Previous work on the relationship between worker safety and patient safety has focused on nurses and physicians.[1] Safety climate and nurses' working conditions predict both patient injuries and nurse injuries, supporting the premise that these outcomes may be linked.[2] Less attention has been paid to other members of the health care team, including nursing assistants, orderlies, aides, food service workers, janitors and other environ-

proving patient safety" to "reducing unsafe driving in the parking lot").

■ A high-reliability approach reflects a preoccupation with failure and a reluctance to simplify, a sensitivity to operations, a commitment to resilience, and a deference to expertise (rather than title).

■ Leaders should listen and advocate for others. They should get to know staff personally (take off the suit and put on the scrubs and hairnet) and sincerely care about staff welfare.

■ Leaders and managers need to build goodwill and exemplify a nonpunitive culture that builds trust and promotes safety for all.

■ Champions may come from physicians, workers, and patients and their families.

■ The notion of a "just culture" admits the occurrence of errors and mistakes and does not punish human error. Discipline (accountability) is reserved for reckless behavior, not errors.

Panel 2. Worker Safety–Patient Safety Nexus: Summary of Key Information

Jeffrey Brady (AHRQ) and Jim Battles (AHRQ) provided anrs need to build goo6 03w 0 -1.286 TD[(in16(vid(ed -18(v)6ie)-6 st (t6(elf anr)6(kers,efety)]ud pa-, a 12(rady (der)-ib anRQ)TJ-0.0002 Tc 0.0002 Tc T*[((as223)50(, d ersncof Kefacityats and mi

Frontline Health Care Workers

The third panel featured presentations by Laura Chenven and Danielle Copeland (H-CAP) and from EVS workers Carl D. Samuels (1199SEIU), Will Johnson (1199SEIU), and Clarence Smith (1199SEIU), and Rodney Trammel (SEIU UHW-W). Deborah Berkowitz (OSHA) and L. Clifford McDonald (CDC) served as discussants. Kathleen Fagan moderated the session, which provided extensive information from worker perspectives.

Chenven and Copeland provided an overview of career development and education that supported the active engagement of frontline workers in a green-jobs program for EVS workers. The frontline worker participants on the panel provided examples of their work in developing projects that supported patient and worker health and safety and lowered their institutions' carbon footprints. The program was characterized by, for example, the following features:

- Labor-management cooperation and formal agreements
- Multilevel training and education
- Creating culture and systems change
- Improving entry-level jobs
- Developing a national model, curriculum, and certification
- Building a national labor-management consortium for green jobs in health care

Workers were offered opportunities to attend community college to study principles of environmental science and health. They learned the "why" of conservation, substitution, recycling, and infection control, along with the importance of using less toxic chemicals, when possible. Workers on the panel described their own successes in engaging coworkers and management in recycling, room cleaning to reduce health care–associated infections (HAIs), reduction and management of red-bag medical waste, and energy conservation.

Berkowitz spoke to OSHA's growing reliance on worker participation to promote safe and healthy workplaces. She described workers as the frontline inspectors, pointing out that OSHA has only about 2,000 inspectors in the United States for 7 million workplaces. A strategic goal of the US Department of Labor is to increase worker participation.

McDonald discussed the challenges posed by HAIs and noted the toolkits available through the CDC to help hospitals and other health care facilities manage the problem.[13] Expanded efforts are needed to address HAIs, including frontline workers in problem solving, identifying appropriate levels of cleaning for different circumstances, and engaging workers wholeheartedly in the creation of a safety culture, as well as in education, training, tracking exposures, and program evaluation. Recent evidence suggests continued gaps between hospital leadership and both mid-level and frontline workers with respect to perceptions of safety.[14]

Small-Group Discussions

In small-group discussions, the workshop attendees participated in one of seven concurrent 90-minute breakout sessions.

