THROUGH THE EYES OF THE WORKFORCE

Creating Joy, Meaning, and Safer Health Care

Lucian Leape Institute

Report of the Roundtable on Joy and Meaning in Work and Workforce Safety

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The Lucian Leape Institute and the National Patient Safety Foundation value your response to this white paper, *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care*. We respectfully request that you complete the reader survey that may be accessed online at: http://www.surveymonkey.com/s/LLI_WorkforceSafety.

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Providing a strategic vision for improving patient safety

Lucian Leape Institute at the National Patient Safety Foundation

The Lucian Leape Institute at NPSF, established in 2007, is charged with defining strategic paths and calls to action for the field of patient safety, offering vision and context for the many efforts under way within health care, and providing the leverage necessary for system-level change. Its members comprise national thought leaders with a common interest in patient safety whose expertise and influence are brought to bear as the Institute calls for the innovation necessary to expedite the work and create significant, sustainable improvements in culture, process, and outcomes critical to safer health care.

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EXECUTIVE SUMMARY

The health care workforce is composed of well-intentioned, well-prepared people in a variety of roles and clinical disciplines who do their best every day to ensure that patients are well cared for. It is from this mission of caring for people in times of their greatest vulnerability and need that health care workers find meaning in their work, as well as their experience of joy.

Yet many health care workers suffer harm—emotional and physical—in the course of providing care. Many are subjected to being bullied, harassed, demeaned, ignored, and in the most extreme cases, physically assaulted. They are also physically injured by working in conditions of known and preventable environmental risk. In addition, production and cost pressures have reduced complex, intimate, caregiving relationships into a series of demanding tasks performed under severe time constraints. Under these conditions, it is difficult for caregivers to find purpose and joy in their work, or to meet the challenge of making health care safe for patients they serve.

Vulnerable Workplaces

The basic precondition of a safe workplace is protection of the physical and psychological safety of the workforce. Both are conspicuously absent or considered optional in many care-delivery organizations. The prevalence of physical harm experienced by the health care workforce is striking, much higher than in other industries. Up to a third of nurses experience back or musculoskeletal injuries in a year, and many have unprotected contact with blood-borne pathogens.

Psychological harm is also common. In many health care organizations, staff are not treated with respect—or, worse yet, they are routinely treated with disrespect. Emotional abuse, bullying, and even threats of physical assault and learning by humiliation are all often accepted as "normal" conditions of the health care workplace, creating a culture of fear and intimidation that saps joy and meaning from work.

The absence of cultural norms that create the preconditions of psychological and physical safety obscures meaning of work and drains motivation. The costs of burnout, litigation, lost work hours,

employee turnover, and the inability to attract newcomers to caring professions are wasteful and add to the burden of illness. Disrespectful treatment of workers increases the risk of patient injury.

What Can Be Done?

An environment of mutual respect is critical if the workforce is to find joy and meaning in work. In modern health care, teamwork is essential for safe practice, and teamwork is impossible in the absence of mutual respect.

Former CEO of Alcoa Paul O'Neill advises that, to find joy and meaning in their daily work, each person in the workforce must be able to answer affirmatively to three questions each day:

1. Am I treated with dignity and respect by everyone?
2. Do I have what I need so I can make a contribution that gives meaning to my life?
3. Am I recognized and thanked for what I do?

Developing Effective Organizations

To create a safe and supportive work environment, health care organizations must become effective, high-reliability organizations, characterized by continuous learning, improvement, teamwork, and transparency. Effective organizations care for their employees and continuously meet preconditions not subject to annual priority and budget setting. The most fundamental precondition is workforce safety, physical and psychological. The workforce needs to know that their safety is an enduring and non-negotiable priority for the governing board, CEO, and organization.

Knowing that their well-being is a priority enables the workforce to be meaningfully engaged in their work, to be more satisfied, less likely to experience burnout, and to deliver more effective and safer care.

Achieving this vision requires leadership. The governing board, CEO, and organizational leaders create the cultural norms and conditions that produce workforce safety, meaning, and joy. Effective leaders shape safety culture through management practices that demonstrate a priority to safety and compassionately engage the workforce to speak about and report errors, mistakes, and hazards that threaten safety—their own or their patients'. Joy and meaning will be created when the workforce feels valued, safe from harm, and part of the solutions for change.

Recommendations

Strategy 1: Develop and embody shared core values of mutual respect and civility; transparency and truth telling; safety of all workers and patients; and alignment and accountability from the boardroom through the front lines.

Strategy 2: Adopt the explicit aim to eliminate harm to the workforce and to patients.

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.

Strategy 4: Create a learning and improvement system.

Strategy 5: Establish data capture, database, and performance metrics for accountability and improvement.

Strategy 6: Recognize and celebrate the work and accomplishments of the workforce, regularly and with high visibility.

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 patients.

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PREFACE

Across the health care workforce, ambiguity of roles, wasteful and non-value-added work, lack of teamwork, and an environment of disrespect are robbing people of the experiences that bring meaning and joy into their working lives. These problems affect the entirety of the workforce, from a caregiver unduly burdened with non-caregiving work to an executive dispirited by unnecessary reporting requirements. Without joy and meaning, the workforce cannot perform to its potential. Joy and meaning are generative and allow the best to be contributed by each individual, and the teams they comprise, to the work of safe health care every day.

Although many elements are necessary to create an environment where everyone finds joy and meaning in their work, an essential characteristic is workplace safety, defined as a workplace free from risks of both physical and psychological harm. This requires that all in the workforce accept a collective accountability and obligation to create a culture in which everyone in the workforce feels safe and respected. The aspiration to relieve suffering, protect human dignity, and improve the human condition is what makes the health care workforce "tick." If we expect the health care workforce to care for patients, we need to care for the workforce.

