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When work harms: how better understanding of avoidable employee harm can improve employee safety, patient safety and healthcare quality

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A good experience of work is internationally recognised as directly enhancing the health and well-being of employees; conversely a poor experience of work can directly harm employees.[1] Although maintaining the well-being of employees is important in its own right, the benefits of doing so extend beyond the workforce. For example, healthcare workplaces which are physically and psychosocially safe for employees are known to enhance patient safety.[2–4]

Ground-breaking work published by Bodenheimer and Sinsky[5] argued that healthcare providers' well-being is crucial to achieving better patient care and outcomes. The Triple Aim originally comprised three goals: improving patient experience, enhancing population health and reducing healthcare costs. However, the authors argue that to achieve these aims, it is crucial for healthcare organisations to prioritise the well-being and satisfaction of healthcare providers. In order to do these organisations must acknowledge and address the risks and potential for harm to psychosocial well-being faced by healthcare employees, which occur as a result of how work is organised and inappropriate or suboptimal deployment of workforce processes and policies.[6 7] When healthcare providers feel considered, are supported, and their well-being is prioritised, they are more likely to deliver high-quality care and have better interactions with patients.

Yet, almost a decade on from Bodenheimer and Sinksy's paper,[5] considerable efforts to better understand and improve patient safety, and to better understand and control physical harms occurring to employees, greatly surpass attempts to better understand psychosocial harms occurring to employees.[8 9] In this paper, we argue that establishing a clear definition of employee harm is an important first step in improving the physical and psychosocial safety of healthcare employees. In doing so, we introduce the concept of 'avoidable employee harm (AEH)' and outline a series of critical next steps, including the need for a 'paradigm shift' towards a more integrated and systematic understanding of employee and patient safety.

EXAMPLES OF AVOIDABLE HARM OCCURRING TO EMPLOYEES

Healthcare settings are inherently dangerous environments, where employees globally are exposed to a myriad of overt risk hazards and stressors. Although employees globally have long been protected in law against physical or material hazards, such as radiation or the discharge of chemicals, psychosocial workplace risks and related avoidable harms are less tangible and poorly understood in healthcare literature. For example, a recent comprehensive review and analysis of national policies and approaches to occupational health across 12 countries concluded that workplace related psychosocial risks, mental health and well-being are overshadowed by the focus on physical workplace safety issues, due to lack of awareness and expertise on management of psychosocial risks and promotion of mental health.[9] The following summary examples describe how suboptimal implementation of workforce policies can directly impact on the psychosocial health of employees. These exemplars also demonstrate the need to recalibrate the focus toward a more holistic and integrated approach to understanding employee well-being and harm.

Avoidable harm occurring from implementation of disciplinary investigations and procedures

A national review[10] of local human resources (HR) investigations and disciplinary procedures noted a range of suboptimal HR management (HRM) practices occurring across the health service in England. The review focused specifically on one particularly distressing case. In 2016, Amin Abdullah, a staff nurse working at a National Health Service (NHS) hospital, died of suicide, having experienced severe mental health issues during and following a seriously flawed, unfair and protracted workplace investigation and disciplinary procedure. The independent investigation into the management of the disciplinary process[11] reported no concerns with the employer's policies, but found that their flawed implementation had significantly impacted the well-being of Amin Abdullah.

Avoidable harm occurring when employees speak up

Employees' testimony during a review of speaking up by employees in NHS England[12] described several instances where the implementation of HR processes resulted in intimidation and physical and psychological harm occurring to employees who had raised concerns in the NHS. Recent research similarly describes significant harm and detriment occurring to those speaking up in healthcare in England[13] and internationally.[14] In such circumstances, speaking up policies and procedures are often inappropriately implemented, or

'weaponised', by managers entrusted to protect and learn from employees' concerns.

