HOGAN

FIVE BEST PRACTICES

FOR IMPROVING SAFETY IN HEALTHCARE ORGANIZATIONS

INTRODUCTION

Patient safety is a preeminent concern in the healthcare industry. A healthcare organization that cannot keep its patients safe and improve their health is one that will not be around for long. Although most reputable healthcare organizations have adopted practices to keep patients as safe as possible in a clinical sense, the personality and behaviors of individual caregivers are an often-overlooked aspect of patient care.

To make patients even safer, healthcare organizations must increase safety awareness for doctors, nurses and other staffers. Companies should rethink their training initiatives and provide more effective coaching for individuals and supervisors to produce a culture of safe work practices on every rung of the organizational ladder.

A study from the Institute of Medicine estimated that 98,000 Americans die each year due to medical errors.[1] A study published in *The Journal of the American Medical Association* showed that more than 32,000 Americans die each year due to 18 common injuries suffered under the care of medical personnel. This study also showed that these same injuries added 2.4 million extra days of hospitalization and $9.3 billion in excess charges.[2]

One of the conclusions from the Institute of Medicine report was that faulty systems, processes and conditions led people to make mistakes or failed to prevent them. It implored healthcare organizations to make a culture of safety a top priority.

Hogan Assessment Systems, a global personality assessment provider that has studied unsafe work behavior for more than 30 years, offers 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 non-medical personnel must understand the role of a safety culture and how it plays into patient safety.
2. **UNDERSTAND THE IMPORTANCE OF COMPLIANCE VS. 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 TECHNICALLY SKILLED EMPLOYEES AREN'T NECESSARILY SAFE EMPLOYEES** – The jobs of most healthcare employees involve more than just skills and qualifications. Even the best can make mistakes if the situation isn't right.
5. **RECOGNIZE SAFETY AND REVENUE ARE RELATED** – A healthcare organization that does not emphasize safety can incur steep financial penalties and lose customers, caregivers and ultimately, the company itself.

1. To Err is Human: Building A Safer Health System, http://www.iom.edu/Reports/1999/To-Err-is-Human-Building-A-Safer-Health-System.aspx .
2. Zhan C, Miller MR. Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization. JAMA 2003 Oct 8, http://jama.ama-assn.org/cgi/content/full/290/14/1868#SEC2 .

1. RAISING AWARENESS AND CREATING A CULTURE OF SAFETY

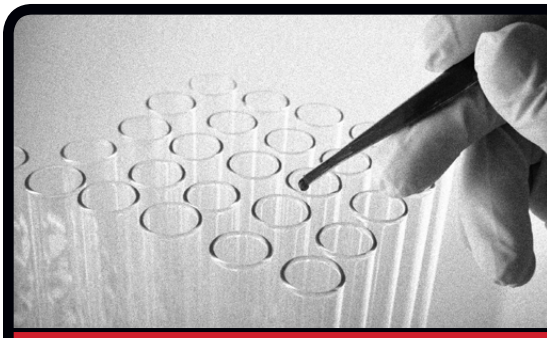
It can be a challenge for organizations to help their staff understand how their individual personality and behavior could result in unsafe work practices. Helping management and administrators grasp the importance of personality-based safety training is often the first step in getting other personnel to follow suit.

"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 play a role in patient safety can also be 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."

Ryan Ross, vice president of consulting for Hogan Assessment Systems, 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 very vested interest in the safety awareness of their team was instrumental."

Non-medical staffers also play a significant role in patient safety. It's important for administrators to realize that patient safety is a priority in all positions and departments, from housekeeping and janitorial staff who ensure that linens and all parts of the hospital are clean and sanitary to the record keeping department that controls information and patient confidentiality.



"IT'S IMPORTANT FOR ADMINISTRATORS TO TAKE A STEP BACK AND TO THINK ABOUT AND UNDERSTAND WHAT PATIENT SAFETY ACTUALLY MEANS. 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."