Workplace safety is inextricably linked to patient safety. Unless caregivers are given the protection, respect, and support they need, they are more likely to make errors, fail to follow safe practices, and not work well in teams.

Workplace safety is also inextricably linked to patient safety. Unless caregivers are given the protection, respect, and support they need, they are more likely to make

errors, fail to follow safe practices, and not work well in teams. Similarly, efficiency and effectiveness cannot be achieved unless every member of the workforce is part of the problem-solving team.

Meaning: The sense or importance of an action.

Joy: The emotion of pleasure, feeling of success, and satisfaction as the result of meaningful action, which in the context of this paper is meaningful work in health care.[1]

The stakes are high. An environment that is deficient in joy and meaning, where the workforce is burdened by extreme production pressures, toxic sociocultural norms, and the risk that they could be physically or psychologically harmed, is an environment where both the workforce and patients suffer.

The rewards of an inspirational and healthy workplace could be immense. No other industry has more potential to free up resources from non-value-added and inefficient production practices than health care, and no other industry has greater potential to use its resources to add value, promote health, and relieve suffering.

INTRODUCTION

The Lucian Leape Institute at the National Patient Safety Foundation held two Roundtables and multiple focus groups to consider joy, meaning, and workforce safety as critical imperatives and transformational levers in our efforts to improve the safety of the health care system.

The Roundtables brought together experienced clinicians, managers, and scholars who share the belief that productivity, safety, and a positive patient experience require an environment where the health care workforce finds joy and meaning in their work. While empirical evidence is being generated to support this proposition, there is practice and experiential evidence, grounded in psychological and organizational theory, that give it validity.

The Roundtables focused on the development of conditions that define a safe workplace both physically and psychologically, nurture joy and meaning, and create the necessary conditions for patient safety. The goal was to agree upon the organizational values, practices, and characteristics that enable health care organizations and clinicians to make rapid progress in closing the gap between the current state of workforce and patient safety and a culture of habitual excellence.

To get an impression of how participants saw their roles relative to the work of the Roundtable, the attendees were surveyed in advance. The results of this small but powerful sample helped shape the discussion. We found that:

1. There was agreement that although patient safety is thought to be a top priority, progress is slow.
2. Most organizations do not have a systemic approach to learning and improvement.
3. There is little awareness or concern about workforce safety.
4. There has been little progress in improving the environment. Health care workers are no more likely to be treated with respect than they were 10 years ago, and much less so compared to workers in other industries.

CURRENT STATE OF THE HEALTH CARE WORKPLACE

The health care workforce in the United States numbers more than 18 million[2] with a great range of diversity in terms of race, ethnicity, age, socioeconomic background, education, and training. This workforce is composed of well-intentioned, well-prepared people across a variety of roles and clinical disciplines, doing their best every day to ensure that patients are well cared for. This is what sets the work of health care apart and makes health care uniquely different: the service mission of people caring for people in times of their greatest vulnerability and need. This is the mission of the health care workforce—the mission from which its members derive their meaning as well as their experience of joy.

We believe that many health care workers are suffering harm—emotional and physical—in the course of providing care. Many are subjected to being bullied, harassed, demeaned, ignored, and in the most extreme cases, physically assaulted. They are also being physically injured, working in conditions of known and preventable environmental risk.

Caregivers cannot meet the challenge of making health care safe for patients unless they feel safe and valued, and find purpose in their work that brings joy and meaning to their lives. There is evidence at all levels that many do not: 60% of surveyed physicians are thinking of leaving practice because they feel discouraged; 33% of new registered nurses seek another job within a year.[3] Lack of respect, the burdens of regulation and record keeping, and tolerance of disrespectful and non-team-promoting behaviors are all cited throughout the literature as challenges facing the health care workforce.

Production and cost pressures have been building in health care over the past half century for a variety of reasons, not the least of which is a reimbursement system that pays for production and transactions, thereby reducing complex, intimate, caregiving relationships into a series of demanding tasks performed under severe time constraints.

Vulnerable Workplaces, by Omissions in Design and Inattention

The basic precondition of a safe workplace is protection of the physical and psychological safety of the workforce. Both are conspicuously absent or considered optional in many care-delivery organizations. Disrespect of workers is manifest in poor treatment by colleagues and supervisors and the presence of hazardous physical conditions in the workplace where staff often find themselves working under risk-prone conditions. If the workforce cannot feel safe in the workplace, it cannot perform to its potential, which is key to delivering safe care and is necessary for deriving meaning from the work.

Physical Harm

The prevalence of physical harm experienced by the health care workforce is striking. Recent data put the rate, especially among nurses, 30 times higher than in other industries.[4] Back and musculoskeletal injuries are common, as is unprotected contact with blood-borne pathogens.[5] As far back as 1998, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry elaborated on a disturbing trend: "The rate of occupational injuries and illnesses in the health care industry has been rising for some time. Between 1985 and 1995, the injury and illness incidence rate for workers in hospitals rose by 25%, while the rate for workers in nursing and personal care facilities rose by 37%. During the same period, the rate for workers in private industry as a whole increased by 3%."[6] This led the commission to conclude, "Action must be taken to reduce the unacceptably high rate of injury in the health care workplace."

Ten years later, the story was no better, with the Bureau of Labor Statistics reporting 670,600 injuries and illnesses in the health care and social assistance industry in 2007, and an injury and illness rate of 5.6 per 100 full-time workers compared with 4.2 for all of private industry.[7]

The health care workforce lives in a dangerous state of unnecessary risk driven by rigid organizational structures and hierarchical models that are deficient in respect, teamwork, and transparency. The statement "People are our most important asset" appears in vision statements of health care organizations across the United States, but in many of these organizations there is little evidence of either strategy or action to support this claim.

