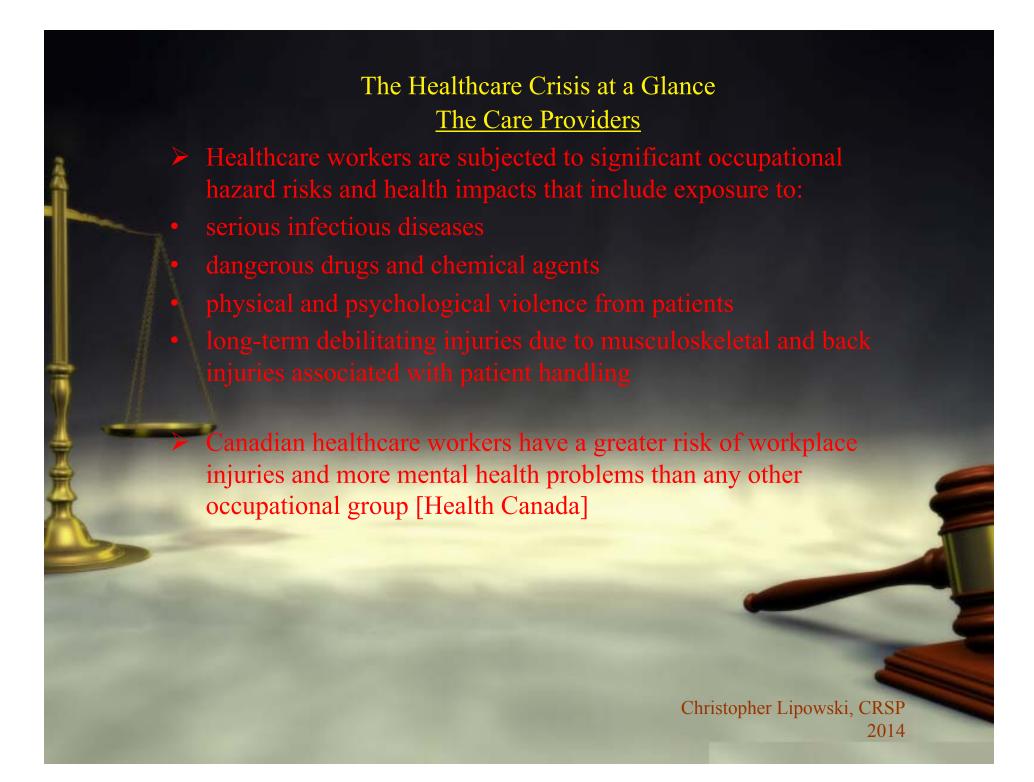


The Healthcare Crisis at a Glance <u>The Patients</u>

- ➤ In Canada, 7.5% of adult medical or surgical patients suffered adverse events in hospital, about one third of which were deemed preventable [Canadian Institutes of Health Research]
- ➤ Each year between 9,250 and 23,750 Canadian adults experience a "preventable" adverse event in hospital and later die [Baker, 2004]
- ➤ Healthcare acquired infections (HAI) affect more than 220,000 people annually resulting in excess of 8,000 deaths in Canadian hospitals each year [(Zoutman et al 2003]
- Each year, there are approximately 1.7 million HAIs in American hospitals resulting in 99,000 related deaths [U.S. CDC]
- ➤ It is now well known that medical errors in the United States result in an estimated 44,000 to 98,000 unnecessary deaths and more than 1,000,000 instances of harm each year The cost of these medical errors? According to the Institute of Medicine, \$17 to \$29 billion per year [IHI]



The Healthcare Crisis at a Glance The Damaged Workforce

- 88% of health care workers report insomnia, headaches, depression, weight changes, and panic attacks related to work stress
- 35% of Ontario nurses report at least one musculoskeletal condition
- 28% of Ontario nurses report that they were physically assaulted by a patient at work over the past 12 months
- 46% of Canadian physicians report that they are in advanced stages of burnout
- Average number of days of work lost due to illness or disability is at least 1.5 times greater for workers in health care than the average for all workers
- If the average absenteeism rate for health care could be reduced to that of all Canadian workers, it could mean the equivalent of more than 13,700 "extra" full-time employees on the job, including 5,500 Registered Nurses

 [HealthForceOntario Report]

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A Recipe for Health Care Failure

FINANCIAL CONSEQUENCES OF A DAMAGED WORKFORCE "AN EXAMPLE"

