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HOGAN

Safety Report

5 Best Practices

for Improving Safety in Healthcare Organizations

Patient safety is of vital importance in the healthcare industry. A healthcare organization that cannot keep its patients safe while improving their health is one that will not be around for long.

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Companies should rethink training initiatives to foster a culture of safety.

Although most reputable healthcare organizations have adopted practices to keep patients as safe as possible in a clinical sense, the personalities and behaviors of individual caregivers are an often-overlooked aspect of patient care.

Healthcare organizations must educate all staff on the factors that contribute to a safe workplace, and where risks may lie. Companies should rethink their training initiatives and provide more effective coaching for employees and leaders to foster a culture of safety on every rung of the organizational ladder.

A 2016 study conducted by patient safety experts at Johns Hopkins suggested that medical error is the third leading cause of death in the United States, contributing to approximately 250,000 fatalities per year. By comparison, a classic 2010 study from the Institute of Medicine estimated that 98,000 Americans die each year due to medical errors,[2] and a 2003 study in the *Journal of the American Medical Association* showed that more than 32,000 Americans die each year under the care of medical personnel. The *JAMA* study also showed that these injuries added 2.4 million extra days of hospitalization and $9.3 billion in excess charges.[3]

Although no consensus exists as to the precise number of preventable deaths caused by medical error, any number is too many. It is imperative for healthcare organizations to make safety a top priority.

As a global personality assessment provider that has studied unsafe work behavior for more than 30 years, Hogan Assessment Systems offers the following five best practices to help improve safety within healthcare organizations.

1. **Raise awareness and create a culture of safety** - In a healthcare organization, administrators, medical staff, and nonmedical personnel must understand the importance of a culture of safety and the immediate impact it has on patients.
2. **Understand the importance of compliance versus commitment** - Healthcare employees must feel that their organization supports a culture of patient safety and that mistakes can be reported without fear of reprisal.
3. **Realize safety and patient care are not mutually exclusive** - If employees are focused on safety, patient care will improve.
4. **Acknowledge that technically skilled employees aren't necessarily safe employees** - The jobs of most healthcare employees involve more than just skills and qualifications. The best of the best can make mistakes if the situation isn't right.
5. **Recognize that safety and revenue are related** - A healthcare organization that does not emphasize safety is likely to incur steep financial penalties and lose customers, caregivers, and ultimately, the company itself.

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[1] Makary, M. A., & Daniel, M. (2016, May 3). Medical error—the third leading cause of death in the US. *BMJ*, *353*, Article i2139. https://doi.org/10.1136/bmj.i2139

[2] Institute of Medicine (US) Committee on Quality of Health Care in America, Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To Err is Human: Building a Safer Health System*. National Academies Press (US). https://doi.org/10.17226/9728

[3] Zhan, C., & Miller, M. R. (2003, October 8). Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization. *JAMA*, *290*(14), 1868–1874

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1 Raising Awareness and Creating a Culture of Safety

It can be a challenge for organizations to help staff understand how an individual's personality and behavior could result in unsafe work practices. Educating management and administrators on the importance of personality-based safety training is often the first step toward getting all personnel on board.

"It's important for administrators to take a step back and to think about and understand what patient safety actually means," says Kenneth Randall, executive talent director at Banner Health. "They need to look at each person, regardless of their department or what level they are at within the organization, and see how they play a role in the patient's experience in order to help create a safer environment."

Convincing highly educated doctors that personality and behavior affect patient safety can be equally daunting. "Simply stating it or having it written in a handout will be met with resistance," says Randall. "You need to be available and have time to answer questions. It needs to be a two-way conversation to ensure understanding and gain commitment."

Christopher Duffy, Hogan partner and director of global solutions, agreed that making an impact with doctors can be difficult. "It can be a hard road," he says. "It took us several years to break through. Getting department heads to understand that they have a vested interest in the safety awareness of their team was instrumental."

