Culture of Safety
Change Package

FOSTERING A CULTURE THAT FULLY INTEGRATES PATIENT AND WORKER SAFETY

American Hospital Association®

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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ACKNOWLEDGEMENTS

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How to Use this Change Package

This change package is intended for hospitals participating in the Hospital Engagement Network (HEN) 2.0 project led by the Centers for Medicare & Medicaid Services (CMS) and Partnership for Patients (PFP). It is meant to be a tool to help you make patient care safer and improve care transitions. This change package is a summary of themes from the successful practices of high performing health organizations across the country. It was developed through clinical practice sharing, organization site visits and subject matter expert contributions. This change package includes a menu of strategies, change concepts and specific actionable items that any hospital can choose to implement based on need or for purposes of improving patient quality of life and care. This change package is intended to be complementary to literature reviews and other evidence-based tools and resources.

PART 1: ADVERSE EVENT AREA (AEA) DEFINITION AND SCOPE

The World Health Organization (WHO) defines patient safety as the prevention of errors and adverse effects to patients associated with health care. In patient safety theory and practice, emphasis is placed on the system of care that prevents errors, learns from any errors that may occur and is built on a culture of safety. Since the Institute of Medicine report in 1999, *To Err is Human: Building a Safer Health Care System*[1], patient safety has become a national priority.

Closely related to patient safety, worker safety is defined as having an environment free of physical and psychological harm. It involves hazard identification and control, as well as the provision of ongoing safety training for employees. While worker safety comprises several areas, this change package emphasizes two: harm from workplace violence and harm from patient handling.

Workplace violence is any act or threat of physical violence, harassment, intimidation or other threatening disruptive behavior that occurs at the work site. Violence ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors.[2]

Safe patient handling is also addressed in this change packet as a key component of worker safety. The single greatest risk factor for overexertion injuries in health care workers is the manual lifting, moving and repositioning of patients, residents or clients (i.e., manual patient handling).[3] Rates of musculoskeletal injuries from overexertion in health care settings are among the highest of all occupations in the U.S.

Many organizations pursue a worker safety agenda or initiatives separately from patient safety, when in fact the two are very much intertwined. Health care organizations may find significant overlap in the necessary structures, processes as well as outcomes tracked to ensure both patient and worker safety.

- The *structure* of environment of care safety committees and patient safety committees overlap in many organizations, both in membership (e.g., infection control, quality and risk staff) and in reporting structure.

- In addition, the *processes* to improve patient and worker safety are also often connected. For example, strategies to achieve safe patient handling often include provisions around patient lifting equipment; no-lift policies and specialized lift teams. These strategies lead to increased patient satisfaction, quicker ambulation, fewer falls and improved patient outcomes – all positive outcomes for patient safety. They also, however increase worker satisfaction and decrease musculoskeletal injuries.[4]

- Worker and patient safety *outcomes* are also closely linked. In a 2011 study, patient satisfaction levels were lower in hospitals with lower nurse satisfaction.[5] A 2012 study found that lower staff perceptions of teamwork and safety among nurses are correlated with higher odds of decubitus ulcers in patients and increased nurse injury.[6] In addition to structures, processes and outcomes being interrelated for patient and worker safety, both worker and patient safety efforts require a commitment to an organizational safety culture as a foundation for success.

A culture of safety is one where everyone feels responsible for safety, pursues it on a daily basis and is comfortable reporting unsafe conditions and behaviors. An organization that has a strong safety culture experiences fewer at-risk behaviors and consequently, they also experience lower incident rates of harm, lower turn-over, lower absenteeism and high productivity.[7] To improve safety outcomes, organizations should cultivate a culture of safety that integrates patient safety with worker safety. This change package provides change ideas both to cultivate a culture of safety and also to specifically reduce workplace violence and promote safe patient handling.

Magnitude of the Problem

Both patients and health care workers sustain injuries at relatively high rates. Related to worker safety, U.S. hospitals recorded 6.8 work related injuries and illnesses for every 100 full-time employees in 2011. In addition to being harmful to employees, these injuries can also impact a hospital financially. On average, hospitals pay $0.78 in workers compensation losses for every $100 of payroll; totaling a national annual expense of two billion dollars.[8] Nearly half of workplace injuries are caused by overexertion of bodily reaction such as lifting, bending and reaching.[9] Additionally, assaults comprise 10-11 percent of workplace injuries involving days away from work. These assaults result primarily from violent behavior of patients, clients or residents.[10]

Despite recent decreases nationally in the rates of many hospital-acquired conditions, the patient harm rate in the U.S. is still far from zero. Researchers estimate more than 400,000 premature patient deaths associated with preventable harm occur annually.[11] The HAI Prevalence Survey estimated that in 2011 there were 722,000 health care associated infections in U.S. acute care hospitals;[12] nearly 20 percent of Medicare patients who are discharged from a hospital are readmitted within 20 days;[13] patient falls affect between 700,000 and 1,000,000 patients each year;[14] and the Agency for Healthcare Research and Quality estimated that drug-related adverse events occurred in nearly 1.9 million inpatient stays.[15]

HEN 2.0 Reduction Goals

Improve hospital culture of safety and reduce harms, including both patient and worker safety by 40 percent by September 23, 2016.

PART 2: MEASUREMENT

A key component to making patient care safer in your hospital is to track your progress toward improvement. This section outlines the nationally recognized process and outcome measures that you will be collecting and submitting as part of the AHA/HRET HEN 2.0 initiative. Collecting these monthly data points at your hospital will guide your quality improvement efforts as part of the Plan-Do-Study-Act (PDSA) process. Tracking your data in this manner will provide valuable information needed to study your data across time and will help determine the impact of your improvement strategies. Furthermore, collecting these standardized metrics will allow the AHA/HRET HEN to aggregate, analyze and report its progress toward reaching the project's 40/20 goals across all adverse event areas by September 2016.

Nationally Recognized Measures: Process and Outcome

Please download and reference the encyclopedia of measures (EOM) on the AHA/HRET HEN website for additional measure specifications and for any updates after publication at: http://www.hret-hen.org/audience/data-informatics-teams/EOM-AdditionalTopics.pdf

HEN 2.0 EVALUATION MEASURES

- Days Lost to Harm Events Related to Patient Handling

- Harm Events Related to Patient Mobilization

- Harm Events Related to Workplace Violence

- Days Lost to Harm Events Related to Workplace Violence

- Workplace Violence Prevention Gap Analysis (Appendix III)

- Adoption of Workplace Violence Guidelines

- Use of the OSHA Safe Patient Handling Program Checklist (Appendix V)

- Gap Analysis for Safe Handling of Patients (Appendix IV)

In addition to these measures related specifically to workplace violence and safe patient handling, the AHA/HRET HEN project promotes the organizational assessment and administration of the AHRQ Surveys on Patient Safety Culture. These surveys enable hospitals, medical offices, nursing homes, community pharmacies and ambulatory surgery centers to examine their staff perception of patient safety culture. The survey can be used to assess various aspects of patient safety culture within an organization. We encourage all HEN hospitals to both administer the AHRQ Patient Safety Culture Surveys and develop action plans based on your facilities' data. Benchmark data are also available in the AHRQ databases available at: http://www.ahrq. gov/professionals/quality-patient-safety/patientsafetyculture/index.html. Hospitals are encouraged to simultaneously pursue interventions related to culture change that promote a safety workplace and also to implement discrete interventions related to workplace violence and safe patient handling, as outlined in the change package below.

PART 3: APPROACHING YOUR AEA

Suggested Bundles and Toolkits

- Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation. Retrieved at: http://www. jointcommission.org/assets/1/18/tjc-improvingpatientandworkersafety-monograph.pdf

- OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. Retrieved at: https:// www.osha.gov/Publications/osha3148.pdf

- AONE/ENA Tool Kit for Mitigating Violence in the Workplace. Retrieved at: http://www.aone.org/resources/mitigating-workplace-violence-Tool%20Kit

- Beyond Getting Started: A Resource Guide for Implementing a Safe Patient Handling Program in an Acute Care Setting. Retrieved at: https://www.aohp.org/aohp/Portals/0/Documents/AboutAOHP/BGS_Summer2011.pdf

- Safe Patient Handling and Movement Algorithms. Retrieved at: http://www.cbs.state.or.us/osha/grants/safe-patient-handling-health-care/resources/files-from-original-cd/va-algorithms-for-patient-handling-rev-2006.pdf

- Hospital Survey on Patient Safety Culture. Retrieved at: http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html

- Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS). Retrieved at: http://www. teamsteppsportal.org/

- Action Planning Tool for the AHRQ Surveys on Patient Safety Culture. Retrieved at: http://www.ahrq.gov/sites/default/files/publications/files/planningtool_0.pdf

- Patient and Family Engagement Resource Compendium. Retrieved at: http://www.hret-hen.org/topics/pfe/20160104-PFEcompendium.pdf

- For key tools and resources related to creating a culture of safety, visit www.hret-hen.org

Investigate Your Problem and Implement Best Practices

Driver diagrams: A driver diagram visually demonstrates the causal relationship between your change ideas, secondary drivers, primary drivers and your overall aim. A description of each of these components is outlined in the table below. This change package reviews the components of the driver diagram to first, help you and your care team identify potential change ideas to implement at your facility and second, to show how this quality improvement tool can be used by your team to tackle new process problems.

