Actionable Patient Safety Solutions (APSS):
Workplace Safety

How to use this guide

This guide gives actions and resources for Workplace Safety. In it, you'll find:

Patient Safety MOVEMENT

Executive Summary

The Problem

A lack of priority around healthcare worker safety directly compromises the ability for an organization to optimize performance. Safe work environments and patient safety are two sides of the same coin, and therefore one is not achievable without the other. Many of the factors that impact patient safety also impact healthcare worker safety including, but not limited to, fatigue, burnout, built environment, communication, safe handling and movement, team dynamics, workload, production pressure, coping, intimidation, hazardous materials, and transmissible infections (Loeppke, 2017).

The Cost

Lack of workplace safety permeates into every aspect of patient care but the costs directly associated with poor workplace safety are still astronomical, with a cost of $27,000-$103,000 for replacing a nurse in the example of circumstances of high turnover. It has been estimated that the costs of turnover per nurse accounts for $16,600 in Australia, $10,100 in Canada, and $33,000 in the US (Wiskow et al., 2010). Other direct costs include litigation, time off, and lawsuits and various indirect costs and impacts on patient safety due to the lack of staffing availability. Worldwide, it is estimated that stress and violence together account for approximately 30% of the overall costs of ill-health and accidents (WHO, 2002). In the US alone, workers' compensation results in a loss of $2 billion for hospitals annually (OSHA, 2020).

The Solution

Workplace safety requires an organization-wide, multilevel, cultural shift to open and honest communication to anticipate and prevent workplace violence, hazards, and injuries and to promote well-being, joy at work, communication, and collaboration. The basis for promoting workplace safety and preventing violence, injury, and hazards is to identify problems early and to have an organization-wide culture of transparency, fairness, and accountability (Holbrook et al., 2019) Many healthcare organizations have successfully implemented and sustained improvements from workplace safety initiatives. These organizations have used a systematic approach and focused on projects that included **prioritizing workplace safety for everyone in the organization, highlighting the relationship between workplace safety and patient safety, linking business development and employee well-being, and standardizing reporting guidelines.**

This document provides a blueprint that outlines the actionable steps organizations should take to successfully improve workplace safety and the workplace environment and summarizes the available evidence-based practice protocols. This document is revised annually and is always available free of charge on our website. Hospitals who make a formal commitment to improve workplace safety and share their successes on the PSMF website have access to an additional level of consulting services.

Leadership Checklist

It is the responsibility of those in leadership positions to establish the expectation for workplace safety for all, illustrate its relationship to patient safety, and reinforce the behaviors that enhance workplace safety, while highlighting the behaviors that compromise it. The engagement and support from leaders will influence behavior on the frontlines. The following leadership checklist contains essential elements that should be implemented and sustained in order to improve workplace safety for all across the organization.

Be the change you wish to see.

- ☐ Normalize help-seeking behavior by engaging in open, ongoing conversations and checking in with staff routinely. Demonstrate help seeking behavior yourself to lead by example.
- ☐ Maintain a balance between allowing grief and underlining hope in the next steps forward after any negative event. Practice 'grief leadership' by openly acknowledging grief and loss.
- ☐ Make leadership support visible via leader rounding.
- ☐ Be approachable and perpetuate the idea of failure as a learning opportunity.
- ☐ Acknowledge vulnerability in leadership.
- ☐ Do not only converse with those who have positive feedback. Ensure equal attention and consideration are given to those who may have negative feedback.
- ☐ Show gratitude and appreciation for your workforce.

Meet your people where they are.

- ☐ Ask staff what matters to them and offer feedback mechanisms both anonymously and in open dialogue. Share a story about what matters to you to demonstrate the task. Ensure that once you ask, you take action. Strive to minimize the gap in time between the ask and the follow up conversation.
- ☐ Establish a top-down multidisciplinary, multilevel approach (ASIS, 2020:SHRM, 2018) and devise a method for feedback from the frontline to optimize effectiveness and universality.
- ☐ Allow choice and flexibility in daily responsibilities. Encourage freedom in decision making while following necessary guidelines.
- ☐ Establish clear, concise workplace safety responsibilities for all staff members.
- ☐ Ensure frontline involvement in workplace safety improvement activities. Maintain their engagement and remove barriers to progress.
- ☐ Understand the needs of the workers, such as child services, mental health services, or other types of support.

