Searching for Joy and Meaning at Work: Supporting Staff Satisfaction and Engagement

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Objectives

- Explore the concepts of joy and meaning within one’s professional work
- Understand the issues around staff engagement, clinical leadership behaviors, and how these directly relate to high quality clinical outcomes
- Discuss specific strategies for developing joy and meaning in one’s work
Why Do People Choose Nursing?

- To provide caring, competent care

- When nurses feel powerless, they become disillusioned and may leave their job or even the profession
What Keeps Nurses in Nursing?

- Practicing from inner core beliefs
- Understanding others from within (a sense of empathy and connection to patients as persons)
- Making a difference
- Evolving as a professional nurse, willing to learn and open to others

What is Joy at Work?

An intensely positive, vivid, and expansive emotion that arises from an internal state or results form an external event or situation.

Personal Attributes Underlying Joy & Meaning

- Gratitude
- Intentional listening
- Mindfulness with each interaction
- Personal health & well-being
- Willingness to help
- Positivity
What Creates Joy and Meaning?

- Loving your work
- Being recognized
- Achieving something meaningful
- Feeling connected

Leads to satisfaction and engagement

Current State of Joy and Meaning

- USA physicians: 60% respondents considering leaving practice; 70% knew at least one colleague who left due to poor morale
- British physicians: 44% respondents had low or very low morale
- USA nurses: 35% felt like resigning from their current job
- European surveys report nurse dissatisfaction ranging from 11% to 56%
What Prevents or Diminishes Joy & Meaning?

- Lack of organizational/unit support
- Inability to provide quality care
- Being overwhelmed with workload, exhaustion
- Lack of challenge, boredom
What Really Is Fatigue?

Fatigue: “the body’s response to sleep loss or to prolonged physical or mental exertion” (Am Coll Occup Envir Med, 2012)
- Not the same as “sleepiness” which is the tendency to fall asleep (e.g., boredom, post-prandial, night time)

Affected by both the quantity and quality of sleep
- Sufficient hours, individual variation
- Uninterrupted
- Consistency with natural day/night Circadian rhythms

Acute or chronic
### Contributing Factors

<table>
<thead>
<tr>
<th>Organization &amp; Management</th>
<th>Nature of the Work</th>
<th>Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Overtime requirements</td>
<td>• Shift work</td>
<td>• “Moonlighting”</td>
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<tr>
<td>• Inadequate staffing</td>
<td>• (around the clock)</td>
<td>• Extra work, education</td>
</tr>
<tr>
<td>• Excessive workload</td>
<td>• Shift rotation</td>
<td>• Habits, choices</td>
</tr>
<tr>
<td>• Lack of safety culture, trust</td>
<td>• Shift length</td>
<td>• Family (new baby, multiple care-giving roles)</td>
</tr>
<tr>
<td>• Lack of support systems, provisions (places to rest, etc.)</td>
<td>• Patient / resident acuity, needs</td>
<td>• Sleep disorders</td>
</tr>
<tr>
<td></td>
<td>• Mental and physical demands of activities</td>
<td>• Overconfidence</td>
</tr>
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</table>
Contributing Factor: Staff Shortages

Staff Shortages

Impact on Quality of Care

Difficulty in Recruiting & Retaining Staff

Changing Work Patterns (OT) & Physical demands

Impact on Quality of Care

Staff Shortages

Difficulty in Recruiting & Retaining Staff

Changing Work Patterns (OT) & Physical demands
Costly and Dangerous Cycle When Workload-Staffing Imbalance Exists

Understaffing → Increased Turnover → Staff Burnout → Fatigue → Increasing Overtime

Source: Lerman et al., 2012, ACOEM Fatigue Risk Management
Consequences of Fatigue

Lapses in attention
Inability to stay focused
Memory lapses
Confusion
Irritability

Diminished reaction time
Slowed or faulty information processing and judgment
Compromised problem solving
Impaired communication

Reduced motivation
Indifference and loss of empathy*
Adverse effects on worker nervous, cardiovascular, metabolic, and immune functioning **

Sources: Sentinel Event Alert 48, Dec 14, 2011; *Hughes 2004; **NIOSH 2009
Potential Impact of Fatigue

Increased Rate of Errors

- Medication errors
- Charting errors
- Transcription
- Medical errors

Worker Adverse Events
- Sharps injuries
- Musculoskeletal injuries
- Decreased physical/emotional well-being
- Decreased personal safety (e.g., motor vehicle accidents)

Organizational Effects
- Legal issues, injury claims
- Satisfaction
- Staff turnover

