Actionable Patient Safety Solutions™ (APSS™):

Workplace Safety

How to use this guide

This APSS provides evidence-based resources and recommendations for workplace safety for executives, leaders, clinicians, and performance improvement specialists. This document is intended to be used as a guide for healthcare organizations to examine their own workflows, identify practice gaps, and implement improvements. In it, you will find:

Best Practice Summary: A high level summary of evidence-based, clinical best practices. (page 2)

Executive Summary: Executives should understand the breadth of the problem and its clinical and financial implications. (page 2)

Leadership Checklist: This section is for senior leaders to understand common patient safety problems and their implications related to poor workplace safety. Most preventable medical harm occurs due to system defects rather than individual mistakes. Leaders can use this checklist to assess whether best practices are being followed and whether action is needed in their organization around workplace safety. (page 3)

Clinical Workflow: This section includes more specific information around workplace safety across the continuum of care. Leaders should include the people doing the work in improving the work. This section outlines what should be happening on the frontline. Clinicians can use this section to inform leaders whether there are gaps and variations in current processes. This is presented as an infographic that can be used for display in a clinical area. (page 6)

Education for Patients and Family Members: This section outlines what frontline healthcare professionals should be teaching patients and family members about how poor workplace safety undermines the most robust clinician recommendations. Clinicians can inform leaders whether there are gaps and variations in current educational processes.
(page 7)

Performance Improvement Plan: If it has been determined that there are gaps in current practice, this section can be used by organizational teams to guide them through an improvement project. (page 8)

What We Know about Workplace Safety: This section provides additional detailed information about moderate sedation. (page 11)

Resources: This section includes helpful links to free resources from other groups working to improve patient safety. (page 13)

Endnotes: This section includes the conflict of interest statement, workgroup member list, and references. (page 14)

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Patient Safety MOVEMENT

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Best Practice Summary

Create a safe workplace culture.

- ☐ Take workers' concerns seriously.
- ☐ Normalize help-seeking behaviors.
- ☐ Ensure that the Supply Chain has adequate supplies to protect staff if another pandemic hits.
- ☐ Implement a workplace safety reporting system and apply principles of effective reporting system management.
- ☐ Continuously praise reporting of workplace safety incidents.
- ☐ Provide timely feedback to those reporting workplace safety concerns.
- ☐ Encourage use of peer support programs.
- ☐ Increase inclusion efforts by encouraging input from all team members such as staff, patients, and family members.

Review workplace safety-related data and share findings.

- ☐ Review workplace safety-related data routinely and discuss with those on the frontline.
- ☐ Utilize multidisciplinary root cause analysis for workplace safety incidents and share findings across the organization.

Perform routine workplace safety assessments.

- ☐ Identify potential workplace safety risks using validated assessment tools.
- ☐ Involve those on the frontline in the assessment.
- ☐ Ensure findings from the assessment are used for actionable solutions.

Executive Summary

The Problem

Violence, unsafe ergonomic conditions, poor patient handling, excessive workload, exposure to hazardous materials, and vulnerability to transmissible infections are among the most common and preventable risks for workplace safety (Loeppke, 2017). 75% of yearly workplace assaults occur in healthcare, but only 30% of nurses and 26% of emergency department physicians report incidences (The Joint Commission, 2018). Poor workplace safety increases risks to patient harm and death. Among patient readmission rates, patients were 16% more likely to die after an in-hospital cardiac arrest in cases of unsafe work environments ACN, n.d.; McHugh et al., 2016; Ma, McHugh & Aiken, 2016).

The Cost

Prioritizing a safe work environment lowers the cost of occupational harm, which is associated with 2% of healthcare spending, and reduces patient harm, which is associated with 12% of healthcare spending (OECD, 2021) It has been estimated that, per nurse, the cost of turnover, a key indicator of workplace safety, accounts for $16,600 in Australia, $10,100 in Canada, and $33,000 in the US (Wiskow et al., 2010). Other direct costs include litigation, time off, lawsuits and various indirect costs due to impacts on patient safety, team effectiveness, and morale. In the US alone, workers' compensation results in a loss of $2 billion for hospitals annually (OSHA,

2020). A Health Affairs survey showed that hospitals in which the workplace environment improved also improved by 15% on the percentage of nurses reporting excellent quality of care, by 16% on reported job satisfaction, and by 12% on burnout (Aiken et al., 2018).

