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The Joint Commission Update

In this column an expert from The Joint Commission provides an update for readers.

Improving Patient and Worker Safety: Exploring Opportunities for Synergy

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THE INSTITUTE OF MEDICINE report that medical errors claim the lives of 44 000 to 98 000 patients annually[1] has prompted many health care safety initiatives during the past decade. These initiatives often focus solely on patients, although many safety issues also place nurses and other health care workers at risk for harm. In fact, the National Institute for Occupational Safety and Health[2] and US Department of Labor[3] report that health care workers experience some of the highest rates of nonfatal occupational illness and injury—exceeding even construction and manufacturing industries. Given the high risk, high volume, and significant costs associated with adverse health events, it seems imperative that the health care industry explores new opportunities to reduce preventable harm. One possible approach is by integrating patient and worker health and safety activities wherever feasible. There is growing consensus that integrating patient and worker health and safety activities can offer significant opportunities to reduce preventable harm.[4]

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HIGH RELIABILITY AND PATIENT, WORKER SAFETY

Certain industries, such as nuclear power and air traffic control, are considered to be highly reliable because they prioritize safety for all due to the high risk, high hazard nature of their business. High reliability organizations have been defined as "systems operating in hazardous conditions that have fewer than their fair share of adverse events."[5(p769)] High reliability organizations are deeply concerned with safety, valuing near-miss events as opportunities to learn how to improve.[6] Leadership and staff embrace a culture of safety that becomes a fundamental characteristic of the organization and "the way it does business." In health care, this would logically include safety for both patients and workers.

The evidence that staff working conditions are related to patient safety continues to grow.[7] Stone et al[8] suggested that there are common structural and process factors that affect outcomes for both workers and patients. Some of the relationships are direct, whereas others are indirect. For example, leadership can have a direct effect on the work environment by influencing factors such as work process design and quality emphasis, which, in turn, indirectly affects patient outcomes. The organizational culture established by leaders has a direct effect on worker outcomes, such as satisfaction and intention to leave. McHugh et al[9] found that patient satisfaction levels were lower in hospitals with more nurses who are dissatisfied or burned-out. Taylor et al[10] found that lower perception of safety and teamwork among nurses was associated with increased odds of decubitus ulcers in patients and increased nurse injury. The study also found that more nursing hours per patient-day was associated with fewer patient falls.[10]

Interestingly, the relationship between worker outcomes and patient characteristics and outcomes is bidirectional. McCaughey and colleagues[11] reported that health care workers who routinely care for high-risk patients, for example, patients who are cognitively impaired, morbidly obese, or infected with contagious pathogens, were more likely to have poorer perceptions of safety climate and higher levels of stress. However, organizational safety climate was found to mediate the relationship between high-risk patients and worker stress.[11]

SYNERGIES IN PATIENT, WORKER SAFETY

Despite commonalities between the patient safety movement and worker safety, separation of patient and worker safety can result in "departmental silos" of staff competing for leadership attention and resources, as well as fragmentation, duplication of effort, inefficiencies, and additional expense.[4] High reliability organizations, however, have likely learned how to integrate or coordinate functions across departments and to identify and maximize synergies where possible while recognizing responsibilities that are unique to specific purposes and stakeholders. There are numerous clinical and nonclinical activities and programs that can benefit from consolidated improvement initiatives. Many of these improvement initiatives are applicable not only in hospitals but also in home care, nursing homes, behavioral health, and several other settings.

Examples of safety improvement activities that would simultaneously benefit workers and patients range from well-known areas, such as falls, safe patient handling, and violence prevention, to lesser known topics, such as active surveillance for environmental hazards and improving civility, respect, and teamwork.[4] While some interventions involve significant capital expenditures, others require minimal investment of resources. For example, implementing daily huddles (briefings with senior leaders) that focus on worker and patient safety hazards within or across units minimizes staff time and optimizes real-time identification.[4]

Recommendations for successfully integrating patient and worker safety as well as examples of strategies and action steps identified at a July 2011 meeting of health care practitioners and safety experts include the following[4]:

1. *Encourage leaders to make patient and worker safety a core organizational value.*
   - Establish a vision that makes safety for both patients and workers a core value across the entire organization.
   - Establish specific goals and incorporate plans to communicate and achieve the goals into strategic planning activities.
   - "Walk the talk." Become highly visible by making safety rounds at the unit and department level to actively engage with frontline staff.
   - Communicate daily with all levels of management to learn about safety events through vehicles such as a "daily huddle."

