Workers and Patients:  
A Single Culture of Safety

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Disclosures

The faculty for this session have nothing to disclose.
Agenda

Explore the high hazard industry known as health care

Link highly reliable organizational performance to a unified culture of safety for workers and patients

Discuss clinical and organizational application of these concepts

A Few Assumptions Before We Get Started

- Health care workplace injuries can result in patient injuries.
- Patient injuries harm our health care workers.
- Our workers can inadvertently harm our patients, and, in the process, harm themselves.
- Risks to worker safety are also risks to patient safety.
“Workforce 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 safe practices and not work well in teams.”

Evolution of the Transforming Concept: Joy and Meaning of Work

A lever for patient safety if optimized

- **Joy**: The emotion of pleasure, feeling of success, and satisfaction as a result of meaningful action
- **Meaning**: The sense of importance of an action
- **Workforce Safety**: Physical and psychological freedom from harm, neglect, and disrespect – a precondition to joy and meaning

JOY and MEANING are essential components of a safe culture
Health Care is a High Hazard Industry
Physical harm to the workforce

- Worker injury rates in hospitals are double the rate for private industry as a whole.
- More FTE days are lost due to occupational injury in health care than in industries such as mining and construction.
- In a national survey, 76% of nurses indicated that unsafe working conditions interfere with the delivery of quality care.
- An RN or MD has a 5 to 6 times higher chance of being assaulted than a cab driver in an urban area.

The Financial Impact of Workplace Injuries

- Workers’ compensation costs are in direct competition with operations dollars.
- Lost time (indemnity) claims can cost $60,000+ each in direct and indirect costs
  - Direct costs include medical benefits, indemnity payments, and modified duty.
  - Indirect costs are estimated at 110% of direct costs; these include triage visits, sick pay, replacement labor, injury investigations, and illness/injury reporting costs.
Health Care is a High Hazard Industry
Physical harm to patients

- Research shows that 4% of hospitalized patients suffer an unintended injury.

- Medication-related errors are estimated to account for about 7,000 deaths each year.

- Nearly 2 million patients annually get an infection while being treated for another illness or injury, and 88,000 die.

- Between 2002 and 2004, 1.24 million patient safety incidents occurred to hospitalized Medicare patients.

Health Care is a High Hazard Industry
Psychological harm

- Lack of respect
  - A root cause of dysfunctional cultures
  - 95% of nurses report it; 100% of medical students; huge issue for patients

- Lack of support

- Lack of appreciation

- Non-value add work

- Production pressures
Patient Safety Efforts Have Stalled

Call to realign around “The Quadruple Aim”

- Improving the individual experience of care
- Reducing the cost per capita of healthcare
- Improving the health of populations
- Improving the experience of providing care

Recommendations from the Lucian Leape Report

**STRATEGY 1**
Develop and embody shared core values of mutual respect and civility; transparency and truth telling; safety of all workers and patients; and alignment and accountability from the boardroom through the front lines.

**STRATEGY 2**
Adopt the explicit aim to eliminate harm to the workforce and to patients.

**STRATEGY 3**
Commit to creating a high-reliability organization (HRO) and demonstrate the discipline to achieve highly reliable performance.

**STRATEGY 4**
Create a learning and improvement system.

**STRATEGY 5**
Establish data capture and performance metrics for accountability and improvement.

**STRATEGY 6**
Recognize and celebrate the work and accomplishments of the workforce, regularly and with high visibility.

**STRATEGY 7**
Support industry-wide research to design and conduct studies that will explore issues and conditions in health care that are harming our workforce and our patients.
Culture of Safety – High Reliability Organization

- Management commitment
- Discipline and rules
- Supervisor control, emphasis, and goals
- Personal knowledge, commitment, and standards
- Internalization
- Care for self
- Help others conform
- Others’ keeper
- Organizational pride

Work Styles

- Reactive: Safety by natural instinct, Compliance is the goal, Delegated to manager
- Dependent: Management commitment, Discipline and rules, Supervisor control, emphasis, and goals
- Independent: Personal knowledge, commitment, and standards, Internalization, Care for self
- Interdependent: Help others conform, Others’ keeper, Organizational pride

Through the Eyes of the Workforce Elements

- Joy and meaning in work
- Resources
- Respect
- Recognition
### Workplace Safety Index Measures Culture

<table>
<thead>
<tr>
<th>Workplace Safety Index</th>
<th>...as it relates to the literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necessary steps are taken in my department or work unit to ensure employee and physician safety.</td>
<td>Allocation of attention and resources to safety.</td>
</tr>
<tr>
<td>My immediate supervisor recognizes me when I do a good job.</td>
<td>Supportive supervisor; two-way communication</td>
</tr>
<tr>
<td>Kaiser Permanente provides the resources necessary for me to work effectively (hardware, tools, equipment, supplies, etc.).</td>
<td>Job resources (physical, psychological, social, etc.)</td>
</tr>
<tr>
<td>The people with whom I work treat each other with respect regardless of race, religion, ethnicity, gender, age, sexual orientation, or disability.</td>
<td>Teamwork; supportive environment.</td>
</tr>
</tbody>
</table>