In one prestigious East Coast medical center, 62 staff members suffered exposure to blood-borne pathogens in a two-month period. Examination of these events revealed that in 90% of the cases, personal protective equipment was not used.[4] This finding suggests that neither the staff nor their supervisors were very concerned about occupational hazards in their day-to-day work. Does the current culture carry a belief that such exposure is part of the nature of the work?

> Sylvia Emory* is an experienced surgical technician. She was exposed to a large volume of body fluid while assisting in a surgical case. Rather than scrub out, disinfect, and exchange her scrubs and gown, she proceeded in the case while the saturated gown and scrub shirt served as a vehicle to infect a small lesion on her arm associated with a rash. No one on the surgical team challenged her decision, offered to call a relief scrub tech, or stopped the line. The pace of the case and the schedule for the day were protected. She developed a severe infection that required months of treatment.

Poor working conditions, unmitigated risks, and high injury rates have profound effects on health care providers. Almost one-third of the nurses in a national sample reported experiencing back or musculoskeletal injuries in the past year, and 13% of the nurses reported unprotected contact with blood-borne pathogens.[5] A striking 75.9% of nurses surveyed by the American Nurses Association indicated that unsafe working conditions interfere with the delivery of quality care.[8]

> Dennis Moore is a nurse who has been in practice for two years. He sustained a needlestick injury while walking across a patient room to dispose of the needle in a sharps container. The distance between use and disposal introduced greater risk of injury. In this case, Dennis sustained an HIV-positive exposure and is undergoing preventive treatment, with his life and relationships altered for the foreseeable future.

> Amanda Jones is a nurse of 20 years who works nights in a rural community hospital. She has noted an increase in the body size of patients over the past decade. While patient lifts have been in the capital budget for several years, the funding has always been deferred. Also deferred has been staff training in safe lifting and "smooth moves." Unable to locate a coworker to assist in moving her patient, Amanda attempted repositioning the patient from bed to chair by herself. In doing so, she sustained an acute back injury. She is currently fully disabled and suffers from chronic pain.

Psychological Harm

In many health care organizations, staff are not treated with respect—or, worse yet, they are routinely treated with disrespect. They do not feel psychologically safe; they are not provided the necessary resources to carry out their work; and they do not feel

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* Scenarios are based on actual events. All names and locations have been changed to protect the privacy and identity of those involved.

appreciated. Health care has a long history of toleration of disrespectful behavior by physicians, and to some degree by nurses, and evidence indicates that this toleration continues.[9–12] Emotional abuse, bullying, and even threats of physical assault and learning by humiliation are all often accepted as "normal" conditions of the health care workplace.[13–16] There are also less overt behaviors of ignoring, isolating, and using nonverbal expressions of judgment, mocking, or exasperation. These behaviors impact safety, the organizational climate, and job satisfaction.[17–18] Such behaviors create a culture of fear and intimidation, diminish individual and collective pride and morale, impair learning, and sap joy and meaning from work.

Nancy Walker is an experienced labor and delivery nurse at a large teaching hospital. She was cornered in a stairwell by a physician who grabbed her by the throat and warned her never to ask him a question again in the delivery room. She did not report this event until she feared for her safety when the physician "stalked her in the hall with menacing looks." It was suggested to the nurse by her manager that she transfer to a new assignment away from L&D. The nurse escalated her concern to the director of nursing and a department head. The physician was suspended, directed for a fitness-to-work evaluation, and successfully completed an anger management program prior to returning to work. However, Nancy subsequently transferred from the unit because she did not believe the actions taken were sufficient to prevent a similar event of abuse in the future and lacked confidence that management would create a safe practice environment.

Virtually all health care workers can recall stories that, while infrequent, dramatize the seriousness of fear, intimidation, and abusive-assaultive behavior in health care organizations. But these dramatic stories, while critically important, should not detract attention from the much more common, often pervasive, subtle instances of humiliating and dismissive behavior, put-downs, and humor at the expense of a colleague that erode confidence and self-esteem. The result is demeaning and non-team-promoting behavior. Remarks such as "When did **you** become a doctor?" "What are **you** doing here?" "How could **you not know** this?" and the use of profanity and sexual innuendo are reported as widespread and toxic. Such behaviors are seldom visible to governing boards and senior leaders in health care organizations.

Carl Jones is the CEO of a midsize community hospital. His undergraduate degree is in industrial engineering, and he has a master's degree in health care administration. Carl is committed to improving access and financial sustainability by improving systems. In a meeting with clinical colleagues to discuss some of these issues, he was informed that his job was "to keep the lights on and the water running," that patient care systems were the jurisdiction of the clinical staff.

Michele Veng is a highly skilled nurse in a surgical setting. She works in a complex, high-risk, specialized environment. The lead surgeon has had a pattern of yelling, using profanity, questioning her judgment during surgical procedures, and making blaming remarks. Michele finally had enough and reported this behavior to the Director of Nursing and to the Chief of Surgery. A facilitated meeting was scheduled for her to confront the surgeon about his behavior and for him to apologize. In the course of the meeting, the surgeon realized that he did not know her name or her history—that she had escaped from a war-torn country, traveling by night to hide from enemies, often carrying her young son, and after enduring years in refugee camps had moved to the United States and re-established her career. The surgeon, absorbed in his own performance, not that of the team, knew nothing about the strength and courage of his colleague. He apologized for his behavior.

