The healthcare industry has a poor record in protecting both patients and employees from injuries and illnesses (DiBenedetto 1995; Dunbar et al. 2007; Foley 2004; Foley et al. 2001; Lundstrom et al. 2002). There has been considerable effort in the last few years to address the problem of patient safety, particularly as it relates to medical errors (Lundstrom et al. 2002; Rozovsky 2005). This effort has been motivated in large part to avoid malpractice claims. Injuries to healthcare workers continue to exceed the general industry average, and the most common cause of injuries is strains or sprains (BLS 2006):

- **Lost time rates per 10^5 workers**

- Total industry = 127.8 (strain and sprains = 51.1)
- Hospitals = 175.9 (strain and sprains = 97.0)
- Nursing homes = 264.3 (strain and sprains = 135.9)
Workplace violence to healthcare workers is also a growing problem. See Chapter 12 for more information on the prevention of workplace violence. The actual number of healthcare worker deaths due to injuries or assaults is unknown. The best estimates for healthcare occupational death rate range from 17 to 57 per 10^6 workers (Sepkowitz and Eisenberg 2005). However, this death rate also includes deaths from infectious diseases. While the number of healthcare workers killed on the job is unknown, there is a clearly a need to better protect them from injuries and fatalities.

One reason why the healthcare occupational injury rate has been higher than other industries is that traditionally, hospital workers think first about the safety and welfare of their patients and second about themselves. This culture of concern for the patient rather than the employee continues today in many instances. (The issue of safety climate and culture is discussed later in this chapter.) It is important to remember that there are linkages between patient safety and employee safety (Foley 2004; Foley et al. 2001; Ramsay et al. 2006; Lundstrom et al. 2002). For example, if a patient falls, a healthcare provider may be injured while attempting to catch the patient or attempting to lift the fallen patient. Other reasons for the high injury rate in hospitals are that the work can be unpredictable and involve awkward postures. In the previous example, it is difficult to predict when a patient will lose balance or muscle control and fall, and moving or lifting patients often results in awkward postures for the healthcare provider. Fortunately, the same basic safety management approaches can be applied to either patients or employees; in preventing patient injury, employee injury may also be prevented.

There are some differences in managing employee and patient safety programs. Injuries to employees may be discussed openly in occupational safety committee meetings, but patient incidents can only be discussed in ways that do not disclose patient identifiers due to privacy and malpractice concerns. Even though the names of patients who are injured are never discussed in open meetings, researchers have found that open disclosure with the patient or the patient’s family about the specifics of the incident tends to reduce the number of malpractice lawsuits (Popp 2005). As with employee injuries, there is value in identifying patient injury trends in order to identify effective solutions. The focus of this book is primarily on prevention of occupational injuries and illnesses, and prevention strategies are presented below.

**PURPOSE OF HEALTHCARE SAFETY PROGRAM**

Safety programs in hospitals and other healthcare institutions are similar to those in other industries with some important exceptions. As previously discussed, healthcare safety programs must protect non-occupationally exposed individuals (patients and visitors) as well as employees. Obviously, safety programs must protect property and obey the law by complying with regulations. In addition, healthcare operations must maintain accreditation through the Joint
Commission on Accreditation of Healthcare Organizations (Joint Commission or JCAHO) or other organizations. Therefore, the four purposes of a healthcare safety program should be to:

- Prevent injuries and illnesses
- Contain costs
- Comply with Occupational Safety and Health Administration (OSHA) or other regulations
- Meet accreditation requirements

Each of these purposes is essential in the establishment of a culture of safety, which is described later in this chapter.

**Prevention of Injuries and Illnesses**

A safety program that fails to prevent occupational injuries and illnesses to its employees or injuries to patients is an ineffective one. In Chapter 1, the importance of anticipating, recognizing, evaluating, and controlling hazards was examined, and a method was described to sort through potential options to prevent or control the hazard using Haddon’s Matrix (Robertson 1992; AIHA 2003). Whether the concern is patient safety or employee safety, the most successful program is one that anticipates a potential hazard and eliminates it before anyone is injured. One approach to anticipating a problem is to review prior years’ injury and illness data to look for patterns where injuries are more likely to occur. For instance, if there is a high back-injury incident rate in one nursing unit, an investigation may reveal design, equipment, training, or personnel problems. If prior records are not revealing or are not available, another approach is to maintain frequent and open communications with employees or colleagues at similar institutions. If any employee believes there are design, equipment, training, or staffing issues that may cause a future incident, it is critical that this information be communicated to the health and safety program manager. Lastly, it is important to stay current with the relevant health and safety literature. If there are published reports about a new problem in another institution, what is the likelihood that it will occur in your institution?

If we fail to anticipate the problem, then we must recognize hazards through a safety surveillance system (described below). Figure 5.1 is a simplified schematic of a safety surveillance system.

In surveillance system below, a problem is recognized as the result of referrals from a hospital department, another committee or from the insurance carrier, from routine safety surveys, from an employee complaint, or from other sources. Once the problem is recognized, it must be tracked in the hospital safety surveillance system. This generally involves assigning the problem a code number. For example, 08-001 could be the first entry into the system for fiscal or calendar year 2008. It is important to maintain a tracking system because some problems may require capital improvements that could take