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Improvement from
Front Office to Front Line

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“Leaders, who play a key role in managed diffusion, should establish the expectation for adoption and dissemination of important learning.”

—“Accelerating the Use of Best Practices: The Mayo Clinic Model of Diffusion” (p. 168)

Diffusing Evidence-Based Best Practice Across an Integrated Delivery System

Features

Methods, Tools, and Strategies

- IBCD: Development and Testing of a Checklist to Improve Quality of Care for Hospitalized General Medical Patients

Care Processes

- An Institutionwide Approach to Redesigning Management of Cardiopulmonary Resuscitation

Departments

Forum

- Accelerating the Use of Best Practices: The Mayo Clinic Model of Diffusion

Tool Tutorial

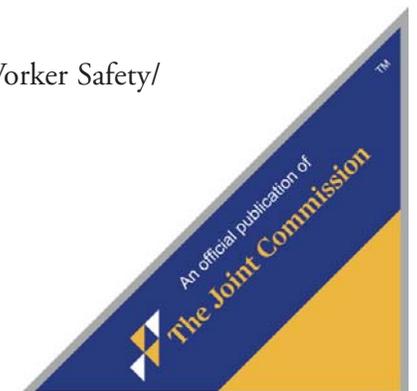
- Using a Hospital Quality Improvement Toolkit to Improve Performance on the AHRQ Quality Indicators

Conference Report

- Frontline Hospital Workers and the Worker Safety/ Patient Safety Nexus



Joint Commission
Resources



Conference Report

Frontline Hospital Workers and the Worker Safety/Patient Safety Nexus

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Previous work on the relationship between worker safety and patient safety has focused on nurses and physicians.¹ Safety climate and nurses' working conditions predict both patient injuries and nurse injuries, supporting the premise that these outcomes may be linked.² Less attention has been paid to other members of the health care team, including nursing assistants, orderlies, aides, food service workers, janitors and other environmental service workers, ward clerks, and others. (We use the term *health care workers [HCWs]* to include frontline hospital workers rather than "support personnel" or other terms that may unintentionally exclude them.) Engaging frontline HCWs in developing, implementing, and evaluating interventions to improve safety may improve patient as well as worker outcomes. A recent monograph issued by The Joint Commission has recommended that health care organizations consider making patient and worker safety a core organizational value and develop a business case for integrating patient and worker safety activities across departments and programs.³ The potential benefits of expanding research to explore the relationship between underlying safety culture and patient and frontline worker outcomes include savings in workers' compensation costs, lower staff turnover, improved staff morale, increased patient satisfaction, and fewer patient adverse events. A day-long workshop was held in Washington, D.C., on October 25, 2012, to explore whether and how hospital-based frontline HCWs affect patient safety and how they experience safety in their work settings.*

The four panels and small-group discussions addressed the following questions:

- What recommendations do frontline HCWs have to improve patient safety as well as worker safety?
- What is the current state of the evidence for a relationship between worker safety and patient safety?
- Are effective, data-driven interventions available that improve both worker and patient safety?

- What are the data gaps?
- How could they be filled?
- What are institutional and policy barriers to implementing interventions that improve safety?

Representatives from academe, the federal government, hospitals, unions, and patient organizations participated in the event, which was sponsored by Georgetown University and co-sponsored by the Johns Hopkins Bloomberg School of Public Health, the University of Illinois at Chicago School of Public Health, the Service Employees International Union (SEIU), the Occupational Safety and Health Administration (OSHA), the National Institute for Occupational Safety and Health (NIOSH), the Agency for Healthcare Research and Quality (AHRQ), in collaboration with the Veterans Health Administration (VHA) Office of Public Health and The Joint Commission. Workshop sessions focused on the intersection of worker safety and patient safety and on specific steps that health care institutions have used to implement a culture of safety in the workplace. The 85 workshop attendees broke out into small groups to identify barriers and opportunities for specific topics.