Aim	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea
	Primary Driver	Secondary Driver	Change Idea

AIM: *A clearly articulated goal or objective describing the desired outcome. It should be specific, measurable and timebound.*

PRIMARY DRIVER: *System components or factors that contribute directly to achieving the aim.*

SECONDARY DRIVER: *Action, interventions or lower-level components necessary to achieve the primary driver.*

CHANGE IDEAS: *Specific change ideas that will support and achieve the secondary driver.*

Drivers in This Change Package

Further a Culture of Safety that Fully Integrates Patient Safety with Worker Safety	Commit and Communicate the Priority of Patient and Worker Safety	Demonstrate the commitment to safety at all levels of the organization and patients	Change Idea
		Build systems and processes that integrate patient and worker safety	Change Idea
		Engage all team members in the commitment to safety; including patients and their families	Change Idea
	Foster a Culture of Trust, Reporting and Learning	Support a culture that balances a systems approach and individual accountability	Change Idea
		Create a reporting mechanism that is easy to use, meaningful and has a built in feedback process	Change Idea
		Promote reflective learning and improvement	Change Idea
	Build a Work Environment to Enable Staff to Provide Safe, Quality Care	Design and ensure a safe work environment	Change Idea
		Provide training on processes to support and improve patient and worker safety	Change Idea
		Furnish staff with necessary equipment and supplies	Change Idea

OVERALL AIM: FURTHER A CULTURE OF SAFETY THAT FULLY INTEGRATES PATIENT SAFETY WITH WORKER SAFETY

Primary Driver > Commit and Communicate the Priority of Patient and Worker Safety

In effective safety cultures, there is a shared commitment to safety. Behaviors that promote safety are encouraged and reinforced by leaders and peers and near-misses are valued as opportunities for learning and improvement.[16] The commitment to safety must be visible, communicated at all levels and reinforced through processes and systems such as safety huddles, open and transparent communication and rewarding "good catches."

Secondary Driver > Demonstrate the commitment to safety at all levels of the organization

A culture of safety requires leadership commitment and participation of physicians and staff at all levels, particularly front line staff. Incorporating patient and worker safety goals into performance evaluations elevates the commitment to safety and highlights the importance each staff member has in furthering a culture of safety. When organizations promote transparency in reporting of events and near-misses, they acknowledge the role of human factors and systems in errors; blame is not fully placed on individuals. Transparency is important to ensure that errors and potential problems are exposed and handled before they endanger others.[17]

Change Ideas

+ Include patient and worker safety in the organizational strategic plan and goals.
+ Embed patient and worker safety goals into performance appraisals.
+ Include patient and worker safety in physician contracts and ongoing professional practice evaluation (OPPE).
+ Incorporate patient and worker safety in operational performance and service line reporting.
+ Tie financial compensation of senior leaders, i.e., bonuses, to meeting quality and safety goals.
+ Embed patient and worker safety into meetings at all levels, including the board.
+ Implement Patient Safety Leadership WalkRounds™[18] and modify to include worker safety.
+ Promote transparency in data and operations through sharing patient and worker data internally and externally, and disclosing incidents to patients and family.

Suggested Process Measures for Your Test of Change

- Percent of performance appraisals that include patient and worker safety goals
- Percent of physician contracts that include patient and worker safety goals
- Percent of senior leaders' financial bonuses and incentives that are tied to meeting patient and worker safety goals
- Percent of board meetings when patient and worker safety metrics are reported and discussed with other quality metrics
- Percent of units rounded on by senior leaders per quarter

Secondary Driver > Build systems and processes that integrate patient and worker safety

Achieving a culture of safety is a continuous journey that requires processes to keep safety as the chief priority. Linking structures and processes aimed at improving patient and worker safety will more efficiently attain a safety culture. Using safety culture surveys can help your organization determine the extent to which the organizational culture helps or hinders patient safety. It is important to also remember that there is not a single organizational culture; culture is local and can differ from unit to unit. Therefore, efforts to improve safety culture should be both organizational wide and unit specific.

Change Ideas

+ Combine patient safety and environment of care safety committees.
+ Improve teamwork and communication through the implementation of TeamSTEPPS, standardized communication tools, e.g., situation-background-assessment-recommendation (SBAR) and standardized handoff communication.
+ Execute safety huddles, briefings and debriefings.
+ Implement safety walk-arounds.
+ Create a system to capture patient and worker safety best practices from within and outside the organization.
+ Conduct safety climate survey, e.g., AHRQ Culture of Safety Survey[19] and analyze survey data in conjunction with patient and worker safety outcomes.
+ Implement Comprehensive Unit-Based Safety Programs (CUSP).[20]

Suggested Process Measures for Your Test of Change

- Percent of patient care units that have completed TeamSTEPPS training
- Percent of units that use a standardized communication tool
- Percent of units that utilize a standardized handoff
- Number of best practices collected
- Percentage of units where safety walk-arounds were conducted quarterly
- Number of downloads of best practices from database
- Percent of units that have created action plans to address unit-specific safety culture survey results
- Percent of action plans in response to survey results that are on target with respect to dates and results

Secondary Driver > Engage all team members in the commitment to safety; including patients and their families

A key feature of a culture of safety is collaboration across ranks and disciplines to seek solutions to patient safety problems.[21] Hospitals with a teamwork culture have better patient safety climates.[22] Employees across the organization should be recognized for not only their technical expertise, but also their ability to work effectively within a team.[23] In addition, research shows that when patients are engaged in their health care it can lead to measurable improvements in safety and quality.[24]

Change Ideas

+ Proactively look for potential failures by conducting Failure Mode and Affects Analyses (FMEA) and creating reporting structures and opportunities.
+ Reward staff and patients for "Good Catch".
+ Engage patients and family in safety efforts through use of a patient and family advisory council.
+ Employ nurse bedside shift report.
+ Utilize multidisciplinary intensive care unit (ICU) rounds that include patients and families.

Suggested Process Measures for Your Test of Change

- Number of "good catch" awards
- Percent of shift reports that occur at the bedside
- Percent of ICU rounds that include patients and families

Hardwire the Process

Incorporate patient and worker safety goals into performance appraisal templates to aid in accountability. Include staff in annual goal setting around patient and worker safety. Establish unit-based worker and patient safety goals.

Primary Driver > Foster a Culture of Trust, Reporting and Learning

An organization with a safety culture prevents adverse events and learns from them when they do occur. A culture of trust allows providers to talk about errors, near misses and actual harm without fear of reprisal.

Secondary Driver > Support a culture that balances a systems approach and individual accountability

An organization with a fair and just culture does not quickly assign blame for medical errors, but encourages employees to report unsafe conditions and adverse events. It also allows an organization to seek an understanding of the underlying cause of variability.[25] Human errors and many at-risk behavior errors result from system design (latent errors) and will not be eliminated by punitive measures. It is important to console the caregiver in these instances. James Reason's Unsafe Acts Algorithm (Appendix II) is often used to help determine accountability when an adverse event occurs. This tool helps to distinguish between individual negligence and systemic failure.[26]

Change Ideas

+ Look at processes and systems in addition to personnel when investigating adverse events and near misses.
+ Use a standard approach to distinguish human errors and at-risk behaviors from reckless behavior. Include the human resources department in the development and implementation of this approach.
+ Create a process to quickly attend to the emotional needs of health care workers involved in an adverse event.

+ Identify behavioral choices, the underlining system issues that drive them and contribute to near misses or safety events and then create action plans to address findings.
+ Identify process errors, equipment absence or failures that lead to at-risk behavioral choices and create action plans to address findings.