The problems are not confined to doctors. Nurses also engage in workplace sexual harassment and verbal and physical abuse. [8,19–21] "Nurses eat their young" is a common expression among nurses in practice settings. Medical students report abuse by everyone—attending physicians, residents, nurses, and patients—increasing the likelihood that they will mimic these disrespectful behaviors upon entering practice.[13–15] Burnout and depressive symptoms lead students to strongly consider dropping out of medical school, even as late as the last year of their education.[14] For those who progressed on to residency, 25% reported being subjected to abusive behavior by fellow trainees, as well as by nurses and midwives, which eroded their self-esteem. More than two-thirds did not complain to anyone about their treatment.[15] Too often, new care providers enter a system in which disrespect for one's peers and coworkers is not only tolerated, it is the norm. This culture begins in the education of health professions with rite of passage practices, lack of team-based approaches to learning and care, and reinforcement of rigid intraprofessional and interprofessional hierarchies that are counter to a culture of safety.[22] This topic is further explored in the Lucian Leape Institute white paper *Unmet Needs: Teaching Physicians to Provide Safe Patient Care*.[23]

James Miller, a new resident assisting a senior surgeon on a case, responded to a command more slowly than the surgeon expected. The surgeon demanded the phone number of James's mother. Intimidated and flustered, he provided the number. The surgeon suspended the case to place the call, and after confirming the mother's identity, stated loudly into the telephone, "Your son is an idiot!" The surgical team provided silent witness to this behavior.

Repeated experiences of disrespect and humiliation lead to avoidance, communication blocks, and distraction.[24–26] A culture that tolerates disruptive, degrading, and patronizing behavior lacks psychological safety for its workers. In such an environment, workers often do not feel safe about reporting an error—their own or that of another—because of fear of punishment.

Another aspect of psychological safety involves whether people are supported when things go wrong.[27] When a serious patient safety event occurs, there are two victims: the patient and the caregiver.[28] A provider who is demoralized in the wake of a serious adverse event may be psychologically hampered from participating fully in all aspects of responding to the situation: communicating honestly and compassionately with the injured and frightened patient, preventing further injury, investigating the possible causes, and analyzing and redesigning the relevant care processes.[29]

Lack of respect for the time of the workforce is another symptom of an injurious workplace. Assigning extended hours and unexpected shift changes produces fatigue and disregards the personal and family needs and schedules of the workforce. Issuing orders that interrupt workflow and attention makes it clear that the manager, or person in the gradient of hierarchy above the worker, possesses interests that are more important than the planned efforts of the health care worker.

Costs of Inaction

The absence of cultural norms that create the preconditions of psychological and physical safety obscures meaning of work and drains motivation. It damages everyone: doctors, nurses, employees, organizations, patients, families, as well as the economy. The costs of burnout, litigation, lost work hours, employee turnover, and the inability to attract newcomers to caring professions are wasteful and add to the burden of illness.[30–35]

More full-time employee (FTE) days are lost in health care each year than in industries such as mining, machinery manufacturing, and construction.[36] In addition to the harm of the individual, the constant shuffling of work schedules to adjust for workers who have been injured takes a physical and emotional toll on every worker, exacerbating the constant risk of harm.

Management practices, expectations, and resource limitations create conditions with major downstream impacts on patient safety, worker safety, and the community.[37–40] Disrespectful treatment of workers increases the risk of patient injury.[41] Disrespectful treatment of patients is also a major cause of malpractice suits that result in both financial and reputational cost to organizations.[42–47]

All of these factors are combining to create a critical shortage of health care workers, particularly registered nurses, that will increase as the Baby Boomers age and their health care needs increase.[48] In recognition of the challenges and opportunities for the nursing workforce, the Institute of Medicine has released a report titled *The Future of Nursing* that outlines important aims and interventions to enhance professional practice, such as access to advance education and working to the top of one's license.[49]

The American Association of Colleges of Nursing identifies insufficient staffing as raising nurses' stress levels, impacting their job satisfaction and driving many nurses to leave the profession.

Workforce safety in health care organizations tends to be considered and managed in silos often unconnected to the work of patient safety, with workers' compensation issues typically overseen as an aspect of employee benefits under the Human Resources function, injury reports and claims managed by the Risk and Employee Health department, workplace safety under the jurisdiction of Environmental Services, and infection control responsibility distributed across multiple clinical departments. What is uncommon is an integrated approach to workforce safety and, importantly, consideration of workforce safety as a quality indicator for the culture of the organization—the culture that provides the critical context for achieving patient safety. The two are inextricably linked and grounded in the same safety science. However, a survey across the health care disciplines conducted by the American Society of Professionals in Patient Safety at the National Patient Safety Foundation found that while 99% of the respondents agreed that there is a link between workforce safety and patient safety, only 16.5% reported that workforce safety was a focus in their organization's quality and safety initiatives.[50] A systems approach to establishing and ensuring a culture of safety would, by definition, argue for alignment, if not integration, of workforce safety efforts with patient safety efforts.

Boards of trustees are usually unaware of these kinds of problems, often interpreting their fiduciary responsibility as limited to financial issues, although it is known that governing board priorities have significant impact on quality performance.[51] Workforce injuries are often not visible to, or a top priority of, CEOs and other hospital leaders. At the same time, leaders are often unaware of or ill equipped to manage disruptive behavior. Budgeting processes could, but rarely do, make investments in worker safety a priority.[52] By this omission of attention and action, leaders of health care organizations are unknowingly condoning and enabling unsafe behaviors and unsafe workplaces.

WHAT CAN BE DONE

Despite the troubling data, there are US health care organizations in which the values of respect, teamwork, and transparency are prized, and in which health care providers operate freer from injury and experience their work as more meaningful. These institutions can serve as models for others wishing to improve. There is also a growing body of research that suggests how organizations may improve patient safety through increasing employee safety and restoring joy and meaning to the workforce.

