OSHA & Worker Safety

Protection Partnership

How health care organizations can better secure the safety of workers and patients alike

Note: *This is Part 2 of a two-part series that explores the significance of mutual patient and worker safety and ways both groups can be better protected.*

A confused elderly patient attempts to leave her hospital bed in the middle of the night to use the bathroom. A nursing assistant rushes to help her return to bed, but the patient slips from her grip and strikes the floor and the bed frame. The patient sustains bruising, and her stay is lengthened, while the nursing assistant experiences back pain and misses three days of work.

Scenes like this hypothetical one play out in health care settings with alarming frequency. Consider that one out of three hospital patients experiences adverse events during hospitalization.[1] And more workers in the health care and social assistance industry sector are injured (5.2 out of 100 workers in 2010, on average) than in any other private industry (an average of 3.5 out of 100 workers).[2]

The example also demonstrates that the safety of employees and patients in health care organizations (HCOs) is inseparably linked. The Joint Commission's recent monograph, *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation,* is devoted to this concept.[3] Understanding this synergy, the value of mutual safety, and how to better protect both groups (issues that are explored in Part 1 of this series, published last month) is vital. Equally important, however, are learning how to increase your organization's reliability, stressing incident reporting and feedback, and creating an effective safety climate.

High-reliability organizations

Working to improve both worker and patient safety is essential to becoming a high-reliability organization (HRO). HROs have been described as "systems operating in hazardous conditions that have fewer than their fair share of adverse events."[4]

"[HROs] understand that humans fail. Everybody makes mistakes; it's part of human nature. And it will happen when you least want it to," says Rosemary Sokas, MD, MOH, professor and chair, Department of Human Science, Georgetown University School of Nursing and Health Studies, Washington, DC. "So you plan for that and create backup systems to catch failures before they can cause a bad outcome. In an [HRO], there's an obsession ahead of time with what can go wrong and how you can prevent it."

To help with prevention of adverse events, HROs should respect the experience of workers and train them appropriately. "That way, when things do go wrong, you have a trained workforce that knows how to adapt," says Sokas. "You should also promote teamwork and communication across hierarchies, and include frontline workers as safety monitors who can really tell you if you're 'walking the walk.'"

The Joint Commission strongly supports health care organizations working toward becoming HROs. In fact, The Joint Commission's High Reliability Resource Center webpage is devoted to tools, tips, and articles to help organizations in this quest. See the website at jointcommission.org/highreliability.aspx.

Essential changes

HCOs must make the following three interdependent, essential changes to become highly reliable:

1. Leadership must commit to the goal of high reliability.
2. An organizational culture that supports high reliability must be fully implemented.
3. The tools of robust process improvement must be adopted.[5]

For example, per Joint Commission Environment of Care (EC) standards, an HCO aiming to become an HRO should carefully evaluate new types of medical equipment before initial use and maintain a written inventory of all medical equipment. (*See* EC.02.04.01 and EC.02.04.03.) An HCO should ensure that it has a reliable emergency electrical power source for alarm systems, exit routes, emergency communication systems, essential medical equipment, and clinical care areas. (*See* EC.02.05.03.)

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Effective reporting systems

A safe culture and workplace is also highly dependent on a proactive surveillance system to identify hazards and risks, evaluate them, prevent future occurrences, and mitigate the effects of breakthrough occurrences. Managers should encourage employees and other stakeholders to report hazards. Hazard identification will be more effective with an easy-to-use reporting system that rewards those who choose to file reports.

Essentially, workers want to do a good job, "but they need to have the tools, information, and training to do so. They also want to be appreciated for what they do," says Sokas. "Encouraging incident reporting and providing healthy feedback lets them know they're appreciated and builds trust."

"Systems for (incident) reporting and investigation of individual events as well as near misses or close calls can generate useful information to identify opportunities for improvement in local systems and processes," says Barbara Braun, PhD, project director, Department of Health Services Research, Division of Healthcare Quality Evaluation for The Joint Commission.

Without an effective feedback system in place, workers either can't report a problem or don't bother because they don't expect anything to be done about it, Sokas says.

Safety culture club

One of the most significant ways to become an HRO and, thus, better protect both patients and workers is to promote an effective culture of safety. According to the Joint Commission monograph, a safety culture is a subset of an organization's overall climate that does the following[3]:

- Focuses on people's perceptions about the degree to which the organization values safety for workers, patients, and/or the environment
- Commits resources to safety-related initiatives and equipment
- Promotes safe behaviors

A safety culture can serve as a leading indicator of safety performance, as opposed to error and injury rates, which are lagging indicators of performance.

"A culture of safety has to start from the top and be consistent day after day. There has to be enough trust and the idea that this is a culture where workers can be respected, where they can be free to admit mistakes without being afraid they'll get in trouble," Sokas says. "It's hard to establish that level of respect and trust, and it's easy to break it if people wind up being punished when they made a mistake but intended to do well."

An inadequate safety culture and poor working conditions are linked to unfavorable outcomes for workers, which are associated with poorer patient outcomes, per the Joint Commission monograph.[3] Thus, HROs should emphasize both worker and patient safety, which are inseparably integrated, and identify their safety culture strengths and weaknesses (*see* "Safety Culture Characteristics," above).

HCOs can improve their safety culture in many ways. For example, they can train frontline and security staff in assault and violence prevention and management. This training can benefit patients by leading to fewer injuries and less use of restraint. Such training can help workers by reducing anxiety and promoting teamwork. HCOs can install effective locks, lights, and video surveillance equipment in and around the facility, which can allay patient and staff fears of violence. HCOs can also enforce better infection prevention programs by

Safety Culture Characteristics

According to findings of a recent survey by the Agency for Healthcare Research and Quality (AHRQ),[6] most health care organizations (HCOs) that could be considered to have a culture of safety display four areas of strength.

Areas of strength

1. Teamwork within units—staff support each other, treat each other with respect, and work together as a team.
2. Supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures, and do not overlook patient safety problems.
3. Organizational learning—mistakes have led to positive changes, and changes are evaluated for effectiveness.
4. Hospital management provides a work climate that promotes patient safety and shows that patient safety is a top priority.

However, for many HCOs, flaws still remain, specifically in three areas for improvement.

Areas for improvement

1. Workers should feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.
2. Important patient care information should be transferred across hospital units and during shift changes.
3. There should be enough staff to handle the workload, and work hours should be appropriate to provide the best care for patients.

having workers receive regular immunizations, follow recommended hygiene practices, and wear personal protective equipment (PPE)—resulting in decreased transmission of pathogens from workers to patients and patients to patients.

Setting a good example

Although it's important to train workers properly and expect them to follow established procedures designed to stress safety, effective modeling from the top down is necessary.

"As with any other business improvement initiative, a proactive approach to safety and health starts with management leadership and visibility," says Patricia Bray, MD, MPH, medical officer for the Office of Occupational Medicine, Occupational Safety and Health Administration (OSHA). "It is essential for management to lead by example and to provide necessary resources to maintain a safe environment and to encourage safe behaviors."

Bray says managers can promote an effective safety culture in several ways—by wearing PPE, asking workers during walk-arounds if they have any safety concerns, responding promptly when issues are raised, and investigating any incidents or near misses involving patients, workers, or visitors.

Bray also encourages health care organizations to enroll in OSHA's Voluntary Protection Program (VPP; *see* http://osha.gov/dcsp/vpp for details). VPP facilities have demonstrated a high degree of effectiveness in reducing injuries and illnesses, and VPP participation can also lead to lower employee turnover, increased productivity, and cost savings. EC

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