# Toward a Healthy Work Environment

*Patient Care Is Better in a Workplace in Which Nurses Are Treated as Respected Colleagues*

*There is mounting evidence that unhealthy work environments contribute to medical errors, ineffective delivery of care, and conflict and stress among health professionals. Negative, demoralizing and unsafe conditions in workplaces cannot be allowed to continue. The creation of healthy work environments is imperative to ensure patient safety, enhance staff recruitment and retention, and maintain an organization's financial viability.*
—Kathleen McCauley, PhD, RN, past president, American Association of Critical-Care Nurse, Aliso Viejo, CA,[1]

**BY CONNIE BARDEN, MSN, RN; & CLAUDIA DISTRITO, MSH, BSN, RN**
*Ms. Barden, a past president of the American Association of Critical-Care Nurses, is a cardiovascular clinical specialist, and Ms. Distrito is senior vice president, nursing and patient services, Mercy Hospital, Miami.*

Few leaders have spoken as powerfully about the significance of the work environment in health care as did Kathleen McCauley, PhD, RN, in the American Association of Critical-Care Nurses's (AACN's) recent statement on standards in the work environment. McCauley's words ask all health care to examine the environment in which care is delivered and to analyze delivery processes and the relationships involved in them with an eye toward improving their impact on patients, staff, and outcomes.

In this article, we will examine certain links among work environment factors, their impact on patient safety and staff retention, and the role leaders can play in creating an environment for change. We will use the AACN Standards as a blueprint for defining and creating work environments that enhance the delivery of care that is safe, effective, and gratifying to health care professionals, employees, patients, and patients' families.

## Toward a Healthy Workplace

The AACN Standards outline six topic areas that, we feel, must be addressed in order to create a health care

environment that can be defined as "healthy." The areas are:

- Skilled communication
- True collaboration
- Effective decision making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership

The six areas describe *relationship* issues—how team members communicate, whether or not real collaboration takes place, how decisions are made, and so on—issues traditionally not viewed as requiring leaders' attention. But there is evidence that these issues do indeed require the focus of an organization's top executives.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) publishes data on errors in the workplace, with special attention to what it calls "sentinel events": unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof.[2] Such events are called "sentinel" because they signal a need for immediate investigation and response. They include unanticipated death or major permanent loss of function, wrong-site surgeries, or other unexpected events in the health care setting. Of the more than 2,900 sentinel events reported to the JCAHO since 1995, more than two thirds involved communication mishaps. More specifically, 60 percent of the sentinel events related to medication errors and ventilator mishaps were linked to faulty communication, as were more than 75 percent of those involving wrong-site surgery, and more than 80 percent of those involving treatment delays.

A brief look around any hospital care unit is likely to corroborate the major role that communication breakdowns play not just in errors but also in staff frustration and frequent emotional upsets on the part of patients and visitors. Indeed, without skilled and precise communication, staff members have little opportunity to "get it right" in the world of health care, which demands precision and accuracy.

The crucial topic of collaboration, which requires skilled communication, sound decision making, and other relationship-based skills, is also often sorely lacking among health care professionals. Environments in which team members are intimidated and fearful of speaking up are known to be environments in which errors—sometimes fatal errors—occur.

In 2002, researchers surveyed 1,200 nurses, physicians, and hospital executives about nurse-physician relationships.[3] The study showed the important role that good relationships play in maintaining communication among care providers—and in retaining nurses who are willing to work at the bedside. More than 90 percent of the study's participants reported witnessing disruptive behavior by physicians and more than a third had knowledge of nurses leaving an institution because of such behavior. Nurse-physician relationships have been called "one of the most important drivers of the work environment" and a major contributor to ensuring patient safety in hospitals.[4] Today, when the average cost of replacing an RN approximates 150 percent of the nurse's salary, an environment in which abusive relationships contribute to nurses to leaving the hospital can be very costly.

An absence of collaboration will affect not only physicians and nurses but also the other members of a care team. A staff member who makes deci-

Communication breakdowns play a major role not just in errors but also in staff frustration and emotional upsets on the part of patients and visitors.

