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Excluded Actors in Patient Safety

Abstract

[Excerpt] In this chapter we argue that it is necessary to create a fundamentally different patient safety template. Creating that template can produce impressive results. Maimonides Medical Center in Brooklyn has been successful at creating a safer hospital environment because it has involved both unions and frontline workers.

Keywords

patient safety, nurses, healthcare workers, hospital environment, unions

Disciplines

Health and Medical Administration | Labor Relations | Nursing Administration | Occupational and Environmental Health Nursing | Unions

Comments

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Excluded Actors in Patient Safety

Peter Lazes, Suzanne Gordon, and Sameh Samy

Diane Sommers is an ICU (intensive care unit) nurse at a major East Coast teaching hospital.¹ Over the past few years her hospital has launched a number of pioneering safety initiatives: operating room and ICU checklists, efforts to reduce falls and infections, as well as safety meetings on individual patient care units. On the unit, a specific time is set aside each week so that staff can meet and learn about new safety methods, as well as discuss their concerns and insights. For Sommers, this has been a promising development. The problem, however, is that she and her colleagues have such a heavy workload caring for two intensely ill patients that they cannot regularly attend these patient safety meetings. Increasingly skeptical about her hospital's commitment to the kind of ongoing staff input that is critical to improving patient safety, Sommers wonders: Why doesn't hospital management adjust the nursing workload—just for an hour a week—so RNs like herself can contribute more effectively to patient safety efforts?

Beth Jones is an intravenous (IV) nurse at a Massachusetts teaching hospital. Although her hospital has implemented efforts to reduce central venous line infections, Jones is quite frustrated because these activities have not included the frontline staff responsible for placement of IVs. "We've had a really serious problem with central venous catheter [CVC] line infections. We have an awful lot of problems with PICC [peripherally inserted central catheter] lines. Management got together some nurses, infectious

disease people, and doctors but left out the IV nurses, who are responsible for maintaining these lines and who'd complained about this problem for years. After all, we're the ones who take care of the central lines. I don't know why they left us out. I can't really figure it out. It's like they don't seem to think practitioners have valuable knowledge."²

Rick Brooks is the executive director of Rhode Island United Nurses and Allied Professionals (UNAP), a union that represents nurses at Rhode Island Hospital and other institutions connected to Lifespan, the largest hospital network in the state. Lifespan is another hospital network that has signed on to various patient safety initiatives. For example, one of Lifespan's physicians has partnered with an airline pilot to train staff in the kinds of teamwork lessons that have been essential to promoting safety in commercial aviation. Although the union is an influential "stakeholder" in hospital culture, Lifespan administrators have never asked UNAP to encourage its members to attend such seminars. In fact, the first Brooks heard of these meetings was when one of the authors asked him about them. Brooks acknowledges that he and fellow union activists could be more proactive when it comes to patient safety, but adds that members tend to be quite cynical about hospital safety initiatives. He explains, "Whenever union members identify workplace issues—mandatory overtime, unsafe staffing, failure to utilize lift equipment when moving heavy patients or failure to empower staff to challenge surgeons who refuse to use operating room checklists—the hospital ignores their concerns." When worker safety and patient safety intersect, says Brooks, "the hospital seems uninterested in pursuing either."³

Pamela Brier is the CEO of Maimonides Medical Center in Brooklyn. Over the past several years, her institution has also initiated a variety of patient safety initiatives. One concerned hospital cleanliness; others focused on patient falls and medication errors. Another was triggered by problems in the cardiology program. Although initiatives that are taking place at Maimonides seem similar to those going on in other hospitals, there is a significant difference. Unlike top-down management- or physician-led patient safety initiatives in many other U.S. institutions, those at Maimonides have been developed, implemented, evaluated, and refined in partnership with the hospital's three unions and led by frontline staff—not only RNs but also nursing aides, lab techs, and even cleaning staff. Brier feels that the inclusion of frontline staff and unions has transformed stalled efforts to make Maimonides a safer hospital, and she and her colleagues in the executive suite are committed to pursuing a bottom-up approach to patient safety.

These four anecdotes highlight one of the most significant issues related to the realization of the patient safety agenda in hospitals today. In the contemporary American hospital, when patient safety initiatives are planned and

designed, this work is almost always done at the top. Physician leaders, safety champions, “green belts,” safety researchers, nurse managers, hospital administrators, outside consultants, patient safety advocacy groups, or hospital regulators identify problems, craft solutions, design and plan initiatives, and/or issue mandates requiring their implementation. As initiatives move from top to bottom, managers are generally enlisted to encourage worker compliance. The evaluation and refinement of safety efforts also takes place with little input from the front lines of care—nursing, nursing assistants, cleaning, food services, and other hospital occupations. In a similar vein, in many hospitals in which unions represent a significant segment of the workforce, union leaders and activists are rarely enlisted as allies and may not even be notified about patient safety projects or plans.

Furthermore, when workers identify patient safety problems that target workload, equipment, supplies, or fatigue and worker safety and health—anything that involves the allocation of significant financial resources or involves significant changes in work organization—hospitals often turn a deaf ear to their concerns. When workers, particularly unionized workers, propose legislative, regulatory, or contractual remedies that could improve patient safety, hospitals generally fight to defeat these efforts. Indeed, rather than allying with workers who have identified significant safety problems, administrators often perceive workers as adversaries rather than allies. When it comes to patient safety, there is also a disconnect between initiatives designed to make patients safer and those that also target the health and well-being of the hospital workforce. Although the two are intimately connected, in the modern patient safety movement and hospitals’ responses to it, worker safety lies on one side of a very wide chasm that separates the health of hospital workers from that of the patients for whom they care.

In this chapter we explore this blind spot in the effort to make hospitals safer, providing an argument for the inclusion of frontline workers and unions, analyzing some of the reasons for their exclusion from safety efforts, and suggesting a different model that would help strengthen safety activities.

Why Frontline Workers and Unions Matter

Including frontline workers in the full spectrum of patient safety initiatives is important for several reasons. While high-level buy-in is critical to patient safety, hospital culture is changed not only through dictates elaborated in the C suite (the hospital department where we find the offices of the chief executive and operations, finance, and nursing officers), or by experts and

researchers at a patient safety conference, or on grand rounds, but also at the grass-roots level, where care is delivered and where the environment in which it is delivered is shaped: in the patient's room, hospital corridor, nurses' station, on-call room, laboratory, X-ray suite, or housekeepers' locker room. The people who must carefully manipulate IV lines, administer medications, wash their hands before and after touching a patient, read tests correctly, keep hospital corridors and patients' rooms clean, or make sure that a patient doesn't die while being transported to or waiting for an X ray are also the people who can best help identify the problems they have doing these things safely and effectively. They are also the people who must help craft workable solutions as well as workable ways to implement and evaluate them. These staff have the implicit knowledge of what works and what doesn't. If hospitals are to learn from their mistakes and thus produce and sustain institution-wide learning, the process of institutional transformation must be circular, not linear—from bottom to top and top to bottom in a continuous manner.⁴

Let's look first at how patient safety problems are identified. Many researchers, policy experts, administrators, and managers have very accurate and innovative ideas about what is wrong in health care institutions and how to fix it. Safety initiatives must be supported by the top of the health care hierarchy and be implemented by—and overcome the resistance of—traditional medical elites. Higher-level administrators and middle managers have control over the resources that make change possible.⁵ They also have a lot of good ideas about what needs changing and how to change it. Nevertheless, many of the things that jeopardize patients are invisible to top management because they occur in what the great sociologist Erving Goffman called “backstage spaces” and involve backstage and often invisible health care workers. These are spaces that upper-level executives or managers (and sometimes even middle-level managers or physician leaders) rarely have access to because they spend very little time actually delivering patient care at the sites where care is delivered, or communicating directly with backstage workers. As the ones who deliver care or tend to the environment in which care is delivered, frontline workers are far more familiar with processes of care delivery and infrastructural maintenance and can thus far more effectively identify aspects of patient care delivery that are unsafe. As Amy Edmondson has put it, “In hospitals senior managers often do not know which group has which culture, making it difficult to ascertain whether and when they are getting the true data on errors.”⁶

