Through the Eyes of the Workforce
Creating Joy, Meaning, and Safer Health Care

Julianne Morath, RN, MS
Hospital Quality Institute
President and Chief Executive Officer
MISSION STATEMENT

The Lucian Leape Institute at the National Patient Safety Foundation is dedicated to providing thought leadership and strategic vision for the field of patient safety.
The LLI Membership

Lucian L. Leape, MD
Chair, Lucian Leape Institute
Adjunct Professor of Health Policy
Harvard School of Public Health

Gary S. Kaplan, MD, FACMPE
Chairman and CEO
Virginia Mason Medical Center

Diane C. Pinakiewicz, MBA, CPPS
President, Lucian Leape Institute
President, National Patient Safety Foundation

Julianne M. Morath, RN, MS
Chief Quality and Patient Safety Officer
Vanderbilt University Medical Center

Carolyn M. Clancy, MD
Director
Agency for Healthcare Research and Quality

Dennis S. O’Leary, MD
President Emeritus
The Joint Commission

Janet M. Corrigan, PhD, MBA
Consultant

Paul O’Neill
Former Chairman and CEO
Alcoa
72nd Secretary of the US Treasury

Susan Edgman-Levitan, PA
Executive Director
John D. Stoeckle Center for Primary Care Innovation
Massachusetts General Hospital

Robert M. Wachter, MD
Associate Chair
Department of Medicine
University of California San Francisco

Former Members:
Jim Conway, MD
Senior Vice President, Institute for Healthcare Improvement

David Lawrence, MD
Chairman and CEO (retired), Kaiser Foundation Health Plan and Kaiser Foundation Hospitals

Donald Berwick, MD, MPP, FRCP
Former President and CEO, Institute for Healthcare Improvement and former administrator, Centers for Medicare & Medicaid Services

Jim Guest
President and CEO, Consumer Union
Five Transformational Concepts for Healthcare

- Transparency
- Integrated care platform
- Consumer engagement
- Joy and meaning in work
- Medical education reform
Transformation is to make a thorough or dramatic change in form, character, or appearance of a current state.
THROUGH THE EYES OF THE WORKFORCE
Creating Joy, Meaning, and Safer Health Care

Lucian Leape Institute
Evolution of the Transforming Concept: Joy and Meaning of Work

- **Meaning:** The sense of importance of an action
- **Joy:** The emotion of pleasure, feeling of success, and satisfaction as a result of meaningful action
- **Workforce Safety:** Physical and psychological freedom from harm, neglect, and disrespect — a precondition to Joy and Meaning
Logic Cascade

- Effective, safe care requires effective care delivery organizations
- Effective organizations care for their employees by continuously fulfilling some basic pre-conditions
- These pre-conditions enable employees to habitually pursue excellence, i.e., engage in continuous learning. As a result, employees derive joy and meaning from their work and their organizations experience better outcomes.
The purposeful creation and maintenance of these pre-conditions is the primary role of leadership and governance.

The absence/violation of these pre-conditions obscures meaning and drains motivation while imposing significant costs on the organization, its employees, its patients and the economy, including costs associated with patient harm and workforce harm.

Safety and respect of the workforce are pre-conditions to patient safety and habitual excellence.

A pre-condition is a non-negotiable, enduring priority and property of a healthcare system.
Evidence for Change

- 60% respondents of MD survey are considering leaving practice
- 70% knew at least one MD who left practice due to poor morale
- 37% of newly licensed RNs are thinking of leaving their job
- 13% vacancy rate for RNs
- Few CEOs have taken up the challenge to transform their organizations
- Health care work force injuries are 30x greater than other industries
How Happy are RNS with their Jobs?

- 90% are satisfied with their choice of career
- 76% are satisfied with the quality of care they are able to provide
- 73% are satisfied with their current job
- 72% would encourage others to become a nurse
- 51% worry that their job is affecting their health
- 46% agree that they usually have the time they need to spend with their patients
- 35% often feel like resigning from their current job
- 33% will likely not be working in the same job one year from now

Source: AMN Healthcare’s 2013 Survey of Registered Nurses
“Most hospital safety programs are focused on patients…little focus on employee safety…Indeed, solid application of basic environmental safety standards to all hospital areas will enhance patient safety and care.” Kagey, JAMA, 1972