The Solution

Increase workplace safety initiatives throughout healthcare centers. This document provides a blueprint that outlines the actionable steps organizations should take to successfully improve workplace safety and the workplace environment and summarizes the available evidence-based practice protocols. This document is revised annually and is always available free of charge on our website.

Leadership Checklist

The following leadership checklist contains essential elements that should be implemented and sustained to improve workplace safety for all across the organization.

Build a shared vision for workplace safety and minimize the "this is how it's always been" mentality.

- ☐ Normalize open, ongoing conversations about workplace safety by leading by example. Be vulnerable.
- ☐ Involve those on the frontline in publishing an organizational "Healthcare Worker Rights and Responsibilities" and "Ethical Code of Conduct" to outline minimum standards for worker respect and safety. Outline what the 'ideal workplace' looks like, describe the expected behaviors of all members of staff to uphold the organizational values, and align workplace safety goals with patient safety goals.
- ☐ Demonstrate organizational priority on workplace safety by
  - ☐ Remaining an active participant in process change
  - ☐ Allocating appropriate resources
  - ☐ Routinely being open and available for staff
  - ☐ Expecting that multidisciplinary team members discuss an event and lessons learned.
  - ☐ Providing staff support in a timely fashion after an event (CISM, n.d.).
  - ☐ Including workplace safety on senior leadership discussion agendas
- ☐ Change the word "complaint" to something more positive (e.g., concern).
- ☐ Ensure proper allocation of resources for prevention of workplace injury and illness (e.g., infection prevention resources).
- ☐ Establish a clear code of conduct for all employees and stakeholders and for those who report concerns ('whistleblowers') (OSHA, 2021).

Improve detection of risk and safety concerns.

- ☐ Conduct a performance improvement initiative to assess risks and priority areas.
- ☐ Inquire about incidents or areas of concern during rounding.
- ☐ Simplify the reporting process as much as possible.
- ☐ Minimize the gap in time between the report and the follow up.
- ☐ Clearly define reporting criteria.
- ☐ Establish a near-miss reporting system for worker safety, just as there is a near miss

reporting system for patient safety.

- ☐ Ensure staff have the ability to report concerns on or offsite.

Thoroughly respond to reports.

- ☐ Set up the reporting system to provide enough information for root cause analysis (Benn et al., 2009).
- ☐ Clearly standardize policies and guidelines that will be referenced when responding to concerns. Revise these policies and guidelines if there are reports made for which there is no clear way to respond.
- ☐ Establish robust mechanisms for closed loop communication, which may include:
  - ☐ Clearly articulating what the user can expect for next steps on the "report successfully submitted" confirmation page.
  - ☐ Provide an opportunity for the reporter to choose to remain anonymous or disclose identify and contact information for follow-up.
  - ☐ Acknowledging efforts responding to reports made anonymously in newsletters, announcements, etc.
  - ☐ Bringing the individuals who have reported into improvement efforts.
- ☐ Link reports to ongoing feedback mechanisms that suit the severity of the report (e.g., email updates versus group discussions).
- ☐ Ensure all reported events are taken seriously and responded to in some way. See Appendix A for an example of a proactive leadership response to workplace violence or reports of hazards.
- ☐ Involve the frontline (e.g., surveys) in understanding the effectiveness of the intervention. Be sure to evaluate both the objective data and their perception of the intervention (WISH Assessment, n.d.; Sorensen et al., 2018).

Involve all in continuous improvement efforts.