- Employ real-life patient and worker stories to engage the "hearts and minds" of leaders, managers, and staff.
- Engage board members in discussions of safety for both workers and patients. Share data on organizational performance.
- Communicate successes both internally and externally to the community through media and to peers through conferences, and so on.

2. *Identify opportunities to integrate patient and worker safety activities across departments and programs.*
   - Build and raise awareness of linkages and crosscutting topic areas.
   - Recognize shared health and safety risks between health care staff and patients.
   - Align patient and worker safety improvement initiatives having common goals. Consider integrating with organizational quality improvement priorities.
   - Convene multidisciplinary safety committees that include representation from patient safety, employee health, occupational/environmental safety and health, infection prevention, risk management, human resources, and other areas.
   - Examine policies for their impact (positive or negative) and unintended consequences on worker and patient safety.
   - Remove structural and functional organizational systems and processes that maintain traditional "silos" for patient and worker health and safety.
   - Develop a business case for integrating patient and worker safety initiatives; calculate a cost-benefit analysis or return on investment for specific initiatives.
3. *Understand and measure performance on safety-related issues.*
   - Learn about evidence-based practices from published literature, conferences, networking, and other sources. Information sources should cross multiple disciplines. Incorporate and tailor relevant practices to your setting. Address obstacles and lessons learned by others in the field.
   - Understand your risks on the basis of facts—not perception. Gather baseline data on your current safety performance for benchmarking future performance. Monitor performance over time.
   - Conduct periodic hazard analyses.
   - Examine data from manual and automated employee and patient incident reporting systems (eg, work-related injury and illness incidence reports, hazard inspections, environmental hazards, patient safety incidents, medication errors, and infection prevention); quality improvement and performance measurement systems (internal and external); and human resources information (such as satisfaction surveys, turnover, absenteeism) to identify patterns and trends.
   - Develop and improve nonpunitive incident reporting systems and encourage reporting for safety incidents, hazards, errors, and near misses.
   - Investigate worker and patient safety events, errors, and near misses, using root cause and other analysis tools to understand and identify contributing factors.
4. *Implement and maintain successful worker and patient safety improvement initiatives*.
   - Develop a work plan, time line, staff accountabilities, and measures of success.
   - Begin with small-scale changes to demonstrate success and then spread to other areas as enthusiasm builds.
   - Develop employee training curricula and educational resources. Implement initial and regular training for new and existing staff. Enhance traditional educational methods with experiential, simulation, and scenario training.
   - Redesign processes and systems on the basis of identification of root causes and contributing factors to prevent future events.
   - Integrate changes into existing process and procedures when possible.
   - Identify and develop frontline worker "champions" who support and guide

employees and promote the initiative's success.
- Use visual, auditory, and electronic reminders to keep staff engaged.
- Provide regular feedback on overall and unit-level safety to staff.
- Post progress as visible recognition of success; for example, posters, and intranet systems.
- Recognize and reward employee efforts to improve patient and worker safety.

CONCLUSION

The growing evidence that employee well-being affects patient safety, both directly and indirectly, suggests that health care organizations striving for high reliability should be concerned with safety for both patients and workers. The recommendations presented in this article represent only a starting point for what should become an ongoing effort to further an understanding of the value, benefits, and challenges of an integrated approach to patient and worker safety. Through research, practical experience, and sharing of information, health care can be improved to prevent adverse events, reduce harm, and improve outcomes for all.

Note. Detailed information about patient and health care worker safety is available in a free monograph, "Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation," published by The Joint Commission. Work on the monograph was supported in part by the National Institute for Occupational Safety and Health, National Occupational Research Agenda Healthcare and Social Assistance Sector Council. Copies can be downloaded at http://www.jointcommission.org/improving_Patient_Worker_Safety/.

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