1. Promising Practices for Improving Safety Culture for both Patients and Workers: Engaging and Empowering Health Care Team Members; Getting Frontline Workers onto the Team; Hierarchy-Free Communication (facilitated by Jim Battles and David DeJoy)

Discussion Highlights:

- The four AHRQ goals—quality, safety, efficiency, and effectiveness—are all interrelated.
- Workers have to be healthy and safe to be able to provide good/safe patient care; the concept of worker safety should be expanded to include psychological safety; safety measures should be nonpunitive; workers at all levels should have a voice and be encouraged to speak up about hazards and other safety problems; a variety of potentially useful data is probably already being collected but is not being analyzed.
- Worker involvement should be improved, with an emphasis on a culture of respect. Legislation and regulations that are primarily punitive may be counterproductive (have unintended consequences) to maximizing safety and to creating a mindset of continuous improvement.

2. Getting and Using Information—Adverse Event Reporting for Patient Events and for Worker Illness and Injury; Reporting Surveillance and Feedback Loops for Analysis and Prevention (facilitated by Lyn Penniman [OSHA], Jennifer Lipkowitz-Eaton [VHA], Kathryn Reback [AHRQ], and Kate Henderson)

Discussion Highlights:

- Data on surveillance—active and passive—and on clinical operations should inform each other—if something is not safe for workers, it is not safe for patients (hazards do not discriminate).
- Hazards may be related; for example, concerns about HAIs may lead to overuse of certain disinfectants.
- Mandatory illness and injury record keeping through the OSHA 300 logs,[6] including the more serious category of "days away from work" or "restricted work activity," may add useful information to other just-in-time data related to patient, family, and worker satisfaction, as well as to measures of medical errors or adverse patient events.
- Concerns that underreporting may affect data quality exist both for workplace illness and injury reporting and for patient event reporting. Attention to quality of data is a cornerstone of

safety that requires nonpunitive reporting incentives.

■ The field of worker safety could learn from patient safety (for example, "never events," taxonomy, unified set of metrics, need to benchmark).

3. Slips/Trips and Falls (facilitated by Whitney Gray and Jennifer Bell [NIOSH])

Interventions aimed at reducing slips, trips, and falls among hospital workers and patients should focus on "People, Place, and Data." *People* refers to staff and patients' mentality that "It won't happen to me . . . I'll be fine." This cycle needs to be broken by supporting staff and patients and allowing them to speak up and discuss such issues. *Place* refers to the extrinsic factors in a hospital room, corridor, or common area (such as flooring selection, location of grab bars next to patient beds, and built-in overhead patient lifts) that are designed into the overall plan that support a culture of safety. *Data* need to support both design and cultural changes.

An innovative information technology strategy would track the location of slips, trips, and falls from both the occupational and patient safety perspective and thus build a case of key "danger spots" to address. Areas of the hospital that need attention, such as cracked tile, wet floor, leaking piping, and malfunctioning or missing equipment, could be mapped. Workers could enter data, access the data to prioritize interventions, and track the interventions' impact on events.

4. Infectious Disease Concerns and the Role Of Environmental Service Workers (facilitated by Barbara Braun, L. Clifford McDonald, Scott Goodell [SEIU UHW-W and Joint Employer Education Fund], and Laura Chenven)

Discussion Highlights:

■ The role of EVS workers is critical for infection control, given growing evidence that infections can be transmitted by patient and/or worker contact with contaminated surfaces.

■ Workers need to understand not only what chemicals to use but how to use them in different circumstances and under what conditions for them to be effective cleaners and disinfectants.

■ Effective interventions start with shared best practices and with increased respect for frontline workers that includes engagement and education.

■ An important barrier is reduced staffing for EVS. EVS workers tend to be the first be the 9 0 0 6th shares tesonly what ofc5 0 als rlbf0s.00manys cracked 9 Scott Ged ibB

care, staff recruitment and retention, law suits, workers' compensation costs, staff morale, and organizational reputation.