Sources: Rogers et al. 2004; Landrigan et al. 2007; Lockley et al 2007; DHHS (NIOSH) 2009
Alarming Statistics

- Risk of error (especially medication errors) increases after 8 hours and is more significant after 12.5 hours
- Employee accident rates increase after 9 hours of work and double after 12 hours of consecutive work
- 3 Mile Island, Chernobyl, Exxon Valdez: accidents occurred at night – contributing factor was sleep deprivation
Alarming Statistics

- Extended work hours per day (>8hrs) = 37% increase in injury rate
- Extended work hours per week (>48hrs) = 23% increase in injury rate
- OT = 61% increase in injury rate
- Time of day night nurses struggle to stay awake:
  - 2 a.m. to 4 a.m. and 12 p.m. to 4 p.m.
Recommendations for Staff

- Eat balanced diet
- Exercise to decrease work-dependent fatigue
- Report unsafe work conditions
- Recognize symptoms of own fatigue
- Collaborate with other staff on taking breaks
- Practice good sleep hygiene (schedule 7-8 hours of sleep)
Evolving Nurse Leader Competencies

- Building and Strengthening Relationships
- Communicating Effectively
- Developing and Retaining Talent
- Financial Acumen
- Forging New Partnerships
- Giving Feedback
- Information and Technology Management
- Initiative
- Knowledge of Health Care Environment
- Managing Vision and Purpose
- Motivating and Influencing
- Personal and Professional Growth
- Process Management
- Service Orientation and Patient Care Quality
- Standards and Accountability
- Strategic Management and Prioritization
- Succession Management
- Systems Thinking
- Workforce Planning

Nobility (n.)

The state of being in one’s character, mind, birthright, rank.

Associated with dignity, goodness and courage.

If one is lucky, one solitary fantasy can totally transform one million realities.

Maya Angelou
What Can Leaders Do to Help?

- Deeply understand work environment challenges for the staff
- Be an active listener and problem-solver
- Develop initiatives to stimulate sense of meaning and achievement
- Use peer role models to help
- Stop “fantasy thinking” about work-life balance
- Money alone won’t provide joy & meaning
Technical and procedural improvements have made surgery safer, but future innovations will focus on reliably organizing the work of patient care.

- **Technical advancements**
  - Improved surgical techniques
  - Novel medical therapies
  - More focused training

- **Standardizing procedures**
  - Implementing process checklists
  - Measuring and reporting process compliance
  - Quality measurement and feedback

- **High reliability organizing**
  - Attention to frontline practices and behaviors
  - Leadership support for responding to and learning from errors
  - Cultural shift toward teamwork and care coordination
High Reliability in Health Care Requires

- Leadership
  Commitment to Zero Patient Harm

- Safety Culture
  Empowering staff to speak up about patient risks

- RPI
  Systematic data-driven approach to solving complex problems
Eight Recommendations for Achieving Total Systems Safety

1. Ensure that leaders establish and sustain a safety culture

Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.

2. Create centralized and coordinated oversight of patient safety

Optimization of patient safety efforts requires the involvement, coordination, and oversight of national governing bodies and other safety organizations.

3. Create a common set of safety metrics that reflect meaningful outcomes

Measurement is foundational to advancing improvement. To advance safety, we need to establish standard metrics across the care continuum and create ways to identify and measure risks and hazards proactively.

4. Increase funding for research in patient safety and implementation science

To make substantial advances in patient safety, both safety science and implementation science should be advanced, to more completely understand safety hazards and the best ways to prevent them.
Eight Recommendations for Achieving Total Systems Safety

5. ADDRESS SAFETY ACROSS THE ENTIRE CARE CONTINUUM

Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to evaluate the safety of care in various settings.

6. SUPPORT THE HEALTH CARE WORKFORCE

Workforce safety, morale, and wellness are absolutely necessary to providing safe care. Nurses, physicians, medical assistants, pharmacists, technicians, and others need support to fulfill their highest potential as healers.

7. PARTNER WITH PATIENTS AND FAMILIES FOR THE SAFEST CARE

Patients and families need to be actively engaged at all levels of health care. At its core, patient engagement is about the free flow of information to and from the patient.

8. ENSURE THAT TECHNOLOGY IS SAFE AND OPTIMIZED TO IMPROVE PATIENT SAFETY

Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.
ECRI Institute
New Safety Concern 2016

Failure to Embrace a Culture of Safety

Healthcare organizations must have a culture of safety that both spans the entire organization and permeates each department.