Nonmedical staffers also play a significant role in patient safety. It's important for administrators to realize that patient safety should be a priority for all positions and departments, from janitorial staff who ensure that the entire hospital is sanitary, to the record-keeping department that controls information and patient confidentiality.

The HR department has a part to play, too. When prospective employees interview for a job, they're being assessed on what skills they bring to the table, but rarely is their psychological makeup considered with regard to safety. With more than 3.7 million workplace injuries and illnesses in the U.S. private industry in 2008,[4] hiring the right people is integral to the safety of both patients and employees.

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[4] U.S. Bureau of Labor Statistics. (2019, November 7). *Employer-Reported Workplace Injury and Illness*, 2018 [Press release]. https://www.bls.gov/news.release/osh.nr0.htm

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2 A Culture of Compliance Versus Committment

When thinking about mistakes in the workplace, one of the main concerns among hospital staff is the reaction of top administration. The Agency for Healthcare Research and Quality (AHRQ) *Hospital Survey on Patient Safety Culture* showed that only 44% of respondents felt that their mistakes would not be held against them.

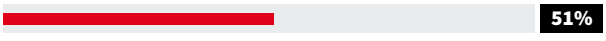
The same survey revealed that 54% of hospital workers felt that when an accident or similar event was reported, the facility was more interested in disciplining the employee than correcting the problem. Additionally, 49% of respondents felt like their mistakes were held against them, and 65% worried that records of mistakes they made were kept in their personnel files.

"This is as much about leadership as it is about safety," says Duffy. "Are you after compliance, or are you after commitment? The research out there is pretty clear that a compliance culture breeds more problems. You can have a much higher performing, higher functioning team environment if everyone is committed to the same goals."

Nonpunitive Response to Error

(Item was negatively worded, where the percent positive response is based on those who responded "Strongly Disagree" or "Disagree," or "Never" or "Rarely," depending on the response category used for the item)

Staff feel like mistakes are held against them



Staff feel like the person is being written up, not the problem

Staff worry that mistakes made are recorded in personnel files

The Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture

In the early 1980s, employees at the Idaho State School and Hospital (ISSH) made up a disproportionate percentage of workers' compensation claims. Although the employees represented only 5% of the state's workforce, they were responsible for 20% of the state's insurance costs. From 1980 to 1986, workers' compensation claims and medical payments for ISSH habilitation therapists totaled nearly $1.6 million.

When further studies showed that in most organizations, 10% of the workforce accounts for 90% of medically related absences, finding a way to reduce the number of injured employees at ISSH became paramount.

An in-depth analysis included reviews of training manuals and job descriptions; day-to-day observation of the employees; interviews and panel discussions; and a questionnaire covering all aspects of the employment situation. The analysis revealed that the physically demanding nature of the job was the prime reason for the large number of injuries.

The results indicated that the best employees were well adjusted, conscientious, empathic, and mindful of their physical limitations with regard to the physical demands of the job.

"There are so many different ways that people can have accidents within a healthcare facility," says Duffy. "You need compliant people who are trainable, who know how to do these tasks without getting hurt or putting other people at risk."

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3 Safety and Patient Care Are Not Mutually Exclusive

The AHRQ *Hospital Survey on Patient Safety Culture* reflected that only 64% of hospital employees felt that their employers would not sacrifice employee safety to get more work done. Only 63% felt patient safety problems in their unit had been addressed adequately, meaning 37% had an unfavorable view of how safety problems were addressed.[5]

Unfortunately, a perception persists within the health-care industry that safety and patient care function independently. In reality, when employees are focused on accident reduction, the benefits extend to patient care.

Residency programs seem to be an area of particular disconnect. Despite the rich tradition of preparing future doctors for the stressful conditions their industry brings, studies show that sleep deprivation and other fatigue-related factors are linked with a significant number of impairments, including an increase in preventable medical errors.

