling hoist like factory workers
  - Auto Factory workers
    - 93% men, prohibited from lifting more than 35 pounds (16 kg) through the course of their work
    - In a 250-300 pound (113-136 kg) patient, to lift just their leg may be 60-70 pounds (27-32 kg)

- When patient is cooperative and unlikely to move suddenly
  - Cannot get as close as when lifting something like a box
  - Difference of about 4 inches (10 cm) changes math equations
  - In ideal patient safe handling situation 35 pounds! [16 kg!]

http://www.npr.org/2015/02/04/382639199/hospitals-fail-to-protect-nursing-staff-from-becoming-patients
http://www.npr.org/2015/02/18/385786650/injured-nurses-case-is-a-symptom-of-industry-problems
Lifting Teams

- Even when 2 or more nursing employees lift a patient together, they are in danger of moving their backs.

- Physics and biology become more complicated:
  - Increases shear force rather than compression force.
  - Because members may be different height and strength, so lifting is uneven.
    - Therefore people bend and increase sideways forces on spine.
    - Body can tolerate more compression than shear.
Workplace Violence in Healthcare

- Definition: violent act, including physical assaults and threats of assaults, directed towards persons at work or on duty
  - Physical assaults
  - Verbal violence
  - Sources include patients, visitors, intruders, coworkers
  - Healthcare (HC) workers at increase risk
  - From 2002-2013, incidents of serious workplace violence (requiring time off from work) were 4x more likely in HC than private injury in general
    - 7.8/10,000 FTE in HC
    - Less than 2/10,000 in construction, manufacturing and retail
    - 80% caused by interactions with patients

www.osha.gov
Risk Factors

- Patient with history of violence
- History of delirium
- Under influence
- Patient handling
- Working alone
- Poor design that blocks vision or escape routes
- Poor lighting
- No means of emergency communication
- Presence of firearms
Risk Factors

- Working in neighborhoods with high crime rate
- Lack of training
- Understaffing, esp. during meal and visiting hours
- High worker turnover
- Inadequate security staff
- Long wait times and overcrowded waiting rooms
- Unrestricted public access
- Perception that such behavior is tolerated
- Perception that reporting will have no effect
An Extreme Case

- **Active Shooter**
  - Need to work closely with law enforcement
  - Understand their roles and priorities
    - They will walk right past you
    - Their main objective is to get the shooter

- Once shooter is engaged with security or cop with a gun
  - Will stop shooting innocent people
  - And shoot at officer or themselves

- Event only lasts a few minutes

An Extreme Case

- Meet with local authorities
  - Become part of their notification or alert system
  - Develop an internal alert system
- Practice
  - Run, Hide, Fight
  - Evacuation Process
Section 3
GLOBAL RESEARCH ON
WORKER AND PATIENT SAFETY
Worker Safety – Emotional

- **Bullying**
  - Threatening behavior
  - Based on intimidation
  - From vantage point of the bully, personal power
    - Bully is egocentric
  - Creates hostile work environment

- **Incivility**
  - Not being respectful of the other person’s perspective
  - Not valuing communication during handoff
  - Non-verbal, less-than-polite behaviors, i.e. toe tapping

- **Both**
  - Perpetrator denies wrongdoing
  - Fulfills a neurotic need

http://www.mindbodynetwork.com/article/incivility-versus-bullying-know-the-difference
Worker Safety – Emotional

Measures of Burnout

- Maslach Burnout Inventory (MBI)
  - Emotional Exhaustion Scale (EE)
    • Measure emotional job distress
      - 0-16 = low
      - 17-26 = moderate
      - 27 or more = high
  - Depersonalization (DP)
    • 10 or more is high
  - Reduced Personal Accomplishment (PA)
    • 5 or less is low
Staff Well Being and Burnout

- Systematic Review of the Literature
- 46 studies were identified
  - 27 measured well being
    • 16 found significant correlation between poor well being and worse patient safety
    • 6 more found correlations with some subscales but not all
    • 1 found correlation in opposite direction
  - 30 studies measured burnout
    • 21 found significant association between burnout and patient safety
    • 4 more found correlation of some subscales