Recent evidence supports the hypothesis that physician empathy is an important factor associated with clinical competence and patient outcomes. Some health care organizations have begun to provide psychologically safe environments for physicians to support one another in addressing the emotional tolls of their work, particularly when they make mistakes.[53,54]

An environment of mutual respect is critical for the workforce to find joy and meaning in work. Studies have shown the critical importance of teamwork in safe practice, and teamwork is impossible in the absence of respect.[41,55] Failure of doctors or nurses to follow safe practices (hand hygiene, time outs, etc.) is a manifestation of lack of respect (for experts, authority, institutional aims) and is clearly hazardous.

Correlations exist between patient safety cultures and patient assessments of care as established by comparison of results from the Agency for Healthcare Research and Quality's Survey on Patient Safety Culture (SOPS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospital Survey.[56] Both federal agencies and private foundations are heeding this wake-up call by supporting research to strengthen providers' work environments in order to improve patient safety.[57]

Paul O'Neill, former Chairman and Chief Executive Officer of Alcoa, puts forth a challenge to organizations aspiring to excellence.[58] The challenge is deceptively simple: Can each person in the workforce answer affirmatively to these three questions each day?

1. 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?
2. 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?
3. Am I recognized and thanked for what I do?

Further, O'Neill asserts that until workplace safety and the safety of each person in the workforce is a collective priority, efforts to achieve the goal of respect and harm-free care will fall far short. Joy and meaning for the workforce is the foundational challenge; worker safety is the precondition. Until all individuals in the workforce can answer yes to these questions, joy, meaning, and patient safety will not be realized.

Developing Effective Organizations

Effective care requires effective organizations to deliver that care. The few organizations that have created respectful and supportive cultures have improved patient safety and reduced accidental workplace injuries.[59] These are health care organizations that are becoming high-reliability organizations that are characterized by continuous learning, improvement, teamwork, and transparency.[23,60]

High-reliability organizations (HROs), or high reliability-seeking organizations (HRSOs), are organizations in hazardous industries that have succeeded in eliminating harm to their workforce and consistently achieve high performance in safety. HROs combine attributes that seem contradictory and hold them in productive tension: they are centralized and decentralized, hierarchical and collegial, rule-bound and learning-centered.[61]

HROs use time-tested safety practices with newer approaches to keep safety and reliability a conscious, heedful set of actions. All team members have a mature understanding of the procedure as a whole and their role in it. Team members are responsible for constant communication with one another, watching and interacting to advise, detect, and act on any sign of trouble. They are continuously on the lookout for ways to improve, and they never take success or safety for granted. In highly reliable industries, no part of the organization is allowed to flounder while the other parts thrive.[62]

High-reliability organizations are organized to anticipate and manage the unexpected and exhibit five basic principles: a preoccupation with failure, a reluctance to simplify interpretations, a sensitivity to operations, a commitment to resilience, and a deference to expertise.[63] Through these, they create an error-tolerant culture in which errors are the catalyst for investigating and addressing systemic failures. In such a culture, errors are acknowledged, but violations of formal rules are not tolerated.[64] Multidisciplinary teamwork is integral to the creation of a safe environment, and open communication, without threat of negative repercussion, is integral to teamwork. In such an environment, the safety of the workforce is paramount.

Can each person in the workforce answer yes to these three questions each day?

1. ***Am I treated with dignity and respect by everyone?***
2. ***Do I have what I need so I can make a contribution that gives meaning to my life?***
3. ***Am I recognized and thanked for what I do?***

The introduction of HRO performance in health care is emphasized in the Institute of Medicine's recently issued report *Best Care at Lower Cost*, which calls on health care organizations to become learning organizations and pursue high reliability.[65] The Joint Commission has also recently called on health care organizations to become HROs.[66]

Fulfilling the Preconditions

Effective organizations are those that care for their employees, are committed to reliability, and continuously meet preconditions. A precondition is an enduring requirement that is not subject to annual priority and budget setting. The most fundamental of these is workforce safety. Studies have correlated employee safety and patient safety and have demonstrated how organizational climate impacts workers' health.[67–71] Other high-risk industries have found that an organizational climate of safety and workers' perception of it are aligned with better safety outcomes.[72–74]

When health care organizations provide programs aimed at improving worker health and safety—such as employee wellness programs, influenza vaccinations, safe instrument and sharps handling, and devices for lifting—patient outcomes improve and workers feel cared for and safer.[75] The Occupational Safety and Health Administration (OSHA), the National Institute for Occupational Safety and Health (NIOSH), and The Joint Commission (TJC) have researched, developed, and promoted best practices for managing safety and aligning patient safety with workforce safety.

In addition, physical safety measures put in place over the years have been informed by federal and state regulatory action, including the federal Needlestick Safety and Prevention Act, passed in 2000, and safe patient handling laws implemented at the

Psychological safety and an unwavering intolerance for deliberate unsafe acts are fundamental characteristics of a safety culture.

state level, which require lifting procedures and equipment. But the importance of the psychological safety of the workforce has not been met with the same attention and focus. Psychological safety that allows and encourages workers to report near misses and errors, and an unwavering intolerance for deliberate unsafe acts by individuals (disrespectful behavior included) are fundamental characteristics of an organizational safety culture.

The workforce needs to know that safety, psychological and physical, is a precondition that is an enduring and non-negotiable priority for the governing board, CEO, and organization.

Creating the Culture

Exemplar organizations (in health care as well as in other industries) offer important principles and practices for transforming the workplace. Case studies of exemplar organizations demonstrate that in order to correct problems regarding respect, civility, engagement, and worker safety, hospitals and other health care organizations need to have strong policies and provide training about conduct, reporting, and response to problems. Governing boards need to take responsibility to review timely postings of data and stories, set objectives, and monitor progress.[76]

Health care organization boards and CEOs need to engage now to create cultures of safety and respect. Following are examples of some that have successfully done so.