**SUMMARY**

Patient safety and the quality of patient care have become important topics in U.S. hospitals in recent years. Nearly all hospitals have made mechanical and procedural changes to improve safety. But a truly healthy hospital is one in which caregivers, especially nurses, are treated with respect.

The American Association of Critical-Care Nurses argues that a genuinely healthy work environment has six qualities: skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition of staff members' contributions, and authentic leadership.

Although training is often needed to create a respectful and healthy workplace, some leaders are reluctant to allocate dollars on what they see as "soft" relationship issues. However, hospital leaders dedicated to improving safety and quality of care will see that they cannot afford to neglect such issues.

sions in isolation runs the risk of working with an incomplete assessment of the situation and an inaccurate perspective on the patient's needs and treatments.

Healthy work environments also require appropriate staffing, a fact substantiated by both the data and common sense. A plethora of research done in the past decade demonstrates the incontestable link between insufficient RN staffing, on one hand, and negative patient outcomes, including complications and perhaps death, on the other. As nurses well know, increasing their daily workloads challenges their ability to continue to deliver high-quality patient care.[5]

Relationship issues often drive staff out of health care.

## The Challenges Ahead

The challenges involved in addressing work environment issues are numerous and often daunting. Only recently did data become available showing that relationship issues often drive staff out of health care. Even today, many executives, managers, and physicians fail to give credence to the importance of these issues. Traditionally, relationship issues are seen as unimportant and not worthy of leaders' attention. Health care institutions—and especially hospitals—are steeped in tradition and hierarchy. Top-down power structures are often viewed as "just the way things are"; physicians are often seen as solitary "captains of the ship." Indeed, such organizations have been described not as goal-directed but, rather, as "dynamic systems changing at the pleasure of those in power."[6]

Even in those organizations that attempt to address such elusive issues, results and improvement are hard to measure. How does one measure improvement in communication? How does one show better collaboration? When does one know that decisions are made effectively and in the best interest of all involved? And, certainly in the era of competition and extreme pressure in the health care marketplace, issues concerning how staff members relate to each other may seem unimportant and neither showy nor "sexy" in decision makers' eyes.

## Leadership's Critical Role

A pioneering theorist of organizational behavior has described one of the most crucial functions of leadership as the creation, management, and—sometimes— destruction and rebuilding of organizational culture.[7] The changes called for in the AACN Standards require fundamental alterations in the day-to-day business of most hospitals. History demonstrates that these changes will not just happen. And, indeed, without a plan in place for change and evaluation of progress, very little can be expected to change.

If change is to occur, the variables contributing to unhealthy work environments must be addressed through the direct involvement of executive leadership. Top leaders will be the drivers of the tough decisions that will make it possible for changes in behaviors and relationships to happen. Although faith-based organizations work hard to create a healing environment for their patients, they don't always do the same for employees. If they are to improve, they must face this fact. As one writer has noted, "all good-to-great companies began the process of finding a path to greatness by confronting the brutal facts of their current reality."[8] That writer, Jim Collins, argues that creating a climate in which the truth is heard involves four basic practices:

- Leading with questions, not answers
- Engaging in dialogue and debate, not coercion
- Conducting "autopsies" without blame (i.e., conducting a thorough review of issues and/or errors without finger-pointing)
- Building "red flag" mechanisms that turn information into information that cannot be ignored[9]

Top leaders can best uncover the truth about an organization through open communication with staff. Whether this communication occurs by way of focus groups, surveys, one-on-one discussions, or another means, leaders will find that staff members will talk honestly with administrators only if they believe they can do so without risking retaliation. Leaders should realize, moreover, that staff members will trust them only insofar as they take action concerning the issues brought to light in these discussions. This action must be obvious to all. And dialogue must continue with staff members after the action, in order to determine its effectiveness. Nothing demoralizes staff members more than discussion that produces no results.