PLOS ONE. 2016. DOI: 10.1371/journal.pone.0159015
Staff Well Being and Burnout

- Conclusions
  - Poor wellbeing and moderate to high levels of burnout are associated in majority of studies with poor patient safety outcomes, such as medical errors
  - Cannot say causality

PLOS ONE. 2016. DOI:10.1371/journal.pone.0159015
A Program of Research

- Six related articles studied similar concepts in worker and patient safety around the world

- Overview article - Importance of work environments on hospital outcomes in nine countries
  - USA, China, South Korea, Thailand, Japan, New Zealand, UK, Canada, Germany
    - From 1999 – 2009
    - 96,116 bedside nurses in 1,406 hospitals
  - Based on original work of Aiken et.al., International Hospital Outcomes Study
    - USA, Canada, England, Scotland, Germany

Main Findings
- High nurse burnout in all countries except Germany
- Burnout from 33% to almost 60% in South Korea and Japan
- Job dissatisfaction from 20% to 60% (Japan)
- Quality of care rated as fair/poor varied from 11% (Canada) to 68% (South Korea)
- One quarter to 1/3 of hospitals in each country had poor work environments
- Working in a hospital with better work environment was associated with lower odds of nurse burnout and job dissatisfaction, and with better quality of care outcomes
The Study in Japanese Hospitals

- Survey of 5,956 staff nurses on 302 units in 19 (15 university) acute care hospitals in Japan
- Published in 2008, at time of study nursing shortage in Japan

Results
- 56% of nurses scored high on burnout
- 60% were dissatisfied with their jobs
- 59% ranked care as fair or poor
- Staff less experienced: 1/3 had fewer than 4 years experience, more than 2/3 had less than 10
- One in 5 reported enough nurses to provide quality care
- More than 1/2 reported lack of teamwork between nurses and physicians
The Study in Japanese Hospitals

- Complex analysis
  - Odds of high burnout, job dissatisfaction and poor/fair quality of care
    - 2x as high in hospitals with 50% inexperienced nurses than with 20% inexperienced nurses
    - 40% higher in hospitals were nurses did not have good working relationships with physicians
  - Nurses in poorly staffed hospitals were
    - 50% more likely to exhibit burnout
    - 2x as likely to be dissatisfied
    - 75% more likely to report poor or fair quality care
A Study in Thai Hospitals

- 2,084 RN in 94 community hospitals
- MBI
  - Emotional Exhaustion – 32% high
  - Depersonalization – 18% high
  - Personal Accomplishment – 35% low
- Quality of care
  - 16 % rated quality of work as fair or poor
    - 5% reported falls
    - 11% medication errors
    - 14% infections

A Study in Thai Hospitals

- All 3 subscales of MBI were associated with increase reporting of adverse events and poor/fair quality of work

- Complex analysis
  - Every unit of increasing EE meant
    - 2.63 times rise in reporting poor/fair quality of care
    - 30% increase in patient falls
    - 47% increase in medications errors
    - 32% increase in infection
A Study of UK Physicians

- Royal College of Physicians (RCP) report National Health Service is underfunded, underdoctored, and overstretched
  - Main argument is that there are no longer enough doctors “to staff our hospitals safely”
  - Number of doctor vacancies increased 60% between 2013 and 2015
  - 7 out of 10 doctors in training report working on a rota with permanent gap
  - Over 1/2 of doctors in training report rota gaps have a serious or extremely serious impact on patient care

- Consultants agree
  - 1 in 4 report rota gaps so serious and frequent that they cause significant problems for patient safety

A Study of UK Physicians

- The working life of a doctor in training
  - 24% say working patterns leave them feeling short of sleep on daily or weekly basis
  - 74% report going through at least one shift per month with insufficient hydration
    - 37% do not drink enough water on seven shifts per month
  - 28% have worked 4 shifts per month without a meal
    - 65% have worked at least one shift per month without a meal
  - On average, these doctors work an extra five weeks per year on top of rostered hours

- How can they care for patients if we are not caring for them?
  - Discouraged from napping during night shift in spite of research showing benefit to patient safety
Bullying in the Operating Room

- Descriptive Study
  - Do demographic variables predict experience of workplace bullying?
  - Is there a relationship between workplace bullying and emotional exhaustion?
  - Is bullying associated with perceptions of patient safety in OR?