Why Culture Is Important

Culture
The shared values and beliefs of individuals in a group or organization

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<thead>
<tr>
<th>Culture</th>
<th>=</th>
<th>Shared Values &amp; Beliefs</th>
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<tbody>
<tr>
<td>Shared Values &amp; Beliefs</td>
<td>→</td>
<td>Our Behaviors</td>
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<tr>
<td>Our Behaviors</td>
<td>→</td>
<td>Outcomes</td>
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The Joint Commission
11 Tenets of a Safety Culture

Definition of a Safety Culture: Safety Culture is the sum of what an organization is and does in the pursuit of safety. The Patient Safety Systems (PS) chapter of The Joint Commission accreditation manuals defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety.

1. Apply a transparent, nonpunitive approach to reporting and learning from adverse events, close calls and unsafe conditions.

2. Use clear, just, and transparent risk-based processes for recognizing and distinguishing human errors and system errors from unsafe, blameworthy actions.

3. CEOs and all leaders adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.

4. Policies support safety culture and the reporting of adverse events, close calls and unsafe conditions. These policies are enforced and communicated to all team members.

5. Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements. Share these “free lessons” with all team members (i.e., feedback loop).

11 Tenets of a Safety Culture
(continued)

6. Determine an organizational baseline measure on safety culture performance using a validated tool.

7. Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvement.

8. Use information from safety assessments and/or surveys to develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety.

9. Embed safety culture team training into quality improvement projects and organizational processes to strengthen safety systems.

10. Proactively assess system strengths and vulnerabilities, and prioritize them for enhancement or improvement.

11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement.

“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.”

- Lucian Leape MD, member of the Quality of Health Care in America Committee at the Institute of Medicine and adjunct professor of the Harvard School of Public Health
A Psychologically Safe Culture: Interlocking Elements

Just culture  Reporting culture  Learning culture

Source: James Reason
Essential Elements: Culture of “Mindfulness” for Psychological Safety

- An atmosphere of trust in which errors and “near misses” are valuable lessons
- A “just” response to human errors, differentiating intentional from unintentional
- A system that provides for easy, de-identified reporting of unexpected events and errors, and that gives feedback and learning to those who report
- A learning system that not only shares feedback, but uses the learning to redesign the operations and challenge the assumptions that underlie the system itself
Safety Culture Maturation

<table>
<thead>
<tr>
<th>Beginning</th>
<th>Approaching</th>
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<tbody>
<tr>
<td>Trust and intimidating behavior are not assessed</td>
<td>High levels of (measured) trust exist in all clinical areas</td>
</tr>
<tr>
<td>Emphasis is on blame; inequitable application of discipline</td>
<td>All staff recognize/act on personal accountability; equitable disciplinary procedures</td>
</tr>
<tr>
<td>Root cause analysis is limited to adverse events</td>
<td>Close calls/unsafe conditions routinely reported with early problem resolution</td>
</tr>
<tr>
<td>Limited or no efforts to assess system defenses against quality failures and remedy weaknesses</td>
<td>System defenses proactively assessed; weaknesses proactively repaired</td>
</tr>
<tr>
<td>No measures of safety culture exist</td>
<td>Safety culture measures results routinely reported to the board; system improvement initiatives under way</td>
</tr>
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</table>
What Behaviors Are Intimidating?

- **Wide range**: from hanging up the phone instead of answering a question to verbal abuse (cursing, yelling) or physical abuse

- **Most common?**

  Refusal to answer questions or to return phone calls or pages; condescending tone or language; impatience with questions

Have we improved?
# Culture Change is Difficult

## AHRQ Safety Culture Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>2007</th>
<th>2012</th>
</tr>
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<tbody>
<tr>
<td>1. Staff feel mistakes are held against them (% YES)</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>2. When event is reported, it feels like the person is being written up, not the problem (% YES)</td>
<td>57</td>
<td>54</td>
</tr>
<tr>
<td>3. Staff worry mistakes are kept in their personnel files (% YES)</td>
<td>65</td>
<td>65</td>
</tr>
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2007 (n=382) 2012 (n=1128)
Bullying has no place in health care

Issue:
Civility is a system value that improves safety in health care settings. The link between civility, workplace safety, and patient care is not a new concept. The 2004 Institute of Medicine report, "Keeping Patients Safe: Transforming the Work Environment of Nurses," emphasizes the importance of the work environment in which nurses provide care. Workplace incivility that is expressed as bullying behavior is at epidemic levels. A recent Occupational Safety and Health Administration (OSHA) report on workplace violence in health care highlights the magnitude of the problem: while 21 percent of registered nurses and nursing students reported being physically assaulted, over 50 percent were verbally abused (a category that included bullying) in a 12-month period. In addition, 12 percent of emergency nurses experienced physical violence, and 59 percent experienced verbal abuse during a seven-day period.

