Hospital Improvement and Innovation Network (HIIN)

The Integration of Worker and Patient Safety "We Share 4 Safety"

Today's Topic:
Building a Business Case:
Integration of Worker and Patient Safety

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Agenda

- Hospital Data Aggregate Review
  - Year in Review
- Building a Culture for Safety: Blueprint for Success
- Building a Business Case: Integration for Worker and Patient Safety
  - Process Overview
  - Slip, Trip, Fall Example
  - Workplace Violence Example
- 2018 Timeline Update
- Questions
- Next Steps

Data Aggregate Review

Data Aggregate Review Snapshot

ALL Hospitals - Combined	Baseline Data		Performance Data			
Total Incidents	**2015**	**2016**	**10/17**	**11/17**	**12/17**	**Annualized**
Total Claims	750	787	50	48	39	704
Frequency Rate	3.10	3.39	0.21	0.18	0.18	2.92
Severity Rate	$12,895	$10,651	$663	$391	$236	$9,565
Patient Handling Incidents						
Total Claims	137	119	2	3	6	91
Frequency Rate	0.57	0.51	0.01	0.01	0.03	0.38
Severity Rate	$2,842	$2,332	$9	$7	$23	$1,066
Aggressive Patient Incidents						
Total Claims	49	57	3	6	2	73
Frequency Rate	0.20	0.25	0.01	0.02	0.01	0.30
Severity Rate	$967	$1,201	$12	$16	$8	$967
Slips, Trips, Falls						
Total Claims	145	174	9	8	11	119
Frequency Rate	0.60	0.75	0.04	0.03	0.05	0.49
Severity Rate	$3,601	$3,722	$357	$184	$113	$3,050

Results

Total Claims Frequency Rates
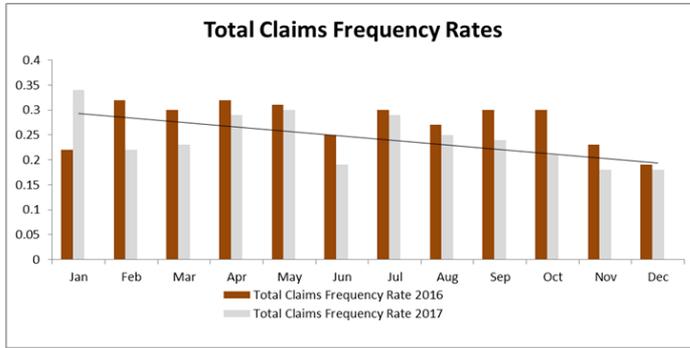
2016 Frequency Rate	3.39
2017 Frequency Rate	2.92

Patient Handling Frequency Rates
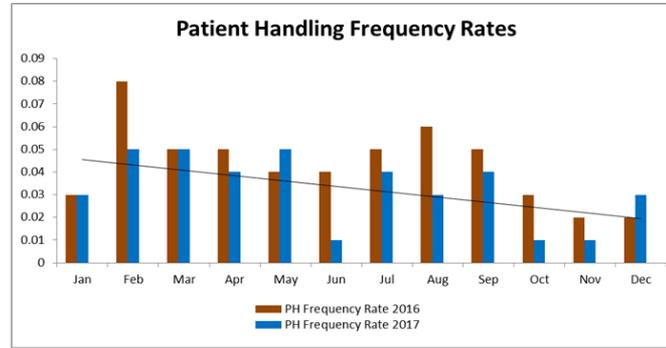
2016 PH Frequency Rate	0.51
2017 PH Frequency Rate	0.38

Aggressive Behavior Frequency Rates
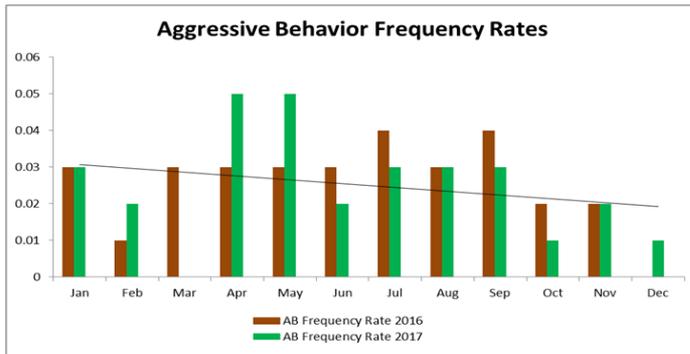
2016 AB Frequency Rate	0.25
2017 AB Frequency Rate	0.30