Kaiser Permanente and the Coalition of Kaiser Permanente Unions, which represents 92,000 union employees, worked with five bargaining subgroups to create the 2012 National Agreement that built on historic success and partnership. Aspects included worker health and well-being, improving partnership, workforce of the future, and a better model for problem solving. The Health and Wellness Agreement focuses on a work environment that eliminates the risk of injury and illness and is one where people feel free and safe to report problems and errors. It also includes workplace safety plans, goals, and measures to track progress. The agreement stresses interest-based problem solving through inclusive workforce teams wherein respect is a grounding principal.[77–79]

The Mayo Clinic has built its Model of Care on the principles of teamwork, collegiality, professionalism, mutual respect, and a commitment to progress. The program includes training on confidential disclosure of errors to peers, examination of legal

and ethical dilemmas, and observed structured clinical encounter (OSCE) simulation exercises addressing patient communication scenarios.[80]

Virginia Mason Medical Center (VMMC) enters into two-way compacts with physicians, leaders, and board members that detail reciprocal responsibilities.[81] VMMC has also pursued other organization-wide culture changes, shifting from a physician-centered perspective to one that is patient-centered.[82] They transformed themselves through adoption of the Virginia Mason Production System based on the Toyota Lean model. The Toyota model is characterized by transparency, standard work, and learning, where failures become productive means by which to improve. In an error-tolerant culture such as Virginia Mason's, organizations embrace best-practice methods that are at the heart of HROs: awareness of system complexity, blameless reporting, accountability, and multidisciplinary participation in identifying risks and solutions.[83]

In 2008, New York City Health and Hospitals Corporation (HHC), the largest public hospital system in the United States, recognized the value of teamwork and began implementing Team Strategies & Tools to Enhance Performance and Patient Safety (TeamSTEPPS®). The evidence-based teamwork system aims to optimize patient outcomes by improving communication and teamwork skills. At HHC, TeamSTEPPS has led to improved patient and employee safety, more frequent and positive staff interaction, and workforce empowerment.[84,85]

Hospital Corporation of America (HCA) developed an Employee Safety and Security initiative to reduce job-related injuries and illnesses and promote a culture of safety and respect. Employee roles and responsibilities are clearly defined at all levels of the organization, surveillance rounds are conducted to identify hazards, and near-miss events are reported in a timely fashion, followed by prompt, thorough investigations and focused training for staff and leadership. Investments in exterior lighting, equipment, and security measures that help employees and patients feel safer and reduce the risk of violence have been made in response to employee engagement surveys.

There are also programs and initiatives that organizations can adopt and encourage their workforces to explore. The Healer's Art courses, used in medical schools and hospitals across the country, offer a curriculum for students and physicians to share experiences and beliefs related to service, healing relationships, and compassionate care that lead to personal and professional meaning in their work.[86] Schwartz Center Rounds offer the health care workforce dedicated time to share emotional and social issues, experiences, and responses related to their care for patients, promoting empathy and insight, and allowing for more personal connections with patients and colleagues.[87] Dr. Jon Kabat-Zinn's Stress Reduction Program, created in 1979, advises

individuals on how to use inherent resources and abilities to manage stress, pain, and illness.[88]

Nurses in organizations that pursue excellence and achievement awards report higher job satisfaction rates and view their work environments as more healthy than those in organizations that do not participate in such programs and initiatives.[89] Magnet status is awarded by the American Nurses Credentialing Center (ANCC) to hospitals where nursing staff meet measures in quality of care, report overall satisfaction in their jobs, and are involved in decision making related to patient care delivery, among other things.[90] These factors, combined with low turnover rates and feelings of being valued, are believed to create the best patient outcomes and work environment. The Beacon Award recognizes organizations that implement processes, procedures, and systems to support excellence and remove barriers. It acknowledges that frontline and front office collaboration lead to a supportive work environment, low turnover, and higher morale, which in turn result in positive patient outcomes and satisfaction with care.[91]

The University of Missouri Health Care System has deployed a "second victim" support team, embedded in every high-risk clinical area, to help identify clinicians involved in serious errors (second victims), provide real-time support and counseling, and refer them for ongoing counseling if appropriate.[92] Importantly, this process takes place independently of any incident investigation. Programs like this help prevent the long-term stigma and trauma that many clinicians feel after being part of a significant medical mistake.

Pursuing Habitual Excellence

Workplace preconditions of respect and safety, in which the well-being of every person is a priority, create the conditions for the workforce to habitually pursue excellence. Meaningfully engaged members of the workforce deliver more effective and safer care, are more satisfied, are less likely to experience burnout, and are less likely to leave the organization or the profession. They are more likely to go beyond the call of duty, consistently exhibit citizenship behaviors, and be patient-centered, leading to greater patient satisfaction.[93–96] The opposite is more likely when the workforce is unable to derive meaning from their work and seek meaning away from the workplace.[97,98] Workplace conditions, physical and psychological, are integral to achieving the cultural change for patient safety, which includes transparency, integration, patient engagement, and learning.[23,99]

Successful health care organizations are learning organizations that model professionalism, collaborative behavior, and transparency, and value the individual learner.

Leaders, as part of the workforce, model the way forward, displaying the interpersonal skills, leadership, teamwork, collaboration, and compassion that other workers can emulate.[100] This learning culture teaches all members of the workforce to identify patient safety problems, improve patient care processes, and effectively deliver care. The long-term intent is that these skills, attitudes, and behaviors become an integral part of the professional way of life for all members of the workforce. In such an environment, all are teachers, and all are learners.

Successful health care organizations are learning organizations that model professionalism, collaborative behavior, and transparency.

FUTURE STATE OF THE HEALTH CARE WORKPLACE

What Would a Healthy and Safe Workplace Look Like?