Workplace bullying (also referred to as lateral or horizontal violence) is repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators. Bullying is abusive conduct that takes one or more of the following forms:

- Verbal abuse
- Threatening, intimidating or humiliating behaviors (including nonverbal)
- Work interference – sabotage – which prevents work from getting done

There are five recognized categories of workplace violence:

- Threat to professional status (public humiliation)
- Threat to personal standing (name calling, insults, teasing)
- Isolation (withholding information)
- Overwork (impossible deadlines)
- Destabilization (failing to give credit where credit is due)
Some Barriers To Safety Culture

- Blaming
- Denial
- Silence
- Temporary fixes
- Trade-offs
Sometimes the silence gets so loud, the only thing left to do is hope your heart is strong enough to beat it out.

Author: Rachel Wolchin
Drive out fear and create trust

- W. Edward Deming
“The Trust Equation”

Trust

Credibility  Reliability  Authenticity

Self-Interest
Safety Culture

What gets rewarded gets repeated

“Recognition”
It’s not a natural skill . . .
It must be taught!

“65% of Americans reported that they received no recognition for good work in the past year …”

# Safety Culture Principles and Traits

<table>
<thead>
<tr>
<th>Principle</th>
<th>Trait</th>
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</thead>
<tbody>
<tr>
<td>Everyone is personally responsible for safety</td>
<td>- Personal Accountability</td>
</tr>
<tr>
<td>Leaders demonstrate a commitment to safety</td>
<td>- Leadership safety values</td>
</tr>
<tr>
<td>Trust permeates the organization</td>
<td>- Effective safety communications</td>
</tr>
<tr>
<td>Decision-making reflects safety first</td>
<td>- Respectful work environment</td>
</tr>
<tr>
<td></td>
<td>- Environment for raising concerns</td>
</tr>
<tr>
<td></td>
<td>- Decision-making</td>
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</table>

Adapted from: Traits of a Healthy Nuclear Safety Culture. INPO 12–012, April 2013. Copyright © 2012, 2013 by the Institute of Nuclear Power Operations
<table>
<thead>
<tr>
<th>Principle</th>
<th>Trait</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care technology is recognized as special and unique</td>
<td>- Work processes automated</td>
</tr>
<tr>
<td>A questioning attitude is cultivated</td>
<td>- Questioning attitude applauded</td>
</tr>
<tr>
<td>Organizational learning is embraced</td>
<td>- Continuous learning</td>
</tr>
<tr>
<td>- Problem identification &amp; resolution</td>
<td></td>
</tr>
<tr>
<td>Patient Safety undergoes constant evaluation</td>
<td>- Continuous learning and fixes</td>
</tr>
<tr>
<td></td>
<td>- Problem identification</td>
</tr>
</tbody>
</table>

What Do Healthcare Staff Need for Psychological Safety?

- Respect and engagement
- Freedom from harm
  - physical
  - psychological
- Meaningful work
- Opportunities to learn and develop

How Clinicians Experience Caregiving

- Cared About
- Respect
- Trust
- Job Security
- Job Fit, Clarity, Pay/Benefits
- Work Training, Development, Physical/Staff Resources
- Good Management Input, Feedback, Autonomy, Leadership
- Communication

- Providing Quality Care
- Providing Safe Care

- Clinical Excellence
- Operational Excellence

- Mission/Values
- Teamwork
- Patient-Centeredness
- Improvement Focus
- Safety as a Priority

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An approach to reduce CareGiver suffering...

- We should **acknowledge** the complexity and gravity of the work provided by caregivers
- It is the responsibility of management to provide **support** in the form of material, human, and emotional resources
- **Teamwork** is a vital component for success
- **Empathy** and **trust** must be fostered and modeled
- Caregivers' perception of a positive **work/life balance** reduces compassion fatigue
- **Communication** at all levels is foundational
Elements of Psychological Safety in Teams

- Trust teammates to support and help each other
- Respectful communications
- Assume good intentions – no “hidden agendas”
- Believe everyone’s goals are aligned
- Able to challenge others’ ideas in positive manner
- Hold each individual accountable for own actions
- Open to learning from mistakes
- Fear is absent
Role of Hospital Leaders in Building a Culture of Psychological Safety

- **Motivate** care teams to uphold a fair and just safety culture
- **Provide** a transparent environment in which patient safety events are honestly reported
- **Model** professional behavior
- **Remove** intimidating behavior that might inhibit a culture of safety
- **Provide** the resources and training necessary to take on improvement initiatives
Where to Start: A Simple Test

Can your staff answer yes to the following three questions?

