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Report: Three key pillars of care team safety

Research supports a new and expanded definition of care team safety to help protect a thriving healthcare workforce

Heart of Safety
Coalition

Inspiring transformation for care team safety and wellbeing

Table of contents

Executive summary

Care team safety is foundational to all aspects of healthcare, from patient safety and experience to system resilience and finances. But what does it mean to be safe at work in healthcare environments?

In this survey of 407 cross-disciplinary leaders and bedside team members, we see that care team safety is more nuanced than traditional definitions imply. To create a culture of safety that supports a thriving workforce, healthcare leaders must embrace an expanded definition of care team safety that safeguards psychological and emotional wellbeing, ensures physical safety and promotes dignity and inclusion.

Dignity and inclusion from a care team perspective ensures work environments are free from bias and discrimination, fostering a space where all team members can fully contribute, feel valued and be their authentic selves at work without fear of judgement, exclusion or retaliation. While dignity and inclusion aren't universally recognized as essential to team member safety, data from research conducted by the Heart of Safety Coalition supports this renewed definition. And while there is broad agreement about what it means to be safe at work, the data shows some important differences between leaders and bedside team members, and between team members of different races, genders, ethnicities, ability and national origins.

A holistic 360-degree, cross-disciplinary approach will be required to drive necessary improvements in resourcing, culture, training and leadership to transform care team safety to include psychological and emotional safety, dignity and inclusion, and physical safety for all healthcare workers.

To create a culture of safety that supports a thriving workforce, healthcare leaders must embrace an expanded definition of care team safety that safeguards psychological and emotional wellbeing, ensures physical safety and promotes dignity and inclusion.

Introduction

The importance and widespread implications of care team member safety and wellbeing have gained more awareness as the U.S. healthcare system navigates the ebbs and flows of a post-pandemic world. As the immediate dangers of COVID-19 eased, leaders and bedside team members across the healthcare spectrum spoke up to say it was past time to address long-standing threats to team member safety as well as issues exacerbated by the pandemic such as burnout and workplace violence.

Focusing on team member safety is essential for leaders to restore trust and build a thriving healthcare workforce for a better and safer future. Not only are safe and supportive working environments what care team members need and deserve, they are essential because of their ripple effect and potential impact to:

- **Patient safety**
  Patient safety starts with care team safety, which includes psychological and emotional safety. According to a meta-analysis and systematic review of 23 research studies, burnout (a workplace injury) is associated with a two-and-a-half-fold increased risk of medical errors among surgeons.[1] In addition, a survey of more than 10,000 healthcare workers concluded that perceived institutional support for second victims (those emotionally traumatized by an unanticipated clinical event) was associated with a better safety culture. Across all survey respondents, significant correlations between perceived support for second victims and the survey domains (improvement readiness, local leadership, teamwork climate, safety climate, emotional exhaustion, burnout climate and work-life balance) were found.[2]

- **Patient experience**
  According to Press Ganey, organizations scoring in the top 25% for team member engagement outperform others on patient satisfaction surveys by an average of 38 percentile points on, "Likelihood to Recommend," for inpatient care than organizations in the bottom 25% of engagement performance.[3]

- **Financial stewardship**
  A COVID-era study looking at survey responses by more than 43,000 cross-disciplinary healthcare professionals, found that work overload was significantly associated with burnout (adjusted risk ratio (ARR) 2.21 to 2.90) and intent to leave (ARR 1.73 to 2.10) across role types.[4] Given that the estimated turnover cost per physician is between $500,000 and $1 million[5], and between $45,100 to $67,500 for nurses[6], elevated team member attrition costs health systems millions annually. In addition, workplace violence (WPV), one source of injury in the healthcare industry, accounted for a rate of 14 nonfatal injuries involving days away from work per 10,000 full-time equivalents (FTEs) in 2021 to 2022, according to the Bureau of Labor Statistics. During this time period, there were 41,960 total nonfatal cases of workplace violence requiring days away from work, job restriction or transfer in the healthcare and social assistance industry over this time, resulting in lost productivity and workplace compensation payments.[7]

A new definition of care team safety

The Heart of Safety Declaration of Principles, coauthored by 10 health system CEOs in 2021, proposed a new definition of care team safety to:

- raise awareness of the critical necessity of team member safety and wellbeing to build a resilient and thriving U.S. healthcare system.
- expand the definition of safety to include psychological and emotional safety, dignity and inclusion, and physical safety for all healthcare team members. These are three pillars of care team safety (see Figure 1).
- identify and spread best practices, actionable insights and innovative ideas that advance team member safety and wellbeing across the industry.
- spark a movement that would inspire industry transformation.

Figure 1: The three pillars of healthcare team member safety

Examining the three pillars of care team safety

This report explores the viability of this new and expanded definition of care team safety. We surveyed 105 U.S. healthcare leaders (directors and above) and 302 bedside team members (managers and individual contributors) to learn what concepts and resources resonate most (see the About the survey section for more demographics). This research sheds light on the principles that define what it means for all healthcare team members to be safe at work.

For the purposes of report, we focused on the similarities and differences between bedside team members (individual contributors and team leaders working in direct patient care) and leaders (directors, vice presidents and c-suite). We use the term "bedside" instead of the more common "frontline" to avoid militarized language, a change we made after the fielding of the survey. We also looked at differences between physicians and those in the nursing profession (RN, LPN, PCT, CNA, etc.), and between underrepresented respondents (based on sexual orientation, gender and gender identity, race, ethnicity, disability status and/or national origin) and others. We pull in those data when they are particularly relevant.

Care team member safety and wellbeing is fundamental to the near- and long-term effectiveness of all healthcare systems. The current workforce crisis is driven by a mix of two shortages: a shortage of qualified team members and a shortage of those willing to work in current conditions. Those conditions are driven by a broad range of factors, including but not limited to: misaligned incentives, system complexity, ingrained inefficiency and a failure to adequately prioritize team member safety and wellbeing as a fundamental strategic priority. These factors are influenced by all stakeholders, from government and regulators to payers and system boards of directors and leaders.

The current workforce crisis is driven by a mix of two shortages: a shortage of qualified team members and a shortage of those willing to work in current conditions.

How important is care team member safety relative to patient safety?

Generally, when the topic of "safety" arises in most healthcare settings, the first thing people think of is patient safety. This is understandable as patient safety is fundamental to healthcare organizations' missions. However, since the pandemic, leading industry organizations including the National Academies of Medicine, CDC/NIOSH and the Office of the U.S. Surgeon General have been working to bring attention to the essential role that team member safety plays in delivering on patient care promises.

To better understand how this has translated into care environments, we asked two questions:

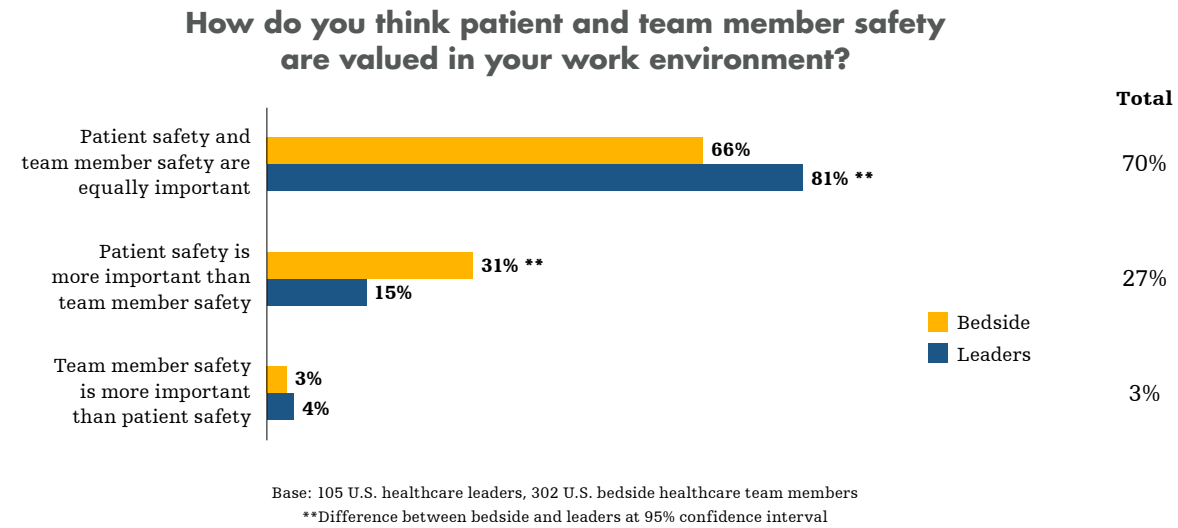
1. **How do you think patient and team member safety are valued in your work environment?**
2. **Ideally, how should safety be valued in a healthcare work environment?**

The good news is that 70% of respondents report that patient safety and team member safety are valued equally at their institutions. However, there is a statistically significant gap between leaders' perception of how team member safety and wellbeing is valued versus bedside respondents. Only 66% of bedside team members feel their safety is valued equally with patient safety versus 81% of leaders. The dissenters believe that patient safety is put ahead of their safety (see Figure 2).

The gap between leaders and bedside team members closes substantially when they reflect on the ideal balance between patient and bedside team safety, with 92% overall believing these should be equally valued. Interestingly, bedside team members are more likely to believe that patient safety should be more important than team member safety (see Figure 3).

The good news is that 70% of respondents report that patient safety and team member safety are valued equally at their institutions.

Figure 2: Bedside team members are less likely than leaders to say team member and patient safety are aligned



Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
**Difference between bedside and leaders at 95% confidence interval

Figure 3: Respondents would like to see a better balance between team member and patient safety

Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
**Difference between bedside and leaders at 95% confidence interval

What does it mean to be safe at work?

To understand what was top of mind for respondents before we introduced any care team safety concepts, the first question we asked was, "In your opinion, what does it mean for healthcare team members to be safe at work?" While some responses were vague, saying things like, "free from harm", most respondents got more specific. Seventy percent of respondents specified that safety means being free from physical threats such as assault, infection, needle sticks or lift injuries. Fifty-two percent said safety means protection from psychological and emotional harm, including verbal abuse and the freedom to speak up without retaliation. And 32% specifically called out concerns around dignity and inclusion, including issues of bullying and harrassment from either patients/families or colleagues (and sometimes both), as well as discrimination based on race, sex or other protected characteristics (see Figure 4).

When we explicitly asked whether our three pillars are essential aspects of safety, almost every respondent agreed that psychological/emotional and physical safety are critical. Dignity and inclusion received a less robust endorsement. A third of respondents did not recognize the importance of dignity and inclusion (defined as a combination of diversity, equity, inclusion and belonging for team members and health equity for patients) as necessary to ensuring safety for all team members (see Figure 5). As one inpatient bedside nurse stated, "Protecting healthcare workers requires more than just resources and communication. It needs a comprehensive approach that addresses burnout, violence and discrimination, fosters a supportive work environment, invests in individual wellbeing and continuously improves practices. This ensures workers feel valued, respected and empowered to deliver quality patient care."

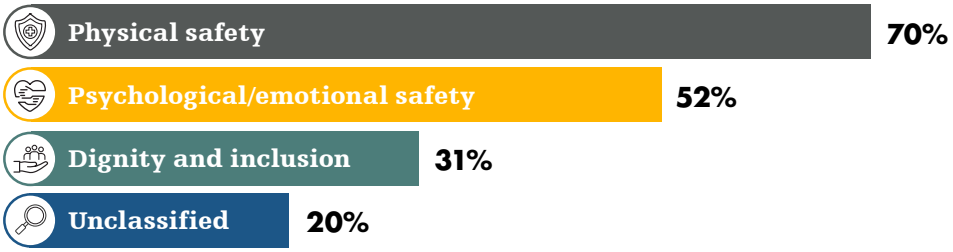
> "Protecting healthcare workers requires ... a comprehensive approach ... [that] ensures workers feel valued, respected and empowered to deliver quality patient care."
>
> ~ Inpatient bedside nurse

When we drilled into the data, we found that women and people who identify as underrepresented were significantly more likely to view dignity and inclusion as an essential aspect of team member safety (see Figure 6).

Figure 4: Respondents shared a complex understanding of what it means to be safe at work

Analysis of unaided responses to the survey question: In your opinion, what does it mean for healthcare team members to be safe at work?

Percent of responses that explicitly reference:



Of the 80% of responses that were classified: **38%** reference one pillar, **36%** reference two pillars and **27%** reference all three pillars. Unclassified responses do not clearly reference a specific pillar.