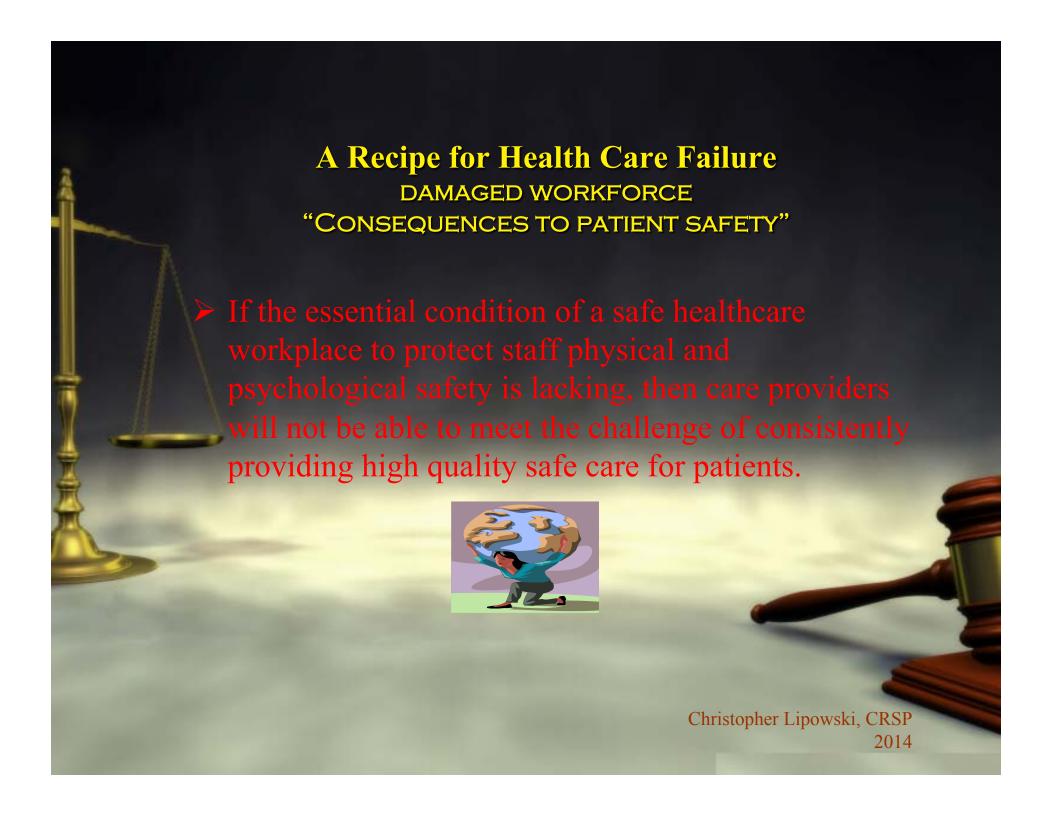
The significant escalating rate of healthcare worker occupational musculoskeletal disorder (MSD) injuries, most of which are related to patient handling activities and slip trip / fall accidents in the hospital environment, has a disturbing trend - a majority of the incidents occur in younger staff, with lumbar involvement being the primary injury.

