The Kaiser Permanente

Labor Management Partnership Workplace Safety Initiative

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Kaiser Permanente (KP) is America's largest not-for-profit health maintenance organization, serving 8.6 million members with approximately 100,000 employees in 18 states and the District of Columbia. Work related injuries and illnesses at KP impact the organization's ability to provide quality healthcare, significantly impact profitability, and adversely affect the lives of each and every employee who is injured on the job. This paper will describe a comprehensive initiative focusing on the total elimination of injuries that is currently underway within the organization.

Approximately 55 employees report injuries each day at KP nationwide, and workers' compensation and related costs to the organization total $400 million each year. In 1998, the California Division alone spent $75 million for workers' compensation claims. For 1999, the total direct cost for claims in the California Division was $81.1 million. An injury analysis of patient care services – inpatient care shows that from 1996-98, there were 4,230 injuries that cost the organization $31.7 million in direct cost, with an additional $66.6 million of indirect costs. Indirect costs include the cost of replacement workers, sick leave, accident investigation, triage, and recordkeeping, but do not include the training of replacement workers or take into account the burden on KP's medical system. Of these 4,230 injuries, approximately 1,731 can be attributed to patient handling injuries, costing the organization $17.0 million in direct incurred cost and $35.6 million in indirect costs. [1]

KP's commitment to provide affordable, quality healthcare requires the dedicated services of healthy employees and physicians. Injured workers not only result in staff shortages, but also affect operational expenses, staff morale and the ability to provide affordable, high quality healthcare. Additionally, KP must contend with an aging workforce and heavier workers and members, which significantly influences patient handling practices. Factors affecting patient handling practices include:

- The average age of a KP registered nurse is 47 (national average is 42)
- The average age of a new RN graduate is 31
- Patients are more overweight and obese (obesity has increased 67% in California in the last 10 years)
- Workers are also experiencing weight problems and lower levels of fitness
- National nursing shortage predicted by 2020 (number of RNs 20% short of demand) causing higher salaries and healthcare costs

In 1997, KP and 26 American local unions (representing 57,000 KP employees at the time, expanded to 85,000 today) signed an historic agreement to enter a comprehensive Labor Management Partnership (LMP). The Partnership has achieved many successes during the first five years. At least 50 projects in different work sites have been developed in which labor and management partners report significant bottom line savings and performance improvement. The parties have agreed on many focused workplace centered initiatives and given unionized employees opportunity to earn additional raises by achieving key goals that are also tied to management compensation.[2] The Partnership chose workplace safety / workers' compensation costs as a priority starting in 2002, and chartered the Workplace Safety Leadership Team (WPS) to lead the effort.

The WPS has members from labor and management, from Northern and Southern California and from regions outside California, working together to lead, coordinate and support Partnership safety efforts throughout KP.

The goal of the program is a workplace free of injuries, beginning with a 50% reduction by 2005. Starting in 2002, the WPS members coordinated efforts throughout KP nationwide that include Reach for Systems of Safety, Systems of Safety, Ongoing Interventions, Broad engagement, and Integrated disability management.

Systems of Safety (SOS) is an LMP centered method that bundles several tried and true risk assessment and injury reduction processes into one holistic effort to change both culture and conditions for the better. These trainings and interventions are being tested in specific high-risk areas and will then be replicated as appropriate throughout KP. Reach for SOS consists of the preliminary activities to implementation of SOS. One pilot program of SOS is training on unit-level labor-management work team development, with a focus on identifying and resolving safety hazards. Another pilot program uses unit-level team development, safety hazard identification and resolution using a rapid-cycle, “break-through” process. The second pilot program targets areas including a chart room, Environmental Services group and an in-patient Ob-Gyn unit.

On-going interventions include earlier safety interventions that the WPS is helping to bring into the new LMP workplace safety structure. An example is the formation of Lift Teams.

