Washington State Healthcare Safety Council
2016 Elaine Carty Award Application
Harborview Medical Center
Liz Kindred, Safety Officer
ekindred@uw.edu
206-744-7244

TOPIC (or problem statement):
Healthcare organizations are large complex systems that pose myriad health and safety risks to the workforce.

Harborview staff are expected and encouraged to submit incident reports to report workplace (staff) injuries, near miss incidents and other safety concerns. In order to effectively review the large number of reports and implement action to prevent further incidents a multi-disciplinary team was created to meet and review incident reports weekly.

DISCUSSION OF THE ISSUE:
According to the Bureau of Labor Statistics the injury and illness rate in hospitals remains nearly double the rate for private industry as a whole, and it is also higher than the rates in construction and manufacturing—two industries that are traditionally thought to be relatively hazardous[1].. Healthcare worker safety is strongly linked to patient safety, patient satisfaction and controllable costs. The healthcare industry recognizes the importance of a safety culture, but many healthcare organizations focus predominantly on patient safety[2].

It is Harborview's philosophy and expectation that employees shall report all health and safety concerns and actual events in real time via online reporting. By fostering a culture of transparent and non-punitive quality improvement reporting, hazards can be mitigated and harm prevented.

Since 2005, Harborview Medical Center has utilized an internet-based electronic incident reporting [**EIR**] system, to collect and report all healthcare related safety concerns and incident events involving patients, staff, visitors, and facilities. The frontline reporter only needs to access one system to initiate a report for either a patient or staff event. Once the report is electronically submitted, all events that impacted staff are electronically distributed to the employee's manager, risk management, the Safety Office, other affected departments and an Occupational Health Nurse in Employee Health Services for review. The average number of monthly reports range from 100-120 events. The institutional challenge was to take meaningful and sustainable action based on the types of hazards that were being reported and the quantity of reports received.

ACTION PLAN/IMPLEMENTATION:
In 2011 HMC formalized the multidisciplinary group that had organically formed over the years named the Employee Safety Quality Improvement Program (**ESQIP**), to manage the influx of incident reports, communicate with affected staff, analyze incident trends and implement

1: Caring for our Caregivers: Facts About Hospital Worker Safety, Occupational Safety and Health Administration, September 2013.
2: Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation, The Joint Commission, 2012.

corrective actions to improve worker safety and the work environment. The ESQIP team systematically reviews submitted incident reports related to employee safety and health and communicates to other committees, managers, or stakeholders for the purposes of identifying, preventing, mitigating and ameliorating potential occupational hazards and conditions. The ESQIP team meets weekly to review the week's incident reports.

The ESQIP team leader, a Certified Occupational Health Nurse, reviews all employee-related incident reports, clarifies facts with affected staff, classifies reports in alignment with OSHA and Bureau of Labor Statistics (BLS) definitions and selects cases for multidisciplinary team review. The ESQIP group is made up of representatives from the following stakeholders:

- Employee Health Services,
- Facilities and Engineering,
- Risk Management (Worker Compensation Case Manager),
- Environmental Services,
- Patient Handling
- Safety Officer,
- Employee Health Medical Director and
- ad hoc safety representatives and front line staff as needed from relevant departments.

Incident reports are selected for ESQIP review based on a numerical harm score, sentinel events, and reports of unusual, potential, or actual hazardous conditions. ESQIP members recommend actions/or follow-up based on their expertise, best practices and occupational health and safety research evidence. Actionable reports also are designated for further review/investigation/mitigation or correction by assigning to an individual manager or other committee. Summary incident/safety reports are provided to stakeholder committees, including the Environment of Care Committee and the UW Medicine Health and Safety Committee.

Staff is empowered with the action taken on behalf of their incident reporting, thus fostering a culture of safety to report all incidents, whether resulting in an injury, near miss or potential hazard.

RESULTS/CONCLUSIONS:

PROGRESS REPORT/EVALUATION (measurable improvement):

Since 2013, ESQIP reviews have resulted in over 100 independent actions and the following outcomes:

- 25% reduction in the rate of incidents resulting in time loss in 2015
- 29% reduction in staff injuries involving patient handling and mobilizing
- 15% reduction in staff injuries from lifting laundry and trash
- Process improvements including
    - 2 year plan to further expand installation of ceiling lifts in to all inpatient rooms
    - Use of custom eye protection by all housekeeping staff
    - Ergonomic improvements for housekeeping lifting of laundry
    - Purchase of new powered air purifying respirators
    - Facility improvements to eliminate physical hazards throughout campus

- Purchase of new motorized patient beds with safe patient handling features
  - Evaluation of new and proposed products for worker safety features
  - Increased use of light duty for injured staff

NEXT STEPS:

Each year the ESQIP group reviews metrics and goals to continue the cycle of process improvement, 2016 goals include:

- 100% of Employee incident reports that are OSHA recordable reviewed by ESQIP team.
- Reduction from the previous year in the overall rate of OSHA recordable patient handling events
- Decrease in the rate of staff Injuries Requiring Time Away From Work

CONCLUSION:

HMC employees are expected to report all safety concerns in real time via an electronic incident reporting system. Having a multidisciplinary committee address system wide issues has helped foster the culture of safety as evidenced by an increase in incident reporting and decrease in compensable lost work days.