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Healthcare Safety Leadership: Back to Basics

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Introduction

As a safety professional working with the healthcare industry, much of your time is spent trying to lead organizations out of a vicious cycle of injuries, turnover, and lack of resources. It has become even more challenging to address safety issues considering the other factors impacting the industry. These factors include, but are not limited to, nursing staff shortages, medical reimbursement, employee turnover, lawsuits, and increased compliance requirements. Safety becomes a lower priority because it is not considered a basic element necessary to achieve the ultimate goal of a healthcare facility. However, there is something to be gained by incorporating safety into all facets of healthcare operations. By getting back to basics and utilizing the following three keys, you can help your organization achieve its goal.

The Problem

As an industry we have gained tremendous knowledge, but the negative trends continue. Even with increased technology, improved research, experience gained from past losses, and more highly skilled staff, injury rates for healthcare workers continue to be one of the highest in the United States.[1] Throughout this article we'll mention the following example of an unsafe resident transfer procedure. The use of gait belts is encouraged to reduce employee and patient injuries while transferring patients who need some form of assistance when ambulating. It is still a commonly accepted practice for staff to use what I refer to as the "Wedgie Grab" when walking with a resident who needs minimal support while ambulating. The staff member is supporting the resident with a good strong grip on the waistband of the resident's pants. This practice is unacceptable for several reasons. First, it is a violation of the resident's dignity and, in the event of an injury, could be considered abuse. Second, it could cause injuries to the resident and staff member if they were to fall. Finally, it demonstrates a lack of administrative controls. The staff member may not have been trained on the proper transfer techniques. Leadership personnel may not be enforcing the resident transfer policies. This lack of enforcement may be implied as condoning the unsafe practice. It could also send a conflicting message to staff who take the time to perform the transfer properly.

Acceptance of Lower Standards

[1] Bureau of Labor Statistics (BLS). News Release: Workplace injuries and illnesses in 2005. Washington, D.C.: U.S. Dept. of Labor, BLS, 10/19/2006. http://www.bls.gov/iif/oshwc/osh/os/osnr0025.pdf

Someone once said that mediocrity has become the standard of excellence. A great way to look at this is as a "normalization of deviance".[2] A substandard practice is done due to pressures of performing a task. The lower standard of performance is accepted and potentially rewarded, either by lack of punishment or by praise for a job well done. This lower standard of performance becomes the newly accepted practice. Although the intention is usually to revert back to the higher standard, when stressful circumstances arise again, the lower standard is accepted. Over time the individual fails to see the actions as deviant. The new, deviant standard will be followed and taught to new employees. Examples demonstrating the acceptance of a lower standard are the use of a chair to reach something on a high shelf or talking on a cell phone while driving. Putting it in perspective for the healthcare industry, we can refer to the example of the "wedgie grab" discussed previously.

Motivation for Safety

Most of us have heard of "Maslow's Hierarchy of Needs" and the many variations of it. Do we incorporate it into our safety efforts? Consider the situation when an employee performs the "wedgie grab" on a resident. What is the motivation to perform the task in this manner? It is doubtful that the staff member is motivated out of a physiological or safety need. If you have provided even basic education, the staff member understands this type of lift can contribute to injuries *and* can result in termination. The most likely motivator for performing in this manner is acceptance by peers and management. It is necessary to consider what motivates staff to perform the desired actions. Many managers believe employees are primarily motivated by money. Give staff more credit. Consider your own motivation to do your job. Why do you have the job you have? Is it strictly for the money? Just like you, staff members are trying to climb the hierarchy of needs. Keep this in mind as you consider the following three keys to stop the injury cycle.

The Three Keys

The following approach is presented to simplify the various theories currently being promoted to improve safe behaviors. The three "keys" to this approach are:

- Provide the tools
- Reinforce and support the policies
- Learn from successes and mistakes

The First Key - Provide the Tools

First, we need to determine how widespread the problem is in the facility through the use of surveys, audits, and inspections. Once we determine the scope of the problem, we can identify additional tools necessary to correct the problem, including the following:

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[2] Vaughan D. The Challenger launch decision: risky technology, culture and deviance at NASA. Chicago, IL: University of Chicago Press; 1996.

- **Financial planning –** Identify the problem you want to tackle and propose a budget. There is a better chance of obtaining financial backing for your efforts if you are able to demonstrate how the investment will eliminate or reduce the problem.
- **Physical Tools** – These items are the machinery or devices necessary to perform tasks safely. Physical tools include, but are not limited to, mechanical lifting devices, resident transfer aids, safer needle devices, and appropriate beds.
- **Operational Tools -** The operational tools include accountability, policies and procedures, safety committees, improved training programs, incentive programs, improved support services, surveys and inspections, etc.
- **Education -** Education should be considered one of the main tools provided to staff. In manufacturing operations, an employee who performs welding is given protective gear such as an air supplied helmet with a face shield with a tinted lens, leather chaps, aprons and gauntlets, work boots with safety toes and metatarsal guards; they are protected like a knight charging into battle. But what tools do we give staff members to protect them? For nursing staff, education is their battle armor. Make sure the education is relevant and provided in a manner that supports learning.

The Second Key - Reinforce and Support the Policies

How you respond to the safety issue you are trying to address has a major impact on achievement of your ultimate goal. Unfortunately, there is a trend for management personnel to utilize an approach of "ignorance is bliss" on safety violations. Even incorporating an old school "three strikes, you're out" response would be a better reaction. With either of these approaches, it is highly unlikely that you will experience the outcome for which you had hoped. A developing trend is a reduction of enforcement to potentially reduce turnover. It is a basic concept that policies exist to protect the organization and their representatives. Policies are made to be followed. If we ignore a safety violation, we are essentially saying, "I don't care if you get hurt."

The process to follow when a policy breach occurs should be to address the situation in a manner that conveys respect for the individual involved and caring for their wellbeing. Consider what you are trying to accomplish with your actions. If support of the policy and improved behavior is the objective, then sending the staff member home without pay is not going to help you achieve your goal. Embarrassing the individual in public will also undermine your efforts. Discuss the situation, identify where weaknesses exist (i.e. training, leadership, and policies), and determine how this situation can be used to reinforce the process and improve it.

The Third Key - Learn from Successes and Mistakes

Once the tools are provided and we can be certain leadership personnel are reinforcing and supporting the established policies, we need to identify the impact of these efforts. Evaluate the problem to determine if it has been corrected or not. This can be accomplished by reviewing developing trends, interviewing/surveying employees, evaluating the management system (determining if leadership personnel are rewarding the desired behaviors or, on the other hand, encouraging short cuts through the lack of enforcement), and focusing on communication. Also, leadership personnel should investigate accidents to identify the factors that allowed the loss to occur. These activities will provide the information necessary to reduce similar incidents in the future.

Conclusion

When the three keys are incorporated into your operations, the injury cycle can be stopped. If you hire the right people, give them the tools to do their jobs, enforce the rules to be followed, and identify where errors are occurring, you will reduce the injury trends experienced by your facilities. In order to achieve this goal more easily, you have to care about employees and get back to basics.

Bibliography

1. Bureau of Labor Statistics (BLS). News Release: Workplace injuries and illnesses in 2005. Washington, D.C.: U.S. Dept. of Labor, BLS, 10/19/2006. http://www.bls.gov/iif/oshwc/osh/os/osnr0025.pdf

2. Vaughan D. The Challenger launch decision: risky technology, culture and deviance at NASA. Chicago, IL: University of Chicago Press; 1996.