- ☐ Involve the subject matter experts in reviewing reports.
- ☐ Debrief on a regular basis to solicit team feedback about barriers to sustained workplace safety. Adjust the plan quickly and nimbly as needed.
- ☐ Make sure patients understand the link between their clinicians' safety and their own.
- ☐ Hold staff accountable for workplace safety using the "Just Culture" approach. Encourage people to provide essential safety-related information and use the Just Culture algorithm to determine response.
- ☐ Clearly define what 'accountability' for workplace safety means (e.g., "I always speak up when I see a workplace safety risk").
- ☐ Share trend analysis across the organization for transparency and process improvements.

Equip staff with the tools needed for a safe working environment.

- ☐ Establish a curriculum for ongoing education around
  - ☐ Identification and early recognition of unsafe environments
  - ☐ Reporting
  - ☐ Conflict resolution
  - ☐ Trauma informed care
  - ☐ De-escalation strategies (Griffin et al., 2021).

- ☐ Establish mechanisms for workers to report patients at risk for violence in the medical record for future procedures. Standardize which patients should be 'flagged' based on evidence-supported risk assessments (Public Services Health & Safety Association, 2017). Establish an emergency support system to address violence (e.g., "Code White" to call security).
- ☐ Improve team relationships by:
  - ☐ Cultivating an environment of psychological safety, so that team members speak up when faced with challenges.
  - ☐ Being transparent and vulnerable.
  - ☐ Prioritizing team building.
  - ☐ Building common values and a shared vision for the team.
  - ☐ Highlighting various strengths in team members.
  - ☐ Identifying and dealing with causes of poor morale.
  - ☐ Providing rewards.
  - ☐ Knowing when it is time to "train hard, run a marathon, peak and recover".

Demonstrate the link between workplace safety and performance across the organization and sustain initiatives.

- ☐ Share the stories and lessons learned to underscore the importance of reporting.
- ☐ Disseminate positive results of safety reporting and report the processes done well to prevent poor safety.
- ☐ Use lagging metrics to inform improved leading metrics for workplace safety (Sheehan et al., 2015; AIHA, 2020).
- ☐ Integrate patient safety and worker safety improvement teams and resources.
- ☐ Calculate your organization's cost due to injuries and describe how these costs due to injuries mean for those within the organization (Jallon et al., 2011; OSHA, n.d.).
- ☐ Establish a simple process to oversee workplace safety improvement work while also considering how it aligns with other initiatives across the organization.

Clinical Workflow : Workplace Safety Responsibilities for Everyone

1. CONTRIBUTE TO A SAFE WORKPLACE CULTURE.

- Recognize one another for the value they bring to the organization. Embody "Commitment to my Coworker" principles.
- Hold team members accountable and learn from yours and others' mistakes.
  - o Participate in root cause analysis workshops and debriefing sessions after the event.
  - o Reflect on all opportunities for personal and team improvement to avoid the same error or risk in the future.
- Listen to other team members if they are explaining concerns or are approaching you for advice.
- Do not leave a team member alone in a potentially hostile environment.
- Treat everyone as your equal.
- Respond to staff, patients, and family members who report bullying. Have a conversation with the reporting individual and try to understand how you can best help them.
- Participate in peer support programs and 'buddy systems' for both social support and safety.
- Normalize and encourage help-seeking behavior in peers. Seek out help yourself when needed.
- Raise concerns about intimidating behavior or exclusion.
- Do not feel as though you are alone in resolving someone's concern. Collaborate with leadership, security, and human resources.
- Practice peer support principles, including presence, psychological safety, empathetic listening, non-judgemental curiosity, problem-solving guidance, coping encouragement and exploration, reframing, resource connection, and appreciation (IHI, 2020).

2. REMAIN VIGILANT FOR AND REPORT WORKPLACE SAFETY RISKS.

- Report conditions that often lead to injury. If you sense a potential future problem, say something and allow the experts to do a risk assessment.
- Be as transparency as possible around workflow and policy gaps that could contribute to unsafe environments.
- Encourage colleagues to use the reporting system.

- Raise concerns of unclear or ambiguous guidelines, procedures, or standards.
- Elevate concerns of increases in workload after the implementation of new processes or technologies.