In a transformed environment, the workforce would spend the vast majority of time directly treating and caring for patients or contributing to patient care through the jobs performed. Time away from the patient would be spent comforting and assisting patients' family members, contributing to providing interdisciplinary transition planning, teaching skills to new health care workers, and learning from more experienced mentors. Nonessential paperwork would be eliminated; the remaining documentation would be valued to provide continuity, becoming a streamlined, intuitive part of care. Administrative teams would thus be freed from the excessive paperwork associated with non-value-added reporting that directs resources and energy away from the patient care mission and matters of importance to the well-being of the workforce.

Walking through the hallways of the organization, staff would see trusted and respected coworkers. They would know each other's names and return trust and respect. There would be a sense of accountability and responsibility to colleagues to combine training and knowledge as a team to produce the best results for the patient. When there was a breach of practice standards or suboptimal patient care, it would be the responsibility of all to report and be part of the improvement process, which would be conducted in a collaborative, nonpunitive manner.

It would be understood and respected that all voices would be heard and individuals would be thanked for reporting. Innovation, critical thinking, and technological and

scientific advancement would be intrinsic to the work, without loss of compassion and relationship. Each day, all members of the workforce would learn something new and experience a sense of meaning and joy. All members of the workforce would be able to identify their contributions to the mission. Management would hold workforce safety and experience as a non-negotiable requirement.

Patients and families would participate as partners in their care. They would enter the health care organization with a sense of relief and confidence that they would be respected, cared for, and safe in the hands of inspired care teams who clearly find their work meaningful.

The Leader's Role in the Workforce

Achieving this vision requires that the governing board, CEO, and organizational leaders create the cultural norms and conditions that produce workforce safety, meaning, and joy. When they view themselves as part of the workforce, not distant from and presiding over it, leaders can begin this work by making transparent to the whole organization each time an employee is injured or a patient is harmed. Effective leaders shape safety culture through management practices that demonstrate a priority to safety (e.g., regular safety rounding) and compassionately engage the workforce to speak about and report errors, mistakes, and hazards that threaten safety. They provide required resources and support to resolve the issues identified.[29]

Leaders of learning organizations eliminate hierarchical authority gradients that can intimidate and stifle teamwork, so there is deference to expertise and there is full analysis, reporting, learning, and accountability for all things gone wrong. They adopt a policy of zero tolerance for confirmed egregious disrespectful or abusive behaviors. Cultural norms with clear, crisp rules can and should be co-created, engaging every member of the workforce and ensuring that no discipline, group, or status permits deviation from practices in safety.[39,101]

Recognizing all of the foregoing needs, The Joint Commission has called for "a serious, evidence-based approach to identify opportunities to improve the quality of the health care workplace, and in so doing, improve both the health of health care workers and the health of those for whom they care."[102]

> Alexander Forthwright was a senior, high-volume physician in a large academic medical center. He consistently demonstrated behavior indicating his belief that safety practices in hand hygiene, structured handovers in care, and procedural timeouts did not apply to him. Despite numerous attempts at behavioral remediation, he became defiant in his intentional violation of safe practices. His employment was terminated. There has been no other such reported behavior in the medical center since then.

There is developing evidence of the value of remedial intervention from programs that identify and address non-team-promoting behaviors in the health care workforce. This information is used to implement programs intended to remediate such behavior by providing physicians and other health care workers with data, feedback, and evidence-based interventions. These programs provide evidence that the use of data and constructive feedback can positively influence physician behavior.[103,104] For example, the Patient Advocacy Reporting System (PARS®) at Vanderbilt University Medical Center tracks individual physicians' and practices' complaint index compared to their peers'. Its findings indicate that two-thirds of physicians showed improvement following structured intervention and feedback.[105]

CONCLUSION

The health care workforce is at risk. As long as conditions persist that compromise the physical and psychological health of the workforce, progress in patient safety is also at risk, and the pace of progress will continue to be slow. We believe the principles for advancing patient safety apply to workforce safety and require the same discipline. Joy and meaning will be created when the workforce feels valued, safe from harm, and part of the solutions for change. The data regarding the current state is jarring and sobering; however, there are stories of successes that are hopeful.

Through the Eyes of the Workforce is intended to present the current state in health care, create urgency for action, and point the way forward for the future. The common purpose that unites the health care workforce is the commitment to protect human dignity, relieve suffering, and promote health. The ability to serve others, regardless of role, is estimable work, filled with meaning. Honoring and respecting the health care workforce by protecting their physical and psychological safety is transformational. A transformed workplace, in a culture of respect, creates joy and meaning for safer health care.

RECOMMENDATIONS: What Are the Seven Things That an Organization Must Do?

For organizations to create joy and meaning in the workplace, the entire workforce must make a commitment to treat each other with civility and respect, to be transparent in reporting errors and unsafe conditions, to adhere to known safe practices, and to be part of the problem-solving team.

This commitment requires leadership, strategy, and discipline. The LLI Roundtable on Joy and Meaning in Work and Workforce Safety recommends the following seven strategies. Tactics and best practices for implementing these strategies can be found in the appendix.

Strategy 1: Develop and embody shared core values of mutual respect and civility; transparency and truth telling; safety of all workers and patients; and alignment and accountability from the boardroom through the front lines.

Core values should be developed through an inclusive process, led by the governing board, the CEO, and organizational leaders, that engages the full workforce and defines these values through behavioral examples. The statement of core values should be disseminated throughout the organization through a shared, collegial process. Application of core values needs to be evident in management and leadership decision making and practices.

Leaders need to ensure that core values are preconditions and therefore are not negotiable or prioritized against the demands of production, costs, and competing programs.

Strategy 2: Adopt the explicit aim to eliminate harm to the workforce and to patients.