Half of all KP injuries occur in about 30 departments known to be high-risk, such as in-patient care. The other half, however, occurs throughout 500 other departments. Broad engagement refers to engaging front-line employees and supervisors to evaluate potential interventions. A fundamental element of the LMP, and a key to injury prevention, is to begin using consensus-based decision-making in labor-management teams to identify and eliminate workplace injuries. Systems of Safety provides tools and interventions that can be used by employees, supervisors and managers on local units to identify and resolve safety hazards, so everyone will have the skills they need to begin this work.

Members of the WPS coordinate the work of exploring improved ways to handle the process of integrated disability management, from injury reporting through return to work policies.

The WPS adopted the following metric to establish baselines and subsequently measure progress toward injury reduction goals: the number of injuries per 100 FTEs.[3] For the purpose of this metric, “injuries” are defined as workers’ compensation claims, and FTEs are counted as “productive Full Time Equivalents” which excludes vacation/sick time. The long-term goal is to track all injuries, not just workers’ compensation data.

Because in-patient care results in a large number of workplace injuries, the WPS adopted two initiatives for injury and illness prevention and management to target these areas: Team-Patient Handling Training – Basic Training and Patient Handling Lift Team implementation.

Team Patient Handling intervention includes a comprehensive educational program entitled “Patient Care Body Mechanics,” which stresses the importance of good communication and teamwork in the patient care environment, while teaching participants how to:

- Recognize and report the signs and symptoms of muscular skeletal disorder (MSD) injuries as they relate to patient handling and seek required medical treatment
- Identify patient handling tasks classified as “high risk.”
- Assess the patient-handling situation and choose the appropriate technique, procedure and equipment for the identified “high risk” patient-handling task.
- Reposition and transfer patients using good patient mobility skills, appropriate patient handling techniques and equipment and proper body mechanics.

The Team Patient Handling intervention also includes training regarding the proper selection and utilization of patient handling equipment (e.g. draw sheets, slide boards, lift equipment, specialty chairs, transfer devices, specialty beds).

Successful patient handling intervention requires that all Patient Care Services staff members must properly assess the patient situation and call Lift Team for all high-risk patient lifts, transfers and repositions.

The Lift Team intervention began before the formation of the LMP WPS. Northern California implemented the first lift team in 2000, then began the next round of lift team implementations in the first quarter of 2003. They currently have lift teams in 15 Medical Centers, with two additional Medical Centers in the process of implementation. Southern California implemented lift teams in the third and fourth quarters of 2002. They currently have lift teams in all 11 Medical Centers. Since separate WPS Subcommittees exist for Northern California, Southern California and Regions Outside California, minor differences in implementation have resulted.

One of these differences is the use of a functional capacity test, which is administered before the final awarding of the position. Southern California employs an incremental isoinertial test to observe the strength and body mechanics of the applicant. This screening technique should serve to select individuals whose capabilities match the job demands, within a margin of safety.[4] Northern California, however, which began implementing lift teams before the LMP structure, does not rely on functional capacity testing. Their focus is to use equipment as the first priority to eliminate the majority of manual lifting tasks.

Candidates are chosen based on seniority and the results of a panel interview for the trained Lift Technician positions. Lift Technicians may report to a newly created department; other options include reporting to Nursing, the House Supervisor/Manager, Materials Management (Transporters) or Physical Therapy.

Training for the Lift Technician occurs over a 3-day period for internal hires and five or more days for new hires (to include New Employee Orientation and CPR certification). The first day of training focuses on classroom instruction in the history of the Lift Team, a Back Safety Orientation, instruction in Medical Terminology, Patient Care Body Mechanics (Manual Techniques) and Hospital Policies and Practices, such as infection control, patient confidentiality and reporting of equipment malfunctions. The second day is spent on orientation rounds with Physical Therapy staff. Day 3 includes instruction in Patient Care Body Mechanics (Lift Equipment), facility-based guidelines for Lift Team Practices, and orientation rounds with Patient Care Staff.

