SafeWork NSW

Preventing work-related violence in NSW Hospitals

Reporting culture improvement roadmap

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UniSC Australia

Centre for Human Factors and Sociotechnical Systems

Developed by the Centre for Human Factors and Sociotechnical Systems at UniSC for SafeWork NSW, in consultation with the Action Against Violence in NSW Hospitals Working Group.

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SafeWork NSW, 92–100 Donnison Street, Gosford, NSW 2250
Locked Bag 2906, Lisarow, NSW 2252 | Customer Experience 13 10 50
Website www.safework.nsw.gov.au
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1. Background

Work-related violence (WRV) is an important health and safety issue in healthcare and especially within hospital environments. Research worldwide has shown that healthcare workers in hospitals are at high risk of WRV from patients / consumers, visitors, and other healthcare workers (Mento et al., 2020; Nelson, 2014; World Health Organisation, 2020). Previous research has also shown that WRV is a complex and multi-factorial issue and has identified the need for systems thinking approaches to be taken (Salmon, Coventon & Read, 2021; 2022).

Incident reporting is a vital process for healthcare organisations and the sector more broadly to understand current WRV incident rates and the effectiveness of existing risk controls. However, under-reporting of incidents is an issue both in Australia (e.g., Dafny & Beccaria, 2020; Hogarth, Beattie & Morphet, 2016) and internationally (e.g., García-Pérez et al., 2021; Kumari et al., 2020; Tyler et al., 2022). This suggests that healthcare organisations and other stakeholders do not currently have means of determining the current extent of the problem and whether existing controls address all WRV situations.

Safety reporting is a complex issue. Some reporting is mandated by law, but safety reporting of all types can assist Persons Conducting a Business or Undertaking (PCBUs) to manage risks associated with WRV, and thus should be encouraged. For individual workers, there are various reasons or motivations to report workplace health and safety incidents. For example, workers may wish to inform management about a hazard or incident so that changes can be made to create a safer workplace for themselves and their colleagues. Additionally, they may wish to document evidence for an injury compensation claim or they may report in order to comply with organisational policies and procedures. Stakeholders at higher levels of the system (e.g., managers, senior management, policy makers, regulators, unions, the media), who are key users of the reported data, may also have various needs. In addition to compliance with mandatory reporting requirements, reports are used to learn about risks in order to make changes in the organisation or local workplace. Further, aggregated data may be used for benchmarking across organisations, to understand where sector-wide improvements are needed, or to raise awareness of safety issues within the sector or the wider community. All of these various needs are valid and need to be taken into consideration. However, the focus of this document will be incident reporting by healthcare workers as it relates to supporting a positive safety culture and learning culture associated with WRV, both within healthcare organisations and across the sector.

The aim of this document is to outline a systems thinking-based reporting culture improvement roadmap. The roadmap is not intended to be prescriptive, but to identify a set of initiatives that stakeholders across the system can consider for implementation. It is anticipated that the roadmap could be used during organisational planning processes (e.g., strategic planning), when embarking on culture change or safety improvement projects or during risk assessments to identify potential controls.

This guidance document is part of a suite of systems thinking resources for preventing WRV in hospitals. More information about the problem of WRV in hospitals, systems thinking approaches, and the suite of tools, is available in the Systems Thinking for Preventing Work-Related Violence in NSW Hospitals Overview.

2. Reporting culture as a pre-requisite for safety culture

Organisational culture is a term used to describe shared values that affect and influence workers' attitudes and behaviours. It is often referred to as "the way we do things around here". It is deeply ingrained within an organisation and its operations; determining how the organisation conducts its core business, treats its employees, evaluates its leaders, serves its consumers, and handles productivity and performance (Australian Commission on Safety and Quality in Health Care, 2023). Safety culture focuses on the aspects of organisational culture that relate to health and safety management, with a positive culture found to be associated with a wide range of patient outcomes, including reduced mortality rates (Braithwaite et al., 2017).