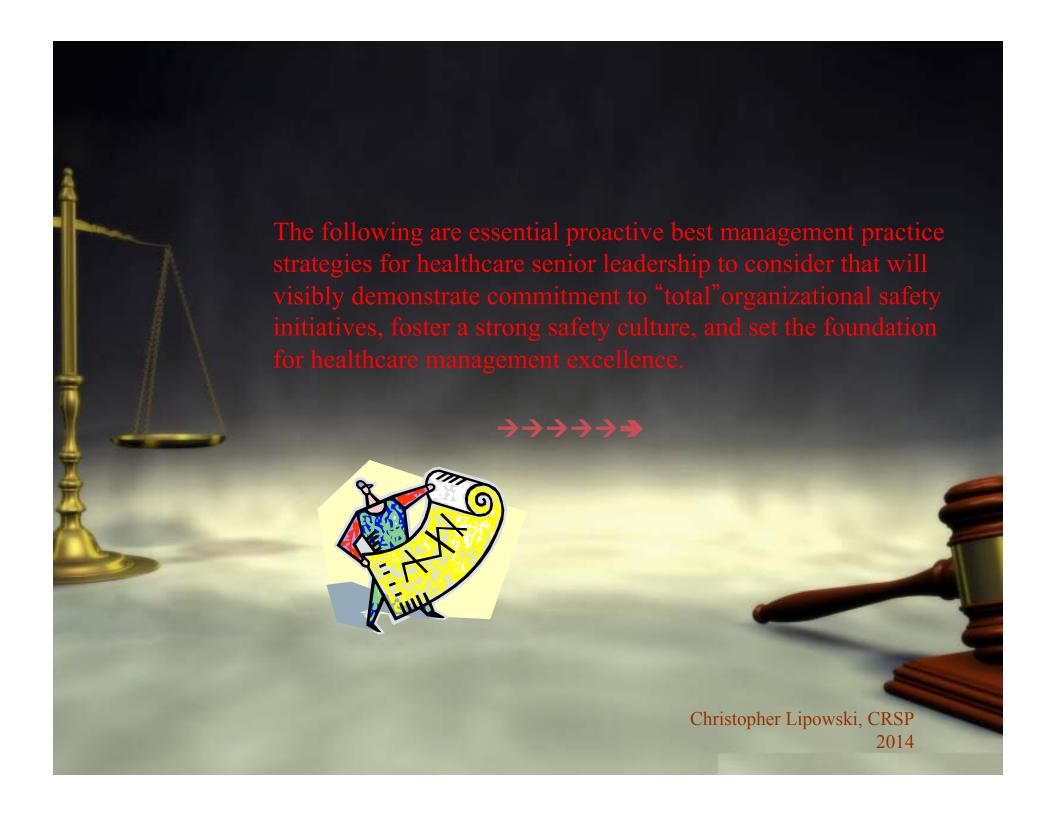
For example, if a 37-year-old nurse suffers a workplace back injury today that results in lost work-time of four weeks for recuperation, we can reasonably assume that this individual is now at higher personal risk for a recurrence of an MSD or back injury. If we take into consideration the aging factor, we could expect an elevated injury risk and severity probability. A workplace back injury for such a staff member in their fifties will likely result in even more time loss and associated direct and indirect costs.

A Recipe for Health Care Failure

FINANCIAL CONSEQUENCES OF A DAMAGED WORKFORCE "THE RESULT"

Senior healthcare administration has to seriously consider the future financial implications of continuous escalating care provider injury trends. An aging healthcare workforce with a constant evolving history of occupational injury can logically be regarded as a situation heading towards a healthcare staffing crisis with associated substantial financial burden on an already highly restrictive healthcare budget - a recipe for a non-sustainable healthcare system.