Additional training for Patient Care Staff includes modules on conflict resolution, Body Mechanics, “Team Lift” and Patient Lift equipment. New Patient Care Services staff must receive this training as part of new hire orientation and annual skills in-service for all Patient Care staff reinforces the training.

Standards of Care have been developed which identify “high risk” criteria for which the Lift Team should be contacted, such as patients over 150 pounds, quadriplegic and paraplegic patients, patients that require total assistance in movement or have limited weight bearing and/or mobility status, patients requiring repetitive turning/movement, patients who have fallen, transportation assistance with “high risk” patients, and combative or confused patients.

Equipment recommendations include a ratio of one piece of equipment for every 24-26 hospital beds. Specific equipment recommendations are for the Liko Golvo Lift ($10,000) for vertical lifts and weighing patients, the WyEast Totalift Patient Chair ($7500) for lateral transfer which allows staff to convert lifting tasks to push-pull tasks, and the Arjo Stedy ($1500) to assist patients to and from the bed for seating or toileting. While funds have been appropriated in a Workplace Safety Equipment budget, the local Medical Center determines how the money is split among all initiatives. Estimates of the total intervention cost for the first year for the California Division (including capital equipment and Lift Team personnel) include $3,524,000 for coverage 5 days per week / 8 hours per day and $4,550,000 for coverage 7 days per week / 8 hours per day.

Several success factors have been identified through statistical analysis of questionnaires from seven Medical Centers with lift teams in place. They include working as Lift Team pairs for the entire duration of the shift; enforcing Lift Team policies / procedures (Standards of Care); fully utilizing equipment – as the first resource; and training Patient Care Staff to properly utilize the Lift Team and use team lifting procedures. These success factors will be re-evaluated in 2003 by sending questionnaires to all 28 Medical Centers that have implemented lift teams.

Because the majority of lift team implementations occurred in the first quarter of 2003, national data on actual reduction in injuries and actual cost savings has not been released by the LMP yet. Within one service area that consists of three Medical Centers, data shows a metric of 12.55 in the first quarter of 2003 compared to the 2001 baseline rate of 13.94 injuries per 100 FTEs, or a 12% reduction. In addition, the injury rate for Adult Acute Care Nursing in the same service area has dropped an average of 23.6% since the Lift Team began.[5]

Future goals of the Lift Team Task Group may include 24 hour Lift Team coverage / 7 days per week as well as overhead lift systems installed in “high risk” patient rooms.

The Kaiser Permanente Labor Management Partnership Workplace Safety initiative and the Lift Team Task Group have already seen benefits from their interventions. Although national data is not available yet, a reduction of staff injuries associated with patient handling has been demonstrated along with a reduction of injury costs. Compliance with the governmental ergonomics standards as well as improved patient safety and patient outcomes are also expected as a result of specialized practices and equipment. The improvements bring performance outcomes into alignment with the KP Promise to its members:

- We Practice Great Medicine – through increased staff efficiency; increased patient safety; improved patient outcomes
- We Know You – through specialized handling with care and dignity; pain reduction; minimizing staff requirements

- Superior People / Superior Systems – a safer workplace and consistent practices impacts recruitment and retention as KP strives to be the “Employer of Choice.”
- Superior Care Experience – providing members safe, affordable (because costs are lower) high-quality healthcare as KP strives to be the “Provider of Choice.”

Footnotes

[1] Donaldson, A.W. (2001). Patient Handling (PH) Lift Team – Business Case.

[2] Eaton, S.C., Kochan, T.A., McKersie, R.B. (2003, January). The Kaiser Permanente Labor Management Partnership – The First Five Years. MIT, Sloan School of Management.

[3] Smisko, B. (2002, May 28). KP Safety Net.

[4] Kroemer K., Kroemer H., Kroemer-Elbert E. (2001). Ergonomics How to Design for Ease and Efficiency, In W. J. Fabrycky & J. H. Mize (Eds.), (p. 521). Upper Saddle River, NJ: Prentice Hall

[5] Duplechen, L. (2003, June). Systems of Safety. Safety Watch, Vol 1, Issue 6.