In the same way that safety culture is one aspect of organisational culture; reporting culture can be considered one aspect of a safety culture. Reason (1997) defined a safety culture as encompassing:

- An informed culture: Where management have current knowledge about the safety of the system, and the factors influencing it.
- A reporting culture: Where workers are prepared to report errors and near misses.
- A just culture: Where there is an atmosphere of trust and blame is not unjustly attributed to those involved in an incident.
- A flexible culture: Where the organisation or work units are able to reconfigure themselves based on the demands of the situation.
- A learning culture: Where there is willingness and competence to draw appropriate conclusions from data and to make required changes within the organisation.

Reason (1997) emphasises that a strong reporting culture is required to support an informed culture, with this in turn supporting a learning and flexible culture. In addition, there is a need for a just culture to be in place as a pre-requisite to a reporting culture; a view supported by patient safety research (e.g., White & Delacroix, 2020). For more information about just culture, see the Systems Thinking in Incident Investigations Guidance for a discussion of the concept in the context of investigations.

Aligned with a just culture approach, leadership commitment is crucial to developing a culture that encourages reporting incidents of WRV (Salmon et al., 2021). Barriers to a positive reporting culture that have been identified include lack of time available to report, unclear definitions of WRV, ambiguous policies and procedures for reporting, limited supervisory support, lack of feedback from management to workers about actions taken as a result of reported incidents, and lack of confidence that data will be used to make effective changes to improve safety (Kim et al., 2023; Odes et al., 2022; Salmon, Coventon & Read, 2021; Song et al., 2021). Finally, it has been suggested that workers may choose not to report an incident as they wish to forget about it, given that reporting often leads to follow up and investigations (Reason, 1997). This may be an influencing factor for WRV, particularly where the worker has experienced psychological harm.

3. Structure of the roadmap

The reporting culture improvement roadmap is shown in Appendix A. It maps initiatives for enhancing reporting culture across levels of the healthcare system, based on Rasmussen's (1997) Risk Management Framework. As described further in the Systems Thinking for Preventing Work-Related Violence in Hospitals Overview, the Risk Management Framework proposes that the decisions and actions of actors across hierarchical levels of the system play a role in WRV. In a similar way, the decisions and actions of actors across the system can influence reporting culture.

The roadmap is designed to achieve a long-term desired outcome of: High quality reporting of all WRV incidents (including relevant contributory factors and protective factors). Contributory factors are factors across the system that contributed to a WRV incident. Protective factors are decisions, actions and/or conditions across the system which prevent or mitigate damage, injury or loss resulting from a WRV incident. Also see the Systems Thinking in Incident Investigations Guidance for a discussion of contributory and protective factors.

Initiatives to support this long-term desired outcome were identified from reviewing the literature on reporting culture and safety culture, as well as identification of initiatives that could assist to address general barriers to reporting. Within the roadmap, the identified initiatives are placed at the hierarchical system level/s where it is expected the initiative would be actioned. However, it is recognised that this may depend on the specific structure of the healthcare organisation. Some initiatives sit across levels, given the need for collaboration across multiple organisations. The initiatives are also placed across three different timescales: short-term, medium-term, and long-term. This acknowledges that culture change takes time, that later initiatives will naturally build on the success and goodwill gained from short-term initiatives, and that resource limitations mean that a staggered approach to implemented initiatives is more practical. In terms of the timeframes, the initiatives are placed where they might first be established. Many are on-going, and it is expected that once established they would be maintained into the future.

Finally, the initiatives are themed across a range of initiatives that can create a positive safety culture (e.g., providing feedback, prioritising WRV and a just culture environment) and create working conditions that support reporting (e.g., improving knowledge and skills, providing staff time to report). Colour coding is used to show the initiatives that relate to:

- Feedback to staff
- Reporting systems
- Leadership prioritisation of WRV
- Staff time to report
- Just culture
- Evaluation & continuous improvement
- Improved knowledge / skills

The roadmap intends to provide an overview of initiatives that stakeholders across the system might consider implementing to improve reporting culture across the system. Each initiative would require further scoping and consideration within the specific context of implementation, to ensure it is feasible, acceptable to stakeholders, and that resources and support systems are in place to ensure it will be maintained over time. In selecting initiatives, stakeholders are encouraged to collaborate with those at other levels. This can support the development of a strong network of initiatives that work together to enhance reporting culture both within healthcare organisations as well as across the sector.