#### The 3 Rs: Resources, Respect, and Recognition

#### Higher Workplace Safety Index Scores Correlate with Fewer Injury Rates

- Steps taken in department to ensure employee safety
- Kaiser Permanente provides resources to work effectively
- Supervisor recognizes me when I do a good job
- People treat each other with respect despite differences

**Insight**

- Higher scores on the Workplace Safety Index correlate to 57% fewer workplace injuries.
The Learning Climate Index, Created Through Merging the Safety Attitudes Questionnaire with People Pulse, Measures Safety Culture

<table>
<thead>
<tr>
<th>Learning Climate Index</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on Patients</td>
<td>Department doing things to improve patient safety</td>
</tr>
<tr>
<td>Focus on Patients</td>
<td>I would feel safe being treated as a patient at Kaiser Permanente</td>
</tr>
<tr>
<td>Focus on Patients</td>
<td>Disagreements resolved by what is best for patients/customers</td>
</tr>
<tr>
<td>Focus on Patients</td>
<td>Supported by others in dept. to satisfy patients/customers</td>
</tr>
<tr>
<td>Learning</td>
<td>Errors handled appropriately in department</td>
</tr>
<tr>
<td>Feedback</td>
<td>Supervisor gives regular feedback to help me improve</td>
</tr>
<tr>
<td>Learning</td>
<td>Easy to learn from errors</td>
</tr>
<tr>
<td>Inclusion</td>
<td>Comfortable voicing opinions</td>
</tr>
<tr>
<td>Enablement</td>
<td>Department operates effectively as a team</td>
</tr>
<tr>
<td>Learning</td>
<td>Easy to speak up about errors and mistakes in department</td>
</tr>
</tbody>
</table>

The New Learning Climate Index Shows Correlations with Patient Safety Outcomes*

Learning climate index

- Blood stream infections rate per 1000 line days
- 30 Day Hospital Readmissions
- Moderate to severe falls per 1000 patient days
- Hospital acquired pressure ulcers Stage 3+ and stage 4

**Insight**
- Higher scores on the Learning Climate Index correlate with better patient safety.
- 83% fewer bloodstream infections
- 8% fewer readmissions
- 44% fewer patient falls
- 80% fewer pressure ulcers

*Kaiser Permanente*
Leading from the Top
Bernard J. Tyson, chairman and CEO

- We make millions of lives better each and every day...that’s why it’s so important that we continue to make Kaiser Permanente the best place to work.

- Our employees’ high level of commitment and engagement is a strength for Kaiser Permanente, and we are proud of the role each person plays in creating this work environment.

- We have opportunities to help employees feel more comfortable voicing opinions. We are improving our “speaking up” and “listening up” environment.
“Being Encouraged” To Speak Up Is Rated More Highly Than “It Being Easy” To Speak Up

Perceptions of Finding It Easy To Speak Up Vary by Position

* Significantly different between genders, such that males are more favorable on item than females

Source of demographic data: Self-reported on People Pulse
Perceived Barriers That Discourage Employees from Speaking Up

- Perceptions of bullying, favoritism, and retaliation negatively impact productivity, morale, teamwork, and trust in management. This may result in turnover.
- Employees are less likely to speak up if they feel their input is not solicited, valued, or used.
- Greater leadership and manager support is needed to make it easier for employees to speak up.

Perceptions of a “Speaking Up Culture” Vary with Use of Direct Report Rounding

Items ordered by largest difference between respondents who experience rounding and those who do not*

<table>
<thead>
<tr>
<th>Item</th>
<th>Round: No</th>
<th>Round: Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>High value employee feels to be employee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rounding item: Does your immediate supervisor do “direct report rounding” with you at least quarterly?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Rounding item: Does your immediate supervisor do “direct report rounding” with you at least quarterly?
2014 People Pulse for Colorado, Hawaii, and Northwest and selected departments in Northern California and Southern California
Perceptions of a “Speaking Up Culture” Vary by Frontline Team Involvement

Insight

- Frontline teams are an effective systemic solution that can be used to improve our “speaking up” culture.

What Can Managers Do?