According to Carol Porter, director of nursing at Mount Sinai Hospital in New York City, “to create an effective patient safety process, frontline staff need to be involved, not just to assure compliance with major initiatives

once they have been designed but to assure that the choice of initiatives, the strategies pursued, and plan for implementation and monitoring of activities include [them].”⁷ Porter found “it was impossible to improve patient safety in our hospital without the full involvement of frontline staff and the support of their unions. Past management refused to see these groups as allies and instead spent time fighting their involvement.”⁸

The renowned business professor Michael Porter (no relation to Carol) pointed out in an interview that institutions that have succeeded in creating a culture of safety have found ways to encourage and include frontline staff in the identification of safety problems without fear of reprisal. They not only involve staff in the design and implementation of appropriate and practical solutions but also, like other high-reliability industries (the aviation and chemical industries, for example), provide staff with the necessary time and resources to create, learn, and master new procedures and processes. Finally, they encourage staff to identify new problems that arise as solutions are rolled out. And, as Edmondson adds, they create an environment of psychological safety so workers can identify problems without risk and suggest if and when safety efforts are not succeeding.⁹

Because “solutions” always create unintended problems, these industries involve frontline staff and management. These two groups are central to any effort to illuminate clearly the dynamic interaction between work organization and the allocation of financial resources to patient care and safety. Clarity around this issue is absolutely critical. When it comes to patient safety, the devil that can undermine the best of patient safety activities often lies in the details of work organization. Consider, for example, the effort to reduce the spread of hospital-acquired infections. When a hospitalized patient acquires an infection, it is important for all staff and visitors to put on a gown and gloves before entering the patient’s room. They must also discard them before exiting the room. To make sure that these procedures are followed consistently, not only RNs but also hospital cleaning, dietary, and any other staff who enter and exit a patient’s room must be carefully and recurrently trained in the proper infection control technique.

In one hospital we visited (a Magnet hospital that had won many other prestigious awards), one of us (Suzanne Gordon) watched closely as nurses gowned and gloved appropriately before entering a room and discarded their protective gear before exiting. A few minutes later, after the RN had left the room, a hospital cleaner entered, similarly gowned and gloved, and proceeded to clean the patient’s room. She, however, exited the room without discarding her gown and gloves inside and then, in the hospital corridor, took them off and threw them into a garbage receptacle. As she was walking by just by

chance, an RN chastised the aide for failing to execute patient safety precautions correctly. The aide had not done this correctly because cleaners had been left out of the patient safety information loop and were not sufficiently educated about the entire infection control procedure.

In another hospital, Gordon and Ross Koppel observed a similar problem. Workers, if consulted early and often, can identify problems and obstacles in the way their work is structured, information communicated, and care planned. The following example illustrates this often ignored fact.

We know that one of the most effective infection control measures is also one of the most simple: hand washing before entering and after exiting a patient's room. Yet we also know that many hospital workers don't wash their hands appropriately. As a recent article in the *Lancet* documented, it is not simply ignorance or laziness that keeps workers from using the soap and water or hand-sanitizing gel available in hospitals—when, that is, it is made available. The lapse also has to do with work organization. The article reported that understaffing and too much emphasis on patient throughput supersede hand washing even when indicators point to the acute need for more of it. Frontline staff are not ignorant of this problem. They know what discourages them from appropriately following hospital policies. As one RN commented tersely, “Don't tell me about hand washing. I know all about universal precautions. My hands are so cracked they are painful because I have them in soap and water all the time.”

This RN works on a medical surgical unit where the average patient load is between seven and eight patients. This may help explain why her hands are so cracked and painful. Increasing a physician's, nurse's, or nurses' aide's patient load significantly increases the number of patient encounters he or she has per day, which in turn increases the number of times he or she must clean his or her hands. To wash hands correctly would eat up a significant amount of time. Clearly if, because of heavy workloads, hospital staff lack the time to wash their hands and perform assigned patient care duties and/or find it too painful, they won't wash their hands.

Frontline workers may also be the only ones who can identify how institutional financial priorities are impacting the success of patient safety initiatives. Once again the issue of hospital cleanliness comes to mind. Cleanliness doesn't involve only washing one's hands or discarding gowns and gloves in the proper place. It involves the basic cleaning activities that Florence Nightingale identified over 150 years ago at the military hospitals in Scutari during the Crimean War. What is usually considered to be the prototypical example of “mindless” work can have lethal consequences if not done properly. Yet a number of studies have highlighted the fact that devaluation and outsourcing

of this kind of work have increased hospital-acquired infections, not to mention worker injuries and illness.¹⁰

The sociologist Dan Zuberi, for example, has analyzed the impact of a trend that began in the United States and has swept hospital systems all across the globe. The job of cleaning the hospital is no longer performed only by staff employed, trained, and controlled by the hospital but has been outsourced to private for-profit contractors. These contractors often try to save money and increase profit by skimping on the number of workers they hire, failing to train workers adequately to do their work safely, and even failing to provide them with adequate cleaning supplies. Zuberi states: "In an era in which about one in ten patients will suffer from a hospital-acquired infection, it is more important than ever that hospitals invest in the training of adequate numbers of cleaning staff. In fact, by disinvesting in cleaning through outsourcing, hospitals are doing the opposite."¹¹ In his research Zuberi has found that managers frequently lose control over every step of the process. In many hospitals they can no longer choose whom to hire, what kind of training staff get, the number of staff assigned, or the kinds of chemicals used.

Zuberi explains that infection control nurses, who used to meet and work regularly with housekeeping staff to provide them with training and supervision or to address critical issues, are no longer able to work directly with housekeepers because they are no longer working directly for the hospital. "When cleaning workers work for outside contractors whose main mission is to maximize profit, patients suffer,"¹² Zuberi says. Using contract employees often leads to reduced communication with nursing and clinical staff, since they are accountable not to the hospital but instead to their contract supervisor. As an article in the *Journal of the Royal Society of Medicine* describes the situation in Great Britain "'outsourcing' of services such as hospital cleaning has produced a demoralized, exploited workforce and a management that has lost touch with what the job entails."¹³

Loss of control over the process of keeping hospitals clean can compromise any and every patient safety initiative that is proposed and implemented. Indeed, this loss of control jeopardizes the very mission of the hospital as well as the fundamental ethical promise of physicians and nurses to "first do no harm." Problems are also caused by the lack of clear, appropriate procedures for these staff, on the assumption that "everyone knows how to clean a room." Making sure that these phenomena do not jeopardize the nonnegotiable aspects of patient care will require discussing workload and working conditions with workers who often fail to capture the attention and imagination of elite experts.

These and other workers can also help us understand the roles that time, energy, and burnout play in the implementation of patient safety. Over the past decade or more, health care has seen a flood of patient safety dictates not only from regulators or accreditors but also from outside consultants coming into the workplace to reorganize, restructure, or reengineer work processes. In one large Manhattan teaching hospital, the chief nursing officer recalled that over a period of ten years, almost the same number of consultants made their way into and out of the hospital, each with a contradictory way of organizing care, creating teams, or structuring work processes. These consultants entered hospitals in a whirlwind of promises and activity but rarely stayed around long enough to implement changes or evaluate what had happened to patient care and the hospital workforce as a result.