Demonstrate the link between workplace safety and performance across the organization.

- ☐ Adopt a holistic view of well-being, highlighting the relationships between workplace safety, patient safety, sustainability, improvement, efficiency, and progress. Adopt strategic alignment between healthcare worker safety and patient safety, in areas such as human resources, design, and risk management.
- ☐ Emphasize connection between workplace safety and business and development. Resources and appropriate staffing will be required and therefore, leaders must present their case with compelling evidence through the business lens.
- ☐ Invest in staff members' personal and professional development.
- ☐ Share the stories, knowledge, and lessons learned with the organization to increase the understanding and the importance of reporting to learn to keep the work environment safe for patients, staff and others.

Ensure involvement from all for continuous improvement efforts.

- ☐ Co-design a peer support program and include disciplines from across the organization (Betsy Lehman Center, 2020).
- ☐ Acknowledge that workplace safety is not a 'project' with a start and end date. It is a culture that should be sustainably adopted and prioritized.
- ☐ Implement a 'buddy system' to improve camaraderie and enhance availability of collective support resources.
- ☐ Make joy at work a shared responsibility for everyone throughout the organization (Perlo et al., 2017).
- ☐ Debrief on a regular basis to solicit team feedback about barriers to sustained workplace safety. Adjust the plan quickly and nimbly as needed.
- ☐ Ensure adequate and routine training and education for all employees around workplace safety, early recognition of potential workplace violence, communication,conflict resolution, de-escalation, and reporting.
- ☐ Inform patients of the need for mutual respect and understanding to assist in the delivery of care.
- ☐ Establish a simple process to oversee workplace safety improvement work while also considering how it aligns with other initiatives across the organization. Minimize silos in favor of collaboration. Keep program elements simple and transferable to other circumstances/departments.
- ☐ Ensure proper allocation of resources for hazard prevention (e.g., infection prevention resources) and consider ergonomics in the design of workspaces. See the CDC's Safety and Health Information for Healthcare Workers.
- ☐ Conduct post-incident critical event reviews for all reports.

Implement standards and systems for sustainable change. Reevaluate for adjustment and optimization potential.

- ☐ Establish and reinforce consistent messaging and language around guidelines and behaviors that are welcomed and those that are not acceptable. Set boundaries for what is acceptable behavior and reinforce these standards. Adopt the "Just Culture" approach for accountability.
- ☐ Set up a comprehensive Workplace Violence Prevention Program including standardized policies and procedures that are as clear as possible for effective implementation (Johnson, 2015).
- ☐ Organize and maintain a Threat Assessment Team (TAT) with the goal that all incidents are taken seriously and thoroughly investigated (Figure 3.1 Holbrook et al., 2019).
- ☐ Create a process to provide patients at risk of or those who have perpetrated violence with a plan of care that bolsters support and resources instead of diminishing them.
- ☐ Establish a system for early reporting, encourage early reporting, and demonstrate the timely subsequent actions taken based on the report. Acknowledge problems as they arise.
- ☐ Ensure all reported events are taken seriously, thoroughly investigate and document all known events. See Appendix A for an example of a proactive leadership response to workplace violence or reports of hazards.
- ☐ Hold staff members, patients, and visitors accountable for behavior that either improves or compromises the workplace safety culture.
- ☐ Expect that when the organization starts tracking wellness and workplace safety, there will be an initial increase in reported events before organizational improvement work begins to reduce error rates over time. Ensure that the frontline staff and leaders understand this so they don't become demotivated to improve.
- ☐ Consider electronic reporting systems for ease of identifying trends and discerning intervention efficacy. Conduct routine assessments of workplace safety. Ensure measurement at both the systems level and at the local level (Perlo et al., 2017).
- ☐ Offer in-facility workshops, including, but not limited limited to topics such as resilience, team building, conflict resolution, empathy, and coping.
- ☐ Adopt a culture of safety survey and continuously reassess outcomes to identify areas for improvement.