2. EXPECT THAT LEADERS RESPOND TO CONCERNS.

- Follow up with leaders after raising a concern or suggestion.
- Participate in debriefing sessions, root cause analyses, and performance improvement initiatives.

Education for Patients and Family Members

Workplace safety and violence prevention is the responsibility of everyone in the organization. While healthcare workers have been trained and educated on workplace safety protocols and violence prevention mechanisms, patients and facility visitors may lack this knowledge and may fail to acknowledge how their actions have a significant impact on the safety of those in the workplace and subsequently, in the delivery of their own care.

Healthcare workers should discuss the following with patients and family members and why each are important to maintain workplace safety:

- Not leaving tripping hazards in rooms
- Asking for help from healthcare professionals instead of insisting on completing things themselves
- Asking questions as they arise
- Using devices to prevent falls and injury
- Expecting mutual respect
- Active listening and two way communication
- Engaging in open discussion to ensure expectations for treatment and pain control are understood
- Participating in bedside rounding
- Discussing patient rights and responsibilities

The patient and visitors should understand that these expectations are in place to both facilitate the well being of those employed by the organization, but to ensure quality provision of care that directly impacts the patient themselves.

Performance Improvement Plan

Follow this checklist to improve performance and move your organization toward eliminating the harm and death associated with unplanned extubation:

☐ **Gather the right project team.** Improving workplace safety is not easy and this improvement initiative will require perspectives from all involved in the organization to truly understand what's really happening and what those on the frontline wish to see in the future. Therefore, the "project team" is the entire leadership team.

Complete this Lean Improvement Activity:
Conduct a SIPOC analysis to understand the current state and scope of the problem. A SIPOC is a lean improvement tool that helps leaders to carefully consider everyone who may be touched by a process, and therefore, should have input on future process design.

RECOMMENDED WORKPLACE SAFETY IMPROVEMENT TEAM	
• Nurses	• Mental health and addiction professionals
• Pharmacists	• Admitting and registration staff
• Providers	• Quality and safety specialists
• Respiratory therapists	• Rapid response team members
• Ancillary staff members	• Patients and family members
• Security personnel	

Table 1: Understanding the necessary disciplines for a workplace safety improvement team. Ensure representatives from across the system and community. Determine the best timeline for which to include each representative (e.g., nurses should be included from inception).

☐ **Understand what is currently happening and why.** Reviewing objective data and trends is a good place to start to understand the current state of your organization. Teams should spend a good amount of time analyzing data (and validating the sources). However, the most important action here is to complete leader rounding at the key locations determined by the data, to observe and engage the staff. Even if team members work in the area daily, examining existing processes from every angle is generally an eye-opening experience. The team should ask questions of the frontline during the observations that allow them to understand each step in the process and identify the people, supplies, or other resources needed to improve patient outcomes.

Create a process map once the workflows are well understood that illustrates each step and the best practice gaps the team has identified (IHI, 2015). Brainstorm with the advisory team to understand why the gaps exist, using whichever root cause analysis tool your organization is accustomed to (IHI, 2019). Review the map with the advisory team and invite the frontline to validate accuracy.