Patient safety has also become part of this flavor-of-the-month consultant trend. One week some staff may be asked to attend trainings in Crucial Conversations led by Vital Smarts, teamwork trainings given by NDelta, or Top Gun (founded by former airline pilots), or Six Sigma or Toyota Lean Production, delivered by yet another cohort of consultants. Hospitals are the site of initiatives pioneered by the Institute for Healthcare Improvement, one of the leaders in the patient safety movement. Over the past several years the IHI has launched the 5 Million Lives campaign, which began as the 100,000 Lives campaign. Its website lists programs like the State Action on Avoidable Rehospitalization (STAAR), or WHO Surgical Safety Checklists,¹⁴ with new initiatives announced sometimes on a weekly basis. In nursing there is the Robert Wood Johnson Foundation's Transforming Care at the Bedside, and the American Nurses Credentialing Center's Magnet hospital movement, as well as the American Association of Critical Care Nurses' Healthy Workplace Initiative. Every one of these initiatives demands time and energy from frontline staff. The crucial questions here are: Are units allocated enough staff, and are staff given enough time to absorb and master these new activities—activities that are too often an add-on to an unadjusted workload? How can these activities be financially sound investments for hospitals? How can they be seen as important critical investments that will reduce outcomes such as medical errors, lawsuits, and length of stay for patients?

The time and energy required by the introduction of new technologies that are discussed in chapters by Koppel and his colleagues also complicate the patient safety picture. Depending on an individual's age and computer literacy, mastering these technological changes takes a great deal of time and effort. Often, staff need to manage both the old system and the new system while technological bugs are ironed out. Again the question arises: Are staff given enough time, and is their workload adjusted so they can master these

technologies? If not, the sheer number of initiatives that workers are asked to implement and absorb can result in the kind of “consultant fatigue” that may, in turn, lead to cynicism.

Frontline workers can be very helpful in identifying how much time it will really take to deal with new initiatives and their accompanying technological demands, as well as in suggesting how staffing levels and workload need to be adjusted so that workers can change practice. Frontline staff, Edmondson writes, must also have the time to do second-order problem solving, not just first-order “workarounds,”¹⁵ whereby a problem is not effectively resolved but instead a temporary solution is implemented in order to resolve the immediate issue. Unfortunately, current staffing patterns leave workers little time to do more than the latter—engaging in time-consuming workarounds. This failure to consider long-term solutions is not merely rewarded on hospital units; it is embedded in medical and nursing education.

“The topic of improving patient safety and problem solving in terms of organizational and system issues are rarely taught in nursing and medical [schools],” commented Dr. George Thibault, president of the Josiah Macy Jr. Foundation, which supports the development of a clinical education–reform curriculum in medical and nursing schools.¹⁶ When programs for health care administrators and middle managers tackle the issue of patient safety, they tend to focus on problem-solving tools but not the processes and skills needed to engage the workforce in activities to identify critical problems and to assist in implementing changes. When hospital staff are promoted out of the ranks of frontline workers and into the ranks of management—when RNs become nurse managers, for example—the hospital generally fails to teach them the kind of coaching and team-building skills that are key to patient safety. As one nurse manager expresses it, “If we were able to figure out how to involve frontline staff sooner, we would be able to improve our performance—not just improve our performance, but improve performance faster.”¹⁷ Furthermore, they are certainly not part of the training of workers on the lower rungs of the health care ladder—workers who, because of class, race, and ethnicity, are unlikely to be asked to participate in problem-solving and decision-making activities when it comes to patient safety. This is ironic, since these workers tend to be long-term employees who know firsthand about systems that work and those that don’t.

Frontline staff must also be involved in patient safety initiatives because they are the ones who directly experience the unintended consequences or glitches of safety initiatives. We know that unintended consequences are common outcomes of well-intentioned projects. High-risk, high-reliability industries that have successfully changed their cultures have long recognized

that safety requires a lot of trial and a lot of error. You can't work out the glitches, however, if the people who can best identify them are not encouraged to speak up and/or aren't heard when they do.

Citing just one of these glitches, Krishna Collie, a consultant who works with the National Institutes of Health (NIH) in Washington, D.C., comments: "A common breakdown is that computer systems for outpatient, inpatient, and specialist and primary care doctors using EMRs [electronic medical records] don't talk with each other. Many of these problems could be controlled if not eliminated if [hospital] staffs had been included in the selection of vendors and the actual software that is used."¹⁸ Many physicians and nurses report that they are evaluated on their display of enthusiasm for newly installed health information technology (HIT). Koppel elaborates:

Even though they experience significant problems with HIT that has profound negative patient safety implications, many doctors and nurses say that they are discouraged from reporting these problems. If they fail to show enthusiastic support for HIT or report problems, they risk being labeled "technophobes" or "troublemakers." Rather than acknowledging that the technology has problems that require remedy, doctors and nurses are accused of being dumb, technophobic, or incompetent. In this way dangers to patient safety are allowed to propagate, workers become increasingly frustrated, and the software is not improved.¹⁹

Failing to include frontline workers in hospital initiatives is clearly documented in an influential article by Harvard Business School professors Anita Tucker and Amy Edmondson, "Why Hospitals Don't Learn from Failures." They write, "Front-line employees in service organizations are well positioned in these efforts to help their organizations learn, that is, to improve organizational outcomes by suggesting changes in processes and activities based on their knowledge of what is and is not working."²⁰ Or as John le Carré expressed in a more literary vein in his novel *Absolute Friends*, "in a mammoth bureaucracy obsessed with its own secrecy, the fault lines are best observed by those who, instead of peering down from the top, stand at the bottom and look up."²¹

Backstage Attitude Change

The most promising patient safety initiative involves more than a technical fix or a brilliant campaign slogan. Patient safety, like any other cultural transformation, involves changing attitudes and not just changing behavior.

Changing attitudes, however, is not simply a matter of individuals acquiring the right information and then applying it under the watchful eyes of an alert expert or manager. Changes in attitudes and beliefs occur in the web of social relationships in which individuals reside. As David Dickinson has pointed out in his excellent book on HIV/AIDS prevention, *Changing the Course of AIDS: Peer Education in South Africa and Its Lessons for the Global Crisis*, changing behavior involves a complex interplay between the front stage, backstage, and private spaces.²² These terms are taken from Erving Goffman, who, in *The Presentation of Self in Everyday Life* (1959), described human interaction as a performance that is executed in a variety of spaces—front stage, backstage, and private.²³ Elite actors, the proverbial experts, generally occupy the front stage spaces, where they give performances and hand down information, advice, and recommendations. They expect their audience of less elite players to accept this information and adjust their behavior accordingly. Actors who are barely recognized by experts as “players”—or, in the new health care jargon, as “stakeholders”—occupy backstage and private spaces. In front stage spaces the powerless or lower-level player may often seem to assent to or comply with the powerful. In private or backstage spaces, to which the powerful do not have access, the less powerful say what they really think and act upon their true beliefs and feelings.

In the hospital or patient safety movement, front stage spaces would involve conferences like those conducted by the IHI, or seminars given inside or outside the hospital by prominent patient safety experts or hospital higher-ups. Backstage spaces would include the hospital ward and even the patient’s room, which managers will try to penetrate through a variety of championship efforts or management by walking around. Private spaces include the nurses’ station, lunchroom, staffroom, hospital corridor, locker room, and so forth. These are the “cultures” that Porter and Edmondson refer to in quotations cited earlier.

What one learns in the culture of backstage and private spaces is key to both attitude and behavioral change, for example, the role played by demoralization and burnout in workers’ responses to patient safety initiatives. As we said earlier, over at least the past decade and a half, hospital management has hired a raft of consultants to help cut costs and reengineer hospitals. These cost-cutting efforts have largely targeted frontline staff such as nurses, as well as cleaners and other nonclinical workers. During this period, hospital workers have also fought for a clear and structured process to work jointly with management on patient safety activities, bans on mandatory overtime for RN staff, safe nurse-to-patient staffing ratios, safe needle technology to prevent the spread of HIV/AIDS and other blood-borne pathogens, safe lifting

technology, the reduction of medical errors, the use of appropriate checklists for critical procedures, and the creation of increased teamwork among doctors and nurses, among other goals. With few exceptions, hospital management has resisted these efforts.