Frequent surveys of staff also provide data that will help leaders develop plans for the environment's improvement. A new book called *Quality Work Environments for Nurse and Patient Safety* describes a number of ideas in this area, some of which could be replicated in other workplaces.[10] In any case, leaders must first determine

the environmental factors that affect patient outcomes and nursing staff stability if they intend to address the factors that do so in a negative way.

Top leaders must also be willing to be involved in evaluating those recurring issues in the workplace that contribute to toxicity—such as chronic shortages of personnel, abusive behavior by staff or physicians, marginal leadership, and poor communication. They must set standards that cannot be ignored or missed and must continually raise the bar in the direction of excellence.

Leaders must confront abusive behavior at all levels, turning the entire organization into a no-tolerance zone for disrespectful behavior.[11] Although most hospitals have policies concerning unacceptable behavior, these policies are often not enforced, particularly when members of the medical staff are involved. Physicians cannot be allowed to abuse other staff members, and hospital leaders must take steps to address such behavior when it is identified as a continued source of stress and interference with patient care. Abusive and disrespectful physicians need to be given guidance in behavior change. And if it becomes evident that change will not take place, those physicians may need to leave the organization. Medical errors and staff turnover related to this type of behavior are far more costly in the long run than the short-term loss of a single disruptive physician.

Marginal leadership must also be dealt with vigorously. In *Good to Great: Why Some Companies Make the Leap and Others Don't*, Collins notes that talented leaders begin changing their organizations by getting the right people "on the bus"—and the wrong people off. The old adage that "people are your most important asset" is more accurately phrased as "the *right* people are your most important asset." Collins says that "good-to-great management teams consist of people who debate vigorously in search of the best answers, yet who unify behind decisions, regardless of parochial interests."[12] In addition to choosing the right managers, leaders must invest in high-quality leadership education; a key component of that education must be the development of relationship skills.

Effective communication among members of the health care team is another critical element in improving the workplace environment. Leaders must not only assess the effectiveness of team members' communication; they must also implement methods to improve communication. Tools that can be used toward this end are outlined in *Quality Work Environments for Nurse and Patient Safety*. Staff members can enhance communication by using electronic medical records. It is essential, moreover, that leaders implement the recommendations of the JCAHO and the Institute of Medicine regarding clear and effective oral and written communication.

In most institutions, a paradigm shift will be required to change thinking so that staffing levels are viewed as important contributors to a healthy work environment. Once that shift has occurred, however, appropriate staffing will be seen not as a matter of mere numbers; rather, it will be seen as a sophisticated appraisal of the nursing staff's skill mix and educational preparation, on one hand, and of the total patient census and the acuity of patient needs, on the other. Appropriate staffing also requires that staff members perceive their coworkers as competent. A recent study described what its authors called a "perception of adequacy of staffing" (PAS) scale; a six-item PAS scale was recommended for hospitals to use to obtain staff input on staffing adequacy.[13] In addition, some recent studies have correlated possession of a bachelor of nursing science degree with improved patient outcomes, particularly in "failure to rescue" situations.[14]

"The participation of health care workers in creating a healthy workplace is an initial sign of respect after the numerous reforms to the health care system in past years," states one writer.[15] "To be shown more respect, nurses are asking doctors and administrators to consult them and consider their recommendations related to patient care and operational and structural changes they envision for the workplace." Including nursing and hospital staff in the process can only strengthen the professionalism of the practice environment and the trust that is essential for a transformed environment.

Leaders must confront abusive behavior at all levels.

## Crafting the Journey

The responsibility for creating the wave of sweeping organizational culture changes suggested here lies squarely in the hands of executive leaders—the people who determine what is valued, what is important, and how values are translated into behaviors. The creation of a healthy work environment will require commitment from all involved, from the board to the bedside. Leaders can begin by outlining and disseminating clear descriptions of the changes to be embraced (e.g., adoption of the AACN Standards). They must

then allocate the resources that enable the staff to acquire the knowledge and skills it will need to implement the changes.