The Honorable David Michaels (OSHA[†]) welcomed the attendees and charged them to integrate the occupational safety and health needs of hospital workers when addressing safety culture in health care. HCWs sustain higher rates of nonfatal occupational injuries and illnesses than workers in other sectors, including construction and mining. OSHA is targeting this problem through outreach efforts, with special sections on safe patient handling, infectious diseases transmission, and workplace violence⁴—and through the OSHA and The Joint Commission and Joint Commission Resources Alliance,⁵ which includes approaches to recognizing and reducing work-related illness and injury by reviewing and acting on the OSHA-required record-keeping.⁶ Frontline workers are central to these efforts.

* Additional information, including conference white papers, presentations, and participants can be found on the website: <http://www.jhsph.edu/erc/HCworkersafety>.

[†] Presenter and facilitator information is provided in Appendix 1 (available in online article).

Panel 1. Worker, Patient, and Provider Perspectives: Problems and Solutions

This panel, moderated by Martin Hatlie (Partnership for Patient Safety), set the stage for the workshop. Patient representatives Regina Greer-Smith (Healthcare Research Associates, LLC) and Knitasha Washington (National Association of Health Services Executives) joined worker representatives Synkeithia Holly (1199SEIU, Food and Nutrition Service) and Eola Byrd (1199SEIU, Environmental Service) and health care industry leaders Kerry Eaton (Sacred Heart Health System, Pensacola, Florida) and Kate Henderson (University Medical Center, Brackenridge, Texas) to share perspectives and explore opportunities and barriers.

PATIENT/FAMILY PERSPECTIVES

A health care executive, Greer-Smith spoke about her role as caregiver when her mother, who is now a resident in an Alzheimer's center, was still at home. This experience enabled her to gain a greater appreciation for the important role and challenges faced by frontline HCWs such as aides, housekeeping staff, and dietary staff.

- Frontline caregivers provide important insights about the patient.

- Staff safety often comes up in conversation: "Who is caring for the (paid and unpaid) caregivers?"

Washington highlighted the importance of learning how to improve services and safety by speaking directly with all levels of staff—"where the work really gets done"—including staff from the mail room or boiler room, for example, and other, often overlooked departments. Her own insights were markedly changed after her father died after a perceived medical error and her mother suffered a back injury while lifting a patient with an assistive device. The view of a family member of a patient or an injured worker is very different from the view of a health care administrator. While frontline workers know the problems and potential solutions, they generally lack training and opportunities to communicate effectively across disciplines and levels of the organizational hierarchy.

FRONTLINE WORKER PERSPECTIVES

Holly described challenges faced by dietary service workers from understaffing and poor communication. Dietary service workers on tight schedules cannot respond as well to individual requests to meet patient needs. Communication and management support are critically important to manage changing dietary requirements and scheduling that takes patients away from their rooms at mealtime. Large facilities must be served on

a reliable schedule, with food kept safe in terms of temperature and storage.

Byrd, a union delegate for environmental service (EVS) workers, noted those workers' importance in ensuring safety for patients, staff, and visitors. With responsibility for such matters as lighting, signage for wet floors, and the proper use and labeling of chemicals, they encounter worker and patient safety issues on every shift. They are often the first to identify hazards and are essential in preventing infection transmission. At her unit's daily safety meetings, workers and management review potential safety concerns and other issues. Such meetings may be particularly helpful to newly contracted EVS managers, who may be new to the facility and lack experience in health care. Understaffing, inadequate training, and use of temporary workers are also concerns for EVS staff.

HOSPITAL LEADERSHIP

Eaton and Henderson described activities that can be undertaken, without the addition of any full-time equivalent (FTE) workers, to improve "person safety"—that is, safety for staff, patients, visitors, vendors, and everyone else who enters the facility. It is not that hospitals do not have the staff they need; they simply need to invest the time and effort to "unleash the local talent." Respectful communication among all levels of staff is essential for all staff to truly be valued and respected. In high-performing hospitals, they found the following:

- Everyone is considered a caregiver because each role contributes directly and indirectly to patient outcomes.

- Daily huddles, such as 15-minute stand-up meetings attended by all staff on every unit, help ensure that safety risks are identified and that accountability for addressing risks is assigned.