Workplace Safety Responsibilities for Everyone

Both leaders and employees have the responsibility to keep the workplace safe. For example, when the leaders provide supplies for sharps disposal, it is the responsibility of the frontline clinicians to appropriately dispose of all sharps used according to procedures set by the leaders. The following have been identified as safety responsibilities for everyone to maintain and improve workplace safety across the organization.

Person-Centered Culture of Safety

- Recognize one another for the value they bring to the organization. Embody "Commitment to my Coworker" principles.
- Hold team members accountable and learn from yours and others' mistakes.
  - Participate in root cause analysis workshops and debriefing sessions after the event.
  - Reflect on all opportunities for personal and team improvement in the future to avoid the same error.
- Listen to other team members if they are explaining concerns or are approaching you for advice. Take all concerns seriously and do not minimize others' concerns.
- Do not leave a team member alone in a potentially hostile environment.
- Treat everyone as your equal.
- Respond to staff, patients, and family members who report bullying. Have a conversation with the reporting individual and try to understand how you can best help them.
- Participate in peer support programs and 'buddy systems' for both social support and safety.
- Normalize and encourage help-seeking behavior in peers. Seek out help yourself when needed.
- Raise concerns about intimidating behavior or exclusion.
- Do not feel as though you are alone in resolving someone's concern. Collaborate with leadership, security, and human resources.

Holistic, Continuous Improvement

- Report conditions that often lead to injury. Do not wait for the hazard to occur to confirm your gut feeling. If you sense a potential future problem, say something and allow the experts to do a risk assessment.
- Actively challenge the expectation that a career-oriented person should work longer hours and not be absent to attend family matters. Respect others' work-life balance at all levels and in all disciplines.
- Participate in debriefing sessions around workplace violence. See the What We Know section for more information about workplace violence.
- Remain vigilant for situations that may lead to workplace injury and mention to leaders during debrief sessions.
- Use early reporting systems and encourage colleagues to do the same.
- Raise concerns of unclear or ambiguous guidelines, procedures, or standards. Follow the organization's policies. If the policy isn't right or can be improved, organize a meeting with leaders to suggest changes to the policy.
- Know when to take time off and don't think about work during your time off. Do not feel guilty taking time off.
- Evaluate what matters to you at work and what hinders that manifestation of what matters to you at work. Be specific and honest when providing feedback to leadership.
- Participate in workplace safety related workshops and apply concepts to your daily activities.
- Raise concerns of increases in workload after the implementation of new processes or technologies.
- Pursue follow up conversations with leaders after raising a concern or suggestion.
- Identify someone in a higher level of hierarchy and identify the aspects of their character that made you feel safe and welcomed in the group. Work to emulate.

Model for Sustainment

- Embrace workplace safety as a culture, not a project with a start and end date.
- Continue reporting opportunities for improvement.
- Report any variations from the established protocol.
- Take ownership of the organization's workplace safety initiatives.
- Expect ongoing change.
- Practice peer support principles, including presence, psychological safety, empathetic listening, non-judgemental curiosity, problem-solving guidance, coping encouragement and exploration, reframing, resource connection, and appreciation (IHI, 2020).

Performance Improvement Plan

Follow this checklist if the leadership team has determined that a performance improvement project is necessary:

- ☐ **Gather the right project team.** Improving workplace safety is not easy and this improvement initiative will require perspectives from all involved in the organization to truly understand what's really happening and what those on the frontline wish to see in the future. Therefore, the "project team" is the entire leadership team. It is important to have representation from all disciplines and to thoughtfully and methodically progress through the same PDSA process you would apply to any performance improvement project, but at a much higher level. This effort will result in the identification of both short-term and long-term organizational improvement goals.

- ☐ **Understand what is currently happening and why.** Reviewing objective data and trends is a good place to start to understand the current state of your organization. Teams should spend a good amount of time analyzing data (and validating the sources). However, the most important action here is to complete leader rounding at the key locations determined by the data, to observe and engage the staff. Even if team members work in the area daily, examining existing processes from every angle is generally an eye-opening experience. The team should ask questions of the frontline during the observations that allow them to understand each step in the process and identify the people, supplies, or other resources needed to improve patient outcomes.