Suggested Process Measures for Your Test of Change

• Percent of adverse events where caregivers involved received emotional support
• Percent of adverse events and near misses that utilized a standardized algorithm to determine level of individual accountability

Secondary Driver > Create a reporting mechanism that is easy to use, meaningful and has a built in feedback process

Building on a culture of trust, an organization must learn from its mistakes and makes changes to unsafe conditions. The organization must actively seek out information on the current state of performance and uses this information to guide improvements and develop a culture of learning and improvement. Anonymous reporting mechanisms have been shown to increase reporting and resulting improvements.[27]

Change Ideas

+ Reward units for the most reports.
+ Feedback information about adverse events and near-misses.
+ Include staff in the development and testing of changes considered in response to reported events.

Suggested Process Measure for Your Test of Change

• Percent of adverse events and near misses that resulted in completed action plans

Secondary Driver > Promote reflective learning and improvement (learning loop)

Incident reports, near misses and observations of unsafe conditions provide valuable information to help understand the boundaries of safe performance and to guide implementation of corrective actions. To be effective, an incident reporting system must be accessible and easy to use. The value of reporting is reinforced through improvement actions, dissemination of lessons learned and direct feedback to the reporter.

Change Ideas

+ Encourage reporting errors and near misses to enable early identification of system issues.
+ Identify, reduce and learn from patient safety incidents identified through trigger tools, adverse events and incident reporting.
+ Analyze adverse events and near misses for common causes.
+ Disseminate learnings from adverse events and aggregate analyses.

Suggested Process Measures for Your Test of Change

• Number of errors and near misses reported (As an organization encourages increased reporting the number of events reported should initially increase)
• Percent of events and near misses analyzed and aggregated to determine common behavior, process or systems issues

Hardwire the Process

Leaders' actions prior to, during and after an adverse event are critical to hardwiring a culture of trust and teamwork. Organizations that acknowledge at-risk behavior in a non-punitive way and seek to prevent those behaviors in the future and create employees who will do the same for one another. 'Closing the loop' is an essential ingredient to effectively hardwiring a learning culture. Dissemination of findings, the creation of action plans and following through with those action plans must occur.

Primary Driver > Build a Work Environment to Enable Staff to Provide Safe, Quality Care

A key factor of successfully establishing a culture of safety is the organizational commitment of resources to address safety concerns.[28]

Secondary Driver > Design and ensure a safe work environment

Integrating worker and patient safety means creating an environment free of physical and psychological harm and reducing workplace violence and injury. Harm can result from hazards such as blood borne pathogens and needle sticks, patient handling, staff-to-staff violence and patient-to-staff violence.

Clinicians and staff cannot make the environment safer for patients if they do not feel safe and valued.[29] Worker safety issues also contribute to turnover, litigation and lost work hours.

Change Ideas

+ Provide a work environment with adequate lighting and security and that is free from hazards.

+ Regularly conduct a hazard assessment for conditions that might contribute to slips, trips and falls as well as needle stick injuries, musculoskeletal injuries and workplace violence.

+ Implement policies to reduce worker fatigue.

+ Establish a Safe Patient Handling program.

+ Train staff on risk factors for violence in the health care setting and control measures available to prevent violent incidents.

Suggested Process Measures for Your Test of Change

• Percent of hazards identified through regular assessment that were addressed in a timely fashion

• Percent of nursing shifts that were greater than 12 hours[30]

Secondary Driver > Provide training on processes to support and improve patient and worker safety

When modifying or implementing process, allow ample time to train staff, correct old habits, clarify any questions and make adjustments. Staff competency in safety knowledge and skills creates a workforce more likely to recognize potential hazards before they occur.

Change Ideas

+ Convey the importance of a new process by linking it to patient and worker safety.

+ Embed new processes into an improved work flow instead of adding it to existing work flow.

+ Utilize simulation training to improve technical skills and communication.

+ Confirm adequate training and orientation of temporary staff, including registry, travelers and physicians. Ensure training is both workplace and job specific.

+ Train staff in safety knowledge and skills.

Suggested Process Measure for Your Test of Change

• Percent of staff that attend at least one simulation training annually

Secondary Driver > Furnish staff with necessary equipment and supplies

Many interventions to improve patient and worker safety require equipment and supplies. For example, prevention of health care infections requires personal protective equipment (PPE) and immediate access to hand soap or gel. If PPE is not readily available and conveniently located, its use will be diminished.

Change Ideas

+ Solicit input from staff before purchasing equipment, e.g., patient lifts.

+ Ensure equipment and supplies are accessible when needed.

+ Provide equipment training for use and cleaning.

+ Follow-up with staff to confirm equipment and personal protective gear is being used, and if not understand why.

Suggested Process Measures for Your Test of Change

• Percent of providers using PPE when warranted

• Percent of providers using safe patient handling equipment when warranted

Hardwire the Process

Establish processes to regularly observe staff implementation of safe practices and use of equipment and PPE in addition to assessing for hazards. Use these opportunities to educate staff when recommended practices are not followed and also to elicit reasons for the 'at-risk behavior.' Aggregate information and implement action plans to address findings.

Implement Small Tests of Change

Implement safety huddles to increase safety awareness.

Begin leadership rounds on safe patient handling.

PLAN

Example Test: Begin testing a safety huddle on one unit, on one shift.

Example Test: Focused, leadership rounds will occur on one unit, one shift.

DO

Example Test: Direct care providers test the safety huddle, discussing recent situations where patient or staff safety was threatened, the causes, potential solutions and a follow-up plan.

Example Test: One nursing leader tests focused leadership rounds, engaging front line staff in discussions about safe patient handling, any barriers and suggestions for improvement.

STUDY

Example Test: After the safety huddle, the team debriefs to ask questions, such as:

- "Were there any challenges with the safety huddle?"
- "Did everyone feel comfortable bringing up safety concerns?"
- "How much time did it take to complete safety huddle?"
- "Are there any suggestions for modifications to the safety huddle process?"

Example Test: After the leadership rounds, the team debriefs to ask questions of both the nursing leader and staff that participated.

- To the nursing leader:
  - > "Were there any challenges with conducting the focused leadership rounds?"
  - > "Do you feel staff were engaged, open and honest?"
- To the front-line staff:
  - > "Did you feel comfortable discussing issues around safe patient handling?"
- To all:
  - > "Was an action or follow-up plan established?"
  - > "How can these focused leadership rounds be improved?"

ACT

Example Test: Make any recommended changes and retest to determine if the changes lead to an improvement. If no changes are suggested, plan additional testing with another shift the following day.

Example Test: Make any recommended changes and retest with another shift the following day to determine if the changes lead to an improvement. If no changes are suggested, plan additional testing with another unit.

Identify Potential Barriers

- Changing behavior is difficult because people have very strong patterns that they follow from habit. Staff will resist change unless the change is framed with positive outcomes.

- The lack of an effective communication structure from the top to the bottom of the organization can hinder improvement.

- Management styles may differ between departments, creating inconsistencies in the message and response to incidents.

- Systems and structures are not always designed to support teamwork.

Enlist Administrative Leadership as Sponsors to Help Remove or Mitigate Barriers

- Make patient and worker safety the number one goal of the organization and provide adequate staffing and resources.

- Assign a senior leader to lead safety culture efforts.

- Demonstrate commitment to a culture of safety through visible actions of all senior leaders

Change not only "The Practice" but also "The Culture"

- Promoting changes in culture can be very challenging. After nearly two decades of a national focus on patient safety, this focus has shifted to integrating worker safety with patient safety. Incorporating worker safety into existing practices, e.g., safety huddles and leadership rounds, will streamline this change.

- Leaderships' commitment and actions are crucial to furthering a culture of safety. It also requires staff participation at all levels. An organization must foster a culture where everyone feels responsible for staff and patient safety.

PART 4: CONCLUSION & ACTION PLANNING

Implementing and achieving a culture of safety that integrates patient safety with worker safety requires changes in attitudes, beliefs and behaviors. It is not quickly nor easily accomplished. Understanding the key components of a safety culture that integrates patient safety with worker safety and assessing the current organizational culture are integral steps to achieving a culture of safety. Leadership and employee commitment are the hallmark of a true safety culture where safety is an integral part of daily operations.