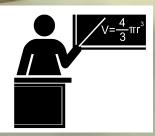




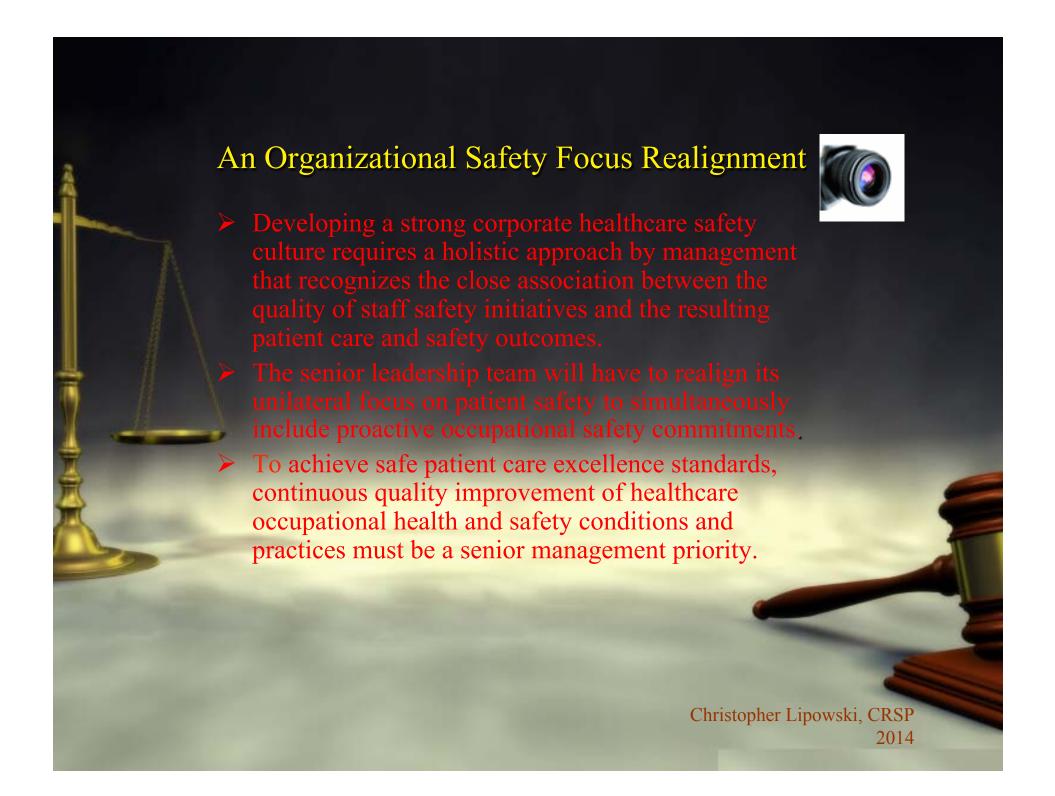
THE HEALTHCARE SAFETY BALANCE EQUATION

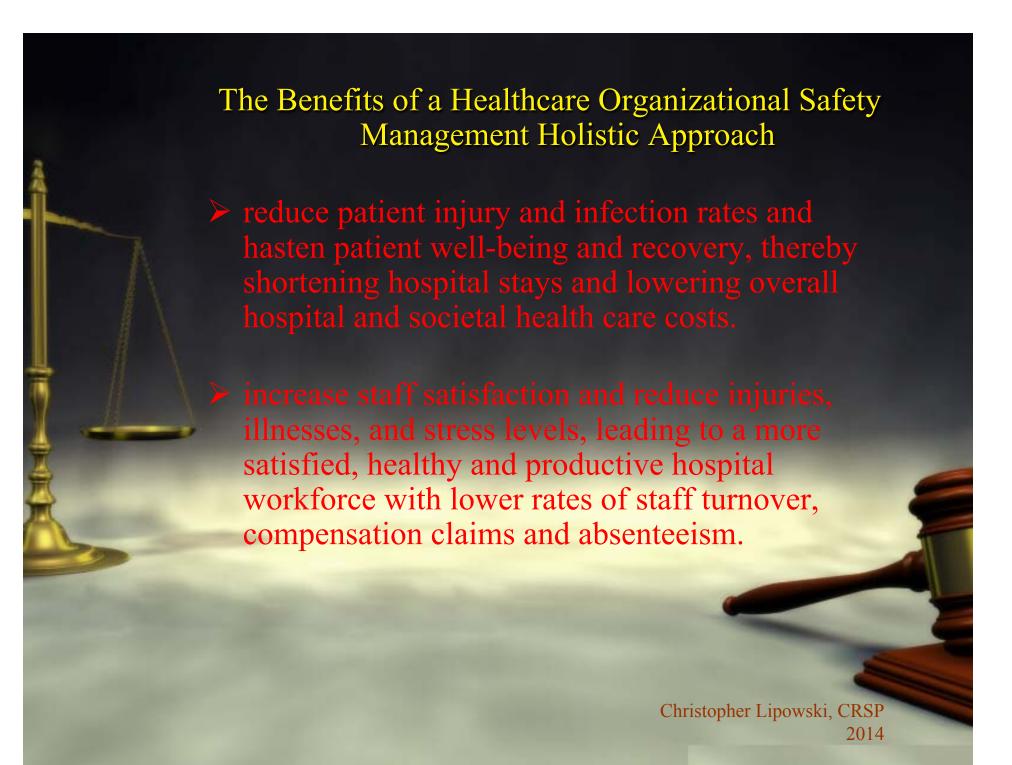
The healthcare safety equation has two distinct sides that require balancing to achieve organizational safety excellence. One side considers specific clinical patient safety improvement initiatives and the other side considers workplace occupational health and safety improvement initiatives.

A strong healthcare "safety culture" has a balanced safety equation that maintains equal emphasis and strategic focus on healthcare provider safety and patient safety programs.











Establish Robust Organizational Integrity Standards "The Power of Trust"

- A successful safety culture is highly dependent on a leadership that sets standards for strong organizational ethics. Strong ethical standards are the building blocks of a solid safety culture and the "power of trust".
- Personal or professional integrity compromises, not only fosters a poor safety culture, but may even jeopardize health and safety of staff or patients in the organization. For example, the potential tragic effects of concealing presence of asbestos hazards dramatically illustrates the consequences of not maintaining appropriate ethical standards.