Create a process map once the workflows are well understood that illustrates each step and the best practice gaps the team has identified (IHI, 2015). Brainstorm with the advisory team to understand why the gaps exist, using whichever root cause analysis tool your organization is accustomed to (IHI, 2019). Review the map with the advisory team and invite the frontline to validate accuracy.

WORKPLACE SAFETY PROCESSES TO CONSIDER ASSESSING	
• Conditions that lead to injury	• Inter-hierarchical dynamic and interactions
• Conflict resolution practices	• Transitions of care for patients
• Division of work and staffing	• Feedback mechanisms after implementation of a new technology or process
• Pace of work	• Buddy system performance
• De-escalation	• Process for consideration and risk assessment after concerns are verbalized
• Counseling with opposing parties	• Anonymous and face to face feedback mechanisms
• Interpretation of feedback from frontline staff and subsequent action that ensues based on feedback	

Table 2: Consider assessing these processes to understand where the barriers contributing to poor workplace safety may be in your organization

☐ **Prioritize the gaps to be addressed and develop an action plan.** Consider the cost effectiveness, time, potential outcomes, and realistic possibilities of each gap identified. Determine which are a priority for the organization to focus on. Be sure that the advisory team supports moving forward with the project plan so they can continue to remove barriers. Design an experiment to be trialed in one small area for a short period of time and create an action plan for implementation.

The action plan should include the following:

- Assess the ability of the culture to change and adopt appropriate strategies
- Revise policies and procedures
- Redesign forms and electronic record pages
- Clarify patient and family education sources and content
- Create a plan for changing documentation forms and systems
- Develop the communication plan
- Design the education plan
- Clarify how and when people will be held accountable

TYPICAL GAPS IDENTIFIED IN WORKPLACE SAFETY	
• Hierarchy	• Ingrained expectation that bullying will occur anyway
• Lack of a person-centered culture	• Cultural acceptance that violence is just part of the job
• Fear of retaliation	• Ostracism
• Little encouragement of open and honest communication	• Lack of team accountability and peer to peer support
• Little or no mechanism for reporting and/or feedback	• Little hope that reported incidents will be acted upon
• Poor training for early recognition of hostile settings	• Lack of transformational leadership styles, including little support from leaders or dismissiveness of leaders
• Poor training for de-escalation strategies	• Not acknowledging problems as they arise and/or before they manifest into bigger problems
• Lack of clear guidelines for reporting	
• Lack of conflict resolution resources	
• Lack of a clear point person to contact with questions or concerns	
• Fragmentation of protocols by unit	

Table 3: By identifying the gaps in workplace safety compliance, organizations can tailor their project improvement efforts more effectively

☐ **Evaluate outcomes, celebrate wins, and adjust the plan when necessary.** Measure both process and outcome metrics. Outcome metrics include the rates outlined in the leadership checklist. Process metrics will depend upon the workflow you are trying to improve and are generally expressed in terms of compliance with workflow changes. Compare your outcomes against other related metrics your organization is tracking.

Routinely review all metrics and trends with both the advisory and project teams and discuss what is going well and what is not. Identify barriers to completion of action plans, and adjust the plan if necessary. Once you have the desired outcomes in the trial area, consider spreading to other areas (IHI, 2006).

It is important to be nimble and move quickly to keep team momentum going, and so that people can see the results of their labor. At the same time, don't move so quickly that you don't consider the larger, organizational ramifications of a change in your plan. Be sure to have a good understanding of the other, similar improvement projects that are taking place so that your efforts are not duplicated or inefficient.

Read this paper **from the Institute for Healthcare Improvement to understand how small local steps can integrate into larger, system changes**

WORKPLACE SAFETY COMPARATIVE OUTCOMES	
• Turnover rate	• Percent of healthcare used sick days
• Job satisfaction rates	• Number of 'sharps log' injuries
• Productivity	• Number of workplace violence incidents
• Employee commitment	• Unscheduled staff time off
• Worker's compensation injury claims	

Table 4: Consider evaluating related metrics to better understand poor workplace safety presence and contributing factor

What We Know About Workplace Safety

Workplace safety requires an organization-wide, multilevel, cultural paradigm shift towards open and honest communication, conflict resolution, psychological safety, and mutual respect to anticipate and prevent workplace violence, hazards, and injuries and to promote well-being, joy at work, communication, and collaboration.