APPENDIX I: CULTURE OF SAFETY TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions for establishing a culture of safety in your facility

Reference: www.hret-hen.org

2016 Safety Culture Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Include patient and worker safety in presentations to the board.	☐	☐	☐	
Use standard approach to distinguish human errors and at-risk behaviors from reckless behavior.	☐	☐	☐	
Create a process to quickly attend to the emotional needs of health care workers involved in an adverse event.	☐	☐	☐	
Identify process errors, equipment absence or failures that lead to at-risk behavioral choices and create action plans to address findings.	☐	☐	☐	
Implement Leadership WalkRounds™.	☐	☐	☐	
Standardize handoff communication.	☐	☐	☐	
Analyze and aggregate adverse events and near misses to determine common causes.	☐	☐	☐	
Conduct a hazard assessment for conditions that might contribute to slips, trips and falls as well as needle stick injuries, musculoskeletal injuries and workplace violence.	☐	☐	☐	
Implement a Safe Patient Handling program.	☐	☐	☐	
Train staff on the risk factors for violence in a health care setting and the control measures available to prevent violent incidents.	☐	☐	☐	

APPENDIX II: UNSAFE ACTS ALGORITHM

Associated Hospital/Organization: James Reason

Purpose of Tool: To help determine accountability when an adverse event occurs, distinguishing between individual negligence and systemic failure

Reference: http://www.patientsafety.va.gov/docs/joe/just_culture_2013_tagged.pdf
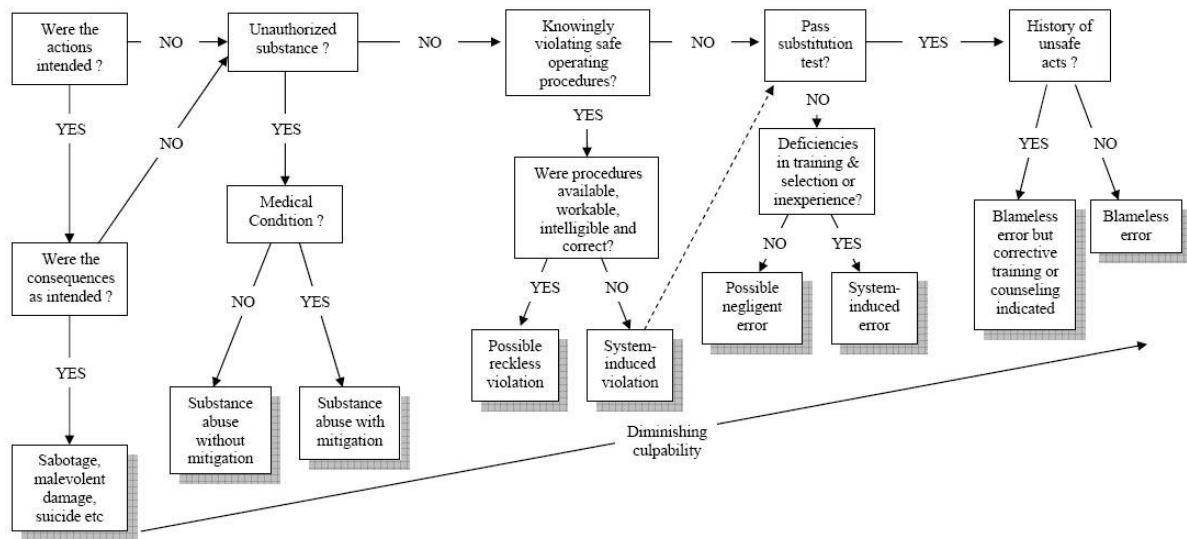
Associated Hospital/Organization: Minnesota Department of Health

Purpose of Tool: To identify gaps in policies and procedures to prevent workplace violence

Reference: http://www.health.state.mn.us/patientsafety/preventionofviolence/preventingviolenceinhealthcaregapanalysis.pdf

Preventing Violence in Healthcare Gap Analysis

	Preventing Violence in Healthcare	Specific Actions(s)	Audit Questions	Yes	No	If answered question "No" – identify the specific action plan(s) including persons responsible and timeline to complete.
S	Safety Coordination – Violence Prevention Program	1) Senior Leadership declares violence prevention a priority.	1a) Violence prevention is aligned with the quality and safety plan (e.g., violence prevention is visible on meeting agendas).	☐	☐	
			1b) The organization provides resources for violence prevention (e.g., time, materials, funding).	☐	☐	
		2) Assembles a violence prevention team.	2a) There is a designated individual(s) to coordinate and lead the organization's violence prevention program.	☐	☐	
			2b) The designated individual(s) has dedicated time to coordinate and lead in this role.	☐	☐	
			2c) The organization promotes a team approach to violence prevention with an interdisciplinary violence prevention team comprised of clinical and non-clinical staff.	☐	☐	
			2d) The team has at least one member that has subject matter expertise in violence prevention and/or is willing to attend additional training/education (e.g., de-escalation techniques, behavioral management).	☐	☐	
			2e) The interdisciplinary team includes representation from across the organization (e.g., nursing, medical staff, security, occupational health, human resources, local law enforcement).	☐	☐	
		3) Violence prevention team is responsible for overseeing an action plan for violence program planning, implementation and evaluation.	3a) An interdisciplinary team oversees the action plan for the violence prevention program.	☐	☐	
			3b) The action plan includes education of staff.	☐	☐	
			3c) The action plan is reviewed by the team and updated at least annually.	☐	☐	
			3d) The violence prevention program includes prevention practices for general populations and special populations such as mental health, emergency room and geriatric patients as appropriate.	☐	☐	
			3e) A process is in place to engage all levels of staff in the violence prevention planning process.	☐	☐	
			3f) The violence prevention team reviews and recommends changes to policies/procedures and training as needed.	☐	☐	

		4) Provides resources and support for violence prevention program.	4a) The organization has a process in place to report to senior leadership on the status of violence prevention efforts.		☐	☐	
			4b) Senior leadership responds to updates with continued support, resource allocation and assistance with barriers that are encountered.		☐	☐	
		5) Collaborates with local law enforcement	5a) The organization has a process for ongoing communication with local law enforcement to discuss updates on violence prevention and issues within the organization.	N/A ☐	☐	☐	
			5b) The organization works with local law enforcement to develop a role for law enforcement with violence prevention procedures and response plans at the organization.	N/A ☐	☐	☐	
A	**Accurate and Concurrent Reporting**	**Data Collection** 1) Collect data on all incidents of violence	1a) The organization has a timely reporting process (such as occurrence reporting) in place to collect information on all incidence of violence within the facility.		☐	☐	
			1b) The event documentation system (electronic or paper) is designed to capture sufficient detail about the event to allow for adequate event analysis.		☐	☐	
			1c) The organization has a central place where all reports of violence are collected and data is aggregated.		☐	☐	
			1d) The organization's data collection process captures (at a minimum) all of the suggested data elements on incidence reports. See toolkit for suggested elements.		☐	☐	
		Data Analysis 2) Analyze violent incident data for common factors and determine if interventions are effective.	2a) A process is in place for the violence prevention team to review and analyze reported incidents of violence on a regular basis		☐	☐	
			2b) Results of analysis used for learnings and improvement opportunities.		☐	☐	
			2c) Violence data is shared across the organization on a regular basis.		☐	☐	
			2d) Violence cases are routinely shared (through staff stories as well as through data) across the organization.		☐	☐	

F	**Facility Culture and Accountability**	1) Clearly communicate roles for violence prevention.	1a) Clinical staff understands their role regarding violence risk screening, assessment and intervention to prevent and mitigate acts of violence.	☐	☐	
			1b) A process is in place to assure non-clinical staff understands their role in the prevention and mitigation of acts of violence.	☐	☐	
		2) Implement strategies toward a violence free workplace	2a) There is a process in place for ongoing communication from leadership to staff that violence is not an accepted part of their job.	☐	☐	
			2b) There is a process in place for ongoing communication from leadership to patients/visitors that violence will not be accepted (e.g., signage, patient handouts and visitation guidelines).	☐	☐	
			2c) Organization uses information from reports and lessons learned to inform staff of what actions are being taken after events to prevent future violence.	☐	☐	
		3) Clearly communicate expectations of incident reporting.	3a) All staff (and security where applicable) confronted violent behavior are expected to report these behaviors through the organization's incident reporting system.	☐	☐	
			3b) All staff are supported by leadership in reporting all acts of violence or threats of violence.	☐	☐	
			3c) There is a process in place for ongoing communication from leadership to staff about expectations of full reporting of violent incidents.	☐	☐	
		4) Communicate daily about risk factors and high risk patients.	4a) The organization has a process in place to facilitate communication at the patient care level about patients/visitors at high-risk for violence and potential situations (e.g., daily morning huddle, shift report).	☐	☐	
		5) Frequent rounding by security	Where applicable, the organization has instituted purposeful security rounding for all patients which includes:			
			5a) A structured process for conducting rounding including clear expectations of components covered during rounds. N/A ☐	☐	☐	
			5b) Involvement of front-line staff and security in the development of rounding process. N/A ☐	☐	☐	