Leaders must believe and communicate to the workforce that preventing harm to the workforce and to patients is achievable. Events that harm members of the workforce or harm patients must be made transparent and seen as the raw material for improvement. Evaluate how the organization approaches workforce safety and define it as a marker for organizational culture. Set aspirational goals at the theoretical limit of what is possible (zero defects), pursue with insistence and persistence, and systematically remove all barriers and excuses as to why excellence is not possible every day.

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.

The governing board, the CEO, and organizational leaders must declare and broadly communicate that a new story involving respect, teamwork, safety, joy, and meaning needs to be created. They need to engage the workforce in conversations related to connections between respect, workforce safety, and patient safety. Personal accountability and responsibility for change must be accepted across the organization.

Leaders need to systematically implement practices of HROs, emphasizing evidence-based management skills for reliability, reporting, communication, teamwork, and training. They need to provide resources, such as debrief, assistance and wellness programs, training and coaching in disclosure and apology after adverse events, and peer support programs for second victims.

Strategy 4: Create a learning and improvement system.

Local improvement systems must be created to empower change. Post measures of reliability and resilience, publish regular performance reports, and provide access to data. Ensure staff are provided resources to understand the data and use it to make decisions and set goals. Change the mode of thinking from assigning blame to solving a problem, using structured tools and methodology. This should occur at local (microsystem) and organization-wide (macrosystem) levels of the organization.

Strategy 5: Establish data capture, database, and performance metrics for accountability and improvement.

The CEO and leaders need to engage workers and patients in the design of processes and measures of effectiveness through a defined and structured method, including standard measures of joy and meaning. They must establish safe reporting systems for workers to express concerns about threats to workforce psychological or physical safety and also use validated safety climate surveys to measure and report sociocultural measures. A risk and safety database must be established to detect and analyze patterns and leverage points for change.

Strategy 6: Recognize and celebrate the work and accomplishments of the workforce, regularly and with high visibility.

The governing board, CEO, and organizational leaders should ensure that core values of respect and compassion are incorporated into performance reviews and are rewarded. They should incorporate testimonials and storytelling into organizational meetings regarding safety improvements and "good catches" where vigilance prevented harm, and regularly publish and disseminate the work of teams in creating greater reliability and safety.

Institutions should create appreciation days, service awards, and other traditions that honor and celebrate the workforce.

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 patients.

Commission cross-sectional studies of workforce and patient safety to determine leverage points for systemic change, and engage researchers to study applications used in other high-risk industries. Conduct studies to determine the effects of patient and family engagement on the workforce and patient safety, and investigate cultural foundations of workforce and patient safety.

APPENDIX:
Practical Tactics and Best Practices from the Field

Strategy 1: Develop and embody shared core values of mutual respect and civility; transparency and truth telling; safety of all workers and patients; and alignment and accountability from the boardroom through the front lines.

1.1 Develop core values through an inclusive process, engaging the full workforce of the organization.

1.2 Specifically define core values through behavioral examples, and disseminate this information through a shared, collegial process throughout the organization.

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

1.4 Assure that core values are preconditions and therefore are not negotiable or prioritized against the demands of production and costs.

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

1.6 Develop and demonstrate a philosophy of shared decision making between management and staff, 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 patients.

2.1 Leaders must authentically communicate the belief that preventing harm to the workforce is knowable and achievable.

2.2 Create full transparency for accidents and incidents of harm.

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

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

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

2.6 Collect, analyze, and act on patient safety and risk data.

2.7 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.

3.1 CEO and clinical staff declare and broadly communicate that the "old story" of medicine is no longer working: we need to create a new story involving respect, teamwork, safety, joy, and meaning.

3.2 Engage the workforce in conversations, making explicit connections between respect, workforce safety, and patient safety.

3.3 Accept personal accountability and responsibility for change, and cascade an accountability model throughout the organization.

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

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

3.5 Implement full workforce training on respect and teamwork.

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

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

3.8 Engage the highly diverse and complex workforce in health care to examine job descriptions and duties to eliminate silos, fragmentation, and disconnects in the ability to care for patients and work effectively in teams.

3.8.a Align skill and staffing levels to correspond with best practices.

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

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

3.11 Establish workplace safety and workforce wellness programs.

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

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

3.14 Assign priority for investments in devices, technologies, and training known to improve safety and protect patients and workers.

3.15 Study workflow and capacity from a process of flow perspective.

3.15.a Establish a high ratio of useful work to "busywork."

Strategy 4: Create a learning and improvement system.

4.1 Create local improvement teams, such as a Comprehensive Unit-based Safety Program (CUSP) or Safety Action Teams, for empowered change at the microsystem level of care.

4.2 Visibly post measures of reliability (adherence to goals) and measures of resilience (failures and follow-up actions to close gaps).

4.3 Publish regular performance reports to enhance accountability, and provide access to real-time performance data for improvement.

4.4 Provide relevant resources for all staff to understand and use data in decision making and local goal setting.

4.5 Publish and disseminate effective better practices for knowledge transfer and scaling improvements.

4.6 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.

5.1 The CEO and leaders must engage workers and patients in the design of processes and measures of effectiveness through a defined and structured method.

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

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

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

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

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

5.5 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.

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

6.2 Establish awards for teamwork and respectful behavior toward colleagues.

6.3 Regularly publish and disseminate the work of teams in creating greater reliability and safety.

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

6.5 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 patients.

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

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

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

7.4 Qualitatively and quantitatively investigate the cultural foundations of workforce and patient safety (and harmful conditions).

The Lucian Leape Institute and the National Patient Safety Foundation value your response to this white paper, *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care*. We respectfully request that you complete the reader survey that may be accessed online at: http://www.surveymonkey.com/s/LLI_WorkforceSafety.

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