■ Risk assessments should evaluate patient and staff injury trends; the physical environment, such as ward/unit design, security systems, and emergency codes; and systems for reporting and responding to threats and assaults. Effectiveness of treatment plans and pain management, training effectiveness, and procedures for assessing patient acuity and staffing, should all be considered.

■ Intervention training and risk assessment for suicide or violence should include everyone.

■ Employee assistance programs should be assessed for accessibility.

■ State legislation focused on violence prevention in health care facilities in Washington State, New York, New Jersey, California, Connecticut, and elsewhere may offer a template.[18]

Panel 4. Policy Implications and Updates from the Panels and Small Groups

Jason Ormsby (Georgetown University) reviewed the history of separate patient and workforce safety efforts; the organizations and stakeholders involved in safety discussions; and the proposed and/or implemented legislative and regulatory initiatives aimed at improving either patient safety or HCW occupational safety and health—these initiatives have generally not overlapped between patient and HCW safety.

Notable federal and state policy efforts include the following:

■ California Hospital Safety and Security Act in 1995, which required implementation of violence prevention programs

■ Nurse and Health Care Worker Protection Act of 2009, which, if passed, would direct the Secretary of Labor to "issue an occupational safety and health standard to reduce injuries to patients, direct-care registered nurses, and all other health care workers by establishing a safe patient handling and injury prevention standard, and for other purposes"[19]

■ Hospital Patient and Health Care Worker Injury Protection Act of 2012, which requires all California hospitals to have a safe patient handling policy.[20]

Robin Hemphill summarized the discussions of the panels and small groups by noting, "Hospitals should be safe places. Why aren't we there yet?"

In summary, whether patient safety and worker safety are connected seems an odd question to even ask because overall safety embraces patients, their families, and the work force. Yet, barriers persist and conclusive studies are lacking. The goal of high reliability may help focus the many areas of the health system toward safety, a just culture, teamwork, and leadership.

So what are the barriers and opportunities that hinder or help progress?

Barriers

■ Tendencies to criminalize human error. These tendencies reach beyond the medical arena but are particularly harmful within health care. If we punish people for mistakes without understanding the background and environment that may have contributed to those errors we will drive people to hide their mistakes. This will allow system weaknesses to persist over time, and we will repeat the same mistakes.

■ Well-intended policies that may drive normal functions of hospitals in unintended ways. Information is needed to determine whether pay-for-performance might have the effect of focusing on some diseases and outcomes over others, and whether it might also affect professional behaviors. The goal is to assure that short-term gains align with long-term outcomes.

■ Policies with the potential for dual impact, such as workforce-hour restrictions. The focus on fatigue in trainees is critical and necessary, but decreasing hours increases the need to hand off patients. Patient handoffs are a well-recognized cause of errors and must be addressed to avoid introducing vulnerability errors of a different sort as needed changes in work hours are implemented.

■ New CMS payment policies (CMS-1390-F), again with good and needed intent, such as nonpayment for hospital-acquired conditions required by the Deficit Reduction Act of 2005,[21] may cause competition among hospitals for shrinking

disciplinary and have embedded simulation.[22]

■ In the long term, work with the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education to require competencies in patient safety and teamwork. After competencies are established, they will be tested, and after people believe that these concepts are being evaluated, they will start training in these skills.

Kathleen A. Curran (Catholic Health Association of the United States) argued that we don't need to wait for new public policy—there are things we can do now. The person is at the center of everything (dignity, just culture). Patient satisfaction (a huge metric) correlates with worker/patient safety. Because the Centers for Medicare & Medicaid Services (CMS) is implementing outcome-related value-based payment,[21] opportunities for action should increase. She noted the importance of studying not only the association between frontline worker safety and patient safety but frontline workers' potential role in reducing health disparities. Frontline workers themselves add socioeconomic and racial diversity to the hospital workforce. To the extent that they may be empowered to engage as members of the health care

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Online-Only Content

Appendix 1. Presenters and Facilitators*

Welcome:

Panel 1

Panel 2

Panel 3

Panel 4

Small-Group Discussion Groups

* (192).