Avoidable harm through change management and implementation processes

Finally, poorly implemented change in healthcare organisations can cause workforce stress and uncertainty when change processes are poorly communicated, are considered unfair and take place too quickly or too slowly.[15] The ramifications can be serious and far-reaching; the additional stress and workload can reduce the quality of patient care and may even impact treatment efficacy when suboptimal change implementation disrupts workflow. Similar issues have been identified in other sectors, such as the case of a French telecommunications company where a restructuring policy was linked to 19 deaths by suicide and a further 12 suicide attempts among employees.[16]

LEARNING FROM PATIENT SAFETY: DEFINING AEH

A critical first step in improving awareness and prevention of avoidable harm to patients was to identify and define key terminology. The concept of 'avoidable' patient harm has since become a foundational principle of healthcare globally.[17] We recommend a parallel approach which starts with defining the term AEH. A clear definition is key to establishing a shared understanding of the concept of AEH within healthcare practice, policy and research.

We suggest the following definition of 'AEH', which is closely aligned to existing definitions of 'avoidable patient harm':

> Where harm occurs to employees because of an identifiable and modifiable workplace cause, the future recurrence of which is avoidable by reasonable adaptation, subsequent adherence to and thoughtful implementation of a workplace process or policy.

Four notable points arise from the above definition:

- The definition encompasses all AEH—both the better understood, legislated against and studied harms occurring from physical or material hazards and the less understood, but increasingly acknowledged psychosocial workplace harms.
- The definition highlights that harm to employees is avoidable through adaptations to existing policy or process and/or through adherence and thoughtful implementation of policies and processes.
- The definition extends the concept of harm not only to those employees who are subjected to a poorly designed and/or implemented organisational policy, or process, but also to those who have to deploy, support and witness flawed policies and processes.
- The word 'avoidable' is key to normalising a new approach which considers harms occurring to employees as preventable and tractable, while also challenging beliefs that such harms are the inevitable 'cost of doing business' in complex healthcare and corporate contexts.

We do not propose that this definition is conclusive; rather, our aim is to promote the wider usage of the term 'AEH' and trigger further debate, which iteratively shapes and evolves the definition and related thinking in this area. The definition has already resulted in improvements in one healthcare system in the UK, as outlined in the following section.

THE BENEFITS OF AN AGREED DEFINITION

Defining and categorising avoidable harms is a necessary precondition to developing the steps needed to reduce future harms occurring. Presently, failing practices and processes that contribute to AEH are often lamented as unusual and isolated failures, with little or no change resultant change.

As a result of agreeing a definition which encompasses physical and psychosocial AEHs, comprehensive typologies and trends can be identified to inform harm prevention or mitigation strategies, organisational learning and service improvement efforts. Where harm to employees is not defined and typologised, it will be incredibly challenging to avoid similar harms occurring in the future. The refrain 'if you can't measure it, you can't manage it' is apposite. It may explain why even in countries with advanced legislative basis for employee safety there can be a lack of coordination between different agencies and stakeholders, which particularly impacts new and emerging forms of occupational risks such as psychosocial risks.[9]

An approach to employee harm underpinned by measurement also enables healthcare organisations to demonstrate accountability to their workforce and a commitment to assuring the quality and safety of services for staff and patients by:

- Explicitly acknowledging the possibility that some harm is avoidable.
- Comparing differences within and across physical and psychosocial AEH data, across disciplines and clinical areas, between organisations and over time.
- Examining the role of system and human factors in AEH.
- Developing and prioritising interventions to improve employee safety.

Application of the definition: a brief improvement case study from NHS Wales

In July 2022, Aneurin Bevan University Health Board (NHS Wales, UK) launched a new programme of improvement focusing on its disciplinary processes. Specifically, the importance of clear decision-making and a compassionate approach in the delivery of its employee investigations process were prioritised, in an attempt to avoid harm occurring to all those involved.[18] The improvement programme adopted the concept and the definition of AEH, in an attempt to change perceptions and understanding of the impact of employee investigations.