Top themes

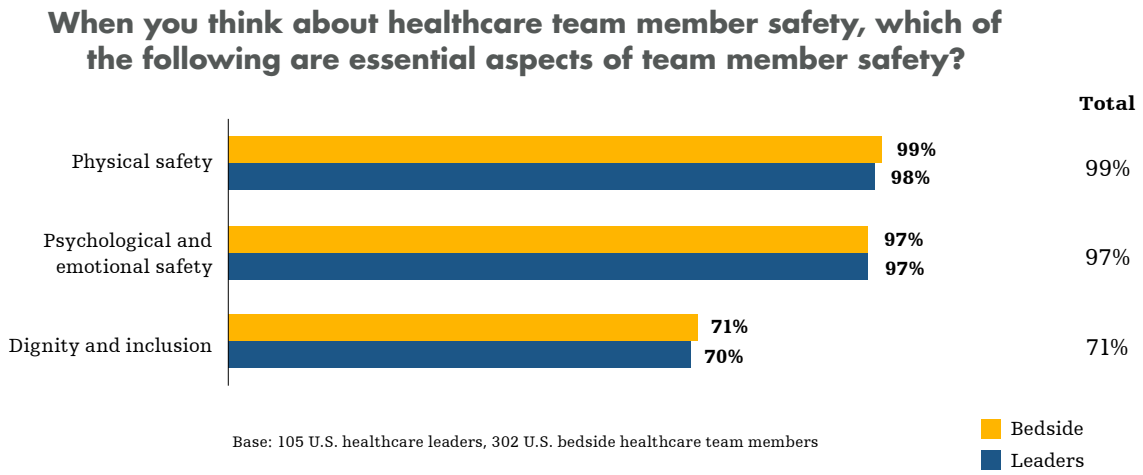
- Workplace violence and harassment: **43%**
  Of this percentage: **55%** called out patients and families as a potential risk factor and **18%** called out colleagues or leaders as a potential risk factor
- Resources (PPE, equipment, protection from chemicals, etc.): **39%**
- Training and protocols: **17%**
- Leadership support (includes ability to speak up without retaliation): **16%**

> "Free from harassment, bullying, racism, sexism, physical or verbal abuse. No contact/exposure to hazards of any kind. No violence from patients, coworkers or anyone else. Free to bring up concerns without fear or retaliation."

> "Team members should feel respected, supported by managers and security even when patients are complaining. Able to speak up for each other. Not afraid to come to work because we are protected if we are confronted by a disgruntled patient."

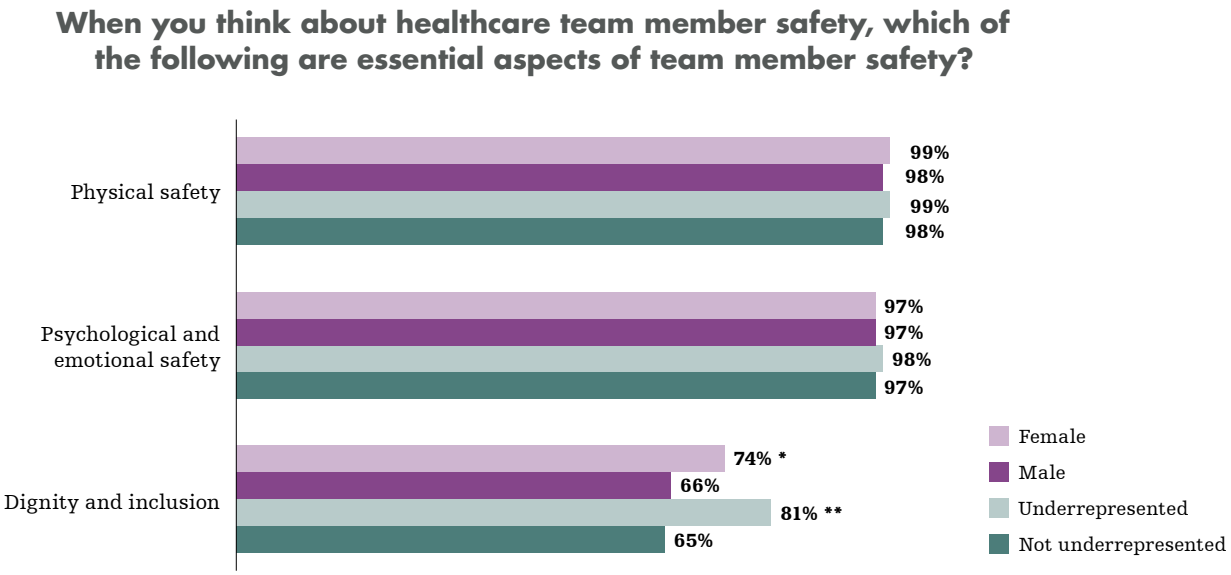
> "It means for them to feel safe around patients, safe from patient violence, safe from communicable diseases via various infectious precautions. It also means being safe from things like needle sticks. Safety is also related to coworkers and being safe from retaliation and assault in various forms."

Figure 5: Physical, psychological and emotional safety are almost universally viewed as essential



Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members

Figure 6: Underrepresented and female respondents are more likely to recognize the importance of dignity and inclusion



Base: 180 male and 217 female U.S. healthcare respondents
Base: 144 underrepresented and 263 not underrepresented U.S. healthcare team members
**Difference between underrepresented and not underrepresented/not at 95% confidence interval
*Difference between male/female at 90% confidence interval

Definitions given in the survey

Physical safety: includes protection from illness, injury and workplace violence

Psychological and emotional safety: includes adequate resourcing, the ability to speak up, as well as emotion, social and spiritual support

Dignity and inclusion*: includes diversity, equity and inclusion, as well as health equity

*In the original research we called this "health justice" but we have since changed the language for clarity.

A detailed look at the three pillars of care team safety

The next sections of this report delve into each of the three pillars of safety: physical safety, psychological and emotional safety, and dignity and inclusion. We divided each pillar into subdomains, asking respondents to indicate which elements are essential to each subdomain. We then combined all of the elements across subdomains and asked respondents to select the top three most essential elements. In the "top three" charts, you will see the options from the pillar's subdomain questions intentionally repeated.

Physical safety

Physical safety is well understood in the traditional definition of care team safety — be it the origins of germ theory, which gave way to clinical protections from infectious disease to today's more stringent OSHA standards that guard against lift injuries, needle sticks, chemical exposure and other physical harms. But the traditional definition of safety falls short as risks persist and grow. Today's conversations about physical safety extend to ergonomics, inadequate personal protective equipment (PPE), the rise of workplace violence and much more.

As one inpatient physician leader put it, "All healthcare workers should be protected not only from contracting diseases, but they should always feel safe in their environment when taking care of patients. This requires multiple layers of protection, including timely reporting of threats, flags in the electronic health record (EHR) for potentially dangerous patient interactions and adequate security presence."

To learn how leaders and bedside team members understand and value physical safety, we drilled into two areas independently and then asked respondents to identify the three most critical elements across all aspects of physical safety. These areas are:

- **Safety from illness or injury**
- **Safety from workplace violence (WPV)**

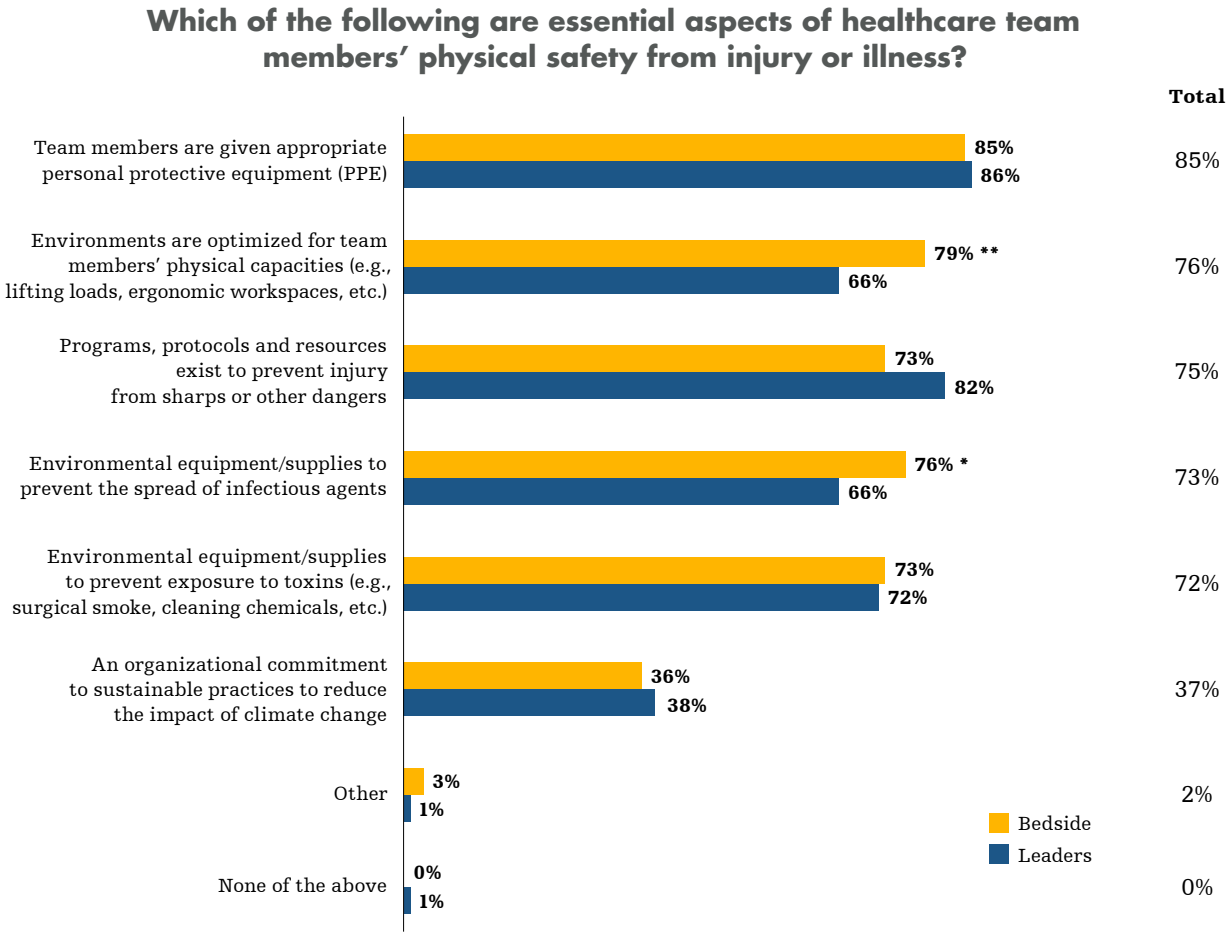
Safety from illness or injury

Perhaps not surprising on the heels of the COVID-19 pandemic, the number one thing that respondents point to as essential for physical safety is the availability of PPE. Bedside team members are also more likely to view environmental equipment or supplies that prevent the spread of infectious agents such as negative pressure rooms or hand sanitizers as essential. Bedside team members are significantly more likely than leaders to value environments that are optimized for their physical capacities, which might include ergonomic design or resources to help with lifting patients, though this result was driven largely by nurses (83%) versus physicians (66%) or APPs (advance practice providers/ others (74%). Leaders have a stronger focus on the programs, protocols and resources that prevent injury, though the difference does not rise to the 90% confidence interval (CI).

Currently, only about a third of respondents believe that an organizational commitment to sustainable practices is essential to team members' physical safety, but we expect that as the impact of stronger storms, longer heat waves, wildfires and other environmental impacts rise, we'll see more interest in sustainability as a key element of team member safety (see Figure 7).

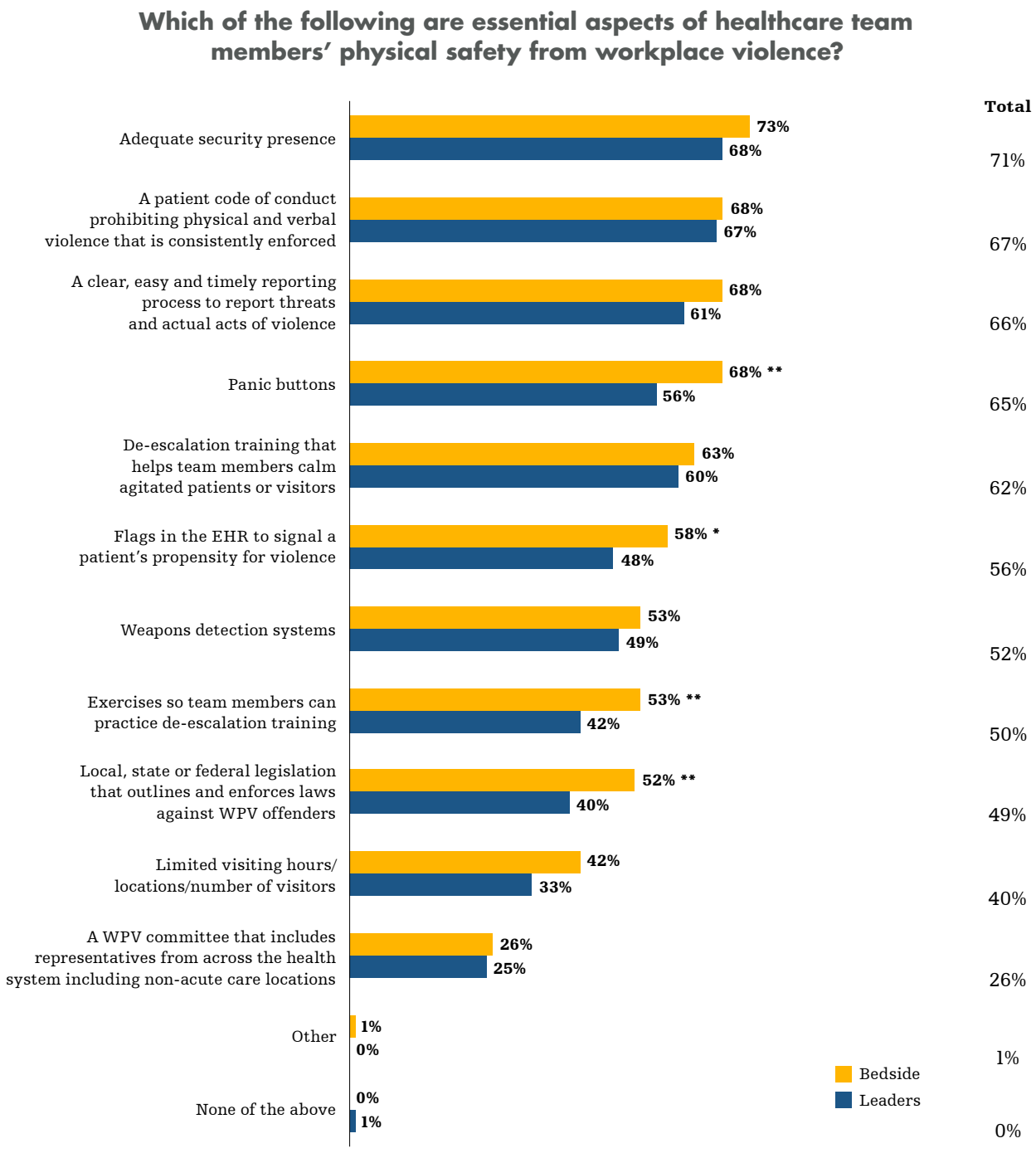
> "All healthcare workers should be protected not only from contracting diseases, but they should always feel safe in their environment when taking care of patients. This requires multiple layers of protection, including timely reporting of threats, flags in the EHR for potentially dangerous patient interaction and adequate security presence."
>
> ~ Inpatient physician leader