The Ideal Workplace

Organizations of high reliability prioritize the safety and wellbeing of those within, regardless of role or status. The following are examples of features of a safe, healthy workplace:

- Early recognition of unsafe behaviors
- Comfort and empowerment of all in reporting
- Confidence that reports will be taken seriously
- Protection from retaliation
- Comfort in asking questions
- Ability to ask for time off without guilt
- Support from leaders when confronted with a difficult situation
- Standardized guidelines to reference in difficult situations
- Confidence pitching ideas for improvement
- Clear, universally understood definitions of behaviors that compromise safe environments
- Comfort in asking for support
- Expectation of being listened to without unnecessary interruptions
- Active listening in all conversations
- Timely provision of materials needed to ensure safety (e.g. PPE)
- Proactive and routine evaluation of workplace culture, safety, and environment
- Open door policy by leaders for their frontline staff
- Freedom of expression without fear of retaliation
- Staff continued education around tools for improving communication and conflict management
- Continued feedback to staff around how their feedback contributes to improvement
- Simulation training for practicing on how to apply tools
- Rewarding achievements and story sharing/telling
- Coaching or mentorships on the what, the why, and the how of leadership

Benefits of Prioritizing Workplace Safety

The benefits of improving workplace culture and safety touch almost every aspect of the organization. For example, appropriate staffing is associated with nurses getting more done during a typical shift (AACN, 2020). A Health Affairs survey showed that hospitals in which the workplace environment improved also improved by 15% on the percentage of nurses reporting excellent quality of care, by 16% on reported job satisfaction, and by 12% on burnout (Aiken et al., 2018). Studies show that improvement in workplace safety:

- Improves efficiency by reducing redundancy
- Enhances opportunities to intervene with safety interventions to intercept a potentially harmful event
- Decreases worker's compensation claim likelihood
- Minimizes litigation
- Decreases turnover
- Improves organizational reputation
- Increases staff retention
- Increases ownership and adherence to standards within the organization
- Increases likelihood of reporting
- Reduces the number of adverse events
- Improves patient and provider satisfaction
- Decreases exposure to hazards such as infections, bloodborne pathogen, or chemicals
- Boosts team and individual morale
- Decreases provider stress, burnout, substance use, and mental health issues
- Improves job satisfaction and quality of care

Identifying and correcting hazards in the workplace is key to minimizing injuries and incidents that compromise safety and wellbeing. Completing a risk assessment, with frontline worker participation, to identify the true hazards is the initial step. Then,

develop a plan to control the hazards identified, measure the implemented plan, and evaluate the effectiveness of the plan (Occupational Safety and Health Administration, 2019).

Workplace Violence

While workplace violence is often the most shocking aspect of poor workplace safety, there are so many additional factors that contribute to poor workplace safety and compromise communication, error reporting, patient safety, mental health, well being, healthy habits, and job performance.

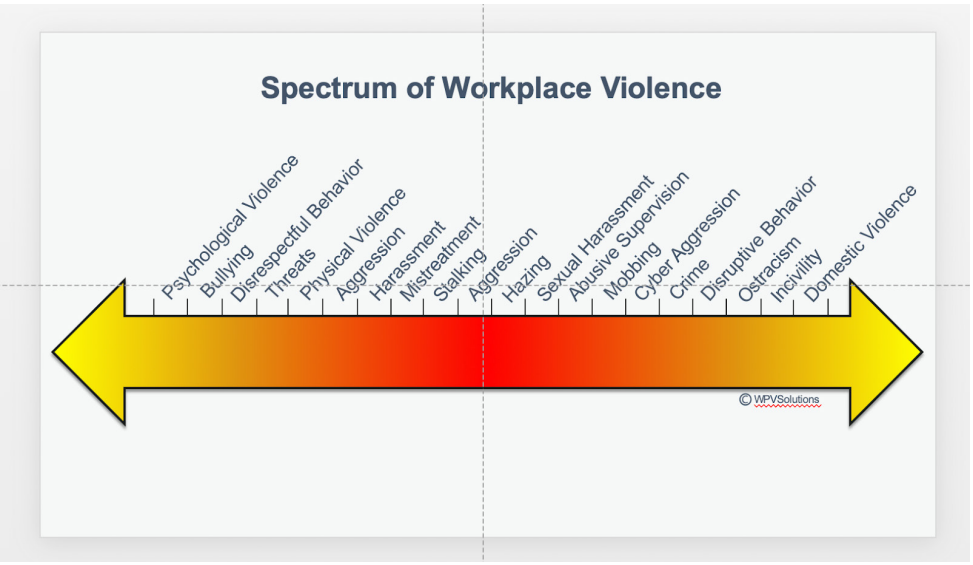
Workplace violence is particularly prevalent in the healthcare space because of the nearly-universal desire to help patients, regardless of the circumstance, and because clinicians may excuse violence from patients due to their condition or cognitive state. But workplace violence doesn't only happen with patients but can involve coworker to coworker violence too. Workplace violence is defined as, "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site" (OSHA, 2020). Intentionality and criminality are not benchmarks, and incidents can fall within a spectrum that ranges from threats and verbal abuse to physical assaults and even homicide (OSHA, 2020). Workplace violence is a global phenomenon that, at its core, negates a healthcare worker's ability to provide safe patient care.