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Health and Safety Policy with a Vision and Mission

- Develop and communicate a high quality occupational health and safety policy with a vision that clearly states senior management's genuine commitment to exceeding industry best practices for achieving safe workplace conditions for all members of the organization.
- Include a mission statement that the organization will strive for continuous improvement of workplace and patient safety initiatives that is central to quality health care as per the Hippocratic Oath:

"Above All, Do No Harm"

A Proactive OHS Policy should:

- be guided by the internal responsibility system (IRS) principles everyone in the organization shares responsibility for saftey
- assure management transparency and the desire to work collaboratively with the workplace health and safety committee
- state that occupational health and safety best practices will be accomplished through the Integrated Healthcare Safety Management System (IHSMS)
- indicate corporate strategic alignment of occupational and patient safety practices as an essential requirement for meeting the Hospital mission of achieving patient care excellence
- clearly define management organizational OHS responsibilities and accountabilities and the method that will be used to determine compliance

How To Demonstrate Management Commitment

- Craft a written statement signed by all members of the senior management team outlining its commitment to and involvement in corporate health and safety initiatives and advertise it throughout the organization (e.g., via intranet mass emailing).
- "Walk the talk". If you care, show it.
 - Make this "statement" available to the public through access on the hospital external website.



The "Integrated Healthcare Safety Management System" Advantage

The primary goal behind the Integrated Healthcare Safety Management System (IHSMS) is to attain safety excellence by integrating patient and worker safety best practices into all management functions of core hospital business activities.

**Cuality Performance Excellence Teams" are formed with members from clinical staff, patient safety, occupational health and safety, risk management, infection control and other stakeholders to collaborate together and use such tools as, Failure Modes and Effects Analysis, Root Cause Analysis, and Risk Matrix Hazard Analysis for identifying occupational and patient health and safety hazards, evaluating and prioritizing level of associated risks, and subsequent development of coseffective risk control measures – for staff and patients.

A major underlying feature of the IHSMS is —

"sustainable continuous improvement"

The Due Diligence Factor "an important consideration for senior administration"

Due Diligence is the primary defense available for organizations charged under the Occupational Health and Safety Act, and requires that all "reasonable precautions in the circumstances" were taken by the employer to ensure compliance with the law and prevent the accident from occurring.

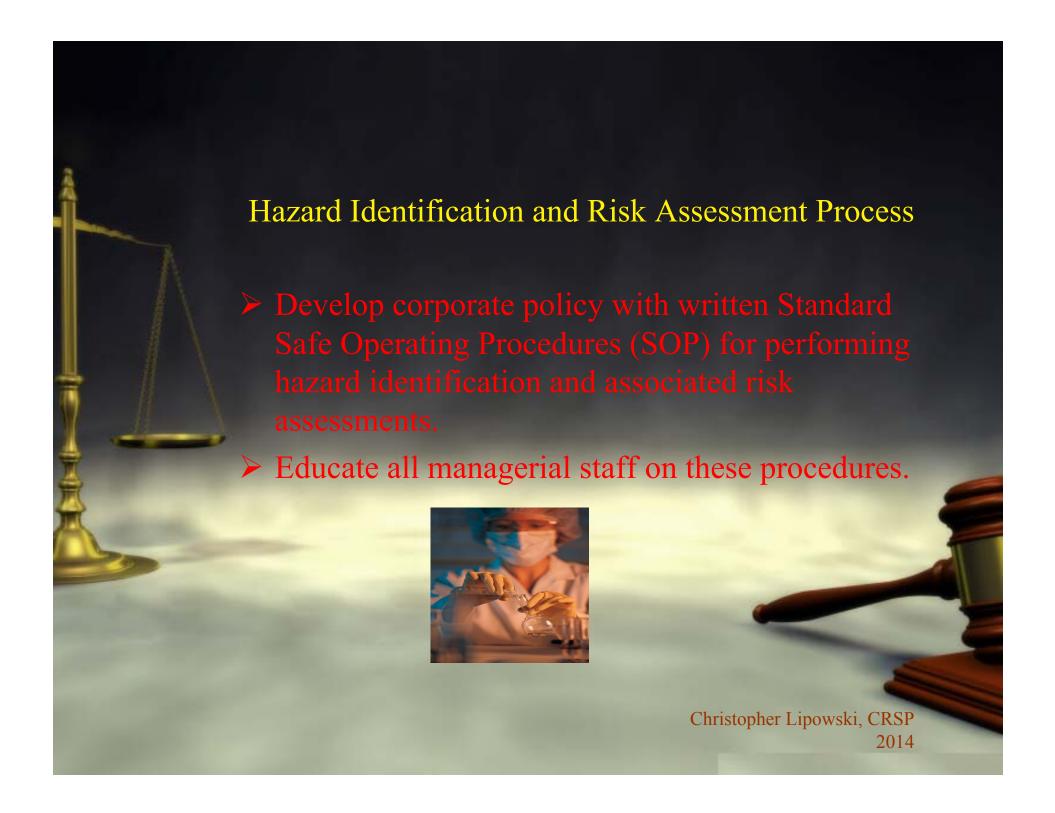
Bill C-45 amended the Canadian Criminal Code that imposes a legal duty on all organizations and their senior management, in both federal and provincial jurisdictions, to take reasonable steps to prevent harm to a worker.