The assumption that staff members and physicians already know how to communicate or collaborate well is a faulty one that is demonstrated by the snafus that occur every day in health care organizations. Education of staff should be undertaken on a team basis, rather than in the traditional "silos" of medical learning (i.e., without reference to nursing and other health care disciplines). Some leaders may be reluctant to allocate dollars for training on what they consider "soft" relationship issues. "How can we afford to do this?" they may ask. But the sensible question for today's health care organization is: "How can we afford not to do it?"

Finally, the organization must acquire the tools that allow it to measure its progress toward a healthy work environment (and must plan to evaluate that progress at regular intervals). Work done with the "human factor analysis" that has become integral to the aviation industry may yield evaluative components that are also relevant to health care. Such programs and resources, including evaluative components, are increasingly becoming available as organizations embark on this crucial initiative.

## Wanted: Courage to Change

Although minor improvements in work environments can always be made in particular departments, transformation of the organization as a whole will depend on the vision, commitment, boldness, and tenacity of its top leaders. Reinventing the way professionals relate to one another in systems teeming with tradition, hierarchy, and a variety of social pressures will require a new courage on the part of leaders, because they will be treading on unfamiliar ground. However, they must embrace this unfamiliarity if they are to create safe environments and retain that most precious resource for patient care: a competent, inspired, and engaged health care team. ■

## NOTES


1. American Association of Critical-Care Nurses, *AACN Standards for Establishing and Sustaining Healthy Work Environments*, Aliso Viejo, CA, 2005.
2. Joint Commission on Accreditation of Healthcare Organizations, *Root Causes of Sentinel Events 1995-2004*, available at www.jcaho.com/accredited+organizations/ambulatory+care/sentinel+events/root+causes+of+sentinel+event.htm. See also Thomas and Nancy Hooyman, "The 'Sentinel Events' Study," *Health Progress*, November-December 2004, pp. 33-36, 62, concerning CHA's own study.
3. A. H. Rosenstein, "Original Research: Nurse-Physician Relationships: Impact on Nurse Satisfaction and Retention, *American Journal of Nursing*, vol. 102, no. 6, June 2002, pp. 26-34.
4. A. P. Smith, "Partners at the Bedside: The Importance of Nurse-Physician Relationships," *Nursing Economics*, vol. 22, no. 3, May-June 2004, pp. 161-164.
5. B. Kimball and E. O'Neil say, in *Health Care's Human Crisis: The American Nursing Shortage*, Robert Wood Johnson Foundation, Princeton, NJ, April 2002, that nurses' primary concern is the way increased workloads affect patient care.
6. P. H. Arford, "Nurse-Physician Communication: An Organizational Accountability," *Nursing Economics*, vol. 23, no. 2, March-April 2005, pp. 72-77.
7. E. H. Schein, *Organizational Culture and Leadership*, Jossey-Bass, Hoboken, NJ, 1992.
8. J. Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't*, HarperBusiness, New York City, 2001, p. 88.
9. Collins.
10. L. M. Hall, ed., *Quality Work Environments for Nurse and Patient Safety*, Jones and Bartlett, Boston, 2005.
11. See J. Briles, *Zapping Conflict in the Health Care Workplace*, Mile High Press, Aurora, CO, 2003.
12. Collins, p. 63.
13. M. Kramer and C. Schmalenberg, "Revising the Essentials of Magnetism Tool: There Is More to Adequate Staffing than Numbers," *Journal of Nursing Administration*, vol. 35, no. 4, April 2003, pp. 188-198.
14. L. Aiken, S. Clarke, R. Cheung, et al., "Educational Levels of Hospital Nurses and Surgical Patient Mortality,"*JAMA*, vol. 290, no. 12, September 24, 2003, pp. 1,617-1,623.
15. M. Lavoie-Tremblay, "Creating a Healthy Workplace: A Participatory Organizational Intervention," *Journal of Nursing Administration*, vol. 34, no. 10, October 2004, pp. 469-474.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, November-December 2005