WORKPLACE SAFETY PROCESSES TO CONSIDER ASSESSING

- Conditions that lead to injury
- Conflict resolution practices
- Staffing decisions
- When and how staff members complete reports
- Functionality of making a report (Morphet, Griffiths & Innes, 2019; Brophy, Keith & Hurley, 2018).
  - Does the system require a password?
  - To whom is the reporting platform accessible?
  - Is the platform compatible with all methods of access (e.g., phones, computers, etc)?
  - How long does it take to fill out a report?
  - Are the directions on the report clear?
  - Is the report available in all primary languages of the staff in the organization?
  - What does the 'confirmation message' once the report is submitted look like?
- The process of completing, receiving, interpreting, and responding to a workplace safety report.
- Content within the report
  - Does the content within a reporting form allow for enough context to understand the full situation?
- When and why staff members step outside of workplace safety protocols
- Circumstances that require de-escalation and how this is employed
- Team interaction in high stress environments
- Feedback mechanisms after implementation of a new technology or process
- Anonymous versus face to face reporting and feedback mechanisms
- Safe patient handling (OSHA, n.d.; OSHA, n.d.).
- Results of organizational assessments to identify workplace safety risks including but not limited to:
  - Workplace violence assessments (ASHRM, n.d.; MDH, n.d.).
  - Perceptions of Just Culture (Petschonek et al., 2013; Fencl et al., 2021)
  - Ergonomic assessments (IEA, 2017)
  - Workplace injuries assessments (OSHA, 2013)
  - Health and safety climate assessments (CDC, n.d.).
- Current lateral violence and bullying guidelines (Johnson, 2015)
- Trainings, competency checks, and ongoing education those in the organization already have to complete for both workplace safety specifically and for other topics

Table 2: Consider assessing these processes to understand where the barriers contributing to unsafe workplace environments may be in your organization

☐ **Prioritize the gaps to be addressed and develop an action plan.** Consider the cost effectiveness, time, potential outcomes, and realistic possibilities of each gap identified. Determine which are priorities of focus for the organization. Be sure that the advisory team supports moving forward with the project plan so they can continue to remove barriers. Design an experiment to be trialed in one small area for a short period of time and create an action plan for implementation.

The action plan should include the following:

- Assess the ability of the culture to change and adopt appropriate strategies
- Revise policies and procedures
- Redesign forms and electronic record pages
- Clarify patient and family education sources and content
- Create a plan for changing documentation forms and systems
- Develop the communication plan
- Design the education plan
- Clarify how and when people will be held accountable

TYPICAL GAPS IDENTIFIED IN WORKPLACE SAFETY

- When charts of violent patients are 'flagged', it may create stigma for that patient.
- Even if patient risk factors for violence are documented in the chart, this information may not be readily available for future encounters.
- The built environment itself may compromise staff safety (e.g., patient is blocking staff member exit from the door in a secluded area).

- Conflict resolution and de-escalation strategies are not widely used.
- Workers may not be aware of high risk circumstances (e.g., patients coming out of sedation).
- Even though the risk may be recognized, the staff member does not have the resources to handle the risk at that moment.
- There's little faith that anything will be improved when reports of poor workplace safety are made.
- Staff members may be fearful of making reports.
- Events that are investigated are only those that resulted in a severe outcome.
- Reports are not made because 'no one got hurt'.
- Staff struggle to put experiences of risk into words (e.g., "I had a gut feeling").
- The reporting system is not available to everyone who may have a workplace safety concern.
- Impairment reports (e.g., due to drugs) may be seen as a defect of the impaired individual rather than looking at root causes of the problem.
- Escalation criteria are not well defined.
- Workplace safety data is not tracked/discussed in a meaningful way.

Table 3: By identifying the gaps in workplace safety efforts, organizations can tailor their project improvement efforts more effectively

☐ **Evaluate outcomes, celebrate wins, and adjust the plan when necessary.** Measure both process and outcome metrics. Outcome metrics include the rates outlined in the leadership checklist. Process metrics will depend upon the workflow you are trying to improve and are generally expressed in terms of compliance with workflow changes. Compare your outcomes against other related metrics your organization is tracking.

Routinely review all metrics and trends with both the advisory and project teams and discuss what is going well and what is not. Identify barriers to completion of action plans, and adjust the plan if necessary. Once you have the desired outcomes in the trial area, consider spreading to other areas (IHI, 2006).

It is important to be nimble and move quickly to keep team momentum going, and so that people can see the results of their labor. At the same time, don't move so quickly that you don't consider the larger, organizational ramifications of a change in your plan. Be sure to have a good understanding of the other, similar improvement projects that are taking place so that your efforts are not duplicated or inefficient.