- Why the OR
  - Negative behaviors often occur in high stress environments and physically limited workspaces

Bullying in the Operating Room

- Sample = 167 staff at 2 academic medical centers
  - Negative Acts Questionnaire
  - Emotional Exhaustion Scale of Maslach Burnout Inventory (MBI)
  - Questions about experiences or witnessing bullying
  - Questions about effect of bullying on near errors, errors, safety of patients

- Results
  - 71% were satisfied or very satisfied with their jobs
  - 62% considered their job stressful or very stressful
  - Over 1/3 (37%) worked more than their scheduled hours in the previous work week

Bullying in the Operating Room

- **Additional Results**
  - Top Bully acts occurring at least monthly
    - Having your opinion ignored (28%)
    - Being shouted at (27%)
    - Withholding information that affects your performance (26%)
    - Being humiliated or ridiculed (25%)
    - Having gossip or rumors spread about you (25%)
    - Ordered to do work below your competency level (23%)
  - Respondents experienced on average 2 bullying acts weekly
  - Staff at hospital A 3x more likely to be bullied than hospital B
Bullying in the Operating Room

- **Results**
  - EE
  - Scores were moderate
  - Significant relationship between bully intensity and EE scores
  - Only 3% indicated that bullying affected errors
  - Only 6% indicated that bullying affected patient safety

- **So what?**
  - Do perioperative staff normalize the bullying experience?
  - Does use of term ‘negative behaviors’ affect responses?
  - Staff who met definition of bullying did not perceive themselves as being bullied
Section 4

INTERVENTIONS ON THE TWO-WAY STREET
Organizational Safety Culture

- Link between patient and worker safety
  - Workers who are concerned for their own safety cannot provide error free care to patients
  - Safety culture has influence on implementing skills and knowledge that workers have gained through training

  - Actions management takes to improve both worker and patient safety
  - Worker participation in safety planning
  - Availability of appropriate protective equipment
  - Influence of group norms about safety practices
  - Organizations socialization process for new personnel

https://www.osha.gov/SLTC/healthcarefacilities/safetyculture.html
Organizational Culture

- Following Occupational Safety and Health Administration (OSHA) guidelines supports more than staff
  - Environmental conditions help patients and visitors
    - Keep surfaces clean and free of obstructions
    - Ice and snow removal
    - Mopping up spills
    - Fixing torn carpeting
    - Human factors for floor design

Organizational Culture

- Following Occupational Safety and Health Administration (OSHA) guidelines supports more than staff
  - Preventing exposure to hazardous materials
    - Sharps disposal programs
    - Hazardous chemicals (chemotherapy)
  - Correct ergonomics and procedures
    - Choice of furniture
    - Lifting equipment

Worker Safety is Good for Patients

- Adequate staffing
  - Staff injured may need to take leave of absence
  - Temporary worker may have to replace injured staff
  - Temp worker will not have same relationship with patients or staff
  - Temp worker may not have same skill level as injured worker
  - May not be able to find or hire temp worker
  - Work short-staffed

- Worker injuries and regulatory citations not good for reputation

- Worried staff
  - Some may quit, some call in sick
  - Some have low morale and enthusiasm at work
Gallup Study

- Employee engagement + employee safety = improved patient safety
  - Partnered with hospital in state of California
  - New way to measure and manage drivers of culture of care that is bedrock of patient safety

- Measures
  - Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture
  - Workers compensation (employee liability) claims
  - Calculated overall safety index score

