SHOULD YOUR ORGANIZATION INTEGRATE WORKER SAFETY AND PATIENT SAFETY?

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After many years of safety consulting with organizations of all kinds, including those in health and medical care, I am struck by the division in healthcare between 'patient safety' and 'worker safety'. In most healthcare organizations these two types of safety have separate staffing, metrics, prevention initiatives and systems, and overall leadership emphasis.

I believe this division grew naturally for reasons that made sense along the way, but for many organizations it is now time to re-examine the issue. Much is to be gained by integrating these kinds of safety and having them share resources and methods. Doing that effectively requires understanding the relationships between the two.

How are patient and worker safety related?

These two aspects of safety are related in both obvious and subtle ways.

1. **Both kinds of safety are crucial to the well-being of healthcare organizations, in direct and indirect ways.** Each kind of safety has significant direct cost implications. This factor is the most visible but the least important of factors. Think about it as a bonus for doing something that should be done anyway. The larger issue is that excellence in each type of safety creates a foundation for performance excellence across the board. Evidence suggests that the reason for this is cultural. [1] A culture that fosters safety (of each kind) is also lower in absenteeism, higher in engagement and generally stronger in positive ways; a positive work environment. Improving safety by addressing cultural issues has benefits across the board.
2. **Common cultural roots underlie both worker and patient safety.** A number of studies have found that cultural variables centered around 'organizational functioning' predict both worker and patient safety. [2, 3] a wide variety of performance outcomes including both patient safety and worker safety.
3. **Worker and patient safety have reciprocal effects on each other.** Many health and medical care organizations have a strong cultural value for avoiding patient harm, one that has carried over from many years. (Some outside healthcare find it hard to reconcile this value with the amount of harm that continues to occur. I'll address this issue from a cultural perspective in another piece.) In one way the value for avoiding patient harm is in conflict with the value for protecting the caregiver. A nurse who dives across the room to protect a patient from falling exemplifies this conflict.

At the same time, it is clear from the research literature [4, 5] that employees who feel supported fully are both more productive and safer. So, what appears to be a conflict doesn't have to be. The gateway to an environment in which both kinds of safety reach levels of excellence is worker safety. Improving both worker safety and patient safety at one time is optimal, one feeds the other. What is most valuable to the health and medical care organization is a culture that recognizes both kinds of safety.

4. **Having separate structures for each kind of safety creates unnecessary duplication and complexity.** Committees, leadership initiatives, types of intervention efforts, and performance assessments are not needed for each type of safety. For example, primary prevention methods like rounding and incident investigation do not need to be separate systems. Integrating these systems has reciprocal benefit.

5. **Safety leadership capability is common to both and takes a similar skill set.** Making sustainable improvements in either kind of safety requires specific leadership capabilities, from the first level of supervision to the senior-most executive leader. In both cases leaders need to understand core principles, their specific roles, and what decisions and actions are critical for them to take. Having duplicative leadership roles is not necessary.

How should we approach the integration of patient safety and worker safety?

The particular circumstances of each organization will create specific requirements and strategies. Here are some general principles:

1. Integrating two types of safety is a major organizational change. Doing it well, so that efficiency is gained and performance improved, requires some effort across the organization.
2. Find the balance between objectives and resources. The most common mistake organizations make with safety change initiatives is to set great goals and then provide limited resources to attain them. Goals should be realistic in relation to resources allocated.
3. Define the desired endpoint at the outset. Engage key stakeholders in doing this. Write a brief statement that describes the desired endpoint.
4. Get a good assessment of how each type of safety is functioning presently. How strong is leadership for each kind of safety, starting with the senior-most leadership team? Are roles and responsibilities clear and do they have corresponding accountabilities? Are metrics sufficient and visible, both leading and lagging indicators? Do leaders understand the core principles of incident prevention and their related mechanisms? Is the existing organizational and safety culture supportive of safety? Are caregivers engaged in prevention efforts? Answers to these and related questions will provide data for the next step.
5. Plan the stages of integration based on the findings of the assessment. Start with the senior-most leadership team and work your way to the caregiver. Based on the findings of the assessment, provide individualized training and coaching for senior leaders.

None of this is easy. Organizational safety change does not happen effectively on its own. But the stakes are high if duplication in safety efforts exists for no reason. At the same time there is reason to think that integrating patient and worker safety will improve performance in both.

[1] Krause TR, Hidley JH. *Taking the lead in patient safety: how healthcare leaders influence behavior and create culture.* John Wiley & Sons, Inc: Hoboken, NJ; 2008[2]Hofmann DA. *An investigation of the relationship between safety climate and medication errors as well as other nurse and patient outcomes.* Kenan-Flagler Business School University of North Carolina at Chapel; 2006

[3] Taylor, JA. *Do nurse and patient injuries share common antecedents? An analysis of associations with safety climate and working conditions.* BMJ Quality and Safety; 2011

[4] Krause TR, Hidley JH. *Taking the lead in patient safety: how healthcare leaders influence behavior and create culture.* John Wiley & Sons, Inc: Hoboken, NJ; 2008

[5] Krause TR. *Leading with Safety*. John R. Wiley & Sons, Inc: Hoboken, NJ; 2005