Three beliefs needed for a culture of speaking up to flourish

- Speaking up is safe
- Speaking up is beneficial
- Speaking up results in action

What managers can do to create those beliefs

- Be open and encourage feedback
- Demonstrate respect for employees
- Be flexible in meeting employee requests
- Show appreciation for others’ contributions to speaking up
- Actively listen, follow up on feedback, and consider making changes
- Be accessible
- Use huddles and meetings as forums for employee voices to be heard
Safe Patient Handling

Patient Safety + Worker Safety

- Increase patient mobilization to prevent deconditioning, pneumonia, and skin breakdown.
- Use safe patient mobilization protocols and equipment to prevent worker injury and patient falls.
Safe Patient Handling: ACT (Assess, Communicate, Transfer)

Evaluation of the patient, task, and staff/equipment needs

**START HERE**
Assess the patient’s mobility, mental status and medical condition before performing any patient handling task.

**ASSESS** the patient and their mobility status
- Ensure ongoing assessment of the patient’s status throughout any mobility task and patient’s stay
- Be sure to document and communicate the patient’s status and ability

**Determine mobility status**

**Evaluate the equipment and staff needed for task**
- Discuss equipment needed
- Discuss staff needed
- Make sure environment is clear and safe to perform task

**Determine appropriate method and device or equipment**
- No equipment nearby
- Equipment on unit or nearby

**Evaluate the equipment and staff needed for task**
- Discuss equipment needed
- Discuss staff needed
- Make sure environment is clear and safe to perform task

**Contact other resources for assistance**
- Develop plan to have staff and equipment available
- Utilize rental agreements

**Communicate**
- Ask for help performing the task, if needed
- Ask for help using the device or equipment, if needed
- Inform the patient on task and how to participate
- Confirm the patient, team, environment, and equipment are set for transfer

**Transfer with care**

**Emergent Situation**

Patient is independent and will assist with movement, gait belt, verbal cues and/or assistive device.

Patient may require mechanical assistance for safe movement or second person for stand-by assist.

Patient requires mechanical assistance and 2+ caregivers for safe movement.

**Safe Patient Handling**

- Patients feel more comfortable
- Staff are safe and able to assist patients
- Injuries are prevented

Developed by Kaiser Permanente Northern California Patient Care Services
Slips/Trips/Falls

Patient Safety + Worker Safety

- Patient and visitor
  - slips, trips, and
  - falls prevented

- Worker slips,
  - trips, and falls
  - prevented

Scope of Problem

- Falls account for 8.9 million visits to the emergency department
- Slips, trips, and falls make up majority of general industry accidents
- Slips, trips, and falls account for 15% of all accidental deaths; 2nd leading cause behind motor vehicles
- One of most frequently-reported injuries; 25% of reported claims/year
- More than 17% of all disabling occupational injuries result from falls
Ten Hazards for Slips, Trips, and Falls

1. Contaminants on the floor
2. Poor drainage: pipes and drains
3. Indoor walking surface irregularities
4. Outdoor walking surface irregularities
5. Weather conditions: ice, snow, and rain
6. Inadequate lighting
7. Stairs and handrails
8. Stepstools and ladders
9. Tripping hazards: clutter, loose cords, hoses, wires, and medical tubing
10. Improper use of floor mats and runners


HRST: What Is It?

- A highly reliable surgical team (HRST) is one in which the performance of high risk activities is the norm, and accidents or harm rates are low. The goal is to take a team of experts and create expert teams with excellent outcomes.
- Idea was launched across NCAL in 2006.
What Are the Components?

Mission:
HRST embodies a culture of learning, where teams provide patient-centered and evidence-based care to achieve optimal outcomes for every patient, every time, everywhere.

NCAL KP HRST Journey

**HRST Launch**
2006

**RFO Summit**
2008

**NSQIP Pilot**
2009

**NSQIP Roll Out**
2011

**RF Technology**
2013

**HRST Reassessment**
2015

Safer Surgery
Structured Communication

Sharing the Plan
- Brief – Short session prior to start to share the plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, and anticipate outcomes and likely contingencies

Monitoring and Modifying the Plan
- Huddle – Ad hoc meeting to re-establish situational awareness, reinforce plans already in place, and assess the need to adjust the plan

Reviewing the Team’s Performance
- Debrief – Informal information exchange session designed to improve team performance and effectiveness through lessons learned and reinforcement of positive behaviors

TeamSTEPPS, Speaking Up
Framework and competencies

Knowledge
- Shared Mental Model

Attitudes
- Mutual Trust
- Team Orientation

Performance
- Adaptability
- Accuracy
- Productivity
- Efficiency
- Safety

I am CONCERNED!
I am UNCOMFORTABLE!
This is a SAFETY ISSUE!
“Stop the Line”
Summary: Safety Is Mission Critical

- **Worker safety** and **patient safety** are more common than they are different.

- A **well workforce**, operating in a **safe workplace**, is a precondition to delivering outstanding health care.

- In an era of constrained resources and increasing demands, **learning to see and use the synergies among “the safeties”** is more important than ever.

- Creating a single culture of safety built on the **“Quadruple Aim”** is our leadership obligation.
Creating a world where patients and those who care for them are free from harm.

– National Patient Safety Foundation, January 2014