Read this paper from the Institute for Healthcare Improvement to understand how small local steps

WORKPLACE SAFETY METRICS TO CONSIDER ASSESSING

- Turnover rate
- Employee retention
- Job satisfaction rates
- Worker's compensation injury claims
- Number of workplace violence incidents, with critical focus on severity and location
- Patient acuity over time

- Number of patients secluded
- Hours of seclusion/1000 hours
- Number of patients restrained
- Hours of restraint use/1000 hours
- Unscheduled staff time off (e.g., sick day use/absenteeism)
- Staff debriefing meetings after an incident
- Reports of bullying
- Burnout rates (NAM, n.d.)
- Employee needlestick injury rate
- Employee hospital-acquired infection rate
- Number of insurance claims by employees due to occupational hazard
- Employee radiation safety rate
- Number of employee sentinel events
- Number of second victims counseled

Table 4: Evaluate related metrics to better understand poor workplace safety presence and contributing factors. Consider delineating these metrics by unit, age, position, ethnicity, gender, etc. Display workplace safety metrics visually right next to patient safety indicators when reporting for easier detection of trends.

What We Know About Workplace Safety

Workplace safety requires an organization-wide, multilevel, cultural paradigm shift towards open and honest communication, conflict resolution, psychological safety, and mutual respect to anticipate and prevent workplace violence, hazards, and injuries and to promote well-being, joy at work, communication, and collaboration.

The Ideal Workplace

Organizations of high reliability prioritize the safety and wellbeing of those within, regardless of role or status. The following are examples of features of a safe, healthy workplace:

- Early recognition of unsafe behaviors
- Comfort and empowerment of all in reporting
- Confidence that reports will be taken seriously
- Comfort in asking questions
- Support from leaders when confronted with a workplace safety risk
- Clear guidelines to reference in situations of workplace safety risk
- Supportive environment for pitching ideas for improvement
- Clear, universally understood definitions of behaviors that compromise safe environments
- Comfort in asking for support
- Expectation of being listened to without unnecessary interruptions
- Active listening in all conversations
- Timely provision of materials needed to ensure safety (e.g. PPE)
- Proactive and routine evaluation of workplace culture, safety, and environment
- Open door policy by leaders for their frontline staff
- Freedom of expression without fear of retaliation
- Staff continued education around tools for improving communication and conflict management

- Continued feedback to staff around how their feedback contributes to improvement
- Rewarding achievements

Workplace Violence

While workplace violence is often the most shocking aspect of poor workplace safety, there are so many additional factors that contribute to poor workplace safety and compromise communication, error reporting, patient safety, mental health, well being, healthy habits, and job performance.

Workplace violence is particularly prevalent in the healthcare space because of the nearly-universal desire to help patients, regardless of the circumstance, and because clinicians may excuse violence from patients due to their condition or cognitive state. Workplace violence is defined as, "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site" (OSHA, 2020). Intentionality and criminality are not benchmarks, and incidents can fall within a spectrum that ranges from threats and verbal abuse to physical assaults and even homicide (OSHA, 2020). Workplace violence is a global phenomenon that, at its core, negates a healthcare worker's ability to provide safe patient care. Violence is one of the most dangerous occupational hazards health care workers face. This makes health care facilities one of the most dangerous places to work, with a rate of 6.8 work-related injuries and illnesses for every 100 full-time employees (OSHA, 2020). To put this into perspective, healthcare workers in Canada have two times the rate of injury due to violence than police officers (CCOHS, 2020). In the United States, healthcare workers have a rate of injury comparable to all other US industry workers combined (GAO, 2016).

Intervention strategies should use the 80/20 rule as a guideline for their efforts. Meaning 80% of an organization's efforts should be focused on the prevention of workplace violence, while the other 20% is action towards response to incidents (Holbrook et al., 2019).