Gallup Study

- Results
  - Additive effect of engagement and worker safety on patient safety
  - 15% increase in patient safety scores on units with high employee engagement and safety

- Interventions need to be at the workgroup level
Injury and Illness Prevention Programs

- Proactive approach to transform workplace culture
  - Need to have information about reasons for injuries and illnesses
    - Types
    - Location
    - Underlying reasons
  - Strong management commitment
  - Strong worker participation
    - Workers are encouraged to offer ideas
    - Workers see their contributions taken seriously
    - Workers more satisfied and productive

https://www.osha.gov/SLTC/healthcarefacilities/safetyculture.html
Safe Patient Handling Programs

- **Ensuring success**
  - Have the right data
  - Have the right evidence and examples
  - Have the right tools

- **Need a program not just a project**
  - Cost of equipment and program can be recovered in less than 5 years
  - Program includes equipment, orientation, safety champions, reinforcement

- **General Thoughts**
  - There is no safe way to lift a patient manually
  - Safe patient handling can reduce incidence by 80%
  - Often causes relatively young workers to stop working early in their careers

Safe Patient Handling Programs

- Are good for patient safety, too!
  - Patient experience
    - Fewer falls, skin tears, pressure ulcers
    - Increase patient mobility
    - Reduce length of stay
    - Patient feels more secure and comfortable when transfer device is used

- One university lifting program
  - Spent $800,000 in program
  - Five year net savings of $2.2 million!
    - Half from workers compensation
    - Half from reducing pressure ulcers in patients
Finding Joy and Meaning in Work

- Workplace safety is inextricably linked to patient safety. Unless caregivers are given the protection, respect and support they need, they are more likely to make errors, fail to follow safety practices and not work well in teams.

- Many healthcare workers are suffering harm – emotional and physical
  - in the course of providing care
  - 30x more physical harm than other industries
  - 13% of nurses have unprotected contact with blood borne pathogens
  - 76% of nurses surveyed by ANA indicated unsafe working conditions interfere with delivery of quality care
  - Psychological harm
    - Bullying, harassed, ignored, demeaned

Joy and Meaning in Work

- Environment of mutual respect
- Paul O'Neill of Alcoa
  - Every staff member, every day should be able to answer “YES” to each of 3 simple questions:

1. Am I treated with dignity and respect by everyone?
2. Do I have what I need so I can make a contribution that gives meaning to my like?
3. Am I recognized and thanked for what I do?
Strategies for Improvement

Importance of Safety Culture

• **DO NOT** differentiate between patient, families, staff, visitors, vendors, contractors in your definition of safety
  – Avoiding both short and long term harm to people resulting from unsafe acts and preventable adverse events
  – Cannot silo groups
  – Underlying causes and therefore solutions to events and near misses in one group may bring to light risks to other groups

The Joint Commission (TJC). 2012. Improving Patient and Worker Safety – Opportunities for Synergy, Collaboration and Innovation
Principles for Implementation

- Necessary precursor to improving safety culture is the need to establish a civil workplace

- Ergonomics
  - Science of fitting workplace conditions and job demands to the capabilities of the working population

- Human factors
  - World Health Organization definition: environmental, organizational, and job factors in combination with the human and individual characteristics that influence behavior at work in a way that can affect health and safety
Principles for Improvement

- **Safer Design of work place processes**
  - Make it harder to do the wrong thing and easier to do the right thing
  - Simplification and standardization
  - Probability that a process will fail is directly related to number of steps

- **Incident reporting and feedback**
  - E.g. employees may be getting injured in their efforts to reduce falls to patients

- **World Health Organization guidelines for reporting**
  - Role is to learn from failures of the health care system
  - Reporting must be safe
  - Reporting is only of value if it leads to a constructive response
  - Meaningful analysis and dissemination of lessons learned requires expertise and resources
Principles for Improvement

- Leadership
  - Demonstrate through deeds rather than words
  - Tell real stories
  - Conduct leadership rounds

