Creating joy, meaning, and safer health care

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Objectives

• At the close of this presentation, attendees should be able to:
  • List one reason why workplace safety is important to resident safety
  • Describe two characteristics of a strong safety culture
  • Discuss three strategies for culture change
Show me the money

Industry wide...

• Estimates: $10.2 billion to cover 153,680 injuries with lost work time in 2011 alone

Are... or were... any of them on your payroll?
The system impact?

- Offset would require
  - More than $100 billion in additional incremental healthcare billings
  - Significant cost-cutting measures, including staffing cuts
  - Combination of both

Can you afford NOT to make a change?

Let’s have a candid conversation...
Caregivers at all levels

- Are committed to caring for people in times of their greatest vulnerability and need
- Find meaning and joy in their work when they are able to deliver care in a safe, thorough, compassionate way

Yet....

Vulnerable workforce

- They are likely to suffer physical harm
  - Caregiver injuries 30 times higher than other industries
  - More days are lost due to occupational illness and injury in health care each year than in high hazard industries such as mining and construction
  - 76% of nurses in national survey indicated that unsafe working conditions interfere with quality care
  - Caregivers have a much greater chance of being assaulted than an urban cab driver
What types of injuries?

Vulnerable workforce

- They are likely to suffer psychological harm
  - Lack of respect
  - Major root cause of dysfunctional cultures
What does lack of respect look like?

"Our employees are our most important asset"

- How is this demonstrated?
- Proof: an injury-free workplace
  - Involve everyone in a continuing activity to identify everything gone wrong, one event at a time, 24 hours a day
  - Work together to share root cause analysis so we don’t have to learn the same lessons over and over
Joy and meaning of work

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

A pre-condition is not a priority

- Priorities can change
- Preconditions:
  - Are like breathing, or electricity
  - Start at the top
  - Begin one location at a time
Organizations are either habitually excellent or they’re not.

--- Paul O’Neill  Former Chairman and CEO, Alcoa; 72nd Secretary of the US Treasury
Your leadership role

- Create conditions that provide employees with the training and encouragement needed for them to make a contribution that adds meaning

These conditions can only exist if leaders create them.

Creating and maintaining pre-conditions

- Primary role of leadership and governance
- Why does it matter?
  - The absence or violation of these pre-conditions obscures meaning and drains motivation
  - Organizational effectiveness erodes, imposing significant costs on the organization, its employees, its residents and the economy
  - Preconditions shape the culture
What is a safety culture?

- Common set of beliefs, assumptions, and behaviors that actively influence how employees think and act
- Reflection of the extent to which people are encouraged to take personal responsibility for their own safety, that of their coworkers, and those in their care
- Reflection of willingness to adopt behaviors that further improve safety and reduce risks

What does success look like?
When each employee can answer “yes” to three questions each day

- Am I treated with dignity and respect by everyone, every day, in each encounter, without regard to race, ethnicity, nationality, gender, religious belief, sexual orientation, title, pay grade, or number of degrees?

- Do I have what I need: education, training, tools, financial support, encouragement, so I can make a contribution to this organization that gives meaning to my life?

- Am I recognized and thanked for what I do?

Characteristics of a safety culture

- Organization-wide commitment to safety
- Visibility and transparency
- Learning as a key prevention tool
- Focus on leading indicators (i.e. hand washing)
- Continuous communication about safety
- Recognition and rewards for a job well done
- No fear of reprisal for reporting non-compliance or error
- Commitment to continuous improvement
Nurturing a safety culture

- Instances where injuries have been avoided can serve as case studies to further educate staff and prevent incidents.

- An effective safety culture embodies a commitment to continuous improvement.

- Each successive initiative to reduce health and safety risks builds on the foundation of prior initiatives and supports future efforts.
Strategy 1

• Develop and embody shared core values of:
  • Mutual respect and civility
  • Transparency and truth telling
  • Safety of all workers and residents
  • Alignment and accountability from the boardroom through the front lines

Leadership action items

• Develop core values through an inclusive process, engaging the entire workforce

• Define core values through behavioral examples (e.g. walk the talk), and spread the word throughout the organization.

