Safer Together
Executive Summary

The *Safer Together* initiative represents a joint endeavour between WorkplaceNL and Eastern Health that began in 2016 with the overarching goals of reducing injuries and strengthening Eastern Health's safety culture. This three year project originally comprised four main components: i) implementation of a safe resident handling (SRH) program in a rural long-term care (LTC) site; ii) development of a training program to address injuries resulting from resident aggression; iii) development and implementation of a safe manual materials handling program and; iv) enhancement of an existing early and safe return to work program. The evaluation that accompanied the *Safer Together* initiative examined the implementation and impact of three of the four project components. Although a report with recommendations was completed, the development or adaptation of an existing intervention to address resident aggression did not occur.

Overall, with the exception of the proposed intervention to address resident aggression, all project components were implemented as intended, although some component-specific challenges were noted. The project was a tremendous example of successful collaboration between two organizations. Project team members worked together to develop, implement, and monitor each of the *Safer Together* components over the three-year period since project inception. Project team members from both WorkplaceNL and Eastern Health describe the joint initiative as resulting in an improved understanding of the operations of healthcare organizations and the complexities associated with implementing or enhancing safety programs. A brief overview of the findings from the evaluation is presented in this executive summary.

Safe Resident Handling

The SRH component of *Safer Together* comprised a series of LTC process improvements implemented at the Private Josiah Squibb Memorial Pavilion (PJSMP) in Carbonear, Newfoundland. These included performance reviews for managers, SRH training for facility personnel, manager-led resident handling task observations, safety huddles, the formation of an incident investigation committee, and a revamped procedure for inspection and maintenance of SRH equipment. The primary objective of the evaluation was to determine the impact of these improvements on the number and rate of resident handling injuries incurred by nursing staff, though the evaluation also encompassed a number of secondary outcomes, including staff satisfaction, perceived knowledge of and confidence in SRH, and organizational safety climate. To meet these objectives, evaluators analyzed employee incident data, administered staff questionnaires, and conducted interviews and focus groups with PJSMP personnel.

In its formative evaluation of the SRH component, evaluators determined that process improvements had been implemented more or less as planned. Performance reviews for managers had been completed by the facility administrator; staff SRH training completion rates approached 80% in the pre-intervention period and rose to 97% thereafter; an Incident Investigation Committee convened on a weekly basis, with participation from both managers, front-line staff and Occupational Health and Safety (OHS) personnel; and the percentage of required sling and floor lift inspections reached 100 part way through the intervention. On the other hand, certain of the project deliverables were implemented in ways that varied from initial expectations. For example, managers were initially charged with conducting SRH task observations but, finding this problematic, attempted to devolve the responsibility to staff persons. These peer-led observations were eventually discontinued as well, partially because of the strain it imposed on unit staffing. Vacant manager positions in the early stages of the intervention posed a challenge for the delivery of safety huddles at the recommended frequency. However, since January 2017, the number of safety huddles delivered by managers and RNs has consistently exceeded the recommended frequency with over 1000 huddles delivered in a 2½ -year period.

Nursing staff satisfaction with the SRH training was high, and over 50% of staff respondents reported that the training had improved safety in the facility. Some staff members noted that, although the training prepared them to engage in SRH with "ideal" residents, it failed to address the challenges associated with engaging in SRH with residents whose physical condition interfered with SRH and/or who exhibited aggressive or responsive behaviors. Despite this, staff reported high levels of knowledge of SRH and confidence in their ability to engage in SRH. Similarly, staff were satisfied with the availability of SRH equipment in the facility.

The nursing staff injury data obtained for the safe resident handling portion of the *Safer Together* evaluation provides evidence of a sustained decrease in resident handling injuries requiring medical aid and resident handling injuries not requiring medical aid or resulting in lost time. In contrast, though demonstrating an initial decrease, lost-time injuries began to return to pre-intervention levels toward the end of the evaluation period. Nevertheless, an examination of injury rates in the pre- and post-periods, overall, show a reduction of 25.0%, 48.1% and 49.2% in lost time, medical aid, and injuries not requiring lost time or medical aid, respectively.

An examination of resident handling injury rates in the pre- and post-implementation periods shows a reduction of 25% to 49%.

Both the questionnaire and interview data suggest that the intervention had a modestly positive effect on several of *Safer Together*'s targeted safety climate outcomes. In particular, the initiative does seem to have encouraged staff and managers at PJSMP to be more cognizant of safety issues and to engage more regularly in open dialogue around potential hazards and areas for improvement. For example, there were positive improvements in nursing staff's perceptions of resident care managers' willingness to listen to safety ideas and

The number of nursing staff respondents who felt that there are barriers to SRH decreased from 48.5% at baseline to 29.5% at an 18-month follow-up.

suggestions and to correct unsafe working habits. Additionally, approximately 1½ years following the implementation of the program, fewer nursing staff identified that there were barriers to SRH at PJSMP compared to baseline.

> "I've done change-out rounds on my floor all by myself and we've had to do lifts ourselves."
>
> *Nursing staff member*

The evaluation has also suggested a number of possible factors that may persist as barriers to nursing staff engaging in SRH practices. Chief among these factors was the difficulty of sustaining SRH practices during periods of higher-than-normal absenteeism; operating in a time pressured, task-oriented work environment; pressures from family members; and the recurring inconsistencies and imbalances in the distribution of SRH-related roles and responsibilities throughout the course of the project. Given the upward trend toward the end of the evaluation period in lost-time injuries associated with resident handling, PJSMP leadership and front-line staff would be well advised to continue to address these potential barriers while also working to maintain the gains made in safety climate, SRH communication and awareness, and RH injuries not resulting in lost-time.

The following recommendations are offered:

1) Any future SRH initiatives at PJSMP or any other LTC facility should prioritize clear communication with managers and staff in the early planning stages and continuously throughout the intervention, so as to ensure that all stakeholders have input into and understanding of intervention objectives and roles and responsibilities.

2) Future SRH initiatives should lay particular emphasis on SRH with residents who exhibit BPSD, as this population poses unique resident-handling challenges that were not fully addressed by *Safer Together*.

3) The work of the inspection investigation committee should continue, and care should be taken to ensure that investigation results are communicated back to staff in a timely manner.

4) Managers and/or RNs should strive to ensure that staff huddles provide opportunities to engage in meaningful discussion of safety issues; otherwise, evaluation results suggest that huddles will simply become an empty 'box-ticking' exercise.

5) PJSMP should continue to employ a dedicated Lift Champion moving forward, as this position has been identified by nursing staff as crucial to sustaining the program and ensuring that staff and residents have access to and utilize the SRH equipment.

6) PJSMP should consider increasing the supply of breeze sheets, as these were regarded by evaluation participants as especially important to SRH.

7) Managers should be encouraged to maintain steadfast support for nursing staff when facing pressure from residents' family members to compromise on SRH; evaluation results suggest that such pressure may have been a barrier to staff uptake of SRH techniques and equipment.

8) Staff should be encouraged to take as much time as is needed to perform SRH with residents, and particularly those who exhibit BPSD or present other kinds of special challenges; evaluation results suggest that a task-oriented approach to resident care and a tendency to rush constitute another barrier to intervention uptake.

9) PJSMP should implement mechanisms to hold managers and staff accountable with respect to SRH.

10) PJSMP should make special efforts to address the discrete but recurring periods of staff shortage that have been found to render certain elements of SRH impracticable.

11) Special care must be taken to ensure that resident care managers are not tasked with an excessive share of the responsibilities for SRH; rather, roles and responsibilities should be allocated evenly among mangers, front-line staff, and the Lift Champion.

Manual Materials Handling

A Safe Manual Materials Handling (MMH) program was developed and implemented in several Eastern Health facilities; however, based on project timelines and the intended outcomes proposed, the evaluation focused on departments within the initial pilot site only – St. Clare's Mercy Hospital.

In general, the MMH program involved the development of policy and procedures to support safe manual materials handling and the development and implementation of a safe MMH training session that included an emphasis on musculoskeletal injury (MSI) or musculoskeletal disorder (MSD) prevention. Data for the evaluation were collected via multiple methods including survey administration, key informant interviews and an examination of injury data also occurred.

> "There's definitely more of a safety culture here. Definitely more of an interest. I think one of the biggest things is that the staff feel valued through this program."

The results of the evaluation confirmed that the MMH program was developed largely as intended with the creation and/or implementation of policy, procedures and data capturing templates (e.g., a standardized MMH Equipment Inspection Record, MMH Task Observation Form, and a Safety Meeting/Huddle Data Collection Form) to support safe MMH. This was a significant improvement in practice as few formalized methods were available to support or track adherence to safe MMH prior to introduction of the *Safer Together* initiative.

A safe MMH training session was delivered to over one hundred staff in five program departments/divisions at St. Clare's representing almost 100% of intended pilot participants.

"This training will reduce the frequency and severity of injuries in the long run. I think a lot of injuries in my department happen over a long period of time, so it's making sure that they don't go back to their old habits… I think it's a long-term goal. I don't think it can be a short-term goal."

Surveys conducted with training participants immediately prior to the training, immediately after the training and again six to eight months post-training revealed favorable perceptions of the training and the overall MMH program. Both staff and managers reported gains in knowledge and understanding relating to MMH safety and MSI prevention. In most cases, the noted increases persisted at the six to eighth month follow-up period demonstrating the efficacious nature of the training session on knowledge and understanding.

The impact on injuries was less clear, with variation in monthly injury rates occurring in both the pre-period and the post-intervention periods for all departments/divisions, and no injuries of any type occurring in many months. With that said, a decrease in LT injuries was noted in the one-year post-period in the Material Support and Patient Portering departments/divisions. However, when all departments/divisions were considered together, no decreases in lost-time (LT) or medical aid (MA) injuries were observed in the one-year period after the initiative was introduced.

The short time-period under examination, as well as the lack of injuries in some departments/divisions make it difficult to form definitive conclusions about the impact of the MMH program on injury rates. Many MMH-related injuries develop over time, through repetitive behaviours, so it is conceivable that many of the benefits of the MMH program could take some time to be realized.

The following recommendations are offered:

1) Create mechanisms to recognize/validate employee reporting.

2) Implement mechanisms to properly resource and sustain change.

3) All employees should have to complete the safe MMH training session that was developed as part of the new MMH program.

"When I heard we were going to be doing an ESRTW pilot at our site I said *'Thank God. I can't wait for it to start, because there's stuff on my desk that I can't get to, and it's nice to know that there's a team looking after it'*. There was someone else to take it on when I went on vacation, the process didn't get slowed down, because there's a team here to help take care

e benefit. Before, if I , this process would tandstill."

4) Continue to offer MMH training but consider adding more time to cover training topics.

Early and Safe Return to Work

While the SRH and the safe MMH

handling components addressed the development and/or implementation of prevention efforts, the third component addressed early and safe return to work (ESRTW) after an injury occurred. Specifically, this evaluation was designed to evaluate enhancements that occurred as part of the *Safer Together* initiative at three long-term care sites (Pleasant View Towers, St. Patrick's Mercy Home and the Agnes Pratt Home). The enhancements included the introduction of an education session that emphasized: i) documentation requirements ii) the introduction of an on-site "binder" or binder(s) containing information on ESRTW procedures, and iii) the incorporation of an injury-prevention talking point, safety-share or workplace safety reflection into new and existing huddle sessions. Again, mixed methods were employed to collect data for the evaluation, including survey implementation, and key informant interviews. Examination of administrative data sources related to documentation also occurred.

Like the safe MMH initiative, gains in self-reported knowledge and/or understanding were noted. Specifically, most indicated their knowledge and/or understanding of items related to roles and responsibilities in the event of an injury, the importance of communication in the ESRTW process, and documentation requirements, increased. The informative nature of the education session and satisfaction with the initiative, in general, was also echoed in key informant interviews; however, additional insights included vocalized preference for the education sessions that were delivered in the larger group format and that communication with, and receipt of functional information from, health providers was essential to an employee's early and safe return to work. Key informants also suggested that the initiative helped managers to "think outside the box" to find creative ways to bring people back into the workplace after an injury.

An examination of ESRTW documentation in the 12-month period prior to, and the 12-month period after, the introduction of the ESRTW enhancements that occurred as part of this initiative suggested improvements in documentation completion across all sites. Specifically, a greater percentage of Form 6's, 7's and 8/10's were completed within the expected timeframes after the initiative began. Additionally, a greater proportion of injured employees participated in ESRTW in the 12-month period after the initiative began at one site and the time between injury and ESRTW commencement decreased across all sites.

Overall, the enhancements to the ESRTW program embodied many of the characteristics that research suggests are critical to the success of return to work programs. For example, the delivery of ESRTW education sessions and the emphasis that was placed on working safely as part of the program demonstrated a strong commitment by the organization to health and safety. The initiative emphasized the importance of timely coordination and communication following an injury. And finally, a team of dedicated individuals throughout the organization supported injured employees throughout the ESRTW process and made a variety of modified work accommodations available to them. In sum, theresults indicate that the enhancements made to the ESRTW program as part of the *Safer Together* initiative in the form of education and awareness activities were a worthwhile endeavor.

Several recommendations are offered:

1) Continue to provide formalized ESRTW education sessions (and refresher information) to employees.

2) ESRTW education should be provided prior to workplace-entry.

3) Provide ESRTW education to health care providers that provide functional information.

4) Conduct ongoing and/or future data monitoring and evaluation.

Conclusion

The delivery of high quality healthcare services is a highly complex and demanding endeavor and the implementation of new initiatives can be challenging; however, WorkplaceNL and Eastern Health worked together to successfully implement the *Safer Together* initiative with a shared vision of reducing injuries and promoting a culture of safety. Three of the four proposed *Safer Together* components were implemented and, although the results failed to show a strong and/or sustained impact on number or rates of lost-time injuries, considerable gains were made in other aspects of the safety climate in those facilities involved.