The 2020 Accreditation Council for Graduate Medical Education Common Program Requirements stipulate that residents average no more than 80 hours per week over a four-week period. Residents may work up to 24 consecutive clinical hours. Beyond that, residents are permitted to spend up to four additional hours of time on activities related to patient safety or resident education. In other words, residents may work up to 28 consecutive hours.[6]

"These folks are on for up to 28 hours straight, they're brand new and just trying to get their hours and meet education requirements," says Duffy. "And when they do get some sleep, they might be jolted awake at 3 a.m. to treat a trauma patient."

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[5] Agency for Healthcare Research and Quality, Sorra, J., Famolaro, T., Dyer, N., Nelson, D., & Khanna, K. (2010, May 19). *Hospital Survey on Patient Safety Culture: 2010 User Comparative Database Report.* U.S. Department of Health and Human Services, National Institutes of Health. https://psnet.ahrq.gov/issue/hospital-survey-patient-safety-culture-2010-user-comparative-database-report

[6] Accreditation Council for Graduate Medical Education. (2020, February 3). *ACGME Common Program Requirements (Residency)* (effective July 1, 2020). https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf

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4 Technically Skilled Employees Aren't Necessarily Safe Employees

A disparity exists between being safe and being skilled. A skilled employee is not necessarily a safe employee, so steps must be taken to bridge any gap. It is essential that healthcare employees, regardless of skill set, are convinced that being as safe as possible is critical to maximum job performance.

"Even the best auto mechanics can cause injuries in their garage," says Duffy.

There are four significant reasons why even the most skilled employees may lack proper safety skills, all related to the long hours many healthcare workers face:

1. **Overworked and overtired employees** - Working long shifts makes employees prone to mistakes.
2. **Poor handoffs and transitions** - A lack of communication between shifts, units, and/or hospitals compromises patient safety.
3. **High turnover rate** - To keep up with high turnover, some newer employees may be rushed into their positions without proper safety training.
4. **High burnout rate** - Because of the stress and hours associated with their positions, many healthcare employees don't stay at the same job for a significant length of time.

A study published in the *Journal of the American Medical Association* showed that lack of sleep for physicians leads to issues with patient safety. The study found an increased rate of complications for surgical procedures performed by physicians with fewer than six hours of sleep following an overnight shift. (The study found no significant increase in complication rates for attending physicians.)[7]

Handoffs and transitions from one unit to the next are also problematic. In fact, in the AHRQ *Hospital Survey on Patient Safety Culture*, handoffs and transitions across hospital units and during shift changes had the lowest average percent positive response, with only 44% of those surveyed agreeing that their organization did a good job in this area.[5]

"This is all about communication," says Duffy. "After a long shift, do they see it as 'My job is over, time to go home,' or do they say 'I really need to transition and follow the proper steps to make sure the patient is as safe as possible?'"

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[7] Rothschild, J. M., Keohane, C. A., Rogers, S., Gardner, R., Lipsitz S. R., Salzberg, C. A., Yu, T., Yoon, C. S., Williams, D. H., Wien, M. F., Czeisler, C. A., Bates, D. W., & Landrigan, C. P. Risks of Complications by Attending Physicians After Performing Nighttime Procedures. (2009, October 14). *JAMA*, *302*(14), 1565–1572. https://doi.org/10.1001/jama.2009.1423

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5 Safety and Revenue Are Related

The bottom line is, as they say, the bottom line. Safety has a direct effect on a healthcare organization's bottom line. Without safe, reliable, top-of-the-line care, it's almost guaranteed that patients will be vocal about shortcomings. And very few people are willing to use a healthcare practitioner their friends don't recommend.

"You stand to lose substantial business," says Randall. "People telling their friends they received less-than-stellar care can have a huge effect."

Regulatory issues have an impact, too. In 2008, in an effort to improve patient safety, Medicare stopped paying for mistakes made by hospitals. If a surgeon were to leave a tool inside a patient, Medicare would no longer pay for the cost of correcting that error. "That hits the bottom line really quickly," says Duffy. "Now the hospital has to eat the cost."