Many hospital staff members are thus deeply suspicious of what they perceive to be hospitals' sudden embrace of "safety," when, in their view, they have been pleading with hospitals to attend to the safety of both their patients and their workers for years. In the private spaces of our interviews, one health care union leader put it this way: "Our attitude is, really, you care about safety? Where were you when we were trying to get safe needle technology to protect patients and us? Now you blame staff for not caring enough about patient safety. Is something wrong with this picture?" Or as Diane Sommers, whom we met at the beginning of this chapter, explains: "We can't even get off the wards to attend safety rounds. Our hospital will just not allocate the financial resources to things like staff that help make patient safety a reality. So when I hear about a new patient safety initiative, I just sigh and roll my eyes."²⁴

The same is true of the outsourced hospital cleaner or food service worker. According to Polly Toynebee, author of *Hard Work: Life in Low-Pay Britain*, "when you combine low pay, low regard and high turn-over what you get is a hospital industry in which there is no loyalty to its outsourced employees and no loyalty of outsourced employees to the institution in which they work. This can be a toxic brew when it comes to patient care and safety."²⁵

In backstage and private spaces, workers also express their concerns about the impact of patient safety initiatives on their perceived status and authority. Just as airline pilots at the beginning of the airline safety movement in the 1980s believed that cockpit (later crew) resource management programs were an industry effort to erode their authority,²⁶ many frontline staff are concerned that patient safety initiatives are really wolves in sheep's clothing. One nurse who was highly critical of the impact of patient restructuring voiced concern about efforts to utilize the SBAR (*situation, background, assessment, and recommendation*) technique to enhance communication between doctors and nurses. "This is just a way to deprofessionalize nursing," she insisted.²⁷ Other nurses have objected on similar grounds to, for example, asking two nurses to check IV medication administration. Many nurses are concerned about the computerization of bedside nursing and the introduction of medication administration records and PDAs (personal digital assistants). As Koppel and his colleagues highlight in chapter 4, their concerns are warranted. If there is no institutional vehicle—no attempt to create the psychological sense of safety that is a prerequisite for institutional learning—through which staff

are made to feel comfortable about voicing their concerns and working to make technology and other safety initiatives not only helpful to patients but also worker friendly, staff may continue to resist such initiatives.

Under these circumstances, resistance, which is all too often viewed as an irrational fear of change, may in fact be a rational response to a poorly planned and executed patient safety agenda. If hospital executives and patient safety advocates are to succeed in transforming institutional culture, they will have to understand the limitations of top-down approaches and the importance of working in backstage and private spaces. New knowledge obtained through frontline staff involvement is also critical to arriving at appropriate and sustainable solutions.²⁸ Organizations able to encourage and capture this knowledge can go on to achieve breakthrough changes and thus effectively improve the quality of the services they provide.

In addition to their generating new knowledge, co-workers are the only ones who can navigate backstage and private spaces by lowering resistance to any ill-conceived and autocratic dicta from above. When one co-worker leads another because that co-worker has been involved in the planning of initiatives, he or she can recognize what a peer understands, what information peers need, what beliefs have to be challenged, what hostilities or resentments need to be addressed and overcome, and how best to negotiate them.

Why Unions Must Be Involved

Many hospital administrators and patient safety advocates are well aware of the successes of the safety movement in aviation and frequently cite the literature of crew resource management (CRM) in discussions of patient safety.²⁹ Yet there is one aspect of CRM that is consistently downplayed: union involvement in the creation of an aviation safety culture was central to its success.

At United Airlines, the first major commercial airline company to initiate CRM training, top-level management began its change initiative with the full participation of the Air Line Pilots Association (ALPA). When cockpit resource management morphed into crew resource management, the Association of Flight Attendants (AFA) participated in trainings and their implementation. "The industry has learned that we are integral to a successful safety process. They would never contemplate going back to the old way,"³⁰ says Keith Hagy, a safety officer for ALPA. ALPA continues to work with management to design and conduct the training for all flight crews. It is also responsible for helping to monitor safety problems of the airline industry. "The involvement of ALPA has been critical to the success of our safety pro-

gram,” Hagy continues. “The unions have helped to make sure the approach we used was practical and relevant, and they helped to create a process that their members would trust since they were critical players in the process. If they were not involved, there would still be issues of whether or not employees would trust this process.”³¹ Just as it was critical to the creation of a safety culture in the aviation industry, the involvement of union leadership and activists is similarly critical to changing culture in health care. In many areas of the United States, aides, janitors, unit clerks, and a variety of other health care workers are represented by trade unions. Almost 20 percent of hospital RNs are in unions, as are many licensed practical nurses (LPNs) and nurses’ aides. In some locales, even medical residents are unionized.³²

In a workplace that is unionized, engaging union leaders is one of the most viable routes to mobilizing the support and input of frontline staff. In hospitals that are unionized, many frontline staff—particularly those who are the most vocal, active, and motivated to help with change activities (precisely the kind to be the “black belts” or “champions” of change)—may feel greater loyalty to their union than they do to hospital management. As we said earlier, since the endless cutbacks and restructuring that began in the 1990s, many workers are deeply suspicious of hospital management. They believe that the C suite does not represent their interests or the interests of patients. Involving union leaders and activists can help overcome the belief that projects pitched as efforts to increase patient safety are in reality ploys to increase productivity from the health care workforce.

Another reason why union participation is critical is that unions can protect workers from either actual reprisals or the fear of reprisals. If reporting problems is the key to addressing them, then protecting those who report problems is essential. In the aviation industry, protecting workers who report safety concerns has been critical to enhancing safety for both passengers and crew.³³ Many lower-level workers, however, are very concerned that their reward for identifying patient safety problems will be disciplinary procedures or even being fired.

In unionized settings, frontline staff, which at times can include supervisors, are protected from reprisals as a result of collective bargaining agreements with management. (For instance, workers cannot be fired without just cause, such as documentation of clear violation of safety procedures.) Unions can protect members from the all too common dangers facing frontline workers who champion safety in nonunion hospitals. To cite just one example, a veteran nurse at Huntington Memorial, a nonunion hospital in Pasadena, California, was recently fired when she tried to challenge an intern’s order to ventilate a patient on a busy medical unit. Not only did she

lose her job, but also she was disciplined by the State Board of Nursing. An even more recent case is the trial in 2010 of nurses in Texas who reported a physician to the medical board and were brought up on felony charges as a result.³⁴ Incidents like these do not help to assuage workers' fears, and prevent them from becoming fearless patient safety champions.

Soliciting the input of unionized frontline workers is particularly important since they may be the only ones who are able to discuss candidly the unintended consequences of patient safety initiatives. Ironically, managers who are responsible for implementing patient safety initiatives may not be comfortable identifying significant and troublesome problems for fear of being reprimanded or even fired. "Many times management sees critical patient safety problems but fear that their job is at risk if they identify a specific problems that upper management would prefer to ignore," says a vice president for human resources at a hospital in the Northeast. "I had this happen to me. I am now more reluctant to share significant patient safety problems with upper management for fear of losing my job."³⁵ This is why managers must also be protected if patient safety is to become a reality.

The fact is that hospital administrators who have put their reputations on the line by spending millions on hiring consultants and/or purchasing new technologies may not want to hear that these are not working as well as expected. Under current conditions, where nonunionized workers, both staff and managers, are employees "at will" (meaning they can be fired without just cause) and there are no guaranteed protections for speaking up and identifying specific problems in the workplace, the sad truth is that many workers and managers are fired if they voice concerns about significant patient safety problems which management is unwilling to address.