Call for” …a serious, evidence-based approach to identifying opportunities to improve the quality of the health care workplace, and in so doing, improve both the health of health care workers and the health of those for whom they care.” JCAHO, 2001

Work done by OSHA, NIOSH, TJC, others to improve workforce safety and align it with patient safety.
The Health Care Industry

- through business practices, regulation, promulgation of standards, and proliferation of initiatives

- has divorced meaning from work, encouraged further fragmentation, and reduced complex, highly intimate care processes to industrial schemata

- has left many of our health care workers living in unmitigated risk of outmoded, rigid organizational structures and hierarchal models, deficient in respect, teamwork, and transparency
“And the wild things roared their terrible roars and gnashed their terrible teeth and rolled their terrible eyes and showed their terrible claws.”

Maurice Sendak
Physical Harm

- Health care workforce injuries 30 times higher than other industries
- More FTE days are lost due to occupational illness and injury in health care each year than in industries such as mining, machinery manufacturing and construction
- 76% of nurses in national survey indicated that unsafe working conditions interfere with the delivery of quality care
- An RN or MD as a 5-6 times higher chance of being assaulted than a cab driver in an urban area
Psychological Harm

- Lack of respect
  - A root cause, if not THE root cause, of dysfunctional cultures
  - 95% of nurses report it; 100% of medical students report it; huge issue for patients
- Lack of support
- Lack of appreciation
- Non-value add work
- Production pressures
- Scheduling demands and fatigue
- Poor design of work environments and work flows
Costs of Inaction

- Burnout, lost work hours, turnover, inability to attract newcomers to caring professions
- Less vigilance with regard to safety practices – both for patients and for workforce
- Increased opportunities for medical errors
- Impact on patient experience
Culture
NEXT EXIT
What does a safe organization look like?

• A learning culture that is open, transparent, supportive, and all health care workers treat each other with respect.

• A culture centered on teamwork, from boardroom to frontline holding each other accountable for safety and quality.

• A culture that removes uncertainties through thoughtful simplification and standardization.

• A culture where every voice – patient’s voice – is heard and all are empowered to prevent system breakdowns.

• A culture in which health care professionals and workforce are no longer targets of blame, but acknowledged experts, protectors, and co-creators of safe and effective systems of care.

• A culture of respect and collective accountability.
Requirements for Effective Care Delivery

- Effective, safe care requires effective care delivery organizations
  - Consistent performance at high levels of safety for extended periods of time
  - Collective mindfulness and vigilance
  - Strong team dynamic
  - Commitment to resilience and deference to expertise
  - Reporting of near-misses and errors without fear of retribution
  - Discipline and framework for process improvement
  - Empowered staff
  - Personal accountability within systems orientation

AND

*Systems Thinking and Safety Science are Foundational*
What are the seven things an organization must do?

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

2. Adopt the explicit aim to eliminate harm to the workforce to patients.

3. Commit to creating a high-reliability organization (HRO) and demonstrate the discipline to achieve highly reliable performance.
What are the seven things an organization must do? – cont.

4. Create a learning and improvement system and adopt evidence-based management skills for reliability.

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

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

7. Support industry-wide research to design and conduct studies that will explore issues and conditions in health care that are harming our workforce and patients.
Can every person in your organization answer YES to the following questions each day?

1. Am I treated with dignity and respect by everyone, every day, by everyone I encounter, without regard to race, ethnicity, nationality, gender, religious belief, sexual orientation, title, pay grade, or number of degrees?
Can every person in your organization answer YES to the following questions each day?

1. Am I treated with dignity and respect by everyone, every day, by everyone I encounter, without regard to race, ethnicity, nationality, gender, religious belief, sexual orientation, title, pay grade, or number of degrees?

2. Do I have the things I need: education, training, tools, financial support, encouragement, so I can make a contribution to this organization…that gives meaning to my life?
Can every person in your organization answer YES to the following questions each day?

1. Am I treated with dignity and respect by everyone, every day, by everyone I encounter, without regard to race, ethnicity, nationality, gender, religious belief, sexual orientation, title, pay grade, or number of degrees?

2. Do I have the things I need: education, training, tools, financial support, encouragement, so I can make a contribution to this organization…that gives meaning to my life?

3. Am I recognized and thanked for what I do?
Conclusion

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

Through the Eyes of the Workforce
Lucian Leape Institute
at the
National Patient Safety Foundation
Feb 2013

Collaboration
and Spread
Questions?