• Recruit visible ambassadors for the core values to demonstrate belief and strength of character in modeling the new way of workplace life.
Leadership action items

- Assure that core values are preconditions and not negotiable or prioritized against the demands of “production” and costs.

- Respect and engage all team members in the problem-solving process and enable everyone to contribute to the top of their capacity.

- Develop and demonstrate a philosophy of shared decision making, with decisions being made as close to the point of impact as possible.

Strategy 2

- Adopt the explicit aim to eliminate harm to the workforce and to residents.
Leadership action items

• Authentically communicate the belief that preventing harm is knowable and achievable.

• Create full transparency for accidents and incidents of harm.

• Create awareness of, intolerance for, and urgency to mitigate and eliminate risk.

• See all things that go wrong as the raw material for improvement.

Leadership action items

• Collect, analyze, and act on worker safety data, including near misses, close calls, and latent errors.

• Collect, analyze, and act on resident safety and risk data.

• Evaluate how the organization approaches workforce safety; define it as a marker for organizational culture; and align associated responsibility, measurement, and reporting with other quality and safety measures.
Strategy 3

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

• This will require creating a learning and improvement system and adopting evidence-based management skills for reliability.

Leadership action items

• Leadership and staff declare and broadly communicate that the “old story” of health care is no more: we will create a new story involving respect, teamwork, safety, joy, and meaning.

• Engage the workforce in conversations, making explicit connections between respect, workforce safety, and resident safety.

• Accept personal accountability and responsibility for change, and cascade an accountability model throughout the organization.
Leadership action items

• Systematically implement practices of HROs, with emphasis on evidence-based management skills for reliability, reporting, communication, teamwork, and training.

• Conduct executive and management safety rounding, inquiring and listening to the workforce in direct, uncensored, face-to-face encounters.

• Implement full workforce training on respect and teamwork.

Leadership action items

• Set aspirational goals at the theoretical limit of what is possible (zero defects), and pursue these with insistence and persistence.

• Systematically remove all barriers and excuses as to why excellence is not possible every day.

• Engage the workforce to examine job descriptions and duties to eliminate silos, fragmentation, and disconnects in the ability to care for residents and work effectively in teams.
Leadership action items

• Align skill and staffing levels to correspond with best practices.

• Set clear and understandable rules or standards, and enforce adherence to these rules; handle violations in a fair, consistent, and timely manner.

• Establish zero tolerance of disrespectful and non-team-promoting behaviors.

• Provide training and coaching in disclosure and apology after adverse events.

Leadership action items

• Establish peer support programs for staff (second victims) following adverse events.

• Assign priority for investments in devices, technologies, and training known to protect residents and workers.

• Study workflow and capacity from a process flow perspective.

• Establish a high ratio of useful work to “busywork.”

• Establish workplace safety and wellness programs.
Strategy 4

- Create a learning and improvement system.

Leadership action items

- Create local improvement teams, such as Safety Action Teams for empowered change at the microsystem level of care.
- Visibly post measures of reliability (adherence to goals) and measures of resilience (failures and follow-up actions to close gaps).
- Publish regular performance reports to enhance accountability, and provide access to real-time performance data for improvement.
- Provide relevant resources to help staff understand and use data in decision making and goal setting.
Leadership action items

- Publish and disseminate effective better practices for knowledge transfer and scaling improvements.
- Change the conversations from assigning blame to objectively solving the problem, using structured tools and methods, such as Define, Measure, Analyze, Improve, Control (DMAIC), Plan Do Study Act (PDSA), Lean principles, and Six Sigma.

Strategy 5

- Establish data capture, database, and performance metrics for accountability and improvement.
Leadership action items

• Engage workers and residents in the design of processes and measures of effectiveness through a defined and structured method.