Another way in which unions can be extremely helpful is their ability to create education and funds for hospitals to train frontline staff and managers in effective methods to improve patient safety. Often it is difficult to create needed training and education just for one hospital. But if multiple hospitals can be persuaded to contribute to a common fund, important training and education activities are possible. Two significant examples of this arrangement are the 1199/SEIU and League of Voluntary Hospitals Training and Upgrading Fund in New York City, and the Worker Education and Resource Center in Los Angeles established by SEIU local 721. Both of these educational centers were created by unions to provide hospitals with educators and trainers to assist in the development of patient safety programs. These educational centers have provided hospitals in New York City and Los Angeles with thousands of dollars in training funds. Unions can also be helpful in working with management to obtain local, federal, and private

foundation funds for patient safety projects, since hospital reimbursements will increasingly be based on higher levels of quality of care and patient safety, and it is clear to many of these funders that training and education activities for frontline staff and supervisors are needed to improve patient safety outcomes. Lobbying for training, education, and pilot projects is another positive way for unions to work with hospitals. Through these activities, health care unions can help expand access to politicians, state and federal agencies, and foundation staff to which management alone does not have access. This is because health care unions represent a large numbers of workers from multiple worksites and thus have larger constituencies than management commonly has.

Finally, given the fact that so many of us resist change no matter where it begins or ends, enlisting every single ally in the cause seems not just simple common sense but something one would avoid at one's—and at patients'—peril. In workplaces where union members are active, they can become significant advocates for making the change to a safety culture. Given their insistence on recruiting stakeholders and on the power of informal leaders, one wonders, therefore, why managers and safety advocates do not spend more time and energy recruiting union leaders and activists in their efforts for cultural change.

Why Frontline Workers and Unions Are Not Sufficiently Involved in Patient Safety

In a study conducted by Peter Lazes and other researchers at Cornell University and the University of North Carolina School of Nursing at Chapel Hill, hospital staff in charge of quality and/or performance improvement at thirty-one U.S. hospitals were interviewed. The researchers wanted to ascertain if—as well as how—frontline staff were involved in patient safety and quality-of-care activities. All of these hospitals had received some sort of publicity, accreditation, or award which suggested that hospital management was deeply committed to engaging frontline staff in quality and safety activities within the hospital. The researchers asked four primary questions: To what extent is your hospital involving frontline staff in improvement activities? How are they involved in these activities? What have been the outcomes? And what role have unions had in these improvement activities?

In spite of their reputations and awards, there seems to be a disconnect between the public stance and reality at these hospitals. Many of those interviewed indicated that frontline staff were only marginally involved in problem solving and had almost no role in identifying problems in the first place.³⁶

If, for example, a hospital was trying to reduce central line infections, the researchers asked about the extent to which frontline staff were involved with devising solutions to the problem. Moreover, and perhaps more disturbingly, frontline staff had almost no role in implementing safety efforts like these. Only 17 percent of hospitals engaged frontline staff in both problem identification and implementation activities. For the most part, only nurses were engaged in such activities. When hospital workers were represented by unions, they were active partners in only some cases and were often not included in monitoring and seeking ways to improve the impact of safety and improvement processes. Indeed, all too often they were sidelined. The researchers were concerned with improving the accuracy of information about frontline staff engagement. Although interviews were conducted with only one staff person involved with the hospital's quality or safety activities, it was nonetheless clear that the level of frontline staff involvement in these cases of excellence was limited. Perhaps the most significant thing researchers uncovered was the fact that management rarely consulted frontline staff about daily patient care issues, concerns, or problems, nor did they ask staff for suggestions for improvement. Even in the few cases where frontline staff were involved in identifying problems, they were not involved in implementing solutions.³⁷

The exclusion of frontline workers is often the result of managerial and professional attitudes. Hospitals are not only some of the most complex but also some of the most hierarchical institutions in industrialized society. Organized into rigid, stratified groups, hospital professionals and workers are divided by both financial and professional status. These sharp divisions are reflected in traditional hospital language. Doctors are called "chief medical officer" or "house officer," and they issue "orders" to other hospital employees as well as patients. Lower-level workers, such as nurses, are termed "physician extenders." Physicians and managers consider themselves to be the designated problem identifiers and solvers. They are the mindful leaders who deliver dictates to workers who do what has often been characterized as "mindless" work.³⁸

Trained and referred to in their higher-level role in the health care hierarchy, many managers and physician leaders do not believe that workers have anything to add to their own knowledge of the big picture. "I don't see a need to involve frontline staff. They don't know enough about the real problems," is a familiar "leadership" refrain. Kamilla Kohn Roadberg, an international management consultant who works for Odhe and Company in Gothenburg, Sweden, notes that it is the job of management "to create needed procedures to improve patient safety and by so doing reduce the

variances in how actual work gets done. This approach is at the core of [the] lean manufacturing process, which has not proven to be an effective process of improving health care delivery problems by itself.”³⁹

Instead of exploring ways to engage frontline staff in the initial stages of planning and development of patient safety processes, the most common approach in hospital management today is the recruitment of management staff who are assigned to find solutions to specific patient safety problems. Referred to as “champions,” “black belts,” “ambassadors,” and “internal consultants,” they are picked by upper-level management and assigned the mission of creating appropriate solutions to a variety of problems—solutions that line management are then required to implement.

This top-down approach is promoted by the many consultants who offer their services to hospital administrators. One has only to Google any one of these terms—“champions,” “internal consultants,” “black belts”—to unleash an avalanche of advertisements posted on consultants’ websites that will tell you where, and how much you have to pay, to get patient safety advice, information, and training. The American Academy of Management, the American Hospital Association, and the Institute for Healthcare Improvement all encourage an approach that concentrates on creating more and more champions, black belts, quality fellows—the list seems endless. The price of their services, seminars, and conferences makes it clear that the audience most consultants target is composed of physician leaders, upper-level, and sometimes middle-level management. Rarely are frontline staff and unions involved.

This top-down approach often produces dismay and resentment in many staff. One nurse at a northeastern teaching hospital described upper-level management’s efforts to encourage hand washing in her institution. A hand washing initiative was designed and implemented at the top, and then a managerial hand washing “champion” walked around the units rewarding staff members with a box of Skittles if he saw them comply with hand washing policies. “It was like we were a bunch of children whom they could pacify by giving out a box of cheap candy,” an RN commented.⁴⁰ Not only did frontline staff resent the fact that they weren’t involved in the design and implementation phase, but also they were deeply offended at being treated like children rather than adult professionals. These resentments were never directly made known to managers but were heartily expressed in private spaces.

From our observations, top-level leaders may at times solicit ideas from staff. One common practice is to conduct interviews, create a team, and survey staff about initiatives that have already been decided. Frontline workers,

however, are rarely included in the overall design of patient safety processes. Once initiatives are designed, workers are then cajoled or exhorted to comply with new practices or activities. Like the patient who either acquiesces or refuses to do what the doctor orders, workers become either “compliant,” and thus good, or “noncompliant,” and thus difficult, and are blamed or disciplined for their failure to obey.