E	Staff education	1)	Provide violence prevention/mitigation education for all staff	1a)	Expectations and supporting education have been incorporated into new employee orientation for clinical and non-clinical staff, including, at a minimum: • Identifying situations with potential for violence • De-escalation strategies • Environmental risk assessments • Personal safety strategies • Conducting patient-specific risk assessments • Reporting of violent incidents	☐	☐	
				1b)	Expectations and supporting education have been incorporated into new employee orientation for contracted staff (e.g., contracted security staff).	☐	☐	
				1c)	Expectations and supporting education have been incorporated into all new provider orientation (including contracted providers)	☐	☐	
				1d)	Ongoing violence prevention education for all staff and providers is provided at least annually.	☐	☐	
				1e)	A process is in place to offer additional conflict and crisis intervention education, to include, de-escalation techniques training to staff working in areas prone to violence, as identified by the organization.	☐	☐	
				1f)	Members of the violence prevention team have additional training on violence prevention so that they can serve as resources to their patient care areas (this may be provided through the violence prevention champions or outside opportunities).	☐	☐	
		2)	Ensures staff familiarity with emergency policies and procedures	2a)	A process is in place to ensure staff know and are familiar with the operation of their organization's emergency devices where applicable (e.g., personal alarms, restraints). N/A ☐	☐	☐	
				2b)	A process is in place to ensure all staff are familiar with how and when to call for an emergency response team (if applicable) in the event of an act of violence or threat of violence. N/A ☐	☐	☐	
				2c)	Organizational emergency response plan is integrated with the emergency preparedness plan as appropriate (active shooter, bomb treat, etc.).	☐	☐	

				Yes	No	
	3)	Identify non-patients/visitors at high risk for violence	3a) All staff have been trained to identify non-patients/visitors at risk or exhibiting at risk behaviors for violence.	☐	☐	
			3b) A structured process is in place for sharing information regarding high-risk non-patients/visitors with appropriate staff members (e.g., security).	☐	☐	
	4)	Coordinate organizational risk assessments	4a) Departmental and organization wide environmental risk assessments are performed at least annually.	☐	☐	
			4b) A process is in place to coordinate risk assessments with security, environmental safety and other departments as necessary and applicable. N/A ☐	☐	☐	

Specific Action(s)	Gap Analysis Questions	Yes	No	If answered question "No" – identify the specific action plan(s) including persons responsible and timeline to complete.
**Risk Identification**			
1) Formally screen and re-screen all inpatients for violence risk.	1a) The organization uses standard, reliable violence risk screening tools (i.e., BROSET tool or other standardized tool) to screen all inpatients for violence risk.	☐	☐	
	1b) The organization requires, AND has a designated place to document, formal screening of all inpatients within 8 hours of admission for inpatients.	☐	☐	
	The organization requires, AND has a designated place to document, re-screening of patient risk:			
	1c) at a frequency designated by the organization;	☐	☐	
	1d) with change in status/condition or if new information becomes available regarding violence risk (e.g., post procedure, high-violence risk medication change);	☐	☐	
	1e) post violent incident	☐	☐	
2) Identify outpatients at high risk for violence.	A structured process is in place to identify outpatients at risk for violence:			
	2a) In the Emergency Department	☐	☐	
	2b) In other outpatient areas identified by the organization as higher risk areas for violent incidents.	☐	☐	
3) Identify non-patients/visitors at high risk for violence	3a) All staff have been trained to identify non-patients/visitors at risk or exhibiting at risk behaviors for violence	☐	☐	

			☐	☐	
		3b) A structured process is in place for sharing information regarding high-risk non-patients/visitors with appropriate staff members (e.g., security).	☐	☐	
4)	Coordinate organizational risk assessments	4a) Departmental and organization wide environmental risk assessments are performed at least annually.	☐	☐	
		4b) A process is in place to coordinate risk assessments with security, environmental safety and other departments as necessary and applicable.	☐	☐	

Linked Interventions

1)	Communicate patient violence risk status as part of hand-off systems.	1a) A system is in place to alert all appropriate staff to the patient's violence-risk status.	☐	☐	
		1b) There is a process in place for communication of patient's violence risk during hand-offs or transitions.	☐	☐	
2)	Link risk analysis findings to specific interventions to individualize violence prevention plan of care.	2a) The organization has a process in place to focus interventions on specific risk factors rather than on general risk score.	☐	☐	
		2b) The organization has decision-support tools accessible (electronic or paper) that provides staff with the intervention options that should be considered based on risk score/risk factors.	☐	☐	
		2c) A process is in place for clearly defined roles regarding which staff is responsible for choosing interventions.	☐	☐	
		2d) A process is in place for documentation of chosen interventions and/or revised plan of care.	☐	☐	
		2e) A process is in place for staff to complete an individualized treatment plan for applicable patients that responds to identified risk factors and review and revise that plan as needed.	☐	☐	
3)	Link risk identification findings to specific responses for non-patients/visitors.	3a) The organization has decision-support tools accessible (electronic or paper) that provide staff with response options that should be considered for non-patients/visitors that are identified at risk for violence.	☐	☐	

Incident Response

1)	Organization has an emergency response plan for violence.	The organization has a defined violence response plan (e.g. violence rapid response team) which includes, at a minimum:			
		1a) Clear roles for staff	☐	☐	
		1b) Clear process for staff to initiate the violence response plan in the event of a violent incident or threat of violence.	☐	☐	
		1c) Plan for conducting drills of the violence response plan at least annually.	☐	☐	

2)	Support all staff after incidents	2a) A process is in place to have immediate evaluation of all staff/visitors involved in violent incidents evaluated by medical staff.	☐	☐	
		2b) A process is in place to assure appropriate support and resources are provided to involved staff/patients/ visitors immediately and on an ongoing basis (e.g. law enforcement, EAP, EOHS).	☐	☐	
		2c) A process is in place to support staff in their right to file a police report after a violent incident/threat of violence occurs.	☐	☐	
3)	Organization has a business continuity and recovery plan in place	3a) Business continuity and recovery plan includes, but is not limited to: • Policies and procedures regarding making appropriate insurance notifications after applicable violent events, such as workers 'compensation • Communication plan for internal and external (if applicable) audiences following high-profile events that is consistent with state, federal and organizational privacy requirements	☐	☐	

Learn from Events

1)	Conduct post event huddles/ debriefs.	1a) A process is in place to conduct a post-event huddle with affected staff as soon as possible after any violent event as defined by policy.	☐	☐	
		1b) A process is in place to follow-up on any issues raised in huddles.	☐	☐	
2)	Conduct analysis of events.	2a) A process is in place to conduct a root cause analysis (RCA) and/or common cause analysis of violent events as defined by policy.	☐	☐	
		2b) A process is in place for violence prevention team and/or leadership to review analyses.	☐	☐	
		2c) A process is in place for learnings from analyses to be shared across the organization.	☐	☐	

APPENDIX IV: GAP ANALYSIS FOR SAFE PATIENT HANDLING

Associated Hospital/Organization: Minnesota Hospital Association

Purpose of Tool: To identify gaps is safe patient handling practices

Reference: http://www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/patient-handling

Specific Action(s)	SAFE LIFT Component: PROGRAM COORDINATION SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
1. Promote a team approach to safe patient handling program with a designated coordinator(s).	a. The facility promotes a team approach to safe patient handling with an interdisciplinary team comprised of clinical and non-clinical staff.				
	b. The facility has a designated coordinator(s) for the facility's safe patient handling program.				
	c. The coordinator(s) has dedicated time to serve in this coordination function.				
	d. The facility has designated a direct patient care staff champion(s) for each unit/department for safe patient handling.				
	e. The facility has designated a physician champion for safe patient handling.				
	f. The facility has defined champion(s) roles and expectations.				
	g. The facility provides support and allotted time for champions to serve in this role, e.g., time for coaching, equipment training, conducting safety huddles, and facilitating meetings.				
2. Identify an interdisciplinary group that is responsible for overseeing a strategic plan for safe patient handling program planning, implementation and evaluation.	a. The facility has an interdisciplinary committee in place to oversee the strategic plan for the safe patient handling program.				
	The composition of the committee and the committee's roles meet the requirements of Minnesota Statute including: (2b – 2f)				
	b. At least half of the committee members are non-managerial nurses and other direct patient care workers.				
	c. The safe patient handling program plan and progress is reviewed by the committee and updated on an annual basis.				
	d. The committee recommends how the organization will incorporate safe patient handling needs during new construction or remodeling of patient care areas.				
	e. The committee makes recommendations on the purchase, use, and maintenance of an adequate supply of appropriate safe patient handling equipment.				
	f. The committee completes a patient handling hazard assessment.				
	g. The impact of an effective safe patient handling program on staff and patient safety.				
	h. Staff injury data				
	i. Patient injury data				
	j. Cost savings related to injury prevention				
	k. Regulatory requirements				
	l. Implementation plan				
	m. The business case is presented to administration and a preliminary budget is approved for equipment and program costs.				