- All meetings, including those at the board level, begin with a safety story that engages both hearts and minds.

- Senior leaders regularly round the floors to hear from staff firsthand; they recognize "good catches" and celebrate safety successes.

- For transparency, the hospital intranet displays to everyone the current metrics for harm or injuries to staff and patients.

- Safety training is mandatory for all staff, and community physicians often lead the sessions.

- Frontline employees receive extra training to become peer "safety coaches" to share information at the unit levels.

- All employees have at least two explicit safety goals written into their performance appraisal (with goals ranging from "improving patient safety" to "reducing unsafe driving in the parking lot").

- A high-reliability approach reflects a preoccupation with

failure and a reluctance to simplify, a sensitivity to operations, a commitment to resilience, and a deference to expertise (rather than title).

- Leaders should listen and advocate for others. They should get to know staff personally (take off the suit and put on the scrubs and hairnet) and sincerely care about staff welfare.

- Leaders and managers need to build goodwill and exemplify a nonpunitive culture that builds trust and promotes safety for all.

- Champions may come from physicians, workers, and patients and their families.

- The notion of a “just culture” admits the occurrence of errors and mistakes and does not punish human error. Discipline (accountability) is reserved for reckless behavior, not errors.

Panel 2. Worker Safety–Patient Safety Nexus: Summary of Key Information

Jeffrey Brady (AHRQ) and Jim Battles (AHRQ) provided an overview of safety culture, research findings, and interventions. In an update on AHRQ-funded research on the worker safety–patient safety nexus, Brady described AHRQ as “an agency of facilitators and packagers of information.” Already challenged for capacity to respond to patient safety needs, AHRQ is now also jointly addressing worker safety and patient safety.

Brady reminded the audience that positive measures of a safety culture have been demonstrated to be inversely associated with adverse events in hospitals.⁷ A “just culture” protects people who come forward to identify risks and opportunities for improvement. It recognizes the importance of learning from patients, who can often describe what happened and important related events. Federal policy reduces hospital payment rates for readmissions for acute myocardial infarction, heart failure, and pneumonia,⁸ encouraging hospitals to work with Patient Safety Organizations (PSOs)⁹ and other community-based groups to address the problem of readmissions.

AHRQ has facilitated the development of PSOs and of tools to help hospitals and other health care organizations improve through programs such as Project RED (Re-engineered discharge) and Project BOOST (Better Outcomes for Older Adults through Safer Transitions).¹⁰ Battles described the following two tools available to assist in promoting safety:

- A Comprehensive Unit-based Safety Program (CUSP) promotes a culture of safety, improves communications, and promotes the use of checklists with US Centers for Disease Control and Prevention (CDC) guidelines.¹¹

- TeamSTEPS®, a patient safety improvement tool that focuses on teamwork, was developed by the US Department of

Defense’s Patient Safety Program in collaboration with AHRQ. Six regional training centers provide train-the-trainer programs.¹²

David DeJoy (University of Georgia College of Public Health), as discussant, provided the perspective of the broader sphere of safety research. His “working definition” of a safety culture was as follows: “Shared safety-related values (what is important) and beliefs (how things work) that interact with an organization’s structures and control systems to produce behavioral norms (the way we do things around here).” He made the following points:

- The very heart of a safety culture is the relative importance of safety compared with other organizational priorities such as production and cost.

- Maximizing safety in modern health care requires a systems perspective, in which safety is an emergent property of the system and HCWs and patients are parts of the same basic system.

- Safety culture influences actions at all levels of organization (not only frontline) and at all stages of safety-related events (prevent, event, postevent).

- Characteristics of a positive safety culture include the following:

- Safety is a clearly recognized value in the organization.
- Accountability for safety in the organization is clear.
- Safety is integrated into all activities in the organization.
- A safety leadership process exists in the organization.
- Safety culture is learning-driven in the organization.

DeJoy suggested looking at the patient and provider as interdependent and interactive but added that to drive change, more evidence is needed that patient safety and worker safety are interrelated. He noted strengths of the AHRQ program but remarked on what he considers a primary reliance on training and insufficient attention to worker safety.