— KENNETH RANDALL, EXECUTIVE TALENT DIRECTOR AT BANNER HEALTH

Hiring the right people plays a role, too. When most people 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. And with over 3.7 million workplace injuries and illnesses in U.S. private industry in 2008 [3], hiring the right people is essential for both patient and employee safety.

3. Bureau of Labor Statistics, Workplace Injury and Illness Summary New Release, October 29, 2009, http://www.bls.gov/news.release/osh.nr0.htm .

2. CULTURE OF COMPLIANCE VS. COMMITMENT

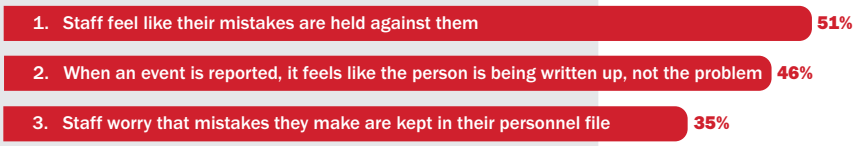
One of the biggest concerns among hospital staff is the administrative reaction to a mistake the staffer may make. The Agency for Healthcare Research and Quality (AHRQ) *Hospital Survey on Patient Safety Culture 2010* showed that only 44 percent of respondents felt that their mistakes would not be held against them. [4]

The same survey revealed that 54 percent 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 percent of respondents felt like their mistakes were held against them, and 65 percent worried that mistakes they made were kept in their personnel file.

"This is as much about leadership as it is about safety," says Ross. "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)



The Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture 2010

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 comprised of only 5% of the state workforce, they were responsible for 20% of the state 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 job questionnaire covering all aspects of the employment situation. The analysis revealed that the physically demanding nature of the job was a prime reason for the large number of injuries.

The results yielded 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 Ross. "You need compliant people who are trainable, who know how to do these tasks without getting hurt or putting other people at risk."

4. AHRQ Hospital Survey on Patient Safety Culture 2010, http://www.ahrq.gov/qual/hospsurvey10/hosp10ch5.htm .

3. SAFETY AND PATIENT CARE ARE NOT MUTUALLY EXCLUSIVE

The AHRQ *Hospital Survey on Patient Safety Culture 2010* reflected that only 64 percent of hospital employees felt that hospital would not sacrifice employee safety to get more work done. Only 63 percent felt patient safety problems in their unit had been addressed adequately, meaning 37 percent had an unfavorable view of how safety problems were addressed.[5]

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

A recent poll shows that although Americans know residents put in countless hours, they underestimate how many. Most respondents believed residents worked a maximum of 12-hour shifts and no more than 80 hours a week. Residents are in fact allowed to work up to 30 consecutive hours, and do so twice a week under established guidelines, and they often dramatically exceed those limits.[6]

“These folks are on for over 30 hours straight, they’re brand new and just trying to get their hours and meet education requirements,” says Ross. “And when they do get some sleep, they’re jolted awake at 3 a.m. to treat a trauma patient.”

5. AHRQ Hospital Survey on Patient Safety Culture 2010, http://www.ahrq.gov/qual/hospsurvey10/hosp10chart5-2.htm .

6. Boston.com, Americans Underestimae resident doctors’ work hours poll says, June 1, 2010, http://www.boston.com/news/health/blog/2010/06/_do_you_know_ho.html .

4. TECHNICALLY SKILLED EMPLOYEES AREN'T NECESSARILY SAFE EMPLOYEES

A dramatic difference 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 Ross.

Four significant reasons explain why 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 the safety of the patient.
3. **HIGH TURNOVER RATE** – To keep up with a high turnover rate, some newer employees may be rushed into their positions without having been properly trained in safety skills.
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 recent 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 less 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 2010*, handoffs and transitions across hospital units and during shift changes had the lowest average percent positive response, with only 44 percent of those surveyed agreeing that their organization did a good job in this area.[8]

"This is all about communication," says Ross. "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'?"