Specific Action(s)	SAFE LIFT Component: PROGRAM COORDINATION SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
(continued) 3. Identify an interdisciplinary team that is responsible for implementing the safe patient handling program.	a. The facility has an interdisciplinary team involved in implementing the safe patient handling program, including representation from across the facility (e.g., nursing, therapy staff, facility engineering, supply chain, radiology, surgery, transport, environmental services, biomed, employee and patient safety).				
	b. The facility has a process in place to engage other team members, such as staff responsible for the falls program, infection prevention, wound care, purchasing, education and communication, in the safe patient handing program as appropriate.				
	c. Policies are in place, and reviewed on a regular basis, to address safe patient handling.				
	d. Department specific work standards are in place to address their patient population-specific needs for safe patient handling.				

Specific Action(s)	SAFE LIFT Component: ACCURATE AND CONCURRENT REPORTING SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
Data Collection 1. Collect data on staff and patient injuries related to patient handling issues.	a. The facility has a concurrent (real-time) reporting process (such as occurrence reporting) in place to collect information on all staff and patient injuries related to patient handling issues.				
	b. The facility's documentation system (electronic or paper) is designed to capture sufficient detail about the event to allow for adequate event analysis.				
Data Collection 1. Collect data on staff and patient injuries related to patient handling issues	*The event documentation system collects the following information related to pt moving injuries, at a minimum: (1c – 1g)*				
	c. Specific type of transfer task, e.g., transfer out of bed, to chair or commode, lateral transfer, re-positioning, up from floor after fall, ambulation, preventing a patient fall.				
	d. Information to triage patient handling events vs. issues related to patient behavior/violence.				
	e. Equipment information, e.g., types of equipment being used and types of equipment available at time of event or near miss.				
	f. Patient fall risk level.				
	g. A narrative of the event or near-miss.				
Data Analysis 2. Analyze patient handling data for common factors.	a. A process is in place to review and analyze reported event information on a regular basis for learnings and improvement opportunities.				
	b. Data are shared within units and across units on a regular basis, e.g., include in daily briefings, unit staff meetings, safety committees.				
	c. Data reports shared with staff provide information beyond injury rates to help staff understand patient handling injury trends, the cause(s) of the injuries, and learnings from the events.				

Specific Action(s)	SAFE LIFT Component: ACCURATE AND CONCURRENT REPORTING SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
(continued) **Data Analysis** 2. Analyze patient handling data for common factors.	d. Patient handling injury events are routinely shared through stories as well as through data, e.g., include in daily briefings, unit staff meetings, safety committees.				

Specific Action(s)	SAFE LIFT Component: FACILITY EXPECTATIONS AND ACCOUNTABLITY SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
1. Clearly communicate expectations.	a. Direct patient care staff, e.g., nursing, physicians, therapy, imaging, transport, EMT, surgery, is informed of expectations regarding safe patient handling.				
	b. Support staff, e.g., environmental services, supply chain, facilities/ operations, linen services, is informed of expectations regarding their role in safe patient handling.				
2. Administration provides resources and visible, active support for the safe patient handling program.	a. The facility has a process in place to provide administration with updates on the status of safe patient handling efforts and any factors that may enhance or limit success.				
	b. Leaders consider safe patient handling and the on-going evaluation of the program in strategic planning and resource allocation.				
	c. Leaders set clear expectations for prompt reporting of any possible staff or patient injury/incident related to patient handling.				
	d. Leaders and managers provide clear expectations for the consistent and appropriate use of lift equipment.				
	e. Leaders and managers support staff in the event of patient, family, provider, or caregiver refusal to use safe patient handling equipment.				
	f. Leaders and managers provide clear expectations that all dependent patients over 35 pounds are moved with equipment.				
	g. Leaders and managers provide clear expectations for how semi-independent, high fall-risk patients should be handled to balance safe lifting and movement with patient rehabilitation needs (with the goal of reducing caregiver patient handling loads at or below 35 pounds).				
	h. The facility has a clearly defined process for speaking up and "stopping the line" if a potential patient handling safety issue has been identified by staff. The process clearly outlines: • When to stop the line; • How to stop the line, e.g., "I need clarity"; • The chain of command to follow if not supported in stopping the line; • Clear communication to staff from managers and leadership that they will be supported if they speak up.				

APPENDIX IV: GAP ANALYSIS FOR SAFE PATIENT HANDLING CONTINUED

Specific Action(s)	SAFE LIFT Component: EDUCATION FOR STAFF, PATIENTS & FAMILIES (JC and SKD)	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
1. Provide safe patient handling education for staff.	a. Expectations and supporting education have been incorporated into new employee orientation for direct patient care staff, including managers/supervisors and leadership.				
	b. Equipment-specific education for direct care staff includes hands-on training with equipment-specific return demonstration and competency checklists as appropriate.				
	c. Expectations and supporting education have been incorporated into new employee orientation for support staff (for example, linen service, environmental service staff etc)				
	d. On-going safe patient handling education is provided at least annually.				
	e. Members of the safe patient handling team(s) (Such as SPM SuperUsers) have additional training on safe patient handling so that they can serve as resources to their units.				
	Note: The Safe Patient Handling Committee's role in the training of direct patient care staff is defined in Minnesota Statute 182.6553.				
2. Educate patient and families so informed decisions can be made and mutual goals can be established.	a. Patient mobility status information is incorporated into the patient fall prevention education process as appropriate for patient risk status.				
	The facility provides patient and family education related to safe patient handling, as appropriate, that includes information on (at a minimum): (2b – 2e)				
	b. Equipment that may be used during their treatment and stay.				
	c. The importance of equipment use.				
	d. Equipment that may be used during patient discharge (e.g., equipment needed to transfer into car).				
	e. Safe patient handling at home (provided during the discharge process).				

Specific Actions	SAFE LIFT Component: LIFT EQUIPMENT & PROCESSES SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
1. Analyze data.	*A process is in place to review and incorporate data as part of the needs assessment process which includes, at a minimum:*				
	a. Review of musculoskeletal injury data related to patient handling, including root causes and contributing factors.				
	b. Review of direct and indirect costs related to injuries.				
	c. Identification of high-risk areas based on data analysis.				
	d. Addressing high-risk areas during evaluation of equipment and patient handling practices.				

Specific Actions	SAFE LIFT Component: LIFT EQUIPMENT & PROCESSES SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
(continued) 2. Complete an analysis of safe patient handling processes.	a. Conduct an analysis of current safe patient handling policies and practices.				
	b. Identify gaps in current policies and practices that may contribute to patient handling injuries.				
	c. Develop strategies to address identified patient handling gaps.				
	d. Engage direct patient care staff in the mapping of current practices,identification of gaps and brainstorming solutions.				
	e. Include current safe patient handling policies and practices for populations with special handling needs, e.g., bariatrics, rehabilitation, operating room, orthopedics, neurology and radiology during the mapping of current practices, identification of gaps and solutions.				
3. Complete an assessment of patient handling and movement equipment needs.	a. An equipment inventory, including availability, storage and use, cleaning and maintenance.				
	b. Evaluation of physical environment needs, e.g., room configuration, showering facilities, ceiling height, carpeting, and thresholds.				
	c. Assessment of patient mobility levels, e.g., independent, supervision, assistance needed.				
	d. Identification of potential high-risk patient-handling tasks.				
	e. Identification of equipment needs for populations with special handling needs, e.g., bariatrics, rehabilitation, operating room, orthopedics, neurology and radiology.				
	Note: The Safe Patient Handling Committee's role in patient handling hazard assessments is defined in Minnesota Statute 182.6553.				
	f. Communicating to direct patient care staff the goals, importance and benefits of a comprehensive safe patient handling program.				
	g. Conducting surveys/interviews with staff to determine their perception and experience with high-risk pt handling tasks, general patient mobility status for their unit and special pt needs.				