Violence is one of the most dangerous occupational hazards health care workers face. This makes health care facilities one of the most dangerous places to work, with a rate of 6.8 work-related injuries and illnesses for every 100 full-time employees (OSHA, 2020). To put this into perspective, healthcare workers in Canada have two times the rate of injury due to violence than police officers (CCOHS, 2020). In the United States, healthcare workers have a rate of injury comparable to all other US industry workers combined (GAO, 2016).

ACCORDING TO NIOSH, TYPES OF VIOLENCE IN THE WORKPLACE CAN BE DELINEATED AS FOLLOWS (CDC, 1996):

- **Type 1 Criminal Intent:** Violent acts by people who enter the workplace to commit a robbery or other crime, or current or former employees who enter the workplace with the intent to commit a crime.
  - Example: A robbery perpetrated within a pharmacy, the intent being to steal prescription opioids.
- **Type 2 Customer/Client/Patients:** Violence directed at employees by customers, clients, patients, students, inmates, or any others to whom the employer provides a service.
  - Example: A patient with altered mental status becomes physically aggressive and hits a healthcare worker who is trying to provide care.
- **Type 3 Co-worker:** Violence against co-workers, supervisors, or a manager.
  - Example: Acts of bullying and harassment between co-workers.
- **Type 4 Personal:** Violence in the workplace by someone who does not work there, but who is known to, or has a personal relationship with, an employee.
  - Example: A staff member's spouse gains access to the hospital and physically assaults the healthcare worker.

It is important to recognize workplace violence as a spectrum. Often, the most frequent occurrences of workplace violence are those that are not immediately recognized. By expanding the definition of workplace violence to incorporate covert violent behaviors, incidents that compromise workplace safety are intercepted and corrected before they manifest further.



Intervention strategies should use the 80/20 rule as a guideline for their efforts. Meaning 80% of an organization's efforts should be focused on the prevention of workplace violence, while the other 20% is action towards response to incidents (Holbrook et al., 2019).

Factors that Contribute to Unsafe Incidents Waiting to Happen

Organizations should not wait until something bad happens to take the first steps. Risk factors that increase the risk of workplace violence and compromise workplace safety include, but are certainly not limited to (Raveel & Schoenmakers, 2019):

ERGONOMIC FACTORS	ORGANIZATIONAL CULTURE FACTORS	HUMAN FACTORS	CULTURAL AND SOCIAL FACTORS
• Poor control over staff only areas and patient areas • Overcrowded and noisy areas • Poor access to amenities such as toilets • Poor lighting • Lack of secure areas for medications, money etc. • Lack of understanding around how to call for help in simulation training • Lack of protective equipment, such as PPE • Fall risk hazards • Lack of support for heavy equipment	• Lack of adequate staff • Lack of recognition of potentially hostile or aggressive situations • Working alone • Lack of a reporting mechanism with consistent and thorough follow up with each report • Little encouragement to report and little faith that reporting will do anything • Unclear guidelines around what constitutes aggressive, hostile, or unhealthy behavior and when to report • Lack of training in de escalation • Unclear, unstandardized protocols for the use of restraints • Lack of robust, standardized, routinely reinforced policies around why something can or cannot be done	• Altered patient mental status due to factors such as medications, substance abuse, or physiological conditions • Fear of retaliation after reporting or confronting • Fear of not being taken seriously • Power imbalances • Patient previous poor experiences with the healthcare system • Frustration due to not being listened to or treated fairly • Poor communication • Mobbing, causing fear that the next individual to report will be the next target	• Language differences • Differences in interpretation of nonverbal communication • Suspicion leading to premature defensiveness • Belief that violence is expected as part of the job