Early Indicators of Unsafe Work Environments

Organizations should not wait until something bad happens to take the first steps. Risk factors for poor workplace safety include, but are certainly not limited to (Raveel & Schoenmakers, 2019):

ENVIRONMENTAL FACTORS	ORGANIZATIONAL CULTURE FACTORS	HUMAN FACTORS	CULTURAL AND SOCIAL FACTORS
Full medical campus factors, such as: • Poor control over staff only areas and patient areas • Overcrowded and noisy areas • Poor access to amenities such as toilets • Poor lighting • Lack of secure areas for medications, money etc. • Lack of understanding around how to call for help in simulation training	• Lack of adequate staff • Lack of leadership knowledge of safety events • Lack of recognition of potentially hostile or aggressive situations • Working alone • Lack of a reporting mechanism with timely, consistent and thorough follow up with each report • Little encouragement to report and little faith that reporting will do anything	• Altered patient mental status due to factors such as medications, substance abuse, or physiological conditions • Altered provider ability due to impairment medications, substance abuse, or physiological conditions • Fear of retaliation after reporting or confronting • Fear of not being taken seriously • Power imbalances • Patient previous poor experiences with the healthcare system	• Language differences • Differences in interpretation of nonverbal communication • Suspicion leading to premature defensiveness • Belief that violence is expected as part of the job

• Lack of protective equipment, such as PPE • Fall risk hazards • Lack of support for heavy equipment • No ability to call for help (e.g., lack of emergency codes) • No ability to examine evidence of workplace safety issues (e.g., lack of CCTV monitoring)	• Unclear guidelines around what constitutes aggressive, hostile, or unhealthy behavior and when to report • Lack of training in de escalation • Unclear, unstandardized protocols for the use of restraints • Lack of robust, standardized, routinely reinforced policies around why something can or cannot be done	• Frustration due to not being listened to or treated fairly • Poor communication • Mobbing, causing fear that the next individual to report will be the next target	

Resources

For Workplace Safety Improvement:

- Interaction of Health Care Worker Health and Safety and Patient Health and Safety in the US Healthcare System: Recommendations from the 2016 Summit
- The Joint Commission: Improving Patient and Workplace Safety
- United States Department of Labor: Occupational Safety and Health Administration
- OSHA: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
- WHO: How to Create an Attractive and Supportive Working Environment for Healthcare Professionals
- IHI: Framework for Improving Joy at Work
- IHI: Three Ways To Create Psychological Safety in Healthcare
- CDC: Safety and Health information for Healthcare Workers
- NIOSH: Fact Sheet: The Buddy System
- Interventions to Prevent Aggression Against Doctors: A Systematic Review
- Workplace Bullying Among Nurses: Developing a Model for Intervention
- United States Government Accountability Office: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence
- Implementation of a Preparedness Program to Address Violent Situations in Healthcare
- Workplace Violence Against Healthcare Professionals: A Systematic Review
- Metropolitan Hospital Compact – Sample template: Management of violence in the healthcare/workplace setting
- Gap Analysis Tool
- Workplace Bullying Prevention: A Critical Discourse Analysis
- Workplace Violence: Prevalence, Risk Factors, and Preventive Measures Across the Globe
- Workplace Violence Prevention and Response

- PA Patient Safety Authority: Violence against Healthcare Workers
- Oregon Association of Hospitals and Health Systems Workplace Safety Initiative
- AHA: Workplace Violence Prevention Resources
- AHA: Grady Memorial Hospital Case Study: Managing Workplace Safety and Reducing Workplace Violence in Hospitals

For General Improvement:

- CMS: Hospital Improvement Innovation Networks
- IHI: A Framework for the Spread of Innovation
- The Joint Commission: Leaders Facilitating Change Workshop
- IHI: Quality Improvement Essentials Toolkit
- SIPOC Example and Template for Download
- SIPOC Description and Example

Endnotes

Conflicts of Interest Disclosure

The Patient Safety Movement Foundation partners with as many stakeholders as possible to focus on how to address patient safety challenges. The recommendations in the APSS are developed by workgroups that may include patient safety experts, healthcare technology professionals, hospital leaders, patient advocates, and medical technology industry volunteers. Workgroup members are required to disclose any potential conflicts of interest.

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Appendices

Appendix A: Example of a proactive leadership response to workplace violence or reports of hazards.