For many healthcare facilities, that may be the chief motivating factor behind creating a culture of safety. It's unfortunate that patient safety isn't enough of a reason unto itself, but the fact that a lack of patient safety could hurt the finances of a healthcare organization may be the truth that tips the scale.

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Hogan's Recommended Approach

As the international authority in personality assessment and consulting, Hogan Assessments created the Hogan Safety Report as a response to requests from clients who wanted to add a safety component to their assessment process.

Based on more than 30 years of research, study, and testing, the Hogan Safety Report uses the Hogan Personality Inventory (HPI), considered the industry standard for measuring personality in relation to job performance. The Hogan Safety Assessment takes about 15 minutes to complete and can be administered online 24 hours a day, seven days a week. Reports are generated within seconds of completion.

Hogan's Safety Report is critical in identifying the behavioral characteristics that may lead to on-the-job accidents and other unsafe behaviors. The report is based on six scales of safety-related behavior:

1. **Defiant - Compliant:** Low scorers ignore authority and company rules. High scorers willingly follow rules and guidelines.
2. **Panicky - Strong:** Low scorers tend to panic under pressure and make mistakes. High scorers are steady under pressure.
3. **Irritable - Poised:** Low scorers lose their temper and can make mistakes. High scorers are able to control their temper.
4. **Distractible - Vigilant:** Low scorers are easily distracted and apt to make mistakes. High scorers stay focused on the task at hand.
5. **Reckless - Cautious:** Low scorers tend to take unnecessary risks. High scorers take the time to evaluate all options before making risky decisions.
6. **Arrogant - Trainable:** Low scorers overestimate their competency and are hard to train. High scorers listen to advice and like to learn.

The Hogan Safety approach enables organizations to understand their employees' safety-related competencies.

Using Hogan's individual assessments based on hundreds of client research projects conducted over four decades, workers and organizations are able to predict and modify unsafe behavior. The Hogan Safety approach is made up of three components to build and maintain a culture of safe working practices:

Safety Climate Survey - Provides critical feedback regarding the existing perceptions of safety at all levels in the organization via a company-wide safety score.

Hogan Safety Assessment - Examines individual participant scores against the six safety-related personality competencies and provides valuable information for hiring and developing safety-conscious candidates.

Safety Coaching Process - This process is designed to accurately identify and teach safe tendencies within an organizational context, providing leadership with the necessary feedback to build and maintain a culture of safe working practices.

Hogan's Safety Report is critical in identifying the behavioral characteristics that may lead to on-the-job accidents and other unsafe behaviors.

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Conclusion

Safety in healthcare extends far beyond the safe treatment of patients. Studies increasingly show that the absence of a culture of safety throughout a healthcare business will result in lost time, higher employee turnover, increased errors, and a loss of revenue. Healthcare organizations can respond by adopting personality-based safety training that works in concert with traditional, clinically based safety practices. When combined, these two safety training methods can elevate patient and workplace safety.

It's critical that established employees understand the role that their personalities play in patient safety, and that new employees prioritize patient safety from the outset. Management at all levels must help create a culture of safety and raise awareness through the organization. They should also work to create a safe environment for employees by listening to concerns from the proverbial front lines.

Hogan has studied worker personality for decades, and has used that knowledge to create a tool that can help healthcare organizations build a climate of safety: the Hogan Safety Report.

Hogan Assessments is a global personality assessment provider that helps companies select employees, develop leaders, and identify talent. Hogan specializes in identifying high-potential candidates for targeted positions, providing leadership development tools to help emerging leaders realize their full potential, and determining relationships between individual personality characteristics and safety performance. Hogan's assessments can be administered in more than 40 languages, and are available on a state-of-the-art platform, giving customers accurate feedback within seconds of completion.

In healthcare, there has to be a willingness to solve the problem instead of just treating the symptoms. Safety training has to go beyond traditional equipment-based safety.

To learn more about Hogan's Safety solutions, contact info@peterberry.com.au

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