• Establish safe reporting systems for workers to express concerns about threats to workforce psychological or physical safety.

• Establish a risk and safety database to detect and analyze patterns and leverage points for change.

Leadership action items

• Develop and report sociocultural measures using validated safety climate surveys.

• Implement action plans based on survey results, including known effective processes.

• Establish access to Employee Assistance Programs, psychological support, and stress-debriefing resources.

• Develop and recommend standard measures of joy and meaning in the new measurement system.
Strategy 6

- Recognize and celebrate the work and accomplishments of the workforce, regularly and with high visibility.

Leadership action items

- Ensure that core values of respect and compassion are incorporated into performance reviews and rewarded.

- Establish awards for teamwork and respectful behavior toward colleagues.

- Regularly publish and disseminate the work of teams in creating greater reliability and safety.
Leadership action items

- Incorporate testimonials and storytelling regarding safety improvements and “good catches” where vigilance prevented harm into governing board, departmental, and staff meetings.

- Create traditions in the workplace that honor and celebrate the workforce, such as appreciation days and service awards.

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 residents.
Leadership action items

• Commission cross-sectional studies of workforce safety and resident safety to find leverage points for systemic change.

• Engage researchers to study the effectiveness of applications from other high-risk industries (e.g., high-reliability organizations) to health care.

Leadership action items

• Conduct randomized controlled intervention studies that examine the effects of resident and family engagement on the workforce and resident safety.

• Qualitatively and quantitatively investigate the cultural foundations of workforce and resident safety (and harmful conditions).
Identifying and controlling risk

Risk management process

- Guides change to increase operating efficiencies
- Improves worker safety and overall quality and safety of resident care.
- Saves money.
Identify, define the risk
*Things are not always as they seem*

Evaluate the impact of change initiatives on risk
*Compare with baseline and revise solution as needed*

Collect and analyze risk data
*Include frequency AND severity*

Identify and implement workflow, process changes
*Often at little to no cost*

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**National emphasis program: nursing and residential care facilities**

- Ergonomic stressors relating to resident handling
- Workplace violence
- Infectious disease
- Slips, trips, and falls

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**PROGRAM DIRECTIVE**

Program Directive: PD-204
Issued: December 15, 2011

SUBJECT: National Emphasis Program (NEP): Nursing and residential care facilities

PURPOSE: This instruction describes policies and procedures for enforcement efforts to reduce occupational illness and injury in nursing and residential care facilities in NOSHS 6231 Nursing Care Facilities, 6232 Residential Mental Retardation, Mental Health and Substance Abuse Facilities, 6233 Community Care Facilities for the Elderly, and 6239 Other Residential Care Facilities that are on the A or B list of the Safety and Health scheduling lists.

EXPIRATION: This program directive expires three years from the date of issuance.

BACKGROUND: Nursing and residential care facilities continue to have one of the highest rates of injury and illness among industries for which nationwide days away, restricted work activity and job transfer (DART) injury and illness rates were calculated for California Year 2009. According to data from the Bureau of Labor Statics (BLS), the national average DART rate for the private industry for CY 2010 was 1.8. Nursing and residential care facilities, i.e., employers within NAICS 6231, 6232 and 6233, experienced average DART rates of 3.9, 3.0, and 4.7, respectively, despite the availability of feasible controls, which have been identified to address hazards within this industry. Note: BLS data for NAICS 6233 contains data for establishments that fall within NAICS 624119, and for NAICS 623119.e., assisted living facilities without onsite nursing care facilities). Data separating the two sectors is currently unavailable.
OSHA-CMS Partnership

• Purpose: to reduce medical error and improve resident and staff safety

• Interagency agreement to develop products in three areas:
  • Injury and illness “factbook”
  • Injury and illness prevention programs (I2P2)
  • Safe resident handling

Next steps

• List two things you will do tomorrow.
• List two things you will do this month.
• List two things you will do this quarter.

How will you stay on track?
References


References