Clear Signs of Poor Workplace Safety and Culture

While the above risk factors may or may not lead to a violent or unsafe incident, the below are clear signs of a poor workplace culture related to safety and wellness:

- Violence
- Nonverbal or verbal bullying
- Harassment
- Purposeful exclusion
- Purposeful intimidation
- Threats
- Isolation of colleagues
- Withholding information an individual needs to perform properly and to the best of their ability
- Failing to give credit where credit is due
- Shaming or guilting, especially upon consideration of reporting or pushback
- Purposeful surprise meetings to expose the participant as unprepared
- Targeting of insecurities
- Normalization of deviance and bullying
- Excessively high workload
- Lack of a reporting mechanism with consistent and thorough follow up with each report
- Little encouragement to report and little faith that reporting will do anything
- Lack of staff empowerment and leadership support to address unsafe behavior immediately
- Lack of leadership followup after reports of poor safety or violence
- The notion that 'no one was hurt' and therefore reporting isn't necessary
- Lack of accountability
- Unscheduled staff time off
- Exposure to chemicals such as cleaning supplies or hazardous drugs such as radiation
- Exposure to infections and diseases

Reporting and Assessing Trends in Data for Appropriate Interventions

Underreporting workplace safety incidents is consistently cited in the literature (Raveel & Schoenmakers, 2019). Although both the Canadian Center for Occupational Health and Safety and the US Occupational Safety and Health Administration (OSHA) mandate formal reporting and violence prevention mechanisms, there are a plethora of incidents in the 'grey' area that remain underreported because these incidents are not explicitly violent or hazardous. However, these incidents contribute significantly to the overall culture of workplace safety and can often escalate into tangible hazardous workplace incidents. Early reporting is essential to identify effectiveness of interventions, employ appropriate protective measures, and understand the breadth of the issues that may not be readily apparent. Reporting mechanisms can range from discussion during huddles, to anonymous reporting, to 1:1 discussion with team leaders.

It is important to consider barriers to reporting, as reporting and delivery of interventions will be compromised until barriers are identified and removed. Barriers to reporting can include, but are not limited to, fear of repercussion, fear of making the situation worse, fear of being identified as incompetent with the workload, or fear of being perceived as unwilling to work with other team members.

See the "Measuring Outcomes" section for more information.

Resources

For workplace safety improvement:

- Interaction of Health Care Worker Health and Safety and Patient Health and Safety in the US Healthcare System: Recommendations from the 2016 Summit
- The Joint Commission: Improving Patient and Workplace Safety
- United States Department of Labor: Occupational Safety and Health Administration
- OSHA: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
- WHO: How to Create an Attractive and Supportive Working Environment for Healthcare Professionals
- IHI: Framework for Improving Joy at Work
- IHI: Three Ways To Create Psychological Safety in Healthcare
- CDC: Safety and Health information for Healthcare Workers
- NIOSH: Fact Sheet: The Buddy System
- Interventions to Prevent Aggression Against Doctors: A Systematic Review
- Workplace Bullying Among Nurses: Developing a Model for Intervention
- United States Government Accountability Office: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence
- Implementation of a Preparedness Program to Address Violent Situations in Healthcare
- Workplace Violence Against Healthcare Professionals: A Systematic Review
- Metropolitan Hospital Compact – Sample template: Management of violence in the healthcare/ workplace setting
- Gap Analysis Tool
- Workplace Bullying Prevention: A Critical Discourse Analysis
- Workplace Violence: Prevalence, Risk Factors, and Preventive Measures Across the Globe