The focus on AEH engendered reflection and a wider understanding of how individuals and organisations can inadvertently, but avoidably, contribute to harm, or actively reduce or mitigate harm to colleagues. The change in perception and understanding of the impact of employee investigations has resulted in a reduction in the number of formal disciplinary processes being undertaken and precipitated a change in local HR culture. Initial feedback has suggested that the AEH approach has created a sense of empowerment: encouraging employees to be curious, ask questions and challenge established processes. It has also broadened understanding of the impact and harm—not only on the individual—but on the wider system and organisation, leading to an increased focus on the need for compassionate practice. The approach has since been adopted by other NHS Wales organisations. An initial exploration is indicating a similar response to the original improvement project, suggesting that the definition was useful in supporting a conversation around cultural change.

INTEGRATED PATIENT AND EMPLOYEE SAFETY SYSTEM

We also believe that formally defining and categorising 'AEH' can trigger a paradigm shift, where patient safety and employee safety are aligned, rather than maintaining their current separation within healthcare organisations.[1] Instead of being siloed, an integrated approach to employee and patient safety should

be considered an indicator of a positive organisational culture. For example, integrated safety committees and senior leadership groups could simultaneously consider, combine and address patient and employee safety key metrics. Adopting an integrated systems approach to establishing a culture of safety offers a practical means of achieving a whole-system governance approach, as outlined in policy ambitions internationally, such as the Quadruple Aim.[5 19] An integrated approach also addresses the historical tendency within the patient safety movement to tackle problems in isolation, the reversal of which was recently identified as one of the major challenges to progress in patient safety.[20]

SUMMARY: SAFETY CRITICAL STEPS

Reducing the rates of 'AEH' will not be easy. However, the future safety of employees and patients depends on the healthcare sector not sidestepping this challenge. We suggest organisations and teams should practically implement the quality mantra of 'being the change we need to see', via a sequence of critical steps, which parallel the nascent development of the patient safety movement 30 years ago.[17 20] These steps are as follows:

1. Define, identify and create a typology of employee harm: agreeing and using a definition and typology of 'AEH' introduces a consistency of language and shared understanding. Such consistency enables more accurate, reliable and systematic identification and categorisation of harm occurring to employees at micro (local), meso (regional) and macro (national and cross-national) levels.
2. Integrate safety siloes: change the mode of thinking at microlevels, mesolevels and macrolevels that currently considers avoidable employee safety and patient safety as separate entities. This change in perspective reinforces that employee and patient safety coexist within one system and that a shared safety culture is one that takes seriously all harms occurring within it.
3. Learn and improve: reviewing harmful processes and investing and supporting staff/team development can drive process and outcome improvements. We have witnessed how reflection on, and subsequent adaptations to, disciplinary/HRM processes and practices can enhance the safety of employees' who are subject to, and work within these processes.

CONCLUSION

Healthy working environments are essential for patient and employee safety to thrive.[1] Over the last three decades, the patient safety movement has developed a shared understanding of avoidable patient harm, reaching the point where it is a globally accepted and respected term in healthcare. The same cannot be said about avoidable harm occurring to healthcare employees, a common phenomenon that is primarily understood in literature, and implemented in policy, in terms of the physical, rather than the psychosocial harms that occur to employees. The novel contribution of this paper is to raise awareness and provide clear examples of the psychosocial harms occurring to employees in healthcare. The practical benefits, although early in an improvement journey, of adopting and operationalising a definition of 'AEH' in a UK healthcare system are described.

We also propose a definition, and approach to measurement and improvement of employee harm which encompasses the previously siloed domains of physical and psychosocial harms. Our novel suggestion is that healthcare leaders/organisations ultimately operationalise a combined holistic view of the safety of healthcare employees and patients. Although existing literature identifies the need to better understand and operationalise a combined view of patient and employee experience and well-being, we further develop these ideas by prioritising an approach which initially defines the phenomenon of 'AEH', which then leads into employee harm typologies and measurements to better understand and ultimately improve employee and patient safety and well-being.

This paper has attempted to address this gap in understanding. Drawing on examples of serious and 'AEH' caused by poorly implemented policies and procedures, we argue that significant benefits to employees, patients and organisations can be realised as a result of developing a shared understanding and definition of 'AEH'.

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