Specific Action(s)	SAFE LIFT Component: IMPLEMENTATION SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
1. Develop safe patient handling policies and practices.	*Safe patient handling policies and practices are in place which address any gaps identified during the assessment process and include, at a minimum: (1a – 1d)*				
	a. Standard processes for determining equipment for primary patient handling tasks.				
	b. Standard processes for handling patient populations with special handling needs.				
	c. Plan for support services departments such as transport staff, materials management and environmental services.				
	d. Plan for safe patient handling to be incorporated as part of the discharge process.				
	e. Assessment of hazards with regard to patient handling.				
	f. Acquisition of an adequate supply of appropriate safe patient handling equipment.				
	g. Initial and ongoing training of nurses and other direct patient care workers on the use of equipment.				
	h. Procedures to ensure that physical plant modifications and major construction projects are consistent with program goals.				
	i. Annual review of the safe patient handling program.				
	Note: Necessary components that must be included in Safe Patient Handling written policies are defined in Minnesota Statute 182.6553.				
2. Evaluate and select equipment.	*A process is in place to evaluate and select equipment which includes, at a minimum: (2a – 2g)*				
	a. Based on the needs assessment findings, evaluate specific equipment, e.g., type, make and model, and number of mechanical devices and other patient movement equipment needed.				
	b. Assess physical environment, e.g., room configuration, showering facilities, ceiling height, carpeting, and thresholds to determine the type of equipment that can be supported and necessary modifications.				
	c. Assess equipment options using basic ergonomic design principles, e.g., grip strength required, repetitive motion, design of controls and displays.				
	d. Research equipment options (research includes discussions and on-site visits with colleagues from other facilities to gather feedback on equipment and vendor education and support resources).				
	e. Involve direct patient care staff in the evaluation, selection and piloting of new products.				
	f. Include review of potential equipment choices by interdisciplinary team members such as infection prevention and facilities/maintenance/biomed.				
	g. Develop a process for equipment trials, product evaluation feedback, and ordering of equipment.				
	h. Equipment is accessible to staff when needed.				
	i. Equipment is in working order.				

APPENDIX IV: GAP ANALYSIS FOR SAFE PATIENT HANDLING CONTINUED

Specific Action(s)	SAFE LIFT Component: IMPLEMENTATION SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
(continued) 2. Evaluate and select equipment.	j. A standardized process is in place for: • Equipment identification, e.g., matching sling with appropriate device. • Delivery of equipment to unit, if applicable. • Managing inventory, including availability, storage and use. • Cleaning and disinfection. • Maintenance.				
	k. Completion of necessary physical environment accommodations.				
3. Address patient mobility status.	a. The facility has a standard process to identify each patient's mobility status and if patient handling equipment is needed.				
	b. There is a process in place to link patient's mobility status and related equipment needs with fall risk when developing patient's care plan.				
	c. There is a system in place to alert all staff to the patient's mobility status.				
	d. There is a process in place for communication of patient mobility status during hand-offs between departments (e.g., transport form, verbal communication process).				
	e. There is a process in place for receiving departments to review mobility status information and implement appropriate strategies.				
	f. There is a process in place for assessment and communication of safe patient handling needs upon discharge (in next care environment).				
4. Develop a roll-out plan for the safe patient handling program.	a. The facility determines whether or not to roll out processes and equipment in a staged or facility-wide approach.				
	b. Information and resources on the safe patient handling program are communicated to all staff identified in the plan.				
	c. Safe Patient Handling Unit Champions and supervisory staff receive training on patient handling equipment and serve as resources to staff.				
	d. Direct patient care staff receives training, including equipment specific return demonstration competency checklist, on mechanical lift equipment prior to using equipment.				

Specific Action(s)	SAFE LIFT Component: FINE TUNING SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
1. Ongoing equipment management.	The facility has a process in place to address the following patient handling equipment issues on an on-going basis: (1a – 1j)				
	a. Conduct unit-level equipment needs evaluation at least annually.				
	b. Involve direct patient care staff in the on-going evaluation, selection and piloting of new products.				
	c. Track equipment locations, storage and ensure accessibility.				
	d. Track operational status and need for maintenance of equipment/batteries/slings.				
	e. Evaluate and replace equipment as needed.				
	f. Ensure annual/preventative maintenance is accomplished.				
	g. Track sling types, quantities, and condition.				
	h. Facilitate battery/sling/equipment orders when needed.				
	i. A standard process to notify appropriate department, e.g., maintenance, biomed, facilities management, when patient handling equipment problems/incidents arise.				
	j. Ensure facility and manufacturer infection control requirements are followed. Consider additional measures for equipment in C.diff/isolation rooms (e.g., deeper cleaning of wheels and foot plates).				
	Note: The Safe Patient Handling Committee's role in the purchase, use and maintenance of safe patient handling equipment is defined in Minnesota Statute 182.6553.				
2. Ongoing process improvement	The facility has a process in place to continuously review safe patient handling processes and revise as needed through: (2a – 2c)				
	a. On-going review of data, including staff injuries or near-misses.				
	b. Feedback from staff to identify equipment and patient handling issues.				
	c. On-going coordination with other unit champions including pressure ulcers, falls and infection prevention champions.				
	Note: The Safe Patient Handling Committee's role in conducting an annual evaluation plan and review progress is defined in Minnesota Statute 182.6553.				
3. Ongoing environmental/ ergonomic evaluations.	The facility has processes in place to address safe patient handling physical environment issues on an on-going basis, including:				
	a. During all remodeling or reconstruction of patient care areas as recommended by the Safe Patient Handling Committee and outlined in the program plan.				
	b. In response to issues identified through injury data.				
	c. In response to new technology evaluation and/or purchase.				
	d. Incorporation in regular environmental rounds, e.g., include safe patient handling considerations in falls environmental safety rounds.				
	e. A process to implement recommendations resulting from resulting from environmental safety rounds.				
	Note: The Safe Patient Handling Committee's role in the remodeling process is defined in Minnesota Statute 182.6553.				

Specific Action(s)	SAFE LIFT Component: TROUBLESHOOTING SAFE LIFT Audit Questions	Hospital Health & Site Specific Responses			
		Meets	Partially Meets	Does Not Meet	Comments
1. Conduct post-event safety incident analyses.	a. The facility has a process is in place to conduct a safety huddle after any patient lifting injury, or near miss, occurs.				
	b. The facility engages unit managers in post-event incident analysis.				
	c. The facility collects information and learnings from good catches.				
2. Address issues identified through safety huddles and incident analyses.	a. The facility has a process in place (which includes the unit manager) to develop and implement recommendations/ actions from safety huddles/ incident analysis/good catches.				
3. Recognize good catches.	a. The facility has a process in place to recognize staff and disseminate learnings from good catches.				

Associated Hospital/Organization: US Department of Labor/OSHA

Purpose of Tool: To identify opportunities for improvement related to safe patient handling

Reference: https://www.osha.gov/dsg/hospitals/documents/3.2_SPH_checklist_508.docx

Safe Patient Handling Program Checklist

I. Policy Development	In Place	Not Done	Will Adopt
A. A safe patient handling policy that eliminates manual lifting to the extent feasible is in place and communicated to all staff.	☐	☐	☐
It is important for a hospital to have a policy in place that is understood by all staff and reviewed on a regular basis. Systematic clarification of the roles and responsibilities of staff in the form of a written safe lifting policy helps maintain program sustainability.	**Notes** (timelines, responsibilities, etc.)		
B. Patients are made aware of the safe patient handling policy.	☐	☐	☐
Making patients aware of the safe patient handling policy will help patients understand how using patient handling equipment will benefit both them and their caregivers.	**Notes**		
C. Management reinforces the safe patient handling policy.	☐	☐	☐
Having management at all levels consistently reinforce the policy is critical.	**Notes**		