For general improvement:

- CMS: Hospital Improvement Innovation Networks
- IHI: A Framework for the Spread of Innovation
- The Joint Commission: Leaders Facilitating Change Workshop
- IHI: Quality Improvement Essentials Toolkit
- SIPOC Example and Template for Download
- SIPOC Description and Example

Education for Patients and Family Members

Workplace safety and violence prevention is the responsibility of everyone in the organization. While healthcare workers have been trained and educated on workplace safety protocols and violence prevention mechanisms patients, and facility visitors may lack this knowledge, may not understand the expectation of mutual respect, and may fail to acknowledge how their actions have a significant impact on the well being of those in the workplace and subsequently, in the delivery of their own care.

Healthcare workers should engage in discussion as early as possible with patients and their loved ones and visitors about which actions can facilitate and which actions can compromise workplace safety and care practices. Healthcare workers should discuss the following with patients and family members and why each are important to maintain workplace safety:

- Not leaving trip hazards in rooms
- Asking for help from healthcare professionals instead of insisting on completing things themselves
- Asking questions as they arise
- Using devices to prevent falls and injury
- Expecting mutual respect
- Active listening and two way communication
- Engaging in open discussion to ensure expectations for treatment and pain control are understood
- Participating in bedside rounding
- Discussing patient rights and responsibilities

The patient and visitors should understand that these expectations are in place to both facilitate the well being of those employed by the organization, but to ensure quality provision of care that directly impacts the patient themselves.

Hospitalization is stressful. Healthcare workers should seek to understand the barriers that patients face beyond the physical. Through active listening and dialogue, relationships can be built between the patient, visitors, and healthcare team. Such relationships can serve as a protective mechanism by decreasing the sense of reactance felt by patients and loved ones in their high stress state. Additionally, these relationships built on trust can serve to identify the resources that the patient may desperately need for their recovery. Lack of these resources may heighten the patient's stress throughout their journey in the hospital or healthcare organization and thereby compromise workplace safety or increase the risk for workplace violence. Healthcare workers should therefore act as advocates for all patients especially those that require additional resources and support mechanisms.

Emphasize that hospitals and healthcare organizations need the help of patients and visitors to sustain the safety and wellbeing of all in the organization.

Measuring Outcomes

Ensure measurement at both the systems level and at the local level (Perlo et al., 2017)

Consider assessment tools such as the Net Promoter Score, Mayo Clinic Leadership Dimensions Assessment, Safety Attitudes Questionnaire, AHRQ Patient Safety Culture Surveys, Maslach Burnout Inventory, Mini Z Burnout Survey, Survey to Measure Physician Engagement in Addressing Health Care Disparities, and/or Hackman and Oldham Job Characteristics Model to Model Job Satisfaction.

Local level measures should include routine conversations, pulse surveys, and/or visualizations of workplace culture where staff are invited to participate (e.g., boards where staff are encouraged to place a sticky note color based on the quality of their day).

Process metrics include, but are not limited to, turnover rate, debriefing meetings, reports of bullying, hostile behavior, violence, satisfaction, engagement, burnout, turnover, employee retention, wellbeing, workplace injuries, or absenteeism. It is helpful to delineate these metrics by unit, discipline, ethnicity, gender, and age.

Outcome metrics include, but are not limited to, worker's compensation claims, incidents of violence, codes related to violence, and incidence of injuries.

Endnotes

Conflicts of Interest Disclosure

The Patient Safety Movement Foundation partners with as many stakeholders as possible to focus on how to address patient safety challenges. The recommendations in the APSS are developed by workgroups that may include patient safety experts, healthcare technology professionals, hospital leaders, patient advocates, and medical technology industry volunteers. Workgroup members are required to disclose any potential conflicts of interest.

Workgroup

Workgroup Members

Katie Ann Blanchard	WPV Solutions LLC.
Jaclyn Castano	WPV Solutions LLC.
Michele Holt	University of Jacksonville Florida
Olivia Lounsbury	Patient Safety Movement Foundation
Donna Prosser	Patient Safety Movement Foundation

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Appendices

Appendix A: Example of a proactive leadership response to workplace violence or reports of hazards.