Even when frontline staff are recruited to join patient safety initiatives, the choice of staff tends to be limited to RNs. Patient safety, however, “is not simply nursing’s work, it is the work of the whole organization,” says a CEO in a study of frontline staff involvement.⁴¹ Depending on the specific nature of a particular problem, other clinical staff, physicians and house staff, respiratory therapists, social workers, pharmacists, lab techs, and non-clinical staff such as housekeeping and food services need to be engaged. As another chief nursing officer (CNO) at a hospital steeped in patient safety activities comments, “I wish we could have done more in a multi-disciplinary fashion. We tend to hand off pieces to each other and work in silos. Nurses themselves are very involved, but a lot [of] what happens is beyond just the nurse.”⁴²

If the positive potential of frontline staff is too often ignored, the potential of unions as allies in the patient safety project is ignored even more so. In Europe, unions are viewed as critical “stakeholders” in any workplace activity. Important social partners, they help ensure that the voice of workers is part of public discourse, and they play a central role in lobbying for funding of hospitals and other health facilities. Reflecting traditional American management’s hostility to unions, many health care employers view unions as hostile at worst and obstructive at best. “The feeling is that unions add to the complexity of an already complex job,” observed a chief nurse executive of a major hospital.⁴³ As Gordon has written in an article analyzing nurse managers’ attitudes toward unions, nursing executives and even nursing academics often socialize nurses and managers to view union leaders and activists as spiders catching flies or manipulative militants trying to dupe goodhearted but ultimately mindless prey. At best unions are considered a necessary evil, at worst the devil incarnate.⁴⁴

“They [unions] have no awareness of management’s difficulties. They just cause us problems,” echoes a middle manager at a hospital in the Northeast.⁴⁵ “We actively keep them out of our hospitals, and if they were present, we would keep them out of any organized patient safety process,” adds an officer of a northeastern hospital association. “They can only cause problems for us.”⁴⁶ Other administrators think that including unions in planning and implementing needed changes takes too much time. “We need to

make important changes now and cannot wait for everyone to be consulted," remarked one administrator.⁴⁷

In our work and discussions with managers and union staff, these sentiments were repeated over and over again. One physician at a major teaching hospital in Boston, which has been an exemplar of patient safety activity, remarked: "I have been very surprised about their [patient safety leaders'] attitude toward bringing the union on board when it comes to patient safety initiatives. People will sit around and talk about something and then someone will say, 'Oh, the union won't like that.' And I say, 'Well, did anyone ask the union?' 'No.' 'Is anyone going to?' 'No.'"⁴⁸ In the United States there tends to be an untested assumption that unions will invariably be an obstacle rather than an ally in any positive transformation.

It is not surprising, then, that union leaders say they are often excluded from the planning, implementation, and evaluation of safety initiatives. One RN union representative at a Massachusetts teaching hospital described her frustration at the failure of management to consult the union about safety initiatives: "They seem to consider us to be an obstacle. We are not advised about safety initiatives before they happen. When, after the fact, we come into the process, it's often in a backdoor way to put out fires or fix problems that didn't have to happen in the first place." This nurse gave the following example. To make sure that RNs practice safely, her hospital decided that they would have to be tested to prove their competence. To do this, the nurses were given a test on medication administration. Seventeen percent of the nurses flunked the test. Why? According to this union representative, it was because the test asked them questions about areas and medications with which they had no familiarity. "Psych nurses were asked about cardiac meds," she recounted.

They don't give cardiac meds. I was given the test, and I haven't passed meds in ten years. The nurses were told that if they flunked the test three times, they would be fired. But they weren't given any review or teaching. We [the union] suggested that they get some classes going to help our nurses get more familiar with medications that are needed for cardiac patients. Some nurses haven't taken a test since they passed their boards twenty years ago.

Finally, management agreed to these classes after a whole day of bargaining to arrive at this solution. "Without the union rep, many would have continued to flunk the test. Did the hospital consider that it would then lose hundreds of nurses? We had to play catch-up and then try to fix the problem. When we were bargaining we asked management, 'Did you ever think that you

could have a floor where five nurses flunked the test and only one nurse passed? Who's going to be giving the medication?"⁴⁹

Cathy Stoddart, vice president of health care for the Pennsylvania chapter of SEIU, summed up: "It is quite frustrating. We see problems affecting patient care on a daily basis . . . but rarely have a chance to help management solve them."⁵⁰ Stoddart decided to move beyond her frustration and started a quality improvement process at Allegheny Medical Center, where she works. She got several managers to join her and other union leaders to establish patient care committees in all of the hospital's medical-surgical units. But most frontline staff don't have Stoddart's confidence and may not feel comfortable trying to push management to listen to their ideas and suggestions.

Far too many unions, as we stated earlier in this chapter, are not invited to participate in patient safety programs. "Many times managers keep us at a distance; they don't value our input," comments David Schildmeier of the Massachusetts Nurses Association.⁵¹ "We have participated on various quality and safety committees, but our suggested solutions don't get implemented. When we have gotten involved, many times members' ideas often get voted down without attempts at genuinely analyzing their merits. This is not only discouraging members from participating in these activities, but puts union leaders at risk for suggesting that it is important to work with management on such issues," says Schildmeier.⁵² "Why should we put out when they won't accept our advice? I have better things to do with my time,"⁵³ says Michael Chacon, organizer for the New York State Nurses Association (NYSNA), expressing a common frustration. "In our hospital, management has established a parallel performance improvement and professional development process to our partnership structure. This parallel process reduces our ability to help improve the safety of patients and leaves our members questioning the value of our activities with management," says Janet McCarthy, staff nurse and negotiating team member at Allegheny Medical Center.⁵⁴

To be fair, unions have not always been proactive enough about involving themselves in certain patient safety agendas and initiatives. While it is true that some nursing unions have fought for transformations in work organization and working conditions that would definitely improve patient care—bans on mandatory overtime, safe staffing, safe needle technology and lifts—union involvement in patient safety issues more generally may be too limited.⁵⁵ "We need to be part of the process to improve patient care," comments Mary Lehman McDonald, director of the American Federation of Teachers' (AFT) health care division.

Most of our members don't have grievances or labor relations issues [traditional areas for the union], but instead they want a voice in what goes on with patients. We as union leaders need to help use our influence to improve their ability to have input in activities to improve patient care. It is no longer just management's responsibility to be concerned with patient care and safety and costs. We have always been concerned about these issues but most of our work was focused on the traditional work of the union [such as handling grievances, negotiating contracts, and organizing new members]. There now needs to be a much broader balancing of these activities; we too need to expand our areas of work.⁵⁶

Rick Brooks, executive director of UNAP, the Rhode Island nurses' union, acknowledges:

Frankly at times, we have not pushed our way into patient safety improvement work. We know that there are quality and safety committees organized in many of the hospitals where we have members, but we have been reluctant to get involved; we decided to stay on the sidelines. We have resisted getting involved in these activities. To some extent this has been caused by being comfortable in just doing our traditional union work. And to some extent we have been hesitant to learn new skills. Why change? Things are pretty good for now. Also, it is discouraging for us to have to fight our way to be heard by management and then get ignored. Many of our members feel that improving patient safety is a critical part of our responsibility as health care workers but many times question the value of needing to spend hours convincing management to listen to us.⁵⁷

Nursing unions, as is pointed out in chapter 9 by Alison Trinkoff and Jeanne Geiger-Brown, have also taken some contradictory positions on patient safety. Unionized nurses have fought for bans against mandatory overtime on the grounds that it is not safe for nurses to work more than one shift, but have defended nurses' right to work as many shifts in a row and as many hours as they want, as long as working more than eight hours is voluntary, not mandatory. When advised that the safety literature documents that errors increase after eight hours on the job and escalate dramatically after twelve, the union response tends to be that "nurses like twelve-hour shifts." Obviously unions and their members can't have it both ways. If it's unsafe to work more than twelve hours when they are mandated to do so, it's also unsafe for them to work more than twelve hours voluntarily.⁵⁸

How Involving Frontline Staff—and Their Unions—Makes a Difference

In this chapter we argue that it is necessary to create a fundamentally different patient safety template. Creating that template can produce impressive results. Maimonides Medical Center in Brooklyn has been successful at creating a safer hospital environment because it has involved both unions and frontline workers.