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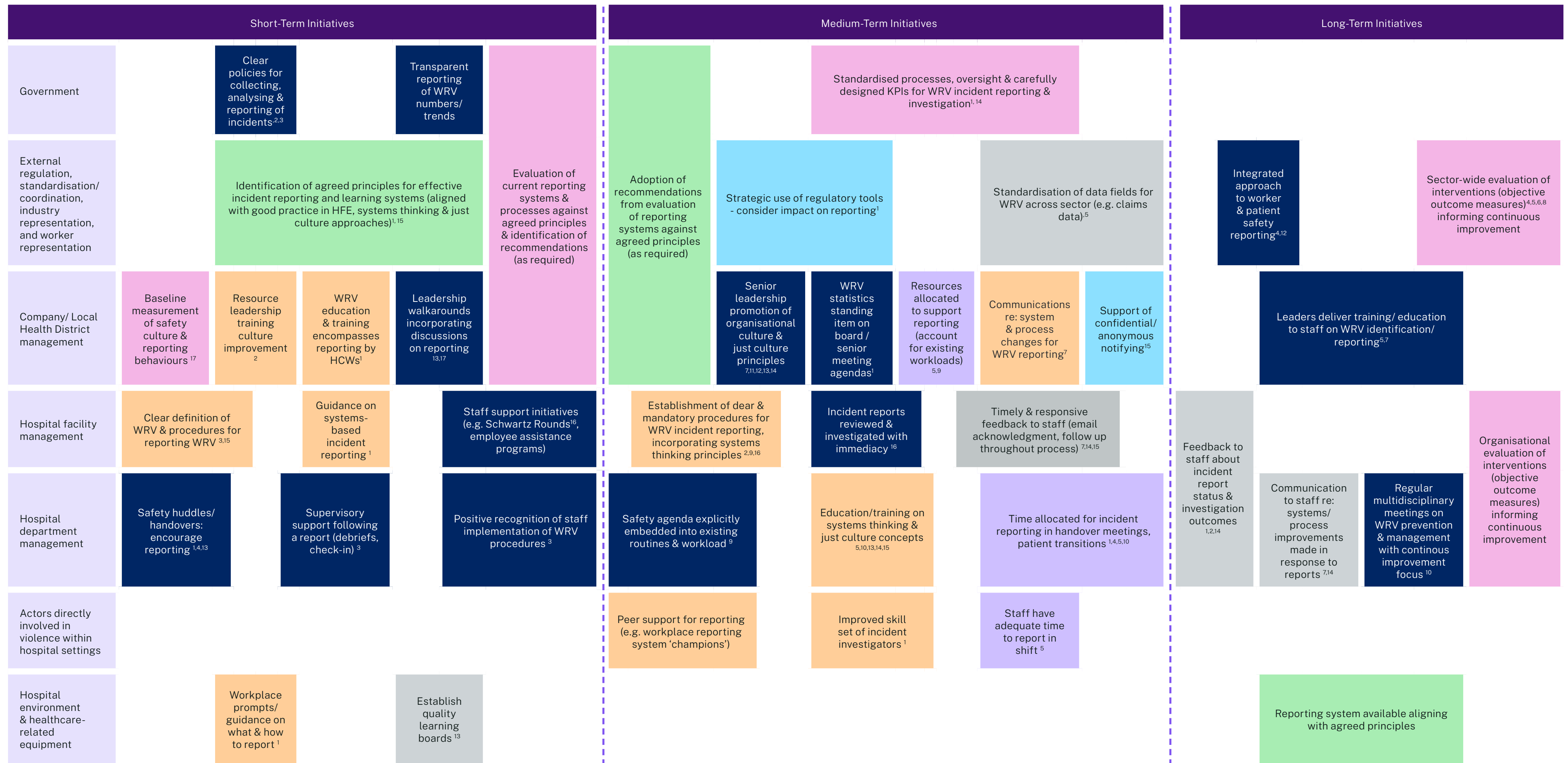
Appendix A. Reporting Culture Roadmap

Reporting Culture Roadmap: Towards high quality reporting of all work-related violence incidents (including relevant contributory factors and protective factors)



- Feedback to staff
- Staff time to report
- Improved knowledge/skills
- Reporting system
- Just culture
- Leadership prioritisation
- Evaluation & continuous improvement

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