II. Management and Staff Involvement	In Place	Not Done	Will Adopt
A. Management fosters safe patient handling and a culture of safety.	☐	☐	☐
Successful programs embrace a culture of safety that includes safe patient handling, as employees appreciate knowing that senior managers care about their well-being.	**Notes** (timelines, responsibilities, etc.)		
B. A safe patient handling committee represents all levels.	☐	☐	☐
Hospitals should form committees that include a range of staff from all affected departments, including members representing administrators and frontline staff.	**Notes**		
C. Staff is involved during every step.	☐	☐	☐
Involve staff during every step of safe patient handling program implementation (e.g., hazard assessment, technology procurement, education and training, program evaluation).	**Notes**		
D. Super users, safety coaches, or champions exist in each unit.	☐	☐	☐
Safety coaches, "champions," or "super users" continually remind and educate their peers about the program, answer questions, troubleshoot issues, and promote the culture of safety. There should be a dedicated staff member who fills this role in each unit.	**Notes**		
E. The safe patient handling program has nurse manager support.	☐	☐	☐
Nurse managers also need to support and reinforce safe patient handling with staff in every unit.	**Notes**		

Safe Patient Handling Program Checklist

	In Place	Not Done	Will Adopt
F. Laundry, maintenance, and engineering staff support the safe patient handling program. *It is essential that departments such as laundry, maintenance, and engineering understand how vital they are to support a hospital's safe patient handling program.*	☐	☐	☐
Notes			

III. Needs Assessment

	In Place	Not Done	Will Adopt
A. Mobility assessment criteria are established and applied to each patient. *Every patient has unique characteristics and mobility capabilities that need to be assessed on a regular basis.*	☐	☐	☐
Notes (timelines, responsibilities, etc.)			
B. A patient handling plan is communicated for each patient. *Once each patient's level of mobility and need for assistance is assessed, that information needs to be communicated to all relevant caregivers.*	☐	☐	☐
Notes			

IV. Equipment

	In Place	Not Done	Will Adopt
A. Frontline staff is involved in selecting equipment. *The workers who actually move and transfer patients are a valuable resource when determining the most effective equipment.*	☐	☐	☐
Notes (timelines, responsibilities, etc.)			
B. Equipment is chosen based on units' needs. *Individual units may have different movement and transfer needs, so make sure to involve staff from all units.*	☐	☐	☐
Notes			
C. Equipment is convenient, available, and accessible. *Having appropriate and easy-to-use safe patient handling equipment conveniently located encourages routine use.*	☐	☐	☐
Notes			
D. Equipment cleaning and maintenance systems are in place. *Equipment needs to be maintained properly and charged at all times. Responsibility for cleaning equipment should be clearly designated.*	☐	☐	☐
Notes			
E. Partnership with vendor(s) is considered. *Vendors can help to develop safe patient handling specifications, troubleshoot issues, answer questions, and maintain equipment.*	☐	☐	☐
Notes			

Safe Patient Handling Program Checklist

F. Construction and remodeling projects take safe patient handling considerations into account.

When undertaking construction and remodeling at a hospital, it is more effective to design with safe patient handling in mind than to retrofit afterward.

☐ ☐ ☐

Notes

V. Education and Training	In Place	Not Done	Will Adopt

A. All relevant staff is trained on using equipment.

If the caregiver uses the equipment correctly and efficiently, patients will feel more comfortable.

☐ ☐ ☐

Notes (timelines, responsibilities, etc.)

B. All staff is educated on the importance of safe patient handling.

By educating all staff, including physicians, about the safe patient handling program, hospitals can reduce instances of a clinician asking—or expecting—colleagues to move patients manually.

☐ ☐ ☐

Notes

C. Staff is trained on equipment annually.

Including safe patient handling in annual competency reviews helps promote the program and equipment proficiency.

☐ ☐ ☐

Notes

D. Patients/families are educated on policy/equipment.

Educating patients and their family members about your hospital's policy and use of equipment will engage them in the safe patient handling process.

☐ ☐ ☐

Notes

VI. Program Evaluation	In Place	Not Done	Will Adopt

A. Metrics are tracked to evaluate program success.

You can track the success of your program by examining the number and type of staff injuries, specific activities that led to these injuries, number of lost work or modified duty days, and the effectiveness of the safe patient handling policy. Consulting your OSHA 300 logs and your supplemental 301 or workers' compensation forms can be an excellent way to gather this information.

☐ ☐ ☐

Notes (timelines, responsibilities, etc.)

B. Improvements to the safe patient handling program are considered.

Every program needs adjustment after being put into practice. Even small changes can improve safe patient handling tremendously in your hospital.

☐ ☐ ☐

Notes

For more information on safe patient handling, visit www.osha.gov/dsg/hospitals.

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Purpose of Tool: To identify opportunities for improvement related to safe patient handling

Reference: https://www.osha.gov/dsg/hospitals/documents/3.8_SPH_self-assessment_508.pdf

Safe Patient Handing

A Self-Assessment

Patient lifting, repositioning, and transfers represent some of the most common—and most preventable—sources of injury for employees in the healthcare industry, particularly musculoskeletal disorders (MSDs). Use this brief question-naire to examine the number and nature of patient handling injuries in your hospital, identify what you are already doing well, and identify opportunities for improvement. You can review data for the most recent year, or you can review three or more years of data to look for trends over time.

Step A: Understand the magnitude of the problem.

Review your hospital's OSHA-recordable injury log, check workers' compensation records, and consult with human resources to quantify employee MSDs from patient handling events and the associated costs.

1. How many OSHA-recordable injuries resulted from patient handling activities such as lifting, repositioning, or lateral transfers?

2. What percentage of our total OSHA-recordable injuries resulted from patient handling activities?

3. How many days away, restricted, or transferred (e.g., lost-time or light-duty days) resulted from patient handling injuries?

4. What was the total cost of all our workers' compensation claims associated with patient handling injuries (medical cost, wage replacement, etc.)?

5. What was the average cost of each patient handling-related workers' compensation claim?

6. If our hospital tracks "near misses," precursor events, or other non-OSHA-recordable incidents, how many of these incidents are related to patient handling?

7. How many employees left the hospital (including early retirement, career change, and permanent disability) at least in part due to injuries associated with patient handling?

> *For reference, in 2011, 32.7 percent of recorded hospital worker injuries nationwide that resulted in days away from work were associated with patient interactions, and nearly three-quarters of these patient-related injuries were classified as MSDs. Hospitals that have focused on safe patient handling have MSD rates below the national average.*

Step B: Find out who is getting hurt, where, and how.

By identifying the occupations or root causes of activities with the highest risk of injury, you can target interventions effectively.

8. Which occupations (registered nurses, nursing assistants, etc.) experience the highest rates of patient handling injuries in our hospital?

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Safe Patient Handling: A Self-Assessment

9. Which units (departments, floors, wards) have the highest rates of worker injuries associated with handling patients?

10. Which activities (lifting, repositioning in bed, lateral transfers, etc.) account for the highest number or severity of injuries?

Step C: Explore the effects on patient care.

Explore how your current patient handling policies and procedures might affect patient care. Manual lifting, repositioning, or transfer can increase patients' risk of falls, fractures, bruises, and skin tears (pressure ulcers). Safe patient handling with mechanical equipment has been shown to reduce this risk.

11. What was our rate of hospital-acquired pressure ulcers (Stage III and IV) per 1,000 patients?

> To learn more about how to calculate the pressure ulcer incidence rate for your hospital, see http://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec.aspx.

12. What was our rate of patient falls with injury per 1,000 patient days?

13. How many patient injuries are known to have occurred during a manual lift, repositioning, or transfer?

Step D: Identify existing strengths and opportunities for improvement.

Use the questions below to identify good programs and practices in place in your own hospital and to initiate conversations about opportunities to do better.

14. Do we have a written safe patient handling policy or program? If yes, are all employees aware of this program and its contents?

15. Does our program minimize the use of manual lifting, repositioning, or transfers (e.g., through a "minimal lift" policy)?

16. Do we provide our caregivers with easy access to equipment (e.g., slide sheets, portable or ceiling-mounted lifts) to assist with patient handling tasks?

17. Which units or activities in particular could benefit from an increased emphasis on safe patient handling programs, policies, and equipment? For example, which units and activities stood out in Step B? Does the hospital have special accommodations for bariatric (obese) patients?

18. Are we planning any renovation or new construction projects that could integrate patient handling considerations in the design (e.g., installing or providing storage for patient handling equipment)?

19. How many safe patient handling best practices do we currently have in place?

> **Take the next step!**
> Visit OSHA's website at www.osha.gov/dsg/hospitals for best practices, case studies, resources, and tools to help you protect your employees and patients through a safe patient handling program.

This document is advisory in nature and informational in content. It is not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by OSHA standards or the Occupational Safety and Health Act.

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