Maimonides Medical Center has seven hundred in-patient beds and employs over six thousand workers, who are represented by three unions: 1199/SEIU, which represents non-nursing staff; New York State Nurses Association (NYSNA), which represents registered nurses; and the Committee of Interns and Residents (CIR). The hospital, like most others in the country, has had its share of patient safety problems. A cardiology patient had died because staff “did not seem to respond to monitors and alarms in a timely manner.” The hospital was not consistently kept clean. Hospital administrators and staff were also concerned about patient falls, among other medical errors and injuries.

CEO Pamela Brier, cited earlier in this chapter, comments that the hospital attempted to deal with a variety of safety issues in the past, but with limited success. In 1997 the hospital finally took a different approach. Rather than initiate safety efforts from above, it formed a labor-management joint process with the three unions and established what became known as a “Strategic Alliance.” The purpose of the alliance was to ensure that labor and management worked together to improve patient care and to increase employees’ input in decision making. This would, the hospital hoped, have a positive impact on employee recruitment and retention.

The alliance established a hospital-wide Labor-Management Council as well as Departmental Labor-Management Committees (DLMCs). To deal with the problems that were occurring on all of the cardiology units, the alliance went into action. Before the union, management, and frontline workers began to meet, management had contemplated disciplining nursing staff “because they were not responding to monitors and alarms in a timely fashion.” Instead, the cardiology DLMC began to investigate why staff—particularly nursing staff—response time to monitors and alarms fluctuated between two and a half and eight minutes rather than the minute or less required to rescue patients successfully.

To understand this discrepancy fully, the twenty-member DLMC decided to do an in-depth analysis of what was going wrong on its units. For five months, registered nurses, patient care technicians, information specialists,

physician assistants, nurse practitioners, nurse managers, physicians, nurse educators, performance improvement specialists, and a resident met weekly. Staff from departments such as Patient Transport, Radiology Health Information Technology (HIT), and Materials Information Systems (MIS) also attended when needed.

The DLMC group began by tracking patients' trajectory into and out of the hospital. This detailed analysis illuminated a number of serious problems. Acuity (severity of illness) measure of patients was not uniformly established or adequately understood. Thus, the proper numbers of RNs and nursing assistants were not assigned to care for patients. Patients were transferred to other departments—say, X ray—without a knowledgeable licensed staff member accompanying them. If a patient's condition deteriorated off-unit, people there were not always equipped to help. At change of shift, information about patient acuity was not conveyed to the next cohort of caregivers, precluding effective coordination of care. Finally, the DLMC discovered that staff did not know how to make simple adjustments to medical equipment, which meant that minor problems would often sideline a piece of equipment.

Because frontline employees from all shifts participated—including attending physicians and nurse practitioners—workers felt far more comfortable expressing their real concerns and making suggestions. The group was therefore able to get an accurate picture of the problem and propose solutions that had been designed with the involvement of these different groups. The solutions—to which all disciplines and occupational groups agreed—included:

- Establishing new clinical protocols to define patient acuity correctly.
- Making sure all patient acuity is assessed on a daily basis.
- Communicating acuity assessments in daily rounds with all staff, including physicians, to ensure accurate staffing levels.
- Including information on acuity in shift-to-shift reports on patients and making sure that acuity information is in the patient's chart.
- Establishing a new procedure to ensure that patients would be accompanied by a licensed practitioner when they leave the unit for tests, and involving patient transport in the implementation of the procedure.
- Creating the same standard for individualized alarm settings, checking the settings at the start of a new shift, and using the same standards on all four cardiology units.
- Providing more training on equipment to make sure it operates properly.

- Retraining nurses in how to set alarms and suspend a monitor without disabling others.
- Creating a logging system for tracking equipment failure and repairs, as well as tracking when patients left and returned to their floor.

Once these solutions were agreed on, DLMC members and nurse educators trained all staff, including physicians, on new procedures and protocols, and the group designated an RN and a nursing assistant to monitor the implementation of all changes to make sure all solutions were implemented and sustained. As one nurse involved in the effort remarked: “What was the tipping point for us was when we realized that blame for these problems was no longer automatically assigned to nurses, that other disciplines were ready to accept accountability for problems and help solve them. That made all the difference.”⁵⁹

Because the group understood that patient safety depends on sustaining solutions over the long term, it continues to meet, collects data about response time and new procedures each month, and reviews reports from each unit to determine whether or not gains have been maintained. If the data show that staff are having problems continuing to follow the procedures just listed or response times to alarms exceed one minute, the DLMC analyzes the particular situation and makes recommendations for needed changes. As a result of the multidisciplinary, all-encompassing work of the cardiac staff, the response time to monitors fell to less than one minute on all four cardiology units and has remained at this level.

At Maimonides, frontline staff were also involved in improving hospital cleanliness. When Pamela Brier was a patient in her own hospital, she discovered that the hospital simply wasn't clean enough. To deal with this problem, five staff members (four cleaners and one supervisor) were relieved of their regular duties and assigned to work as a Study Action Team. For four months their full-time job was to interview staff, analyze work processes on all three shifts, and visit other hospitals to check on their procedures and equipment. They also engaged nursing staff, physicians, unit coordinators, and various administrators throughout the hospital to gather their ideas and concerns about unit and hospital-wide cleanliness.

Again, the fact that the group was made up of cleaners, not just managers, allowed members to enter backstage and private spaces and to understand the actual work processes and concerns of those whose job it is to keep the hospital clean. What the Study Action Team discovered when it looked at the problems of the environmental services departments was that staff lacked the requisite equipment and supplies because the inventory system that

should have made sufficient supplies available didn't function effectively. For example, all supplies were rarely available at the beginning of shifts for employees. There also wasn't enough cleaning staff, particularly on the graveyard shift, which in turn created problems for workers on day and afternoon shifts. As a result, morning or afternoon staff would come into a room or corridor and discover that garbage hadn't been removed, as it should have been on a previous shift. The group also identified another important issue. Even though many workers had been employed as hospital cleaners for a number of years, some weren't adequately trained in how to keep the hospital clean. As a result, cleaning staff weren't really sure if a room was clean and couldn't turn rooms around quickly enough for new patients. Moreover, housekeeping and nursing staff didn't communicate well with each other. Thus housekeepers often didn't know which rooms needed to be cleaned urgently and which less so.

Rather than rely solely on standard hospital satisfaction surveys, such as Press-Ganey scores, to help address these problems, the Study Action Team developed its own survey instrument to determine whether patients' rooms as well as all public areas and nursing stations were cleaned in a timely fashion. Members of the Study Action Team were responsible for making sure that staff had the appropriate training not only in housekeeping skills but also in infection control and dealing with bodily fluids and chemical hazards. The team was also responsible for helping to establish a new process for purchasing cleaning equipment and supplies. In addition, it took responsibility for negotiating with management, particularly around issues of staffing on the graveyard shift. The team also worked on developing more effective communication between nursing and housekeeping staff.

As a result of these activities, Maimonides is now a cleaner and safer hospital. Moreover, these joint efforts did not end with cleanliness and changes on the cardiology units, but continues to target a variety of patient safety problems. The decision to involve frontline staff and unions on an ongoing basis produced not only a genuine group of allies but also an ability to strategize continuously about crucial patient safety and worker safety issues. It uncovered not only problems and solutions but also aspects of work organization that needed to be changed to sustain safety over the long term.

Another important example of a major patient safety initiative that involved frontline staff took place throughout the Veterans Affairs health care system. Beginning in October 2007, acute care hospitals in the VA system addressed one of the most vexing hospital-acquired infections—methicillin-resistant *Staphylococcus aureus* (MRSA). Efforts to reduce incidence of the infection had stalled at the VA, and researchers and clinicians recognized the need to

act more assertively and effectively to decrease MRSA infections. The VA thus implemented what it called a “MRSA” bundle,” which included a number of different activities: “universal surveillance, contact precautions, hand hygiene, and institutional culture change was associated with a decrease in health care–associated transmissions of and infections with MRSA in a large health care system.”⁶⁰

During the study period, all patients admitted to a VA acute care hospital had their nose swabbed to test for the presence of the MRSA organism. If a patient tested positive, that patient was then isolated. Hand hygiene—critical to the spread of infection but sometimes not sufficiently practiced—was emphasized in each facility, but it was done in a way that encouraged culture change by making “infection control the responsibility of everyone who had contact with the patient.” The results of the study were dramatic. Between October 2007 and June 2010, rates of health care–associated MRSA infections in ICUs decreased by 62 percent and in non-ICUs by 45 percent.

According to Dr. Rajiv Jain, principal investigator on the study, the early and consistent engagement of frontline staff to ensure prevention of the spread of infection was key to the success of this effort. Jain commented: “In our view, frontline staff are the experts. On in-patient units, they provide care everyday 24/7. You can have all the policies and procedures you want on the books, but the practice staff follow in delivering care is what makes the difference between safe and unsafe care.”

To make sure that staff followed hand hygiene policies and procedures, it was critical to talk with staff to understand why some people use the proper hygiene and some don't. “Complexity science,” Jain explains, “teaches us that knowledge does not equal practice because there are lots of filters that impact whether knowledge becomes practice.” As Jain points out, it is hard to find anyone who works in health care who does not know that hand hygiene is the single most important mechanism to fight the spread of infection in hospitals. That said, not everyone who “knows” follows policy when it comes to hand hygiene. Why not? “By engaging frontline staff,” says Jain, “we began to understand the barriers to practice and to understand how some people overcome those barriers.”

Next Jain and his colleagues held focus groups with staff. Unlike typical focus groups, these were not led by an outside consultant or by a physician or other institutional leader. “The staff who do it correctly were the ones who led the discussion,” Jain says. “They explained to their co-workers and colleagues how they overcome the barriers they experienced. That was what led to positive behavior change.”

Another aspect of their project that reinforced this kind of positive change was universal testing. Some experts claim that testing everyone who comes into a hospital is too expensive and unnecessary. Jain and his colleagues disagree. They believe that universal testing has both a clinical and a behavioral rationale. From the clinical point of view, testing anyone who is going to be admitted helps the hospital discover who does and who does not carry the MRSA organism. Jain says:

Obviously there is a scientific reason to test people. That is to find out whether the patient has the organism. This allows you to make clinical decisions, like whether to place them in isolation. But there is another reason to test patients. When, in the process of admitting a patient, the staff are doing the swab test, this becomes a reminder that they need to do all the things they need to do to prevent the spread of the organism.

Testing serves as a reminder, and reminders, Jain notes, are very important in real life. “I think of testing like I think of signs that remind us of the speed limit that’s posted on a highway. When we see the sign we remember that maybe we ought to slow down. Without that reminder we might continue speeding and eventually hurt someone.” Although Jain and his colleagues did not scientifically test this particular hypothesis—that universal testing acts as a reminder that in turn leads to improvements in practice—they firmly believe that is the case.

As Robert Reich, secretary of labor in the Clinton administration, has argued, in the new global economy, the workers whom policymakers focus on today are the symbolic analysts, the so-called knowledge workers, who have captured the biggest share of global wealth.⁶¹ Gone are the manufacturing jobs and blue-collar workers of old. In the contemporary universe, the ones who matter are the professionals with minds that can manipulate facts, data, and the latest management theory. Our society, as Mike Rose has pointed out in his excellent book *The Mind at Work*, is now strictly divided into mindful and mindless work. In a twenty-first-century version of early-twentieth-century Taylorism, the frontline worker in an office, hospital, or nursing home is often viewed as a mindless worker who is managed by those who have the minds and the knowledge to do so.

Although health care is a shining temple of twenty-first-century technology, much of the realpolitik of health care management and policy is grounded in classic Taylorist perceptions of the division of labor, updated superficially to address pressures for return on investment, profit maximization, and production speed-ups. Just as the early-twentieth-century factory

owner would not have consulted his workers about better automobile design, few contemporary hospital administrators (rhetoric about teams and inclusion notwithstanding) consult their nurses or other workers about how to provide more effective and safer patient care.

It is thus hardly surprising that some in the modern patient safety movement reproduce and reinforce this paradigm. As we have argued, workers at the bottom of the totem pole are not viewed as having the kind of knowledge that is truly valued. Although there is a great deal of rhetoric about the need to involve frontline staff, the definition of involvement is all too often limited to bringing staff on board solely to ensure compliance with programs that have been designed without their input. Managerial and professional attitudes toward frontline staff can, in fact, create a self-fulfilling prophecy. If higher-level professionals such as physicians or top-level managers see themselves as “the designated problem solvers” for departmental and inter-departmental problems, they won’t consult frontline staff. If frontline staff are never consulted, they can never develop the kind of confidence needed to address controversial issues. If and when they are asked to offer their ideas or suggestions, they may be so intimidated by the education and “expertise” of those above them that they hesitate to contribute. If they are suddenly given leadership roles, without any prior training in how to fulfill those roles, they may fail. If they are reluctant to contribute good ideas, are silent when finally asked to sit at the table, or fail to act in a leader-like manner, physicians or managers may consider them to be useless time wasters. “Why are they here at all,” one physician asked in frustration after a meeting in which RNs sat silently around a table. The RNs spoke to us about some excellent ideas after the meeting was over, but they were hesitant to share their knowledge openly in a very physician-dominated hospital. Rather than delve into the reasons for the nurses’ silence, the elite simply decided to exclude them from future meetings. This in turn convinced nurses that doctors never listen to them and are not interested in their concerns and insights, which simply reinforced the cycle of reluctance and resistance.

Similar resistance is created when managers, administrators, and safety researchers and advocates neglect the safety problems identified by frontline staff (safe lifting, needle-stick injuries, work overload, long hours and lack of sleep, access to medical records and lab results, coordination with other departments, and so on). In a similar vein, managers often focus on regulations and scores—patient satisfaction scores, Medicare payments for hospital-acquired problems, and Joint Commission requirements—and ignore worker concerns. All of the problems that managers and workers identify are important. They are not, however, given equal weight on the

patient safety agenda and in the priorities of hospital administration. Nor are they always integrated into the agenda of unions as representatives of frontline workers.

We are arguing here for a fundamentally different paradigm—one that recognizes that frontline workers and the unions that represent them can have a positive role to play in resolving patient safety problems as well as in contributing to a comprehensive patient safety program. It is not only their compliance that matters but also their insights, their knowledge, and yes, their mindfulness. Recognition of their mindfulness when it comes to patient safety must begin at the beginning, in the identification of patient safety problems, and continue in the design of methods to resolve them; the implementation of those programs and processes; the follow-up; and recurrent training, evaluation, and constant refinement of these programs and processes. Education and training not of but *with* frontline workers, managers, and other hospital players is crucial. So is the kind of recurrent training in safety methodology and practice that has made the airline industry safety movement so successful.

Culture changes not through episodic intervention but through constant repetition and reiteration. Safety training sessions, safety conferences, seminars, and webinars should, therefore, target not only physicians, nurses, and administrative leaders but also other frontline workers, who should not merely attend such conferences but actually present at them. Imagine the message that would be delivered to frontline staff (not just RNs) if they were asked to speak at such events and were offered educational materials and discounts to attend such conferences and seminars. Making such participation possible by including their comments in programs and making participation affordable is critical for those whose jobs are located at the point where the rubber of patient safety meets the road of patient care practice.

Currently our country is involved in various activities to make needed reforms of our health care system. No matter where this discussion leads, health care cannot be reformed without a fundamental reconsideration of the way frontline workers influence the fate of people once they enter the health care system and become patients within it. Nor is reform possible unless the health and safety of frontline staff is considered to be part of, not apart from, the patient safety agenda.