Figure 7: Bedside team members are more likely than leaders to value environmental protections against illness and injury



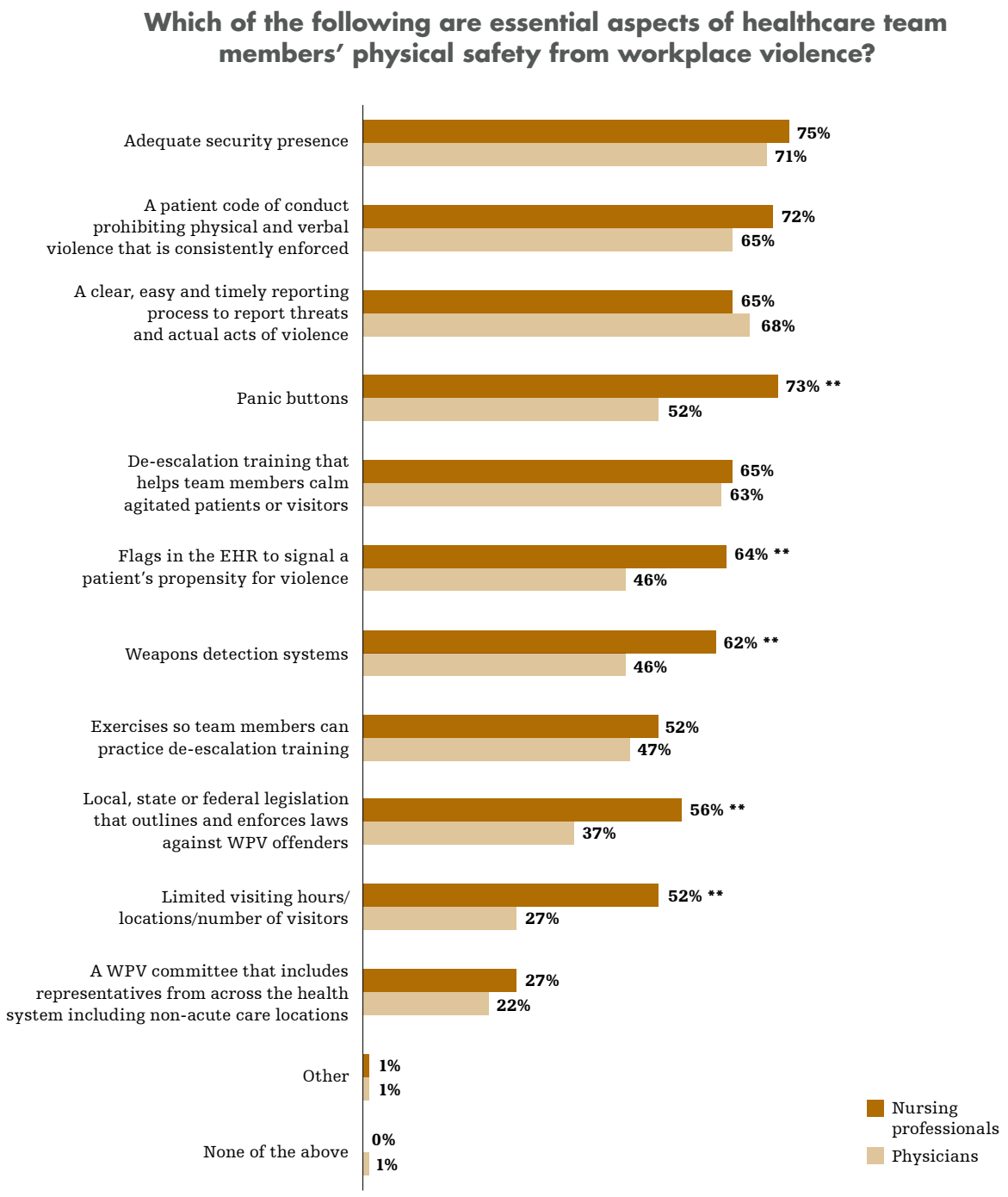
Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
(Multiple responses accepted)
*Difference between bedside and leaders at 90% confidence interval
**Difference between bedside and leaders at 95% confidence interval

Figure 8: Bedside team members are more likely than leaders to view most WPV prevention approaches as essential



Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
(Multiple responses accepted)
*Difference between bedside and leaders at 90% confidence interval
**Difference between bedside and leaders at 95% confidence interval

Figure 9: Nursing professionals are more likely than physicians to want most protections from WPV



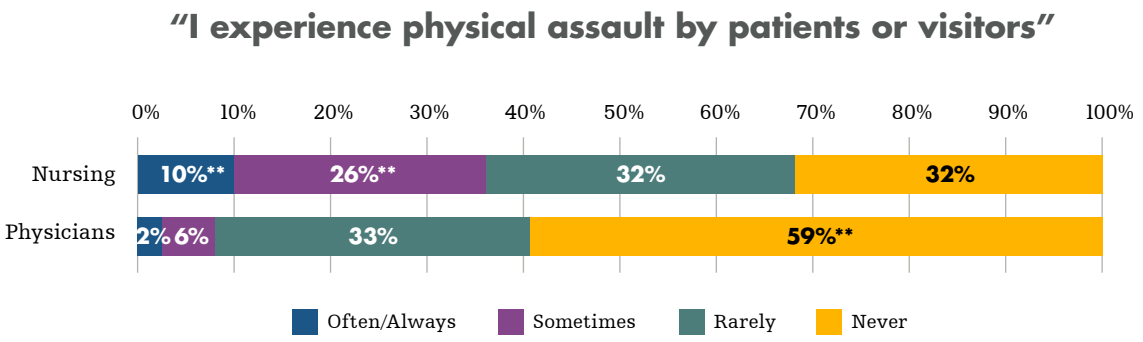
Base: 173 nursing professionals, 115 physicians

**Difference between nursing professionals and physicians at 95% confidence interval

Safety from workplace violence

To protect team members from the rising tide of workplace violence, the most valued resources by respondents are an adequate security presence at 71%. About two thirds want consistent enforcement of a patient code of conduct prohibiting physical and verbal violence, a clear, easy and timely reporting process for violence or threats and panic buttons for rapid summoning of help in risky situations. Interestingly, bedside team members are more likely to value every aspect of WPV prevention, though not all differences rise to the level of statistical significance. The greatest differences are in the desire for panic buttons (68% for bedside team members versus 56% for leaders), exercises to practice de-escalation (53% versus 42%) and local, state or federal legislation that outlines and enforces laws against WPV offenders (52% versus 40%) (see Figure 8). When we looked at the differences between responses from nursing professionals and physicians, we found that those in nursing are more likely to view nearly every element of WPV prevention as essential (see Figure 9). This isn't surprising given that 36% of nursing respondents said they experience physical assault from patients or visitors often, always or sometimes, versus 8% of physicians (see Figure 10).

Figure 10: Nursing professionals experience physical violence from patients or visitors significantly more frequently than physicians



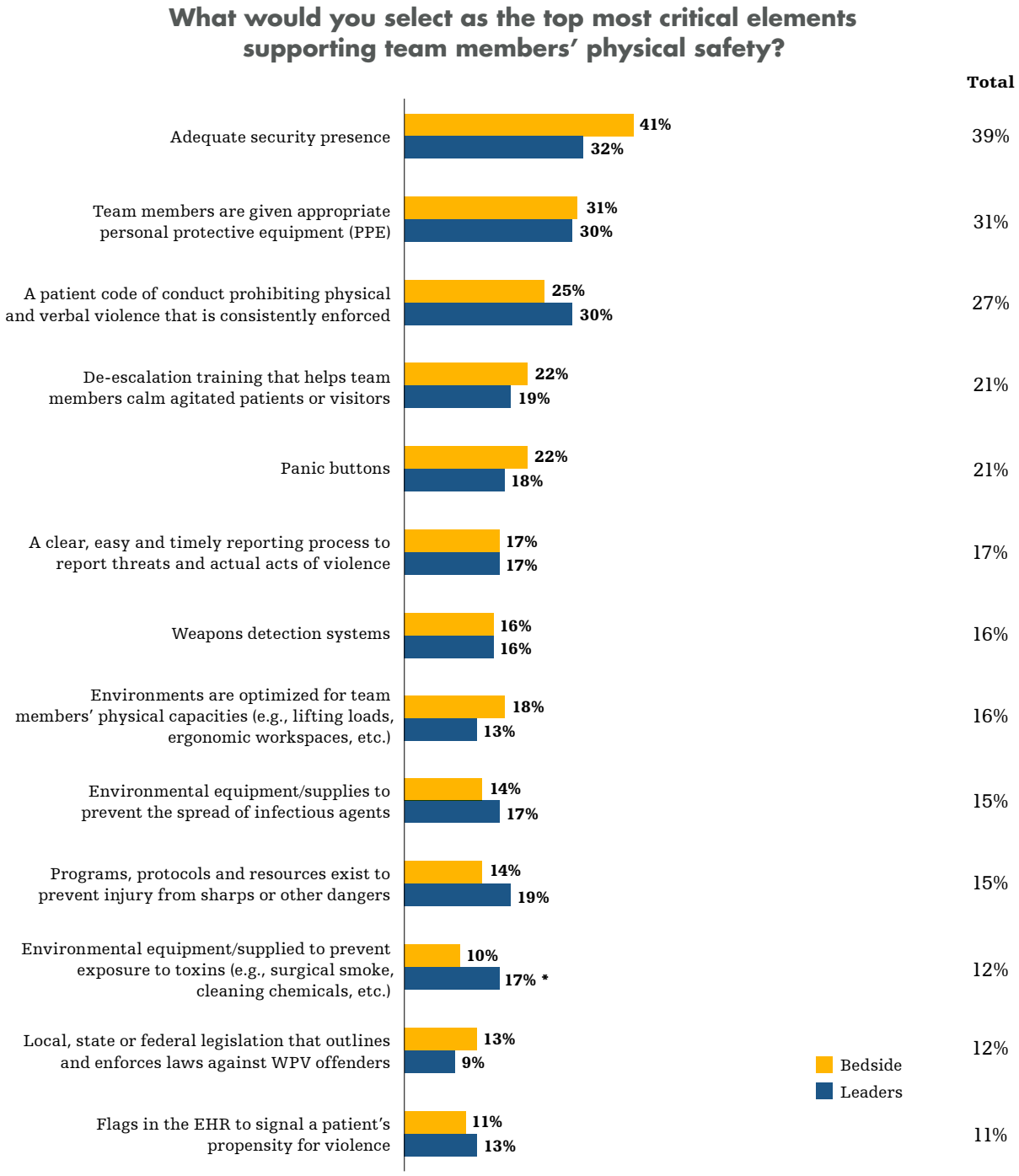
Base: 173 nursing professionals, 115 physicians
**Difference between nursing professionals and physicians at 95% confidence interval

Top elements of physical safety

When we asked respondents to identify the top three most critical aspects of physical safety, the number one thing that they valued collectively was an adequate security presence (39%). However, leaders were less likely to put security in their top three than bedside team members were. Leaders placed a higher value on a patient code of conduct, injury prevention protocols and resources to prevent exposure to toxins than bedside team members did, though none of these rises to the 90% confidence interval. Overall, leaders and bedside team members are largely aligned with each other, which is good news. The greater challenge, as is often the case in healthcare, is aligning on what the most important investments are across all possible approaches (see Figure 11).

After these questions we gave respondents the chance to share any ideas we may have overlooked. Most comments related to concerns about WPV, with 12% of open-ended comments doubling down on the need for well-trained security professionals, 8% citing the need for WPV accountability through legislation, prosecution and consistent enforcement of policies, and 6% writing in about the need for WPV prevention via weapons and access control, panic buttons and EHR flags. Fifteen percent mentioned needing a safe environment with reliable access to resources including PPE. And 12% called out a need for greater leadership commitment to workplace safety, including clear protocols, auditing/reporting and consistent enforcement of policies.