A successfully implemented and maintained safety management system includes a mandate for annual internal audits to identify opportunities for improvement which is a well-recognized practice for meeting organizational Due Diligence.





- Educate management to shift focus from reactive accident blame to proactive response strategies that will result in effective control of latent organizational hazard high-risk processes and practices involving staff and patients.
- Poevelop management policy for use of root cause analysis (RCA) and failure modes and effects analysis (FMEA) as essential tools in standard operating procedures for investigating ALL occupational accidents and disease exposures, and patient care error incidents, in order to examine factors beyond the direct causes such as "management system failures".
- Prioritizing RCA / FMEA results to implement serious longlasting control measures for high risk hazards is a proactive cost effective method for managing staff and patient safety programs.



Hazard Identification and Risk Assessment Matrix for all Organizational Activities

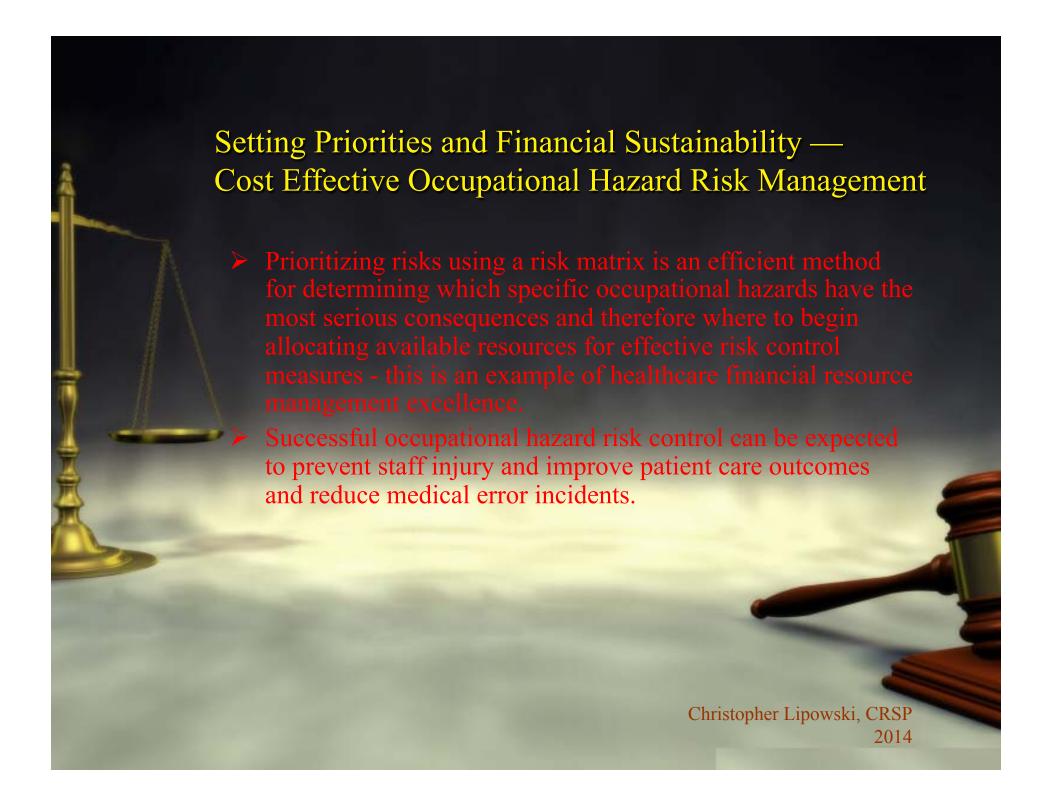
Important Concepts:

- ➤ a hazard is something with the potential to cause harm and includes any condition, practice, act, behaviour or thing that can cause injury, illness, or death to staff or patients.
- risk is the likelihood that illness, injury or death might result due to the hazard.
- each hazard has a probability or likelihood of exposure, frequency of exposure and severity of injury in the event of an unintended incident.
- a risk matrix with hazard probability and exposure frequency criteria is used as a measure to determine risk severity level.

Hazard Risk Assessment Matrix					
Frequency of Occurrence	Hazard Severity				
	1	2	3	4	
	Catastrophic	Criti	cal Marginal	Negligible	
(A) Frequent	1 A	2A	3A	4A	
(B) Probable	1B	2B	3B	4B	
(C) Occasional	1C	2C	3C	4C	
(D) Remote	1D	2D	3D	4D	
(E) Improbable	1E	2E	3E	4E	
Hazard Risk Priority Number			Risk Acceptance		
1A, 1B, 1C, 2A, 2B, 3A			Unacceptable / Controls Mandatory		
1D, 2C, 2D, 3B, 3C			Undesirable / Controls Advisable		
1E, 2E, 3D, 3E, 4A, 4B			Acceptable with Review		
4C, 4D, 4E			Acceptable without Review		

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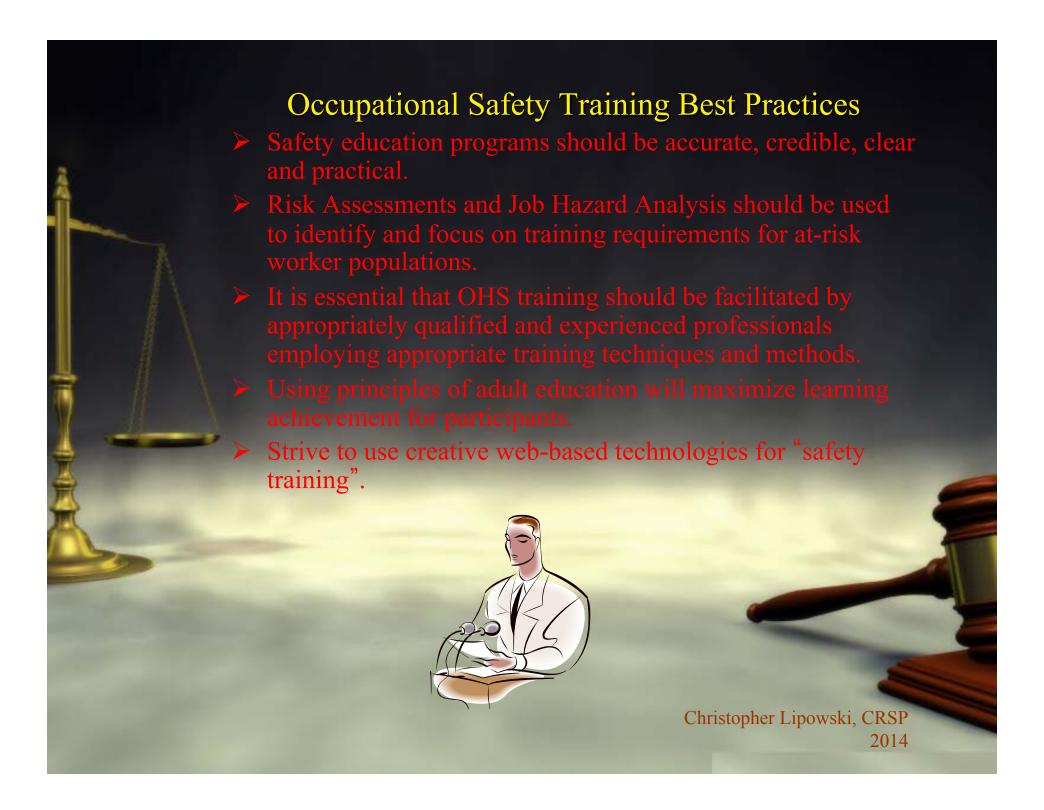


The Occupational Hazard Risk Control Process

- Educate management to implement measures that reduce the risks associated with a hazard. Occupational Hazards are controlled at the source along the path and at the worker. The process must follow the occupational hygiene control hierarchy in decreasing order of effectiveness:
 - a) engineering controls:
 - elimination of hazard
 - substituting hazard for one with an acceptable risk level
 - isolation of the hazard
 - b) administrative controls
 - c) personal protective equipment.
- Patient safety risk control measures can use the same hazard prevention and control methodology concept.



- Senior management must recognize that a high quality training and education program is a vital component of a successful total safety management system.
- Quality health and safety training empowers workers with the knowledge to protect their health and lives, and prevent work-related injury or illness and patient harm.
- ➤ A well managed safety education program will motivate workers to follow safe work practices and procedures.
- And a well educated workforce improves organizational performance, patient care and safety, and financial sustainability.