Slip, Trip, Fall Frequency Rates
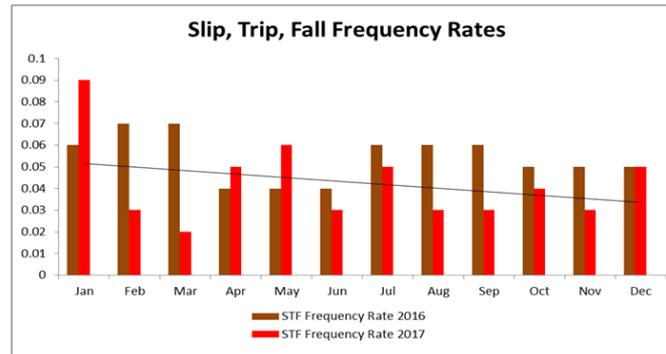
2016 STF Frequency Rate	0.75
2017 STF Frequency Rate	0.49

Building a Culture of Safety: Blueprint for Success

Leading a Culture of Safety: A Blueprint for Success
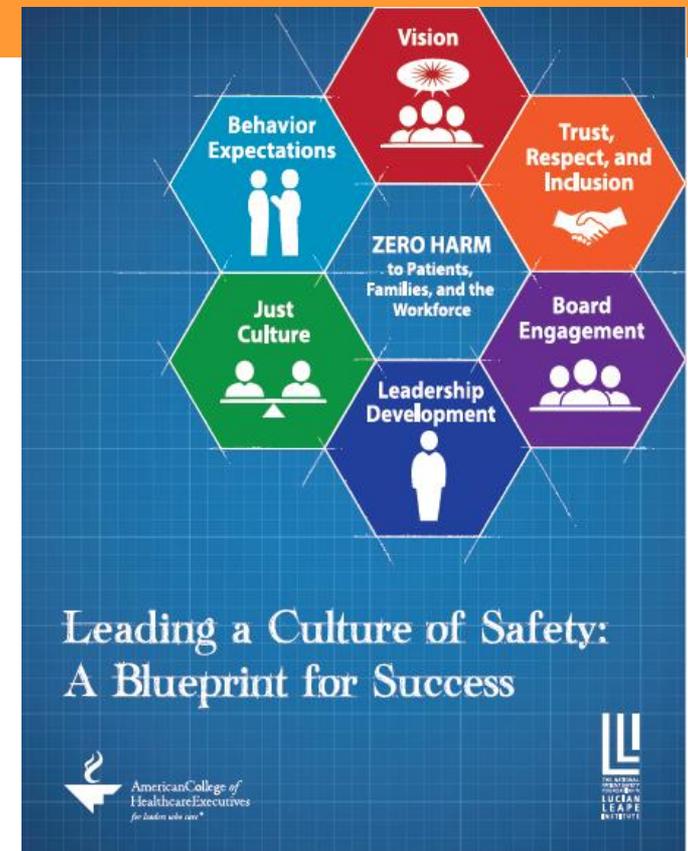
A Culture of Safety: The Six Domains

Vision — Establish a Compelling Vision for Safety

Trust, Respect, and Inclusion — Build Trust, Respect and Inclusion

Board Engagement — Select, Develop and Engage your Board

Leadership Development — Prioritize Safety in the Selection and Development of Leaders

Just Culture — Lead and Reward a Just Culture

Behavior Expectations — Establish Organizational Behavior Expectations

Establish a Compelling Vision for Safety

- Look at purpose statement and core values with worker and patient safety in mind – is it clearly stated as an organizational purpose, goal or value
  - **Definition of safety should include worker safety (many organizations specify patient safety but not patient and worker safety)**
- Be transparent with worker safety rates
- **Recognize worker and patient safety – in departments and organization-wide**
- Create awareness for emphasis on worker safety using flyers / media, etc.

Build Trust, Respect and Inclusion

- Make these a priority during orientation and continuing education
- **Leadership rounding on worker / patient safety – checklist for leaders to look for in terms of worker safety and patient safety**
- Employee driven rounding by leadership
- Measure employee engagement when it comes to safety – be transparent about the results
- **Create an employee engagement program to encourage and incentivize staff to focus on their safety and the importance worker safety has on the organization**

Select, Develop and Engage your Board

- Allow staff to help choose members of the Board – the Board should have a variety of representatives from different backgrounds / levels
- **OHA to hold educational sessions to the board on worker safety / High Reliability Organizations**
- Educate the Board on the importance of worker safety reporting - transparent sharing of worker and patient safety
- In addition to data, build personal staff stories so the Board can understand / relate to the issues surrounding worker safety

Prioritize Safety in Selection and Development of Leaders

- Need to work backgrounds to determine the type of leader we want and then determine the needs
- **Next-Gen Program (SOMC) – younger individuals within the organization who may or may not be in current leadership roles are trained and complete projects with current leadership**

Lead and Reward a Just Culture

- Starts with Senior Leadership – need to stress that it is everyone's responsibility
- Need to educate just culture throughout the organization at every level
- **Help staff understand and realize the changes made throughout the organization and the impact being made (transparency)**
- If there is an incident or near miss incident trace the event back to understand the behavior that may have caused it or the actions that could change to deter it in the future

Establish Organizational Behavior Expectations

- Use a survey as baseline data – look at safety data as a whole (patient and worker together)

- Create a monthly dashboard at every hospital to be transparent throughout the entire hospital

- **Create a culture of safety pledge – have all hospital employees sign the pledge and hang it up in the entrance of the hospital**

- Conduct departmental unit audits – talk to everyone in each unit to determine what is going on and to focus on the issues staff view as issues

- Highlight units and reward them based on certain safety behavior goals

Building a Business Case:
Integration of Worker and Patient Safety

"Leadership is developing things in parallel and knowing when they will converge"

- Robert Ballard, President, Institute for Exploration and Ocean Exploration Trust

Process Overview

1) Survey Monkey Assessment

2) Results will be reviewed / returned to each Facility

3) Internal Action Plan review by each Facility

4) Update Calls with Kelly / Courtney

5) Begin drafting a Business Case – Discuss in April

Survey Monkey Assessment

- 10 Question Survey
  - Multiple Choice (1 – 5 answer choices)
  - Optional comments available
  - https://www.surveymonkey.com/r/CFPLNDK

- Share the survey link to a variety of employees in your organization
  - Patient Safety; Quality; Security; Employee Health; etc.

- Close the Survey on Friday, February 23rd

- Results with be collated, reviewed and sent to each facility

Internal Action Plan Review

- Review current STF and WPV Action Plans with Worker Safety team and Patient Safety representatives

- Go through each Action Item:
  - For Implemented Action Items: Discuss the impact this had made on the organization AND patient safety
  - For Outstanding Action Items: Discuss why this item has yet to be implemented; Can patient safety help?

- Fill out the Column in Smartsheet Action Plans with comments during discussions

- 30-minute update calls with Kelly / Courtney

Action Plan Review – STF Example #1

- **Best Practice:** New Orientation Safety Training / Re-education
  - Discussion Questions:
    - What training are nursing and clinical staff required to go through before starting their job? In particular what are they trained on to prevent patient STF? What are staff trained to look for to prevent potential patient STF?
    - Is the training for worker safety equal to that of patient safety?
  - Goal:
    - Training to prevent STFs for patients AND workers should primarily mirror each other (interacting with the same environment). Begin developing a common language through orientation safety training.

Action Plan Review – STF Example #2

- **Best Practice:** Prevention Strategies
  - Discussion Questions:
    - What prevention strategies are in place to protect patients from slips, trips and falls? What are the common environmental issues that cause patient falls? What are the common issues for worker falls in your organization?
  - Goal:
    - Common strategies to prevent ALL falls. Patients and workers interact with the environment differently but the environment doesn't change. Review prevention strategies already in place for patient safety – identify if any are missing from   current worker safety strategies.

Action Plan Review – STF Example #3

- **Best Practice:** Injury Fall Reporting / Follow-up
  - Discussion Questions:
    - Are staff aware of the last patient fall that occurred? Is this metric shared to all departments and staff? Are staff aware of the last employee fall that occurred? Is this metric shared to all departments and staff?
    - If a patient falls what is the follow-up process? How is the fall communicated to other staff on the unit? Is this process similar to when an employee falls?
  - Goal:
    - Transparency of metrics to focus on falls as a whole. "Let's discuss our falls metric – we had 3 patient falls, 1 worker fall". Shared with staff during morning huddles and shift   changes.

Action Plan Review – WPV Example #1

□ **Best Practice:** WPV Prevention, Response Plan, Policies (Visitor Policy)

  ▪ Discussion Questions:

    ▪ How are a visitor policy and tracking methodology important to the safety of patients? Does the lack of a visitor policy and visitor tracking impact patient safety from a care-team perspective?

    ▪ If you had to funnel all visitors through one or two main entrances in order to track them, what additional benefits would that offer? Would you be able to do so with existing staff / volunteers?

  ▪ Goal:

    ▪ Implementing a visitor policy and tracking methodology to increase the safety of patients as well as workers. The steps to achieve a solid visitor policy will likely involve creating / updating visitor policy, fewer entrances into the facility.

Action Plan Review – WPV Example #2

- **Best Practice:** Environmental Hazard ID Assessment (Employee Assault Survey)
  - Discussion Questions:
    - How is an employee survey that focuses on aggressive patient behavior important to the safety of patients?
    - What consequences to patients can arise out of not knowing specifically what your colleagues / employees are feeling about their safety regarding aggressive behavior patients / visitors?
  - Goals:
    - Gain a deeper understanding of what the frontline staff is experiencing as it relates to current tools, processes and skills in place to prevent and respond to aggressive patient / visitor behavior.

Action Plan Review – WPV Example #3

- Best Practice: Aggressive Patient/Visitor Behavior Risk Assessment

  - Discussion Questions:
    - Is a consistent methodology to assess potential aggressive behavior in patients vital to the safety of all patients? If so, how?
    - How does not having a consistent methodology negatively affect patient safety? Are these important enough to implement an aggressive behavior/violence risk methodology tool?

  - Goal:
    - Implement a consistent aggressive / violent patient risk assessment methodology tool. Consistency in the assessment of potentially aggressive / violent patients helps increase worker safety, which translates to increased patient safety.

2018 Timeline Update

Third Period: HRO / Integration

Month - Year	Webinars & Education	Data Submission	"We Share 4 Safety" Activity
December-2017	Dec. 8th – Webinar 9:00 – 10:00 am "Member Highlight on HRO/Integration" Speaker: HIIN Participant	Dec. 16th* (1/1/16 to 11/30/17)	Peer Connections HRO and Worker Safety - Integration
January-2018	Jan. 5th – Webinar 9:00 – 10:00 am "Member Highlight on HRO/Integration" Speaker: HIIN Participant	Jan. 16th (1/1/16 to 12/31/17)	Peer Connections HRO and Worker Safety - Integration
February-2018	Feb. 2nd – Webinar 9:00 – 10:00 am "Business Case for Integration of Worker and Patient Safety" Speaker: Courtney Ulrich; Kelly Austin	Feb. 16th (1/1/17 to 1/31/18)	Peer Connections HRO and Worker Safety - Integration
March-2018	Action Plan Review / Discussions	Mar. 16th (1/1/17 to 2/28/18)	Mar. 30th HRO and Worker Safety - Integration (Action Plan updates with HRO additions due to RC360)

Fourth Period: Patient Handling

Month - Year	Webinars & Education	Data Submission	"We Share 4 Safety" Activity
April-2018	Apr. 20th – In-Person Networking Event "*Patient Handling Kickoff – Integration of Worker and Patient Safety*"	Apr. 16th (1/1/17 to 3/31/18)	Apr. 30th (Patient Handling program submissions due to RC360)
May-2018	May 4th – Webinar 9:00 – 10:00 am "Member Highlight on Patient Handling" Speaker: HIIN Participant	May 16rd (1/1/17 to 4/30/18)	Peer Connections Patient Handling for Workers & Patients
June-2018	OHA Annual Meeting	Jun. 16th* (1/1/17 to 5/31/18)	Jun. OHA Annual Meeting Peer Connections
July-2018	Jul. 6th – Webinar 9:00 – 10:00 am "Member Highlight on Patient Handling" Speaker: HIIN Participant	Jul. 16th (1/1/17 to 6/30/18)	Peer Connections Patient Handling for Workers & Patients
August-2018	Aug. 3th – Webinar 9:00 – 10:00 am "Member Highlight on Patient Handling" Speaker: HIIN Participant	Aug. 16th (1/1/17 to 7/31/18)	Peer Connections Patient Handling for Workers & Patients
Sept-2018	Sep. 7th – Face-to-Face Seminar 9:00 am – 12:00 pm "HIIN Results and Accomplishments – Participant Awards" Speakers: Panel	Sep. 16th* (1/1/17 to 8/31/18)	Sept. 28th Aggressive Behavior (Program Comparison to Best Practice Reports Due to Participants from RC360 & Gap Analysis Matrix Completed)

Questions?

Next Steps

- ☐ Upcoming Events:
  - ▣ Data Submission #15: February 15th, 2018
    - ◼ **Claims 1/1/17 – 1/31/18; Hours Worked: month of January**
  - ▣ Integration of Worker and Patient Safety Self-Assessment
    - ◼ Due: February 23rd
    - ◼ Worker Safety AND Patient Safety staff / leaders
  - ▣ Internal Action Plan Review / Discussion
    - ◼ 30 Minute Calls with Worker Safety and Patient Safety individuals
    - ◼ Smartsheet Sign-up Available March 1st, 2018
  - ▣ In-Person Event: Friday, April 20th: 10AM – 2PM
    - ◼ OHA Offices in Columbus, OH.
    - ◼ Attendees: Worker and Patient Safety staff / leaders

Thank You For Attending & All You Do To Keep Ohio's Healthcare Workers, Patients, Visitors & Communities Safe!