1. Am I treated with dignity and respect everyday by everyone I work with?
2. Do I have the knowledge, skills, and tools to do my job?
3. Am I recognized and thanked for my contributions?
Triple Aim


Consider Quadruple Aim: Meaningful Work
Quadruple Aim

The Quadruple Aim: care, health, cost and meaning in work

Rishi Sikka,1 Julianne M Morath,2 Ludan Leape3

In 2006, Donald Berwick and colleagues provided a framework for the delivery of high-value care in the USA, the Triple Aim, that is centred around three overarching goals: improving the individual experience of care, improving the health of populations, and reducing the per capita cost of healthcare.1 The intent is that the Triple Aim will guide the redesign of healthcare systems and the transition to population health. Health systems globally grapple with these challenges of improving the health of populations while simultaneously lowering healthcare costs. As a result, the Triple Aim, although originally conceived within the USA, has been adopted as a set of principles for health system reforms within many organisations around the world.

The successful achievement of the Triple Aim requires highly effective healthcare organisations. The backbone of any effective healthcare system is an engaged and productive workforce.” But the Triple Aim does not explicitly acknowledge the critical role of the workforce in healthcare transformation. We propose a modification of the Triple Aim to acknowledge the importance of physicians, nurses, and all employees finding joy and meaning in their work. This ‘Quadruple Aim’ would add a fourth aim improving the experience of providing care.

The sense of workforce engagement is the experience of joy and meaning in the work of healthcare. This is not synonymous with happiness, rather that all members of the workforce have a sense of accomplishment and meaning in their contributions. By meaning, we refer to the sense of importance of daily work. By joy, we refer to the feeling of success and fulfillment that results from meaningful work. In the UK, the National Health Service has engaged with this notion of an engaged staff that “think and act in a positive way about the work they do, the people they work with, and the organisation that they work for.”

The evidence is that the healthcare workforce finds joy and meaning in work is not measurable. In a recent physician survey in the USA, 80% of respondents indicated they were considering leaving practice, 79% of surveyed physicians knew at least one colleague who left their practice due to poor morale. A 2013 survey of British physicians reported similar findings with approximately 40% of respondents reporting very low or low morale.6 These findings also extend to the nursing profession. In a 2013 US survey of registered nurses, 45% of nurses worried that their job was affecting their health; 35% felt like resigning from their current job.7 Similar findings have been reported across Europe, with rates of nursing job dissatisfaction ranging from 11% to 34%.6 This absence of joy and meaning experienced by a majority of the healthcare workforce is in part due to the threats of psychological and physical harm that are common in the work environment.

Workplace injuries are much more frequent in healthcare than in other industries. For example, those in nursing, dental, and restaurant work face four times the industrial average.8 More days are lost due to occupational illness and injury in healthcare than in mining, machinery manufacture, and construction.

The state of physical harm is exacerbated by the extent of psychological harm in the complex environment of the healthcare workplace. Ergonomic examples include bulging, intimation and physical assault. More prevalent is psychological harm due to lack of respect. This degradation is compounded by production pressures, poor design of work flow and the proportion of non-value added work.

The current dysfunctional healthcare work environment is in part a by-product of the gradual shift in healthcare from a public service to a business model that occurred in the latter half of the 20th
Pre-Condition: Joy and Meaning

- Respect and engagement
- Freedom from harm
  - physical
  - psychological
- Meaningful work
- Opportunities to learn and develop

What Are the Seven Things That an Organization Must Do?

- **Strategy 1:** Develop and embody shared core values of mutual respect and civility; transparency and truth telling; safety of all workers and patients; and alignment and accountability from the boardroom through the front lines.

- **Strategy 2:** Adopt the explicit aim to eliminate harm to the workforce and to patients.

- **Strategy 3:** Commit to creating a high-reliability organization (HRO) and demonstrate the discipline to achieve highly reliable performance. This will require adopting evidence-based management skills for reliability.

What Are the Seven Things That an Organization Must Do?

- **Strategy 4:** Create a learning and improvement system
- **Strategy 5:** Establish data capture, database, and performance metrics for accountability and improvement
- **Strategy 6:** Recognize and celebrate the work and accomplishments of the workforce, regularly and with high visibility
- **Strategy 7:** Support industry-wide research to design and conduct studies that will explore issues and conditions in health care that are harming our workforce and our patients


Hughes RG, Rogers, AE: Are you tired? Sleep deprivation compromises nurses’ health – and jeopardizes patients. *American Journal of Nursing,* March 2004;104(3)

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