Organizational Health and Safety Knowledge Management

"it's all about collaboration"

- Shift concept from simple "safety training" to "Total Safety Knowledge Management" that includes staff and patient safety topics, e.g. falls prevention.
- Consider inclusion of raising human error concept awareness.
 - Consider human factors involved in incident prevention strategies.
 - For adult learning and knowledge acquisition to occur successfully develop an interactive health and safety workshop education program. The program should involve a "collaborative team" effort between certified occupational health and safety practitioners, clinical educators, infection control instructors, patient safety professionals, and risk management experts.



➤ Promote genuine collaboration of functional activities between all clinical departments as well as OHS, Patient Safety, Risk Management, and Infection Control, because everyone should be collectively pointing their noses in the same direction - working towards aggressively reducing staff and patient safety risks and associated organizational financial losses.

Open honest communication is an essential component for successful workplace collaboration and the underlying feature of outstanding high performance healthcare organizations.





- Promote overall organizational safety responsibilities by:
 - a) requiring uncompromising compliance with all organizational safety principles and practices e.g., hand hygiene, as a signed condition of employment;
 - b) embedding basic written safe practice requirements into all staff job descriptions;
 - c) establishing in-house safety standards based on proactive leading indicators as an evaluation method for all levels of staff annual performance reviews.

The Job Stress Factor - Healthcare Staff Psychosocial Stress

- "a growing trend with many roots and significant costs"

 Working in a highly stressful healthcare environment
- Working in a highly stressful healthcare environment increases the risk of psychological distress and physical symptoms as well as work-related accidents and injuries
- ➤ Uncontrolled chronic high levels of workplace stress contribute to organizational inefficiency and increased healthcare administrative costs associated with: diminished productivity; increased workplace accident rates; elevated rates of staff musculoskeletal problems; increased absenteeism, and presenteeism; decreased job satisfaction; high staff turnover; compromised quality of patient care; and elevated patient treatment error incidents.

What to do







To provide occupational stress management services:

- ✓ stress awareness education
- stress coping methods training
- ✓ stress counseling

Consult the National Standard of Canada for Psychological Health and Safety in the Workplace



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USE POSITIVE FLOW STRATEGIES

Promote Staff Wellness

- ➤ Develop a staff Wellness Promotion Program and policy that encourages best practice behaviors for staff health and visibly demonstrates that management cares about its staff "its most valuable resource".
- ➤ In well managed healthcare a high quality wellness program will decrease healthcare costs, reduce absenteeism, increase productivity, and reduce patient treatment errors.
- Care providers are more likely to appreciate the importance of patient safety processes when the healthcare organization values the safety and wellness of its own employees.

Shift Focus to Positive Psychology Trends

Positive Psychology has three central concerns: positive emotions, positive individual traits, and positive institutions. Positive institutions foster a workplace philosophy of justice, responsibility, civility, strong work ethic, leadership excellence, teamwork, purpose, and tolerance.

Proactive Integrated Disability Management

- The nature and complexity of disability management is changing and requires an integrated (work and non-work related) absence management strategy. This involves a global proactive approach that considers all disability management components are addressed in concert. These include:
 - occupational accident and illness prevention activities;
 - wellness and health promotion services;
 - early safe return to work program;
 - casual absence monitoring;
 - short- and long-term disability administration;
 - occupational absence management;
 - education and training;
 - employee assistance programs.
- Everyone involved in the disability management process four work together in a cohesive manner, ensuring that there is a common understanding regarding the conditions and objectives.

Summary – Maintaining a Safe Healthcare Work Environment Will:

- I. Reduce occupational injuries and diseases
- II. Improve the quality of patient care
- III. Reduce patient treatment errors
- IV. Reduce the rate of staff absenteeism
 - V. Increase staff job satisfaction and workplace loyalty
 - VI. Improve sustainability of the healthcare system by reducing costs, losses and waste that are achieved from success in the first five reasons above

The Conclusion

Safety must be a property of the system. No one should ever be harmed by healthcare.

The Quality Worklife-Quality Healthcare Collaborative defines a healthy healthcare workplace as (link): A work setting that takes a strategic and comprehensive approach to providing the physical, cultural, psychosocial and work/job design conditions that maximize health and well-being of healthcare providers, quality of patient outcomes and organizational performance.

"A fundamental way to better healthcare is through healthier healthcare workplaces. It is unacceptable to work in, receive care in, govern, manage and fund unhealthy healthcare workplaces."

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