7. Rothschild, Jeffrey, Risks of Complications by Attending Physicians After Performing Nighttime Procedures, JAMA 2009 Oct 14, http://jama.ama-assn.org/cgi/content/full/302/14/1565 .

8. AHRQ Hospital Survey on Patient Safety Culture 2010, http://www.ahrq.gov/qual/hospsurvey10/hosp10chart5-1.htm .

5. SAFETY AND REVENUE ARE RELATED

The bottom line is, as they say, the bottom line. Safety has a direct effect on the bottom line of a healthcare organization. Without a culture of safety, without safe, reliable, top-of-the-line care, your patients will communicate to others just what you're lacking. Very few people are willing to go to 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 Ross. "Now the hospital has to eat the cost."

For many healthcare facilities, that may be the point that drives the creation of 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.

HOGAN'S RECOMMENDED APPROACH

Hogan Assessments, an international authority in personality assessment and consulting, created Hogan SafeSystem 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, SafeSystem uses the Hogan Personality Inventory (HPI), considered the industry standard for measuring personality in relation to job performance. The SafeSystem assessment takes about 15 minutes to complete. It can be administered online 24 hours a day, seven days a week, and reports can be generated within seconds of completion.

Hogan's Safety Report identifies characteristics that individuals possess that may lead to on-the-job accidents and other unsafe behaviors. The six scales of safety-related behavior are:

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

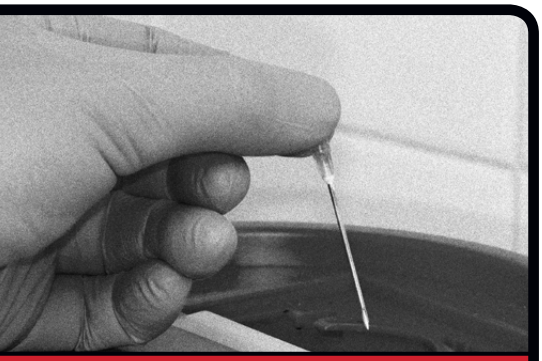
Only the Hogan SafeSystem approach enables organizations to pinpoint with such accuracy the safety profiles of their foundation: their workers.

Using Hogan's individual assessments based on hundreds of client research projects conducted over 30 years, workers and organizations are able to predict and modify unsafe behavior. The Hogan SafeSystem is made up of three components to build and maintain a culture of safe working practices:

- **SafeSystem Climate Survey:** Provides critical feedback regarding the existing perceptions of safety at all levels in the organization via a companywide safety score.
- **Hogan Safety Assessment:** Examines individual participant scores against the six safety-related personality competencies and provides valuable information for hiring and developing candidates with safe work behaviors.
- **SafeSystem 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.

CONCLUSION

Safety in healthcare extends far beyond the safe treatment of patients. Studies increasingly show that the lack of a safe working environment and the failure to imbue the traditional clinical safety philosophy with a sense of safe culture will cost a healthcare business lost time, higher employee turnover, increased patient errors and a loss of revenue.



"SAFETY ISN'T JUST FOR HEAVY INDUSTRY," SAYS ROSS. "IN HEALTHCARE, THERE HAS TO BE A WILLINGNESS TO SOLVE THE PROBLEM INSTEAD OF TREAT THE SYMPTOMS. SAFETY TRAINING HAS TO GO BEYOND TRADITIONAL EQUIPMENT-BASED SAFETY."

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 take patient and workplace safety to higher levels.

It's critical that established employees understand the role that their personality plays in patient safety. It's also important new employees embrace a culture of patient safety.

Management at all levels must help create a culture of patient safety and raise awareness of it through the organization. Management must also encourage a safety culture by listening to employees on the proverbial frontlines.

Hogan has studied worker personality for decades and has applied that knowledge to creating a positive safety climate with the Hogan SafeSystem.

To learn more about Hogan's Safety solution, visit hoganassessments.com or call us at 918.749.0632.

Hogan Assessment Systems 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 over 40 languages and are available on a state-of-the-art platform, giving customers accurate feedback within seconds of completion.