- Training and other initiatives directed at leadership do not effectively reach the intended audience.

- “Blame and train the workforce” is not an effective strategy.

- It is important to assess climate strength/multilevel consistency (the extent of agreement [like-mindedness] among individuals/work unit within an organization) when assessing an organization’s safety culture.

Panel 3. Participatory Approaches to Building Skills and Career Tracks Among Frontline Health Care Workers

The third panel featured presentations by Laura Chenven and Danielle Copeland (H-CAP) and from EVS workers Carl D. Samuels (1199SEIU), Will Johnson (1199SEIU), and Clarence Smith (1199SEIU), and Rodney Trammel (SEIU UHW-W).

Deborah Berkowitz (OSHA) and L. Clifford McDonald (CDC) served as discussants. Kathleen Fagan moderated the session, which provided extensive information from worker perspectives.

Chenven and Copeland provided an overview of career development and education that supported the active engagement of frontline workers in a green-jobs program for EVS workers. The frontline worker participants on the panel provided examples of their work in developing projects that supported patient and worker health and safety and lowered their institutions' carbon footprints. The program was characterized by, for example, the following features:

- Labor-management cooperation and formal agreements
- Multilevel training and education
- Creating culture and systems change
- Improving entry-level jobs
- Developing a national model, curriculum, and certification
- Building a national labor-management consortium for green jobs in health care

Workers were offered opportunities to attend community college to study principles of environmental science and health. They learned the “why” of conservation, substitution, recycling, and infection control, along with the importance of using less toxic chemicals, when possible. Workers on the panel described their own successes in engaging coworkers and management in recycling, room cleaning to reduce health care–associated infections (HAIs), reduction and management of red-bag medical waste, and energy conservation.

Berkowitz spoke to OSHA's growing reliance on worker participation to promote safe and healthy workplaces. She described workers as the frontline inspectors, pointing out that OSHA has only about 2,000 inspectors in the United States for 7 million workplaces. A strategic goal of the US Department of Labor is to increase worker participation.

McDonald discussed the challenges posed by HAIs and noted the toolkits available through the CDC to help hospitals and other health care facilities manage the problem.¹³ Expanded efforts are needed to address HAIs, including frontline workers in problem solving, identifying appropriate levels of cleaning for different circumstances, and engaging workers wholeheartedly in the creation of a safety culture, as well as in education, training, tracking exposures, and program evaluation. Recent evidence suggests continued gaps between hospital leadership and both mid-level and frontline workers with respect to perceptions of safety.¹⁴

Small-Group Discussions

In small-group discussions, the workshop attendees participated

in one of seven concurrent 90-minute breakout sessions.

1. Promising Practices for Improving Safety Culture for both Patients and Workers: Engaging and Empowering Health Care Team Members; Getting Frontline Workers onto the Team; Hierarchy-Free Communication (facilitated by Jim Battles and David DeJoy)

Discussion Highlights:

- The four AHRQ goals—quality, safety, efficiency, and effectiveness—are all interrelated.

- Workers have to be healthy and safe to be able to provide good/safe patient care; the concept of worker safety should be expanded to include psychological safety; safety measures should be nonpunitive; workers at all levels should have a voice and be encouraged to speak up about hazards and other safety problems; a variety of potentially useful data is probably already being collected but is not being analyzed.

- Worker involvement should be improved, with an emphasis on a culture of respect. Legislation and regulations that are primarily punitive may be counterproductive (have unintended consequences) to maximizing safety and to creating a mindset of continuous improvement.

2. Getting and Using Information—Adverse Event Reporting for Patient Events and for Worker Illness and Injury; Reporting Surveillance and Feedback Loops for Analysis and Prevention (facilitated by Lyn Penniman [OSHA], Jennifer Lipkowitz-Eaton [VHA], Kathryn Reback [AHRQ], and Kate Henderson)

Discussion Highlights:

- Data on surveillance—active and passive—and on clinical operations should inform each other—if something is not safe for workers, it is not safe for patients (hazards do not discriminate).

- Hazards may be related; for example, concerns about HAIs may lead to overuse of certain disinfectants.

- Mandatory illness and injury record keeping through the OSHA 300 logs,⁶ including the more serious category of “days away from work” or “restricted work activity,” may add useful information to other just-in-time data related to patient, family, and worker satisfaction, as well as to measures of medical errors or adverse patient events.

- Concerns that underreporting may affect data quality exist both for workplace illness and injury reporting and for patient event reporting. Attention to quality of data is a cornerstone of safety that requires nonpunitive reporting incentives.

- The field of worker safety could learn from patient safety (for example, “never events,” taxonomy, unified set of metrics, need to benchmark).

3. Slips/Trips and Falls (facilitated by Whitney Gray and Jen-

nifer Bell [NIOSH])

Interventions aimed at reducing slips, trips, and falls among hospital workers and patients should focus on “People, Place, and Data.” *People* refers to staff and patients’ mentality that “It won’t happen to me . . . I’ll be fine.” This cycle needs to be broken by supporting staff and patients and allowing them to speak up and discuss such issues. *Place* refers to the extrinsic factors in a hospital room, corridor, or common area (such as flooring selection, location of grab bars next to patient beds, and built-in overhead patient lifts) that are designed into the overall plan that support a culture of safety. *Data* need to support both design and cultural changes.

An innovative information technology strategy would track the location of slips, trips, and falls from both the occupational and patient safety perspective and thus build a case of key “danger spots” to address. Areas of the hospital that need attention, such as cracked tile, wet floor, leaking piping, and malfunctioning or missing equipment, could be mapped. Workers could enter data, access the data to prioritize interventions, and track the interventions’ impact on events.

4. Infectious Disease Concerns and the Role Of Environmental Service Workers (facilitated by Barbara Braun, L. Clifford McDonald, Scott Goodell [SEIU UHW-W and Joint Employer Education Fund], and Laura Chenven)

Discussion Highlights:

- The role of EVS workers is critical for infection control, given growing evidence that infections can be transmitted by patient and/or worker contact with contaminated surfaces.

- Workers need to understand not only what chemicals to use but how to use them in different circumstances and under what conditions for them to be effective cleaners and disinfectants.

- Effective interventions start with shared best practices and with increased respect for frontline workers that includes engagement and education.

- An important barrier is reduced staffing for EVS. EVS workers tend to be the first to be laid off, leaving nurses many other responsibilities, such as cleaning rooms, without information about which chemicals to use on particular surfaces to prevent transmission of specific infections.

5. Safe Patient Handling (facilitated by Jim Collins [NIOSH], Joe Zaroni [University of Illinois at Chicago], and Mary Matz [VHA])

Discussion Highlights:

- State and federal efforts currently include widely varied legislation in 10 states and three failed efforts at national legislation. Prompted by the American Nurses Association’s (ANA) Handle With Care® campaign, 10 states have enacted “safe pa-

tient handling” laws: California, Illinois, Maryland, Minnesota, New Jersey, Rhode Island, Texas, Washington, New York, and Ohio, with a resolution from Hawaii. The first 8 of these states require a comprehensive program in health care facilities, in which there is established policy, guidelines for securing appropriate equipment and training, collection of data, and evaluation.¹⁵

- The ANA’s standards for Safe Patient Handling and Movement will provide program implementation direction for organizations and a template for other state and national legislation as well as standards for health and safety organizations.¹⁶

- The OSHA Nursing Home National Emphasis Program targets the presence and status of patient handling interventions, including programs and equipment.¹⁷

6. Creating a Research Agenda—What Works, What Doesn’t, How Do We Know, What Don’t We Know, and How Do We Scale Up? (facilitated by Dan Merenstein [Georgetown University], Eileen Storey, and Eileen Hogan)

Discussion Highlights:

- Define “person safety” as an overarching approach that merges patient safety, worker safety, and environmental safety and determine mechanisms to operationalize person safety. As an interim step, identify areas of overlap.

- Define and measure success of high reliability organizations and define measures of incipient failure. What are essential features of a high reliability organization? What is the impact of loss of champion in a high reliability organization and how does one document that the high reliability persists after loss of champion leader? What are essential characteristics of nonpunitive systems? How do you know they are working?

- Evaluate the impact of temporary, “traveler,” or contract workers and managers on safety culture and climate.

7. Violence in Hospital Settings—Impact on Patients and Workers (facilitated by Avram Mack [Georgetown University] and Jonathan Rosen [Rosen and Associates])

Discussion Highlights:

- A process that brings together multiple perspectives from patient, worker, family, and others should include the development of effective policies and procedures.

- Threatening and assaultive behavior is a major disruption to the therapeutic environment, affecting patients, HCWs, and health care organizations. Negative impacts include quality of care, staff recruitment and retention, law suits, workers’ compensation costs, staff morale, and organizational reputation.

- Risk assessments should evaluate patient and staff injury trends; the physical environment, such as ward/unit design, security systems, and emergency codes; and systems for reporting

and responding to threats and assaults. Effectiveness of treatment plans and pain management, training effectiveness, and procedures for assessing patient acuity and staffing, should all be considered.

- Intervention training and risk assessment for suicide or violence should include everyone.
- Employee assistance programs should be assessed for accessibility.
- State legislation focused on violence prevention in health care facilities in Washington State, New York, New Jersey, California, Connecticut, and elsewhere may offer a template.¹⁸

Panel 4. Policy Implications and Updates from the Panels and Small Groups

Jason Ormsby (Georgetown University) reviewed the history of separate patient and workforce safety efforts; the organizations and stakeholders involved in safety discussions; and the proposed and/or implemented legislative and regulatory initiatives aimed at improving either patient safety or HCW occupational safety and health—these initiatives have generally not overlapped between patient and HCW safety.

Notable federal and state policy efforts include the following:

- California Hospital Safety and Security Act in 1995, which required implementation of violence prevention programs
- Nurse and Health Care Worker Protection Act of 2009, which, if passed, would direct the Secretary of Labor to “issue an occupational safety and health standard to reduce injuries to patients, direct-care registered nurses, and all other health care workers by establishing a safe patient handling and injury prevention standard, and for other purposes”¹⁹
- Hospital Patient and Health Care Worker Injury Protection Act of 2012, which requires all California hospitals to have a safe patient handling policy.²⁰

Robin Hemphill summarized the discussions of the panels and small groups by noting, “Hospitals should be safe places. Why aren’t we there yet?”

In summary, whether patient safety and worker safety are connected seems an odd question to even ask because overall safety embraces patients, their families, and the work force. Yet, barriers persist and conclusive studies are lacking. The goal of high reliability may help focus the many areas of the health system toward safety, a just culture, teamwork, and leadership.

So what are the barriers and opportunities that hinder or help progress?

BARRIERS

- Tendencies to criminalize human error. These tendencies

reach beyond the medical arena but are particularly harmful within health care. If we punish people for mistakes without understanding the background and environment that may have contributed to those errors we will drive people to hide their mistakes. This will allow system weaknesses to persist over time, and we will repeat the same mistakes.

- Well-intended policies that may drive normal functions of hospitals in unintended ways. Information is needed to determine whether pay-for-performance might have the effect of focusing on some diseases and outcomes over others, and whether it might also affect professional behaviors. The goal is to assure that short-term gains align with long-term outcomes.

- Policies with the potential for dual impact, such as workforce-hour restrictions. The focus on fatigue in trainees is critical and necessary, but decreasing hours increases the need to hand off patients. Patient handoffs are a well-recognized cause of errors and must be addressed to avoid introducing vulnerability errors of a different sort as needed changes in work hours are implemented.

- New CMS payment policies (CMS-1390-F), again with good and needed intent, such as nonpayment for hospital-acquired conditions required by the Deficit Reduction Act of 2005,²¹ may cause competition among hospitals for shrinking dollars, thereby decreasing the sharing of successful strategies between competing hospital systems.

OPPORTUNITIES

- Despite the difficulties, policies that focus on limiting the extent of work hours while putting into place measures to improve handoffs and turnover of patients can generate gains for both providers and patients.

- Public and open reporting of work injury rates highlights variation between various organizations and systems but must be nonpunitive.

- Put in place a just culture and ensure that human error is not punished; require peer review and root cause analysis to determine “why” errors occur rather than “who can we blame”; place in performance plans for senior and mid-level managers expectations to develop a just culture; and require education and training to enhance concepts of teamwork and high-risk communication across providers. For example, the VHA has developed Medical Team Training programs, which are multidisciplinary and have embedded simulation.²²

- In the long term, work with the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education to require competencies in patient safety and teamwork. After competencies are established, they will be

tested, and after people believe that these concepts are being evaluated, they will start training in these skills.

Kathleen A. Curran (Catholic Health Association of the United States) argued that we don't need to wait for new public policy—there are things we can do now. The person is at the center of everything (dignity, just culture). Patient satisfaction (a huge metric) correlates with worker/patient safety. Because the Centers for Medicare & Medicaid Services (CMS) is implementing outcome-related value-based payment,²¹ opportunities for action should increase. She noted the importance of studying not only the association between frontline worker safety and patient safety but frontline workers' potential role in reducing health disparities. Frontline workers themselves add socioeconomic and racial diversity to the hospital workforce. To the extent that they may be empowered to engage as members of the health care team, the focus on care of patients is a goal of every employee, including frontline workers. Frontline worker communications with patients, which occur routinely through empathetic human interactions, may represent an untapped resource of culturally sensitive communication for improving patient care.

Another key message from the workshop is the power of education, as demonstrated by the environmental green movement (for example, Health Care Without Harm,²³ and Practice Greenhealth²⁴). The message is to pay attention to horizontal and vertical reach of movement, to reach out to stakeholders, including workers, and to measure progress.

Comments from the audience included the following:

- Safety is a moral imperative.
- Take action, step out of traditional roles.
- Regulations are critical. Experience has been that you can have great policies, programs that work, but you can't get change until regulations force the change. For example, workplace violence prevention programs in New York State were greatly improved following state regulation.
- Workplace culture is still a big problem in many places. Back and assault injuries may be seen as just part of the job. Union workers may be less reticent than nonunion workers to bring up problems.

Kerry Eaton summarized the message of the workshop as “Getting to We,” instead of “us” and “them,” using both data and narrative to keep up forward momentum until changes become mainstream.

Workshop Action Items

How can hospitals begin to address these issues immediately? The resources cited in this report, such as *The Joint Commission monograph Improving Patient and Worker Safety: Opportunities*

for Synergy, Collaboration and Innovation,²³ (particularly pages 132–134), offer tools, examples, and resources to help.

- Start at the top. Champions and leaders are critical to implementing “person safety”—for patients, staff, visitors, contractors, everybody who enters the facility.
- Implement labor-management partnerships that engage all workers by expanding team approaches and by creating frontline safety monitors from frontline worker occupations.
- Gather and review available data from infection control, Log(s) of Work-Related Injuries and Illnesses (OSHA 300 logs), adverse event reporting, risk management, patient and worker satisfaction surveys, and so forth, to target problems and evaluate solutions and make these data available. Make tracking of illnesses and injuries as important for workers as patients.
- Train on quality core competencies.
- Create a just culture—one that does not punish human error and instead looks to see how the error occurred.
- Make your Quality and Safety Committee multidisciplinary by adding patients and staff members who may not normally have a voice at the administrative level.
- Pick key issues and work on them across departments and programs.

What is needed at the national level? What are the action items for government? For others?

- Facilitate the sharing of information and knowledge across federal agencies—including OSHA, NIOSH, AHRQ, VHA, and CMS—about effective approaches to improving “Person Safety” in hospitals and to support implementation of effective interventions.
- Coordinate activities across federal agencies to promote education and outreach, seeking input from stakeholders representing industry, labor, patients, and health professionals, to engage existing advisory groups or to create new, interagency forums.
- Coordinate federal support for extramural research funding to identify and disseminate effective interventions.
- Establish nongovernmental partnerships to explore policy initiatives through professional and industry associations, unions, and patient rights organizations at the local, state, and national levels and to share best practice. ■

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Online-Only Content

See the online version of this article for
Appendix 1. Presenters and Facilitators

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Appendix 1. Presenters and Facilitators*

Welcome: David Michaels, PhD, MPH, Assistant Secretary of Labor for Occupational Safety and Health (OSHA), Washington, DC.

Panel 1

Regina Greer-Smith, MPH, FACHE, President and Healthcare Project Professional, Healthcare Research Associates, LLC, Chicago. Knitasha Washington, MHA, FACHE, Chapter President, National Association of Health Services Executives, Chicago. Synkeithia Holly (1199SEIU [Service Employees International Union]), Food and Nutrition Service, Washington, DC; Eola Byrd (1199SEIU, Environmental Service), Washington, DC; Kerry Eaton, Senior Vice President and Chief Operating Officer (COO), Sacred Heart Health System, Pensacola, Florida; Kate Henderson, MHA, VP, and COO, University Medical Center, Brackenridge, Texas; Martin Hatlie, JD, President, Partnership for Patient Safety, Chicago.

Panel 2

Jeffrey Brady, MD, MPH, Patient Safety Portfolio Lead, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality (AHRQ), Rockville, MD; Jim Battles, PhD, Center for Quality Improvement and Patient Safety, AHRQ; David DeJoy, PhD, Professor of Health Promotion and Behavior Emeritus, University of Georgia College of Public Health, Atlanta.

Panel 3

Laura Chenven, MS; Danielle Copeland, Assistant Director, H-CAP, Baltimore; Carl D. Samuels (199SEIU [Service Employees International Union]), Green Initiatives Liaison, Montefiore Medical Center, New York City; Will Johnson (1199SEIU), Environmental Service Worker, Prince Georges Hospital, Cheverly MD; Clarence Smith (1199SEIU), Environmental Service Worker, Maryland General Hospital, Baltimore; Rodney Trammel (SEIU United Healthcare Workers West), Kaiser Los Angeles Medical Center; Deborah Berkowitz, OSHA Chief of Staff, Washington, DC; Clifford McDonald, MD, FACP, FSHEA, Senior Advisor, Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta; Kathleen Fagan, MD, MPH.

Panel 4

Jason Ormsby, PhD, MBA, MSHA, Senior Vice President for Atlas Research and Assistant Professor, Health Systems Administration, Georgetown University School of Nursing and Health Studies, Washington, DC, Kathleen Curran, JD, Senior Director of Public Policy, Catholic Health Association of the United States (CHA), Washington, DC, Robin Hemphill, MD, MPH.

Small-Group Discussion Groups

Lyn Penniman, RN, MPH, Director, Office of Physical Hazards and Others, OSHA; Jennifer Lipkovitz-Eaton, MD, MPH, Clinical Program Manager, Occupational Health Strategic Healthcare Group, VHA, Washington, DC; Kathryn Reback, RN, MSN, JD, Program Analyst, AHRQ; Whitney Gray, PhD, Director of Building Science Services, MedStar Institute for Innovation, Washington, DC; Jennifer Bell, PhD, National Institute for Occupational Safety and Health (NIOSH), CDC, Atlanta; Scott Goodell (SEIU UHW-W and Joint Employer Education Fund), Program Director, EVS Green Careers Project, Los Angeles; Laura Chenven MS; Barbara Braun, PhD; Eileen Storey, MD, MPH; L. Clifford McDonald, MD; Jim Collins, PhD, Associate Director, Division of Safety Research, NIOSH; Joe Zaroni, PhD, Continuing Education and Outreach Director, Illinois Education and Research Center, University of Illinois at Chicago; Mary Matz, MSPH, CPE, CSPHP, VHA, National Program Director, Patient Care Ergonomics, Washington, DC; Daniel Merenstein, MD, Associate Professor of Family Medicine, Georgetown University School of Medicine; Avram Mack, MD, Professor of Clinical Psychiatry, Georgetown University School of Medicine, Jonathan Rosen, MS, CIH, Rosen and Associates, New York City.

* Excluding authors' detailed information (see page 192).