- Staff engagement
  - Begins with culture but is executed in job performance
  - Use frontline coaches, champions and peer leaders

- Communication
  - Daily huddles
  - CUS (Critical Language)
  - SBAR (Situation, Background, Assessment, Recommendation)
Programs for Implementation

- Integrate safety into the way you do business
  - Interventions to improve safety for patients often improves safety for workers

- Safe patient handling
  - Intersection of physical work requirements and the capacity of the worker
  - Control solutions: engineering, administrative and behavioral
  - Special population, e.g. bariatric

- Slip, Trips and Falls
- Sharps and Infection Control
- Exposure to hazardous substances
  - Infectious diseases
  - Radiation
- Violence
- Staffing and fatigue
Culture of Ritual

- Different than culture of accountability
- Team members are emotionally positive, self-empowered, fully engaged partners in their organization
- Add ritual to meetings
Culture of Ritual

- Ritual + Reminder = Positive Change
  - 1. Pickle Pledge
    - promise to turn complaints into constructive suggestions
    - Leave gossiping, complaining and toxic emotional negativity at the door
    - First step to be open to second step
  - 2. The self–empowerment pledge
    - Say out loud in pairs, in groups
    - At work, during huddles
    - At home
    - Repeat to yourself 4x each day
Culture of Ritual – Daily Promises

- First 3 are foundation for character strength
  - Responsibility (Monday)
  - Accountability (Tuesday)
  - Determination (Wednesday)
  - Contribution (Thursday)
    • Pay it forward
  - Resilience (Friday)
  - Perspective (Saturday)
  - Faith (Sunday)
    • Appreciate and honor every experience

- Pay it forward
When Bad Things Happen to Good Clinicians

- Respectful Management of Serious Clinical Adverse Events
- First released in 2010 and more than 34,000 visits to site in first 9 months!
  - Second edition in 2015

- Objectives of white paper
  - Encourage and help organizations to develop clinical crisis management plan before they need to use it
  - Provide an approach to integrate the plan into quality and safety program with emphasis on patient and family centered care
  - Provide a concise, practical resource when a serious event occurs in the absence of a crisis management plan or culture of safety

Respectful Management of Serious Clinical Adverse Events

- Questions in the aftermath of a serious clinical adverse event
  - How should we respond?
  - What should we say and to whom?
  - Who should do it?
  - Who is responsible and accountable?

- Hallmarks of a strong crisis management response
  - Immediacy
  - Transparency
  - Apology
  - Accountability
Respectful Management of Serious Clinical Adverse Events

- Priorities of Response
  - Priority 1: Patient and Family
  - Priority 2: Frontline Staff
  - Priority 3: Organization

- Internal and External Communication
  - Engaging with Patients and Families
  - Engaging with Staff
  - Engaging with the Media
When Bad things happen to good clinicians

- **CANDOR** (Communication and Optimal Resolution Process)
  - From the Agency for Healthcare Quality and Research (AHRQ)
  - Process to respond in a timely, thorough and just way when unexpected events cause patient harm

CANDOR

- Key aspects of program
  - Engage patient and families in disclosure communication following adverse events
  - Implement a care for the caregiver program for providers involved in adverse events
  - Investigate and analyze adverse events to prevent future events
  - Review and align organization’s policies with CANDOR process
  - Establish a resolution process for the organization
CANDOR

- Tool Kit for organizations (FREE)
  - Module 1: Overview
  - Module 2: Obtaining Organizational By-In and Support
  - Module 3: Gap Analysis for Implementation
  - Module 4: Event Reporting and Investigation
  - Module 5: Response and Disclosure
  - Module 6: Care for the Caregiver
  - Module 7: Resolution
  - Module 8: Organizational Learning and Stability

- PowerPoint Slides, videos, tools(checklists), and facilitator notes
Closing Thoughts

- It’s all about the culture
- It’s all about leadership
- It’s all about safety
QUESTIONS AND DISCUSSION
References


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