Figure 11: Leaders and bedside team members agree with each other but not among themselves about what's most critical for physical safety



Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
(Up to three responses accepted — chart only includes options selected by 10% or more of either leaders or bedside team members)
*Difference between bedside and leaders at 90% confidence interval

Psychological and emotional safety

Many thought leaders in healthcare have understood the importance of psychological safety since James Reason fleshed out the concept of just culture in his 1997 book, *Managing the Risks of Organizational Accidents*. Around the same time, psychiatrists in the Veterans Administration were uncovering the risk of moral injury for soldiers. In the two-plus decades since, leaders and team members have come to understand that psychological and emotional safety are essential in healthcare, not only to maintaining patient safety environments, but also to support clinicians who face the difficult environment and experiences that are inherent to healing work. As one inpatient hospital executive shared in our survey, "Most non-healthcare workers do not realize the mental and emotional strain of seeing human suffering and death."

To learn how leaders and bedside team members understand and value psychological and emotional safety we drilled into three broad areas of safety independently and then asked respondents to identify the most critical elements across all three of the areas. These areas are:

- **Managing workload at a safe level for healthcare team members**
- **Open communication between healthcare team members and leaders so team members feel safe speaking up**
- **Supporting healthcare team members' psychological, emotional, social and spiritual wellbeing**

> "Most non-healthcare workers do not realize the mental and emotional strain of seeing human suffering and death."
>
> ~ Inpatient hospital executive

Safe workload

Bedside team members and leaders are largely in agreement about the essential aspects of managing workload at safe levels. The number one element for both groups is having adequate staffing — though the survey does not indicate whether they agree on what safe staffing levels look like. Respondents identified supporting work-life balance as the next most important element, followed by aligning responsibilities appropriately according to skills/license. Although differences between leaders and bedside team members don't rise to the 90% CI in any category, bedside team members are somewhat more likely than leaders to agree that measuring and managing workloads to targets agreed on by bedside team members and leaders, and that processes or technologies to reduce cognitive load are essential (see Figure 12).

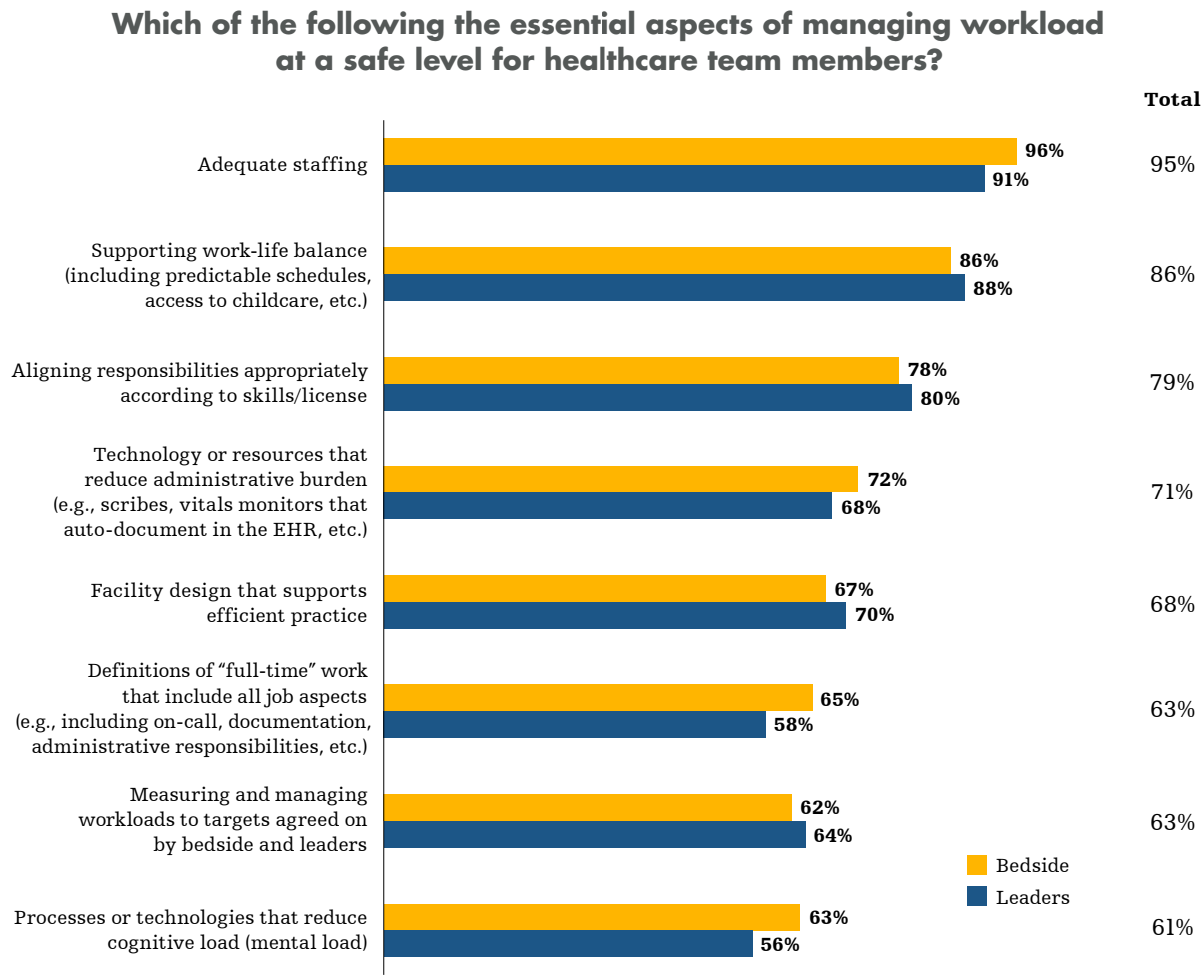
Physicians and nursing professionals differed on two factors related to workload and care team safety. At 99%, nurses almost universally want more staffing compared to 90% for doctors (95% CI). And doctors (68%) are significantly more likely than nursing professionals (54%) to view all full-time job expectations beyond clinical care (i.e., administrative duties) as essential to consider when managing workload at safe levels (95% CI).

Open communication

Eighty-six percent of respondents reported that consistent processes for listening and responding to concerns without fear of punishment or retaliation are essential to creating an environment of open communication, with bedside team members slightly edging out leaders in their rating. An almost equal number value confidential processes for team members to share concerns about ethics or values deviations or violations. These are fundamental to values-driven culture and psychological safety, and two-thirds of respondents also recognized that these processes must be measured and audited to ensure they meet their purpose.

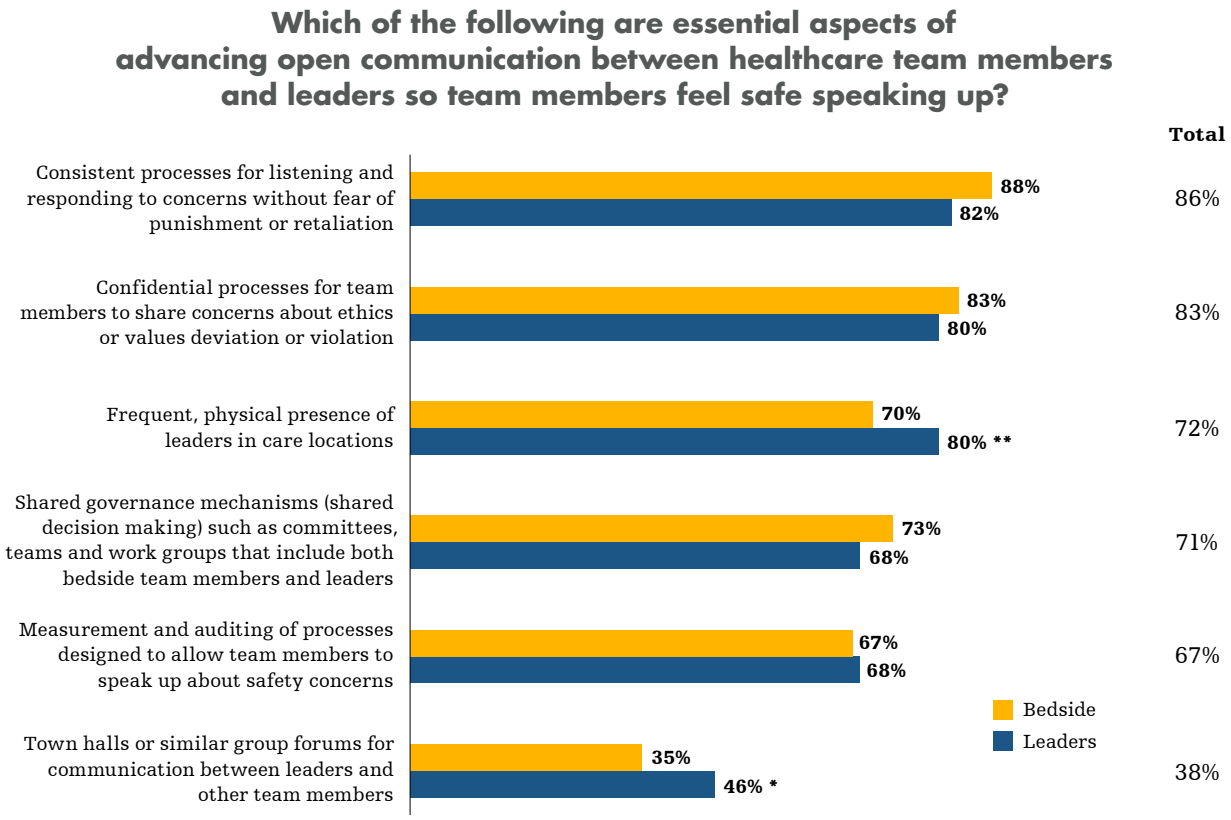
Most respondents also selected shared governance mechanisms and leader presence in care locations as essential to open communication, though leaders themselves were significantly more likely to value on-site visits that allow them to observe care processes directly and to speak with team members about concerns, needs and what's going well. Nurses selected consistent listening processes (91%), shared governance (77%) and measurement/auditing of these approaches (70%) significantly more often than physicians (80%, 66% and 56%, respectively). Bedside team members find the least value in town halls and group forums (see Figure 13).

Figure 12: Adequate staffing tops the list of requirements for safe workload



Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
(Multiple responses accepted)

Figure 13: Town halls are considered least essential for advancing open communication



Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
(Multiple responses accepted)
**Difference between bedside and leaders at 95% confidence interval
*Difference between bedside and leaders at 90% confidence interval

Psychological, emotional, social and spiritual wellbeing

Individual solutions that support team members' psychological, emotional, social and spiritual wellbeing are too numerous to list in detail. Entire Human Resources (HR) disciplines focus on providing this kind of support as part of benefits packages. However, when we asked about broad categories of support, more than two-thirds of respondents selected wellness training or resources, employee assistance programs (EAP) and peer support programs as essential. For this question we saw a higher number of respondents choose "other." These respondents wrote in responses that centered on fair and adequate pay (including as relative to C-suite executives), time off and time to access mental health resources (see Figure 14).

In this domain, we also saw significant differences between physicians and nursing professionals. Nursing professionals were significantly more likely to rate most wellbeing elements as essential to psychological and emotional safety, especially wellness training and resources, employee assistance programs (EAP) and access to pastoral care (see Figure 15).

Top elements of psychological and emotional safety

When we asked respondents to select the top three essential elements that support care team members' psychological and emotional safety, two rose to the top: adequate staffing and supporting work-life balance. In fact, the top seven elements selected by respondents all relate to safe workload and open communication, as opposed to wellbeing. Bedside team members and leaders agree that managing work — and fair

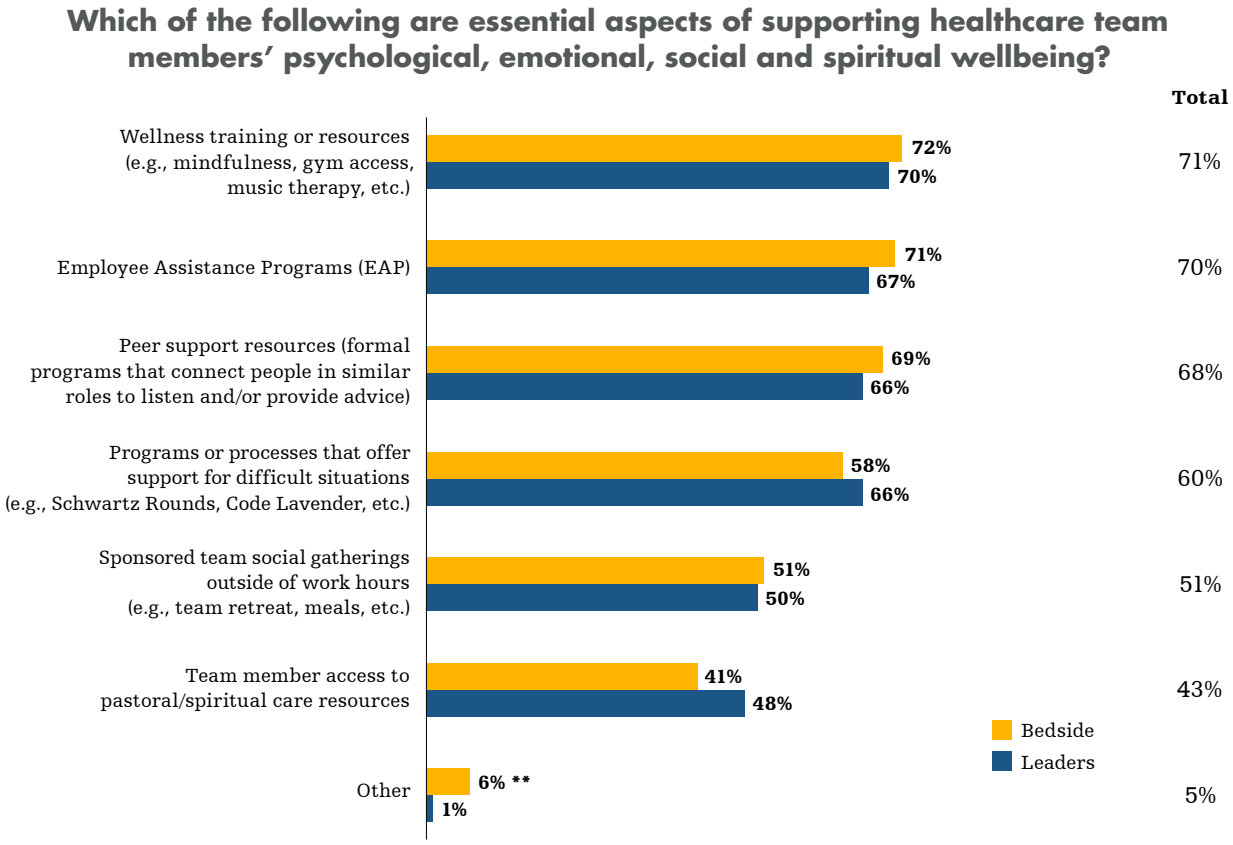
> "Safeguarding healthcare team members' psychological and emotional safety involves creating a supportive culture with access to mental health resources, promoting work-life balance and ensuring open communication without fear of stigma."
>
> ~ Nursing leader

and consistent processes to talk openly about it are essential to safety. Where do they differ? Bedside team members are significantly more likely than leaders to name consistent, non-punitive processes for listening and responding to concerns in their top three (see Figure 16).

We gave respondents the opportunity to elaborate on the topic of psychological and emotional safety. Almost a quarter wrote in that they want more leader support for psychological safety. They express a desire for leaders to make psychological and emotional safety a higher priority, emphasizing the need for leaders to foster deeper connections with bedside team members to gain a better understanding of the issues and the impact of their policies. Suggestions included one-on-ones, open communication and directly seeing or experiencing bedside work. Concepts of psychological and emotional safety need to be deeply embedded in an organization's culture according to 14% of respondents, while 13% said they would like better access to counseling and support. Some went so far as to say psychological counseling should be free and possibly mandatory, given the nature of healthcare work. Additional themes included time off (vacations, reasonable working hours, breaks while working), the desire for fair compensation and to influence decision making by having their voices heard.

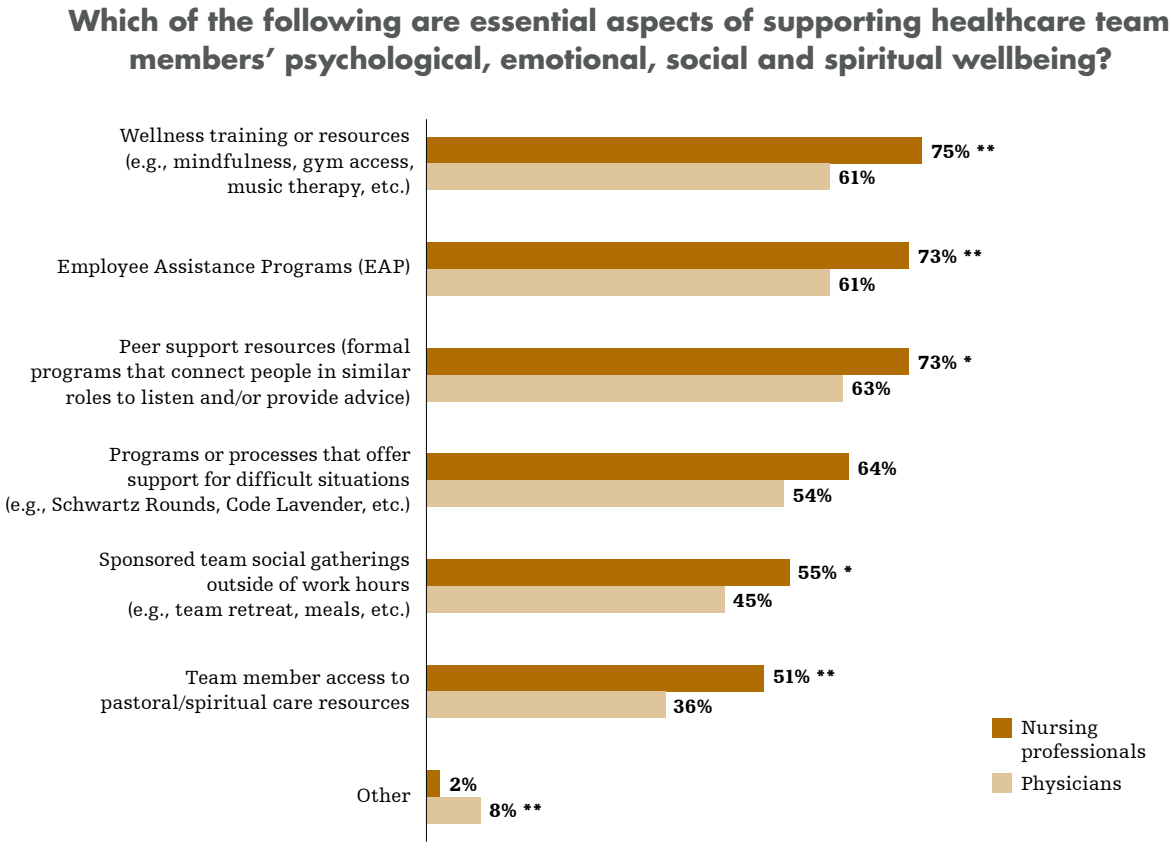
One nursing leader told us, "Safeguarding healthcare team members' psychological and emotional safety involves creating a supportive culture with access to mental health resources, promoting work-life balance and ensuring open communication without fear of stigma. Leadership should be trained to recognize and address burnout. Prioritizing these aspects enhances wellbeing, job satisfaction and patient care."

Figure 14: Leaders and bedside team members are largely aligned on the value of wellbeing interventions



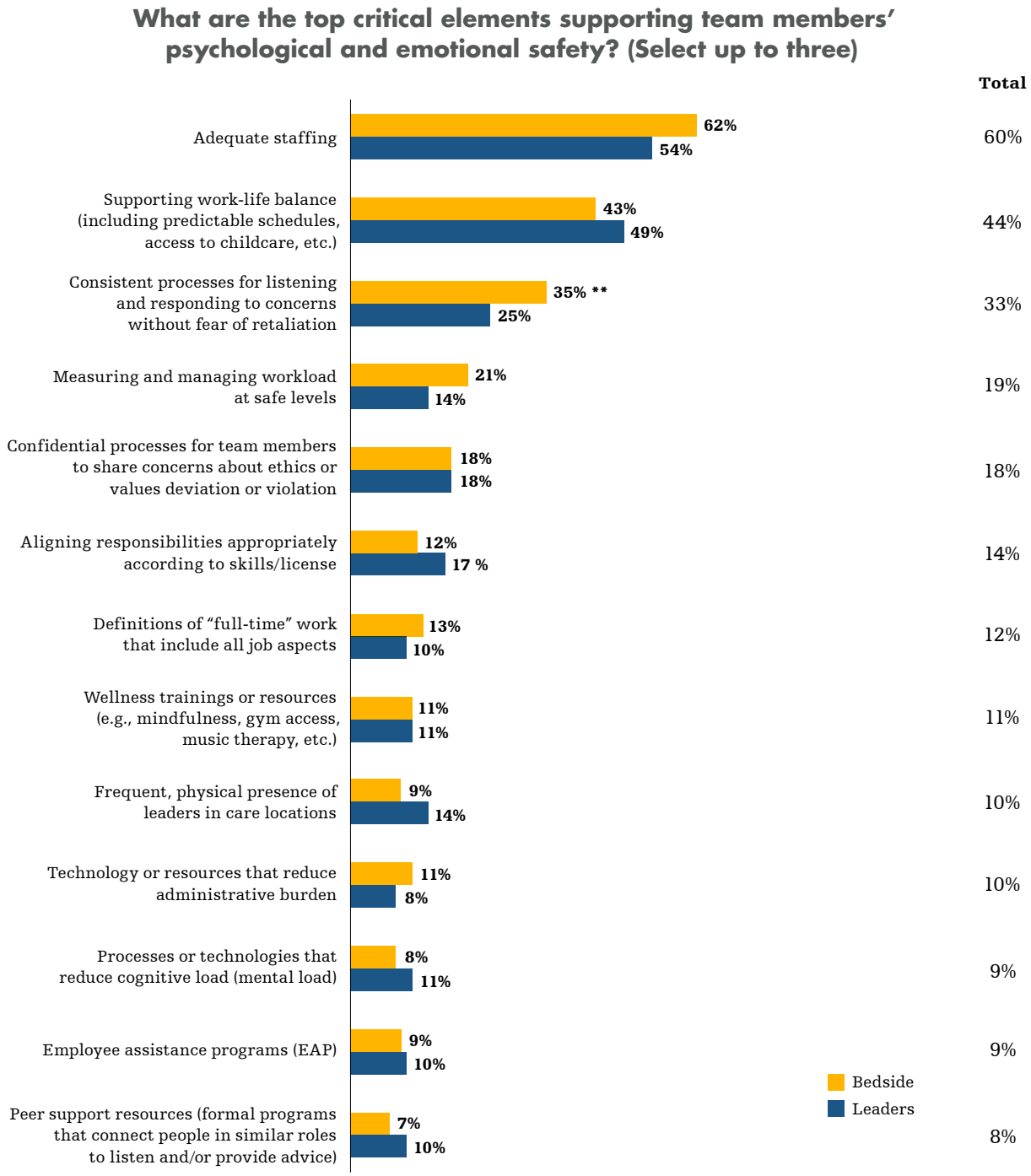
Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
(Multiple responses accepted)
**Difference between bedside and leaders at 95% confidence interval

Figure 15: Nursing professionals are more likely than physicians to view wellbeing resources as essential



Base: 173 nursing professionals, 115 physicians
**Difference between nurses and physicians at 95% confidence interval
*Difference between nurses and physicians at 90% confidence interval

Figure 16: Adequate staffing and work-life balance are most critical for psychological and emotional safety



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(Up to three responses accepted — chart only includes options selected by 10% or more of either leaders or bedside team members)
**Difference between bedside and leaders at 95% confidence interval

Dignity and inclusion

While most understand that psychological and emotional safety are part of the bigger picture of team member safety, dignity and inclusion isn't universally recognized as essential. The Heart of Safety Declaration of Principles is written and supported by healthcare leaders who believe that no work environment is truly safe unless every person can show up as their true authentic self without fear of bias or discrimination. Authors and advocates of the Declaration also believe that when care team members see patients consistently treated in equitable ways it reinforces their own feelings of safety and helps restore and build trust in the healthcare organization. In the words of one inpatient bedside nurse, "Ensuring just treatment for all healthcare team members involves promoting equity, diversity and inclusion, implementing fair hiring practices, providing equal career opportunities and addressing discrimination and harassment. Fostering transparency, accountability and offering training on cultural competence and unconscious bias are crucial. Prioritizing just treatment builds a cohesive, motivated team and improves patient care."

To learn how leaders and bedside team members understand and value dignity and inclusion as an element of safety we drilled into the two components of dignity and inclusion independently and then asked respondents to identify the three most critical elements across both areas. These components are:

- **The ability of team members to show up as their full selves at work**
- **The ability of team members to practice or support inclusive care**

> "Prioritizing just treatment builds a cohesive, motivated team and improves patient care."
>
> ~ Inpatient bedside nurse

Showing up fully and authentically

Almost three quarters of respondents said that the consistent enforcement of a patient code of conduct prohibiting patients and visitors from physical or verbal violence based on team members' protected characteristics is essential to allowing team members to show up as their full selves. This was selected by significantly more bedside team members than leaders, suggesting that discrimination and harassment of team members may be more common — and damaging — than leaders recognize. Fifty-three percent of respondents selected cultural sensitivity and/or unconscious bias training as essential and half value an organizational commitment to equity and antiracism. Unlike in the other pillars, we also saw 5% of leaders and 2% of bedside team members say that none of these are essential (see Figure 17).

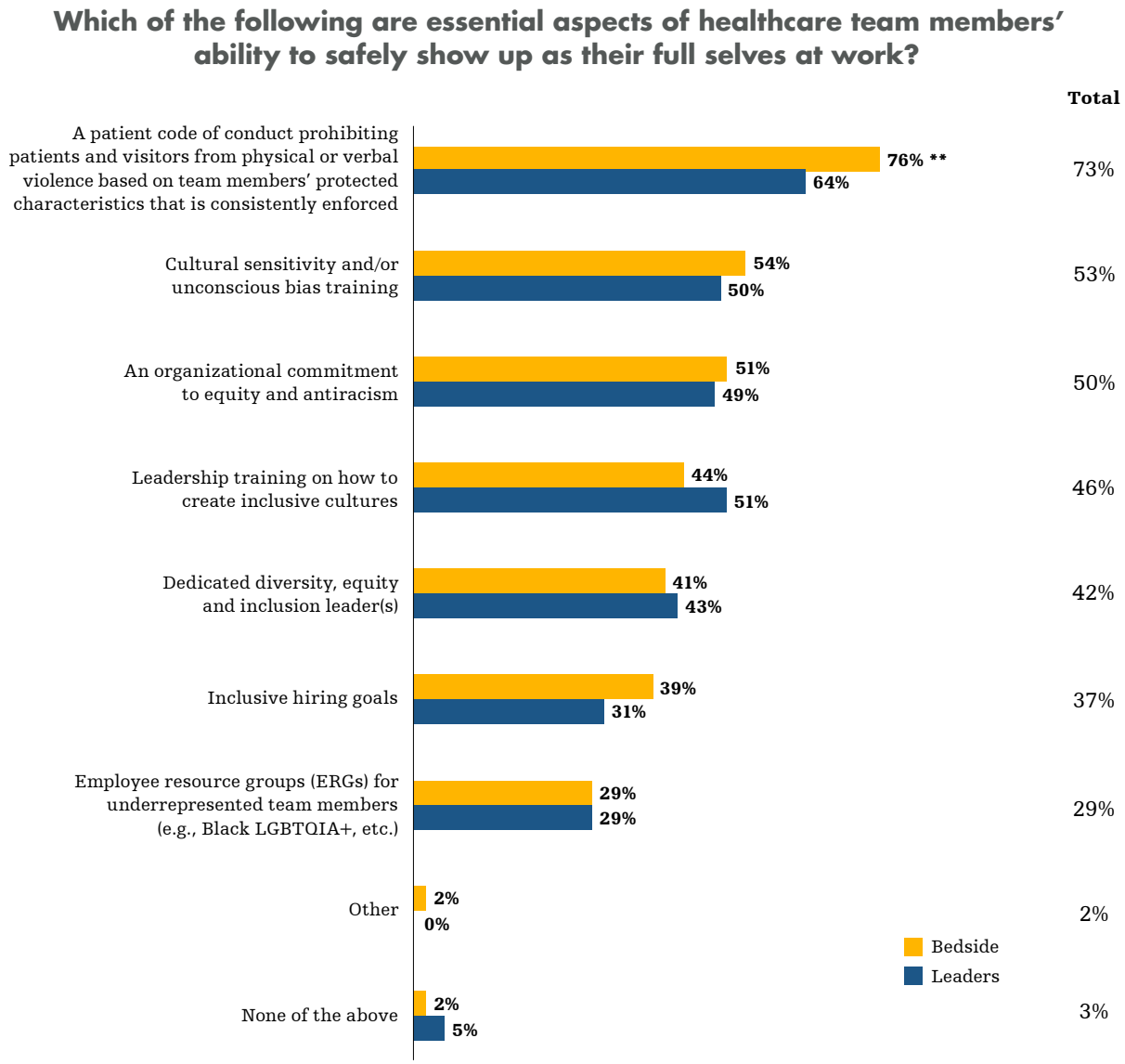
When we examine the responses more closely by demographic type, we see that underrepresented team members selected many more options as essential (see Figure 18).

Practice inclusive care

Seventy-one percent of respondents said that easy access to interpreter services in all care settings is essential to providing inclusive care — and some respondents specified in their open-ended responses that in-person services are especially helpful. Almost as many respondents selected inclusive ways for patients to provide meaningful feedback on the care they receive, but bedside team members were significantly more likely to select this than were leaders. And while only 53% of respondents reported that cultural sensitivity and unconscious bias training is essential for team members to be able to show up as their whole self at work, 67% selected it as essential to the practice of inclusive care. On this question, 7% of leaders and 2% of bedside team members indicated that none of these is essential (CI 95%) (see Figure 19).

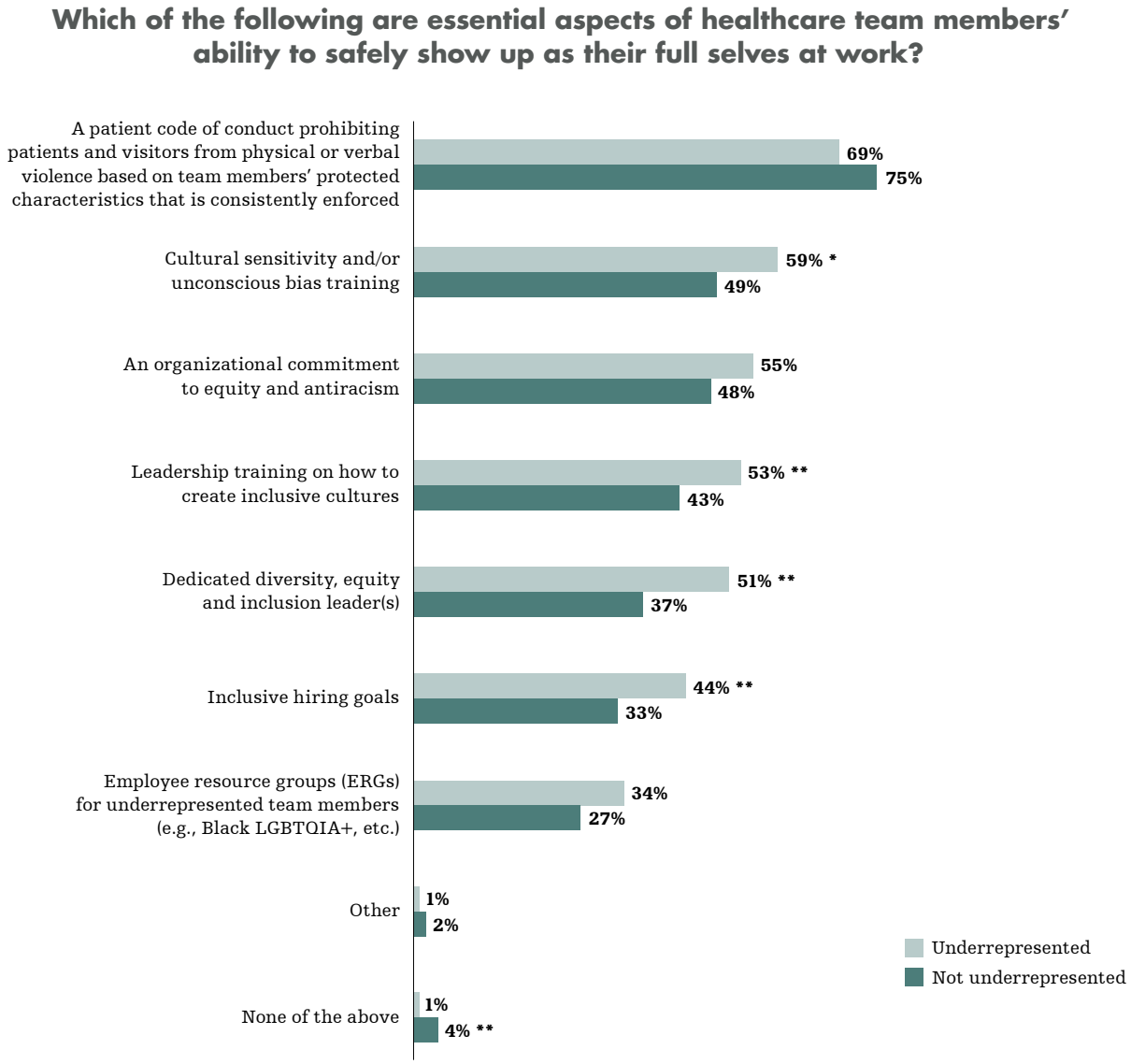
When we looked at the elements essential to practicing inclusive care, underrepresented and not underrepresented team members were more closely aligned than they were on team member equity questions. However, underrepresented team members were significantly more likely to select cultural sensitivity training than were not underrepresented respondents (see Figure 20).

Figure 17: Bedside team members say a patient code of conduct is essential



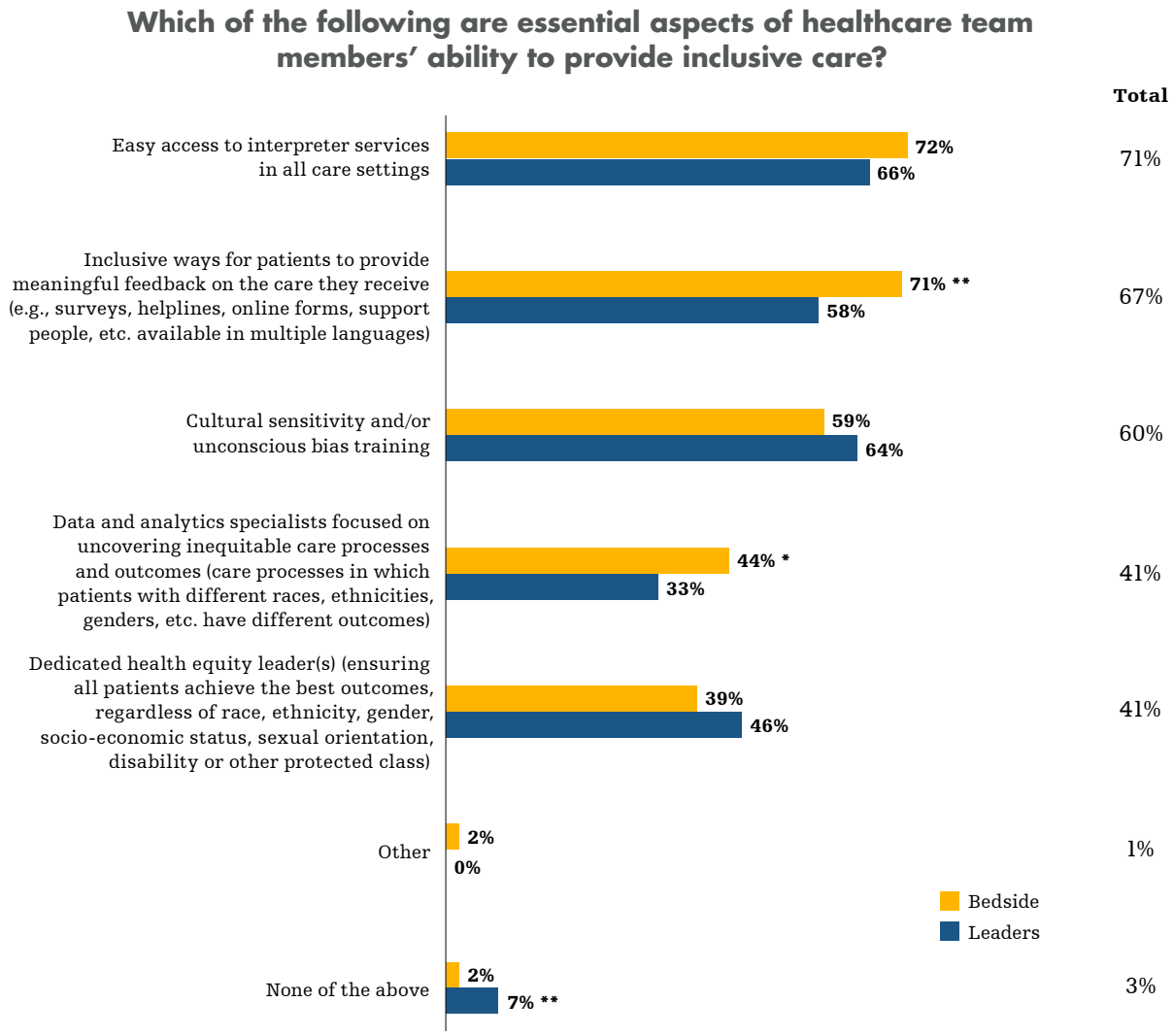
Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
(Multiple responses accepted)
**Difference between bedside and leaders at 95% confidence interval

Figure 18: Underrepresented team members recognize the importance of a broader set of interventions



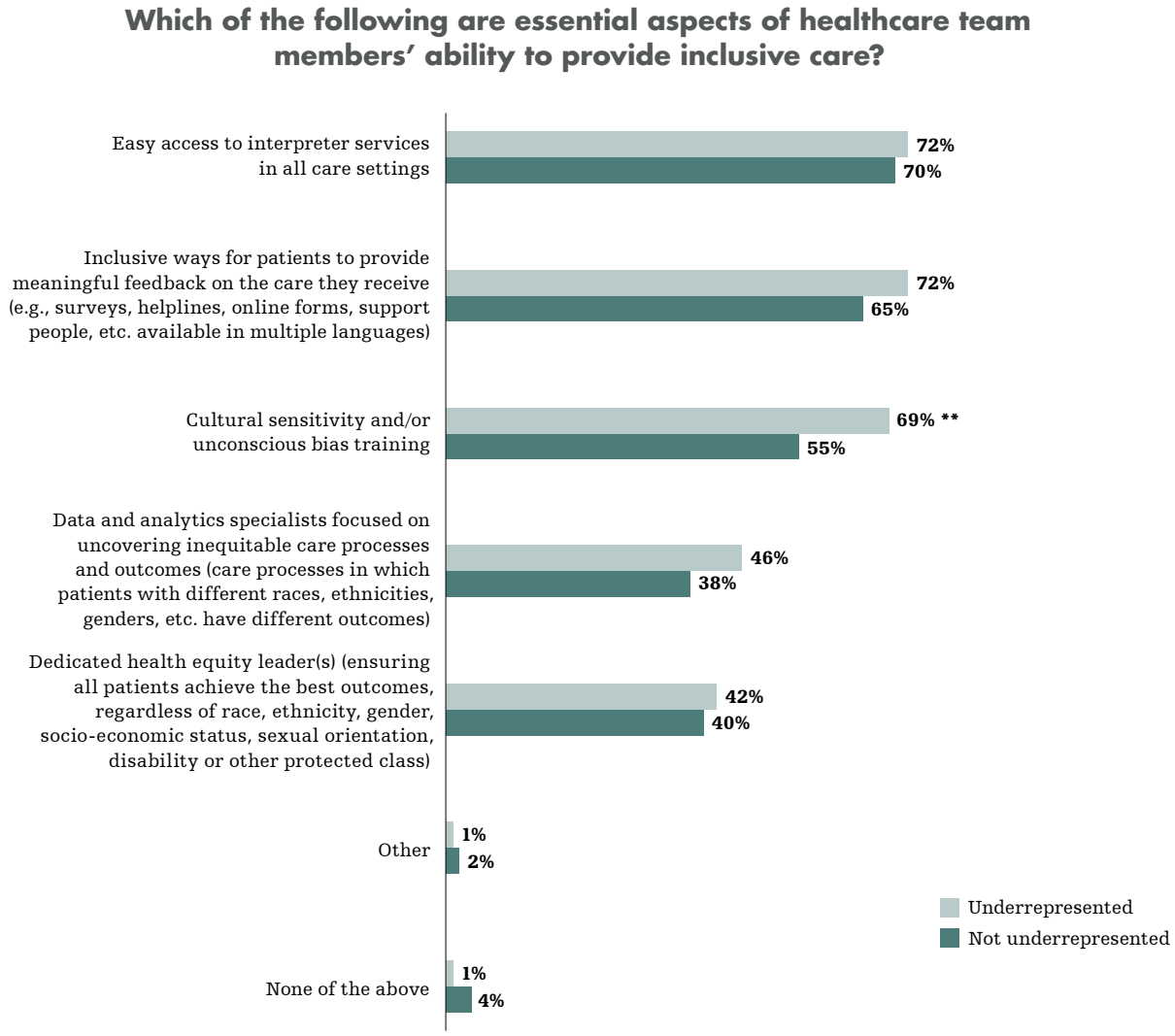
Base: 144 healthcare professionals identifying as non-binary, LGBTQIA+, Hispanic, Latino, Black, indigenous, person of color, born outside of the U.S. or as having a physical, neurological or psychological disability (underrepresented), 263 not underrepresented healthcare professionals
(Multiple responses accepted)
**Difference between underrepresented and not underrepresented at 95% confidence interval
*Difference between underrepresented and not underrepresented at 90% confidence interval

Figure 19: Bedside team members want inclusive ways for patients to provide feedback



Base: 105 U.S. healthcare leaders, 302 U.S. bedside healthcare team members
(Multiple responses accepted)
*Difference between bedside and leaders at 90% confidence interval
**Difference between bedside and leaders at 95% confidence interval

Figure 20: Underrepresented team members are more likely to view cultural sensitivity training as essential



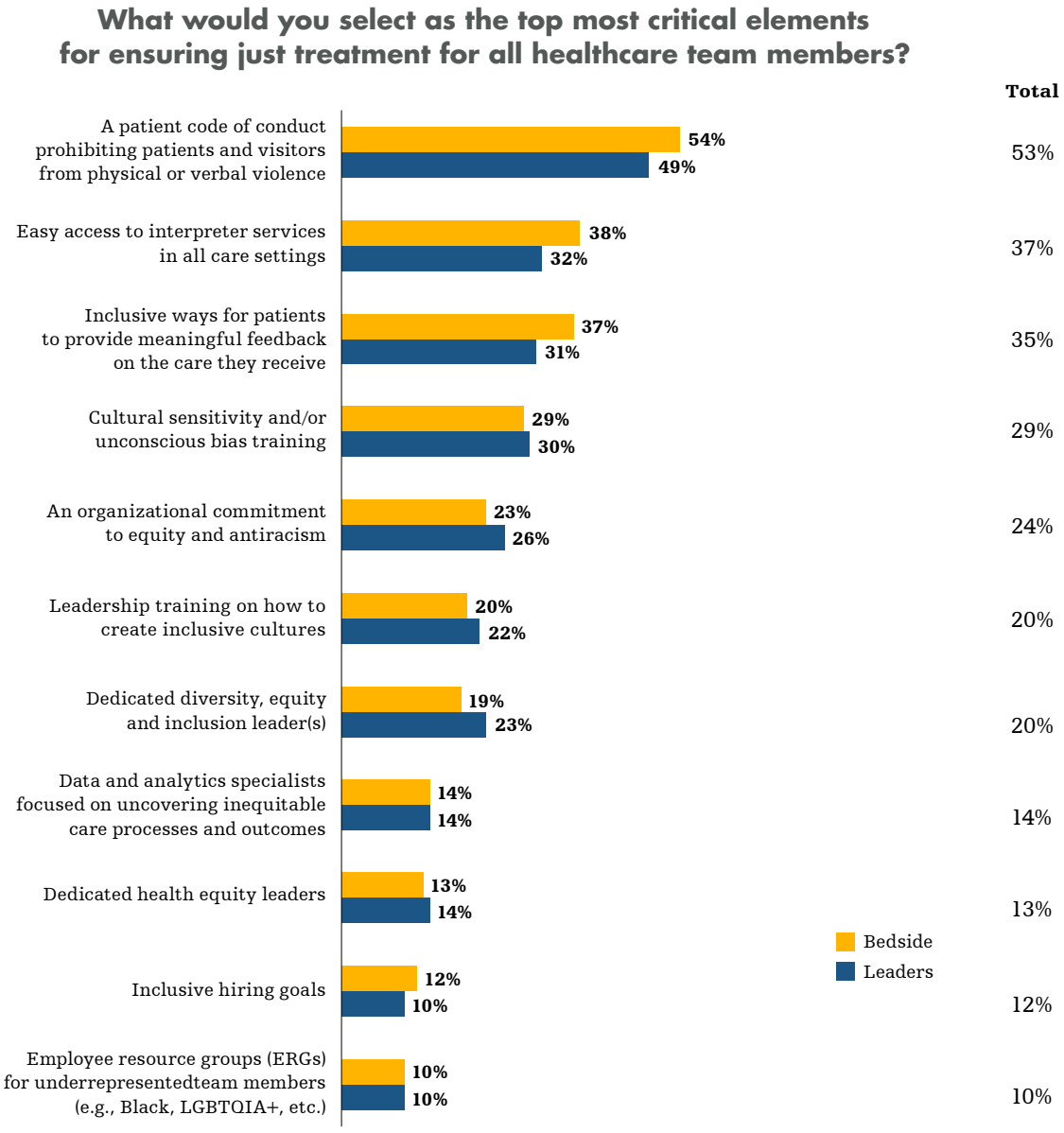
Base: 144 healthcare professionals identifying as non-binary, LGBTQIA+, Hispanic, Latino, Black, indigenous, person of color, born outside of the U.S. or as having a physical, neurological or psychological disability (underrepresented), 263 not underrepresented healthcare professionals
(Multiple responses accepted)
**Difference between underrepresented and not underrepresented at 95% confidence interval

Top elements of dignity and inclusion

When we asked respondents to identify the top three most critical elements for ensuring just treatment for all healthcare team members, slightly more than half selected a patient code of conduct prohibiting bias-based attacks, whether verbal or physical. The next two most selected options (access to interpreters and inclusive patient feedback pathways) related to inclusive patient care rather than equity, inclusion and belonging for team members (see Figure 21). However, when we broke down responses by representation, underrepresented respondents were significantly more likely to select cultural sensitivity or unconscious bias training and dedicated DEI leaders in their top three (see Figure 22).

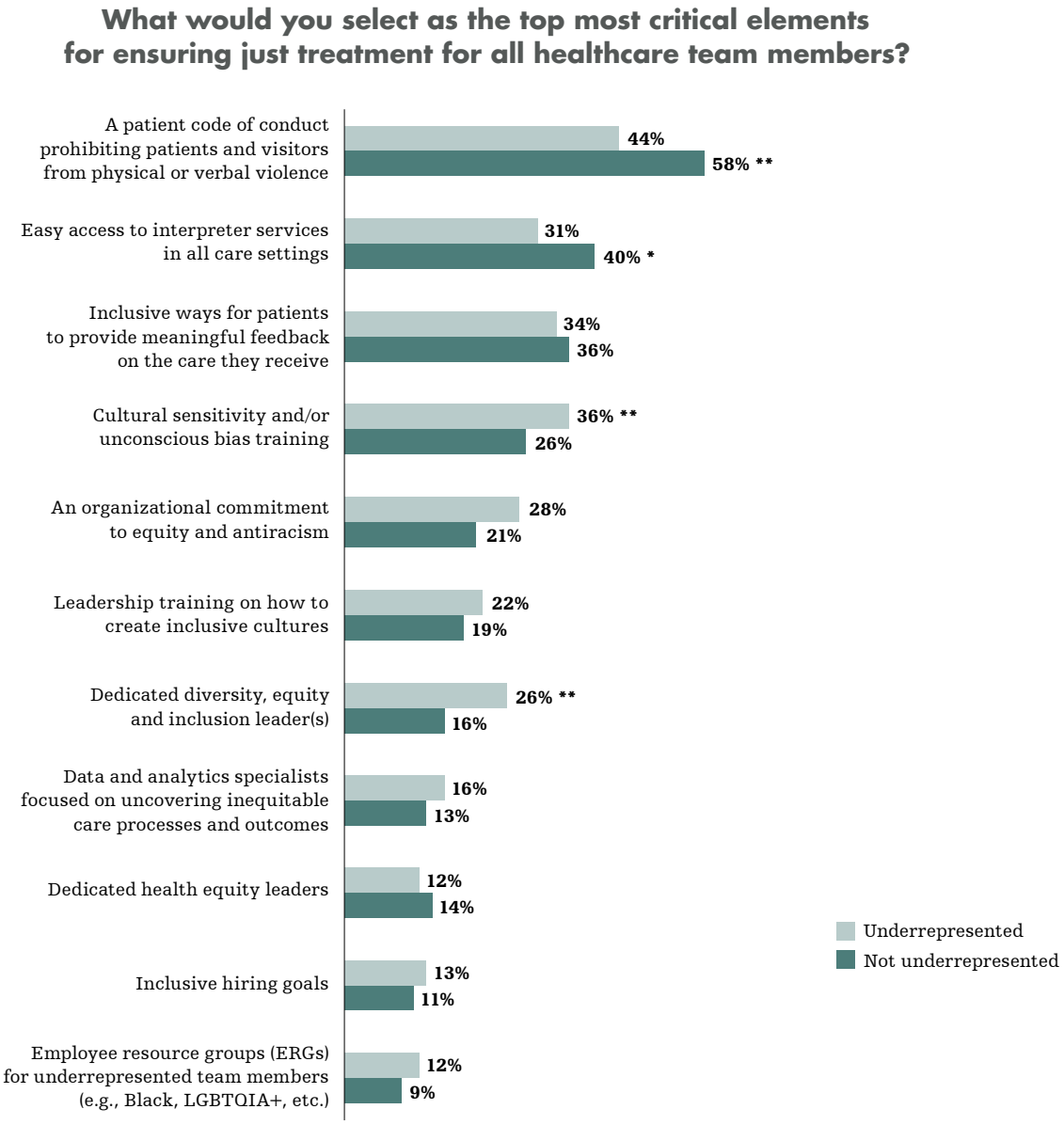
We invited respondents to share their additional thoughts on ensuring the just treatment for all healthcare team members. Because certain words can carry unique meanings in different work environments, we did not aggregate responses that included words such as equal, equity, fair or merit. Most responses were phrased in a way that implied a desire for an environment that is free from discrimination, but 3% of respondents expressed overtly negative sentiments towards DEI efforts. The most referenced concepts were the need for unwavering leader support, better training (for both leaders and team members) and the desire for people to be treated equally (see Figure 23).

Figure 21: The majority of bedside team members want a patient code of conduct prohibiting identity-based violence



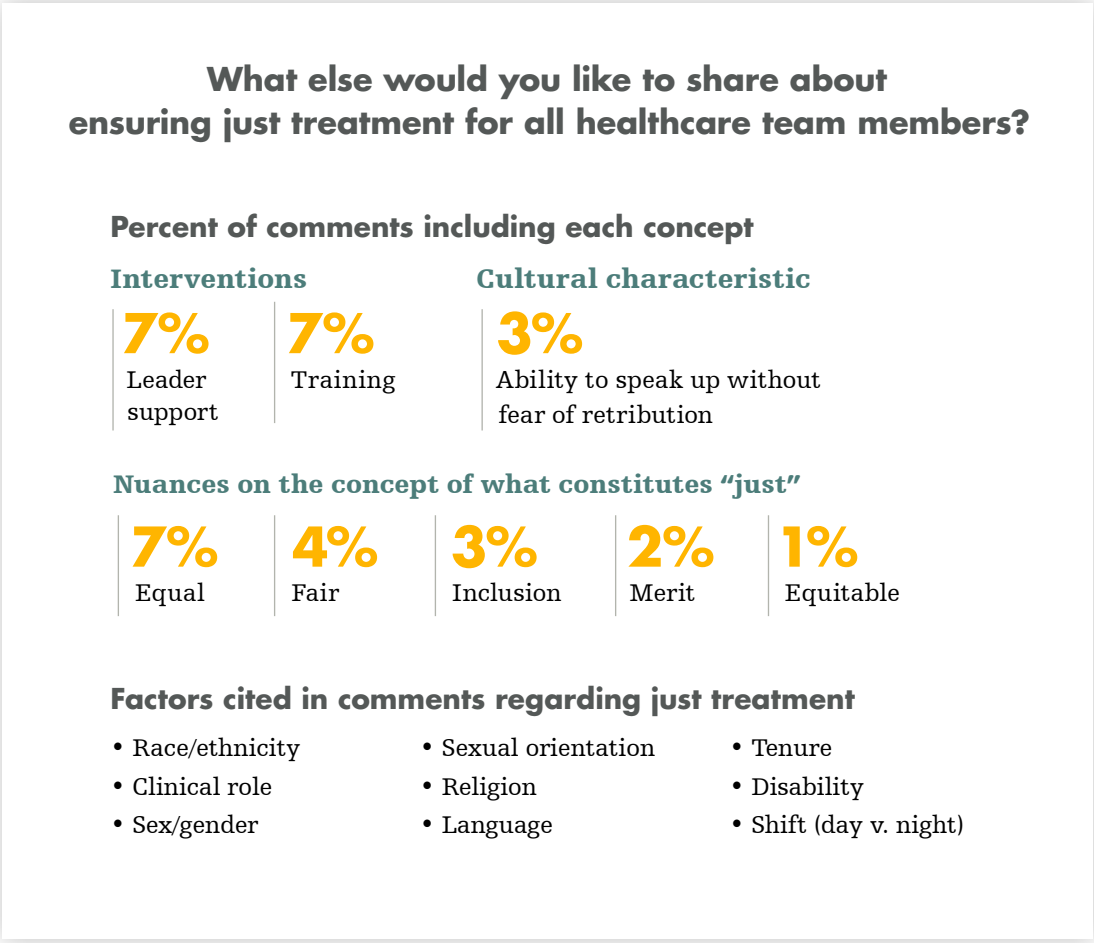
Base: 102 U.S. healthcare leaders, 299 U.S. bedside healthcare team members
(Up to three responses accepted per respondent)

Figure 22: Underrepresented respondents are more likely to select options that support DEI



Base: 143 healthcare professionals identifying as non-binary, LGBTQIA+, Hispanic, Latino, Black, indigenous, person of color, born outside of the U.S. or as having a physical, neurological or psychological disability (underrepresented), 268 not underrepresented healthcare professionals
(Multiple responses accepted)
**Difference between underrepresented and not underrepresented at 95% confidence interval
*Difference between underrepresented and not underrepresented at 90% confidence interval

Figure 23: Open-ended responses suggest a broad view on dignity and inclusion



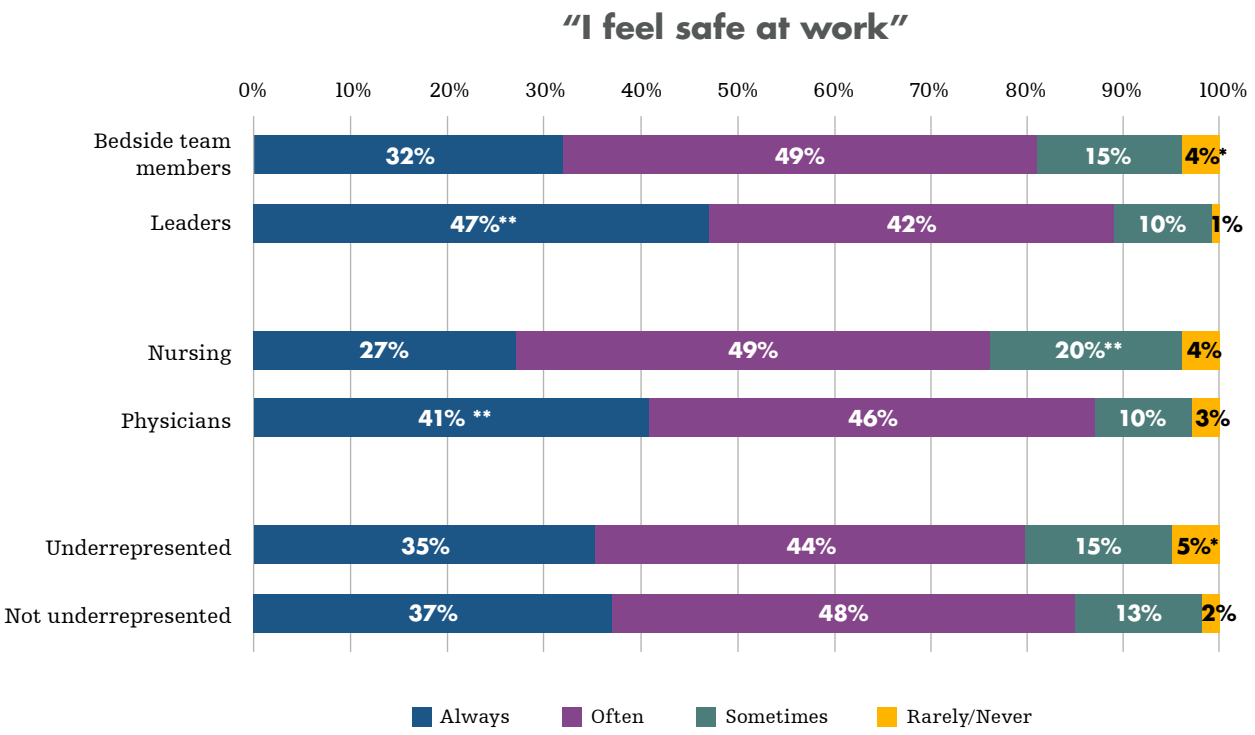
The importance of care team safety

At the Heart of Safety Coalition, we believe that all who work in healthcare deserve to be and feel safe. We asked respondents how often they feel safe at work and how often they consider leaving either their current organization or their profession because they don't feel safe at work. Not surprisingly, leaders feel safe more frequently than bedside team members, and doctors feel safe more often than nurses. However, every group we looked at had more than 10% of respondents indicate that they only sometimes, rarely or never feel safe at work. And for nurses and underrepresented team members, that number is at or above 20% (see Figure 24). That means one in five nurses need more support to be and feel safe at least some of the time. This is also true for one in five underrepresented team members.

When we asked whether respondents consider leaving their organization because they don't feel safe, we see that almost a quarter of nursing professionals and more than one in ten of physicians consider leaving at least sometimes (see Figure 25). This has implications for organizations' bottom lines, given the cost of recruiting and training new clinicians and the less tangible disruptions to team cohesion.

The more concerning trend represented in the data is how often respondents said they consider leaving not just their organization but their profession because they don't feel safe at work. Eleven percent of nursing professionals and 12% of underrepresented team members consider leaving their profession often or always because they don't feel safe — and they are significantly more likely to consider leaving often or always than their physician or not underrepresented counterparts (see Figure 26). For nursing professionals, this suggests that their lack of feeling safe has a likely tie to their desire to leave nursing. For underrepresented team members, whose feeling of safety was very similar to not underrepresented respondents, more research is needed.

Figure 24: Seventeen percent of respondents only sometimes, rarely or never feel safe at work



Base: 105 U.S. healthcare leaders, 302 U.S. bedside team members; Base: 173 nurses, 115 physicians
144 underrepresented healthcare professionals, 263 not underrepresented healthcare professionals
**Differences between respective pairings at 95% confidence interval
*Differences between respective pairings at 90% confidence interval

Eleven percent of nursing professionals and 12% of underrepresented team members consider leaving their profession often or always because they don't feel safe.

Figure 25: A quarter of nurses consider leaving their organization at least sometimes due to safety

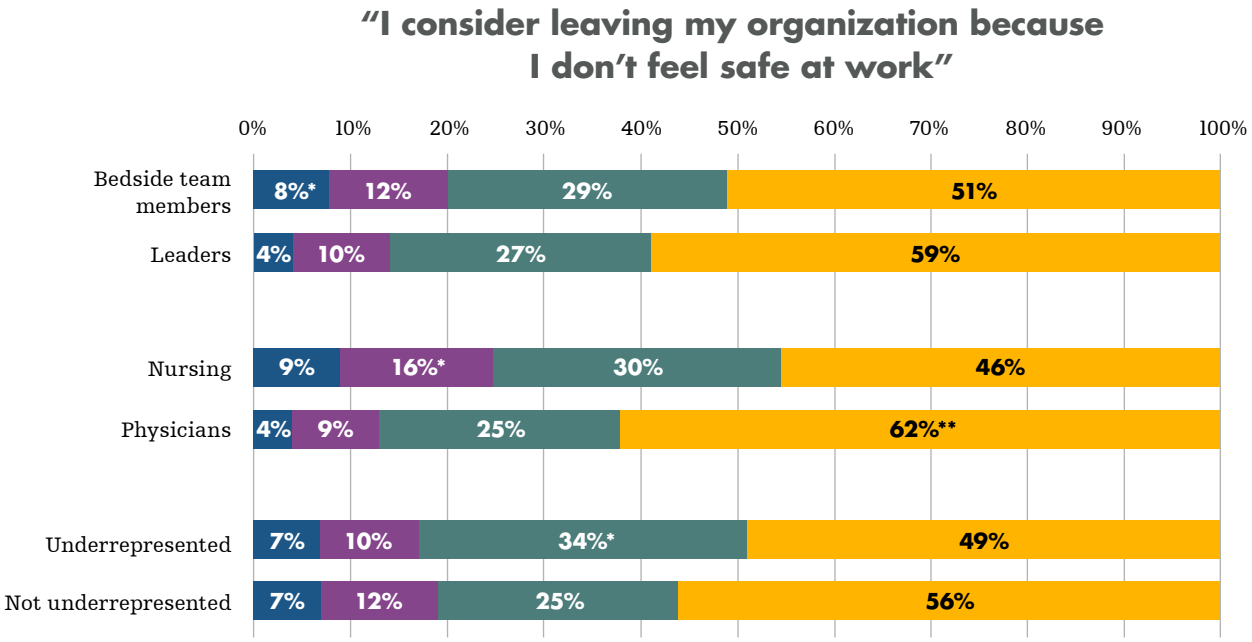
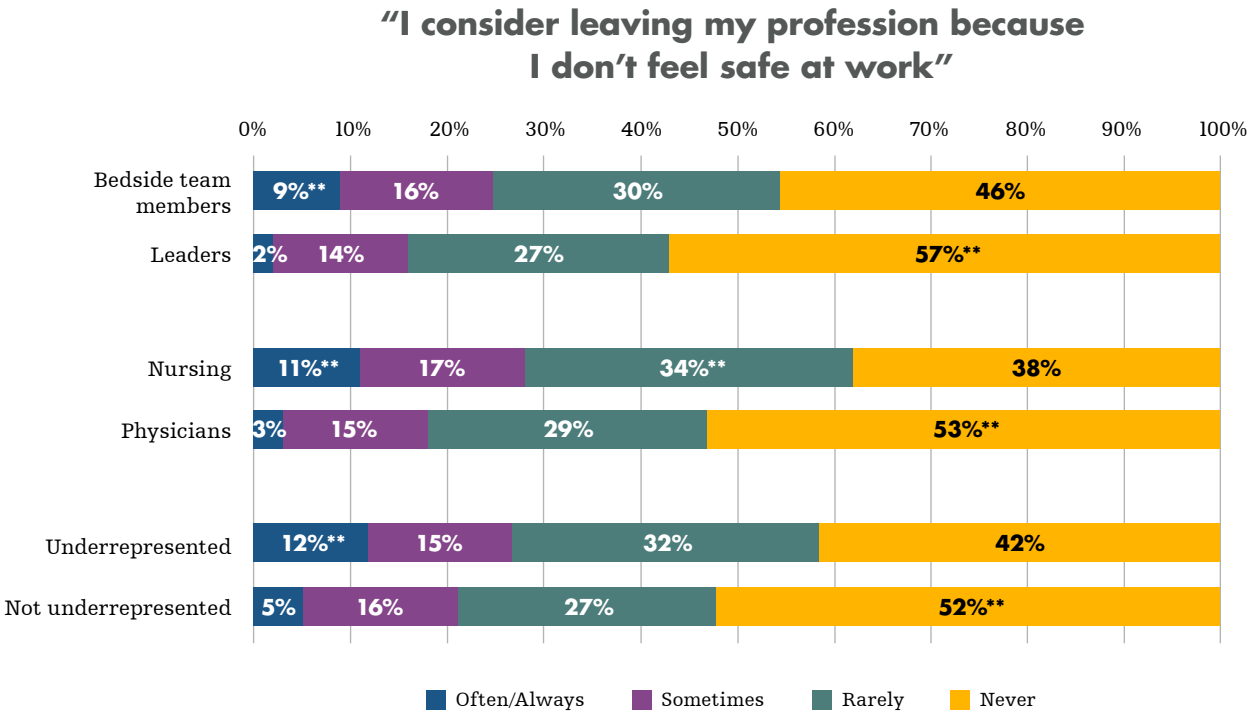


Figure 26: More than one in ten nursing professionals and underrepresented team members consider leaving their profession often or always due to safety concerns



Base: 105 U.S. healthcare leaders, 302 U.S. bedside team members; Base: 173 nursing professionals, 115 physicians
144 underrepresented healthcare professionals, 263 not underrepresented healthcare professionals
**Difference between respective pairings at 95% confidence interval
*Difference between respective pairings at 90% confidence interval

The future of care team safety

Safety is a fundamental need for all human beings.[8] Those working in healthcare voluntarily engage with people in situations where there is infection risk, likelihood of emotional dysregulation, physical threat and the emotional burden of dealing with others' pain, loss and death. They harness their desire to help, knowing that they can't always cure their patients' problems. There are elements within the healing professions that will always ask healthcare team members to take on physical, psychological and emotional demands. They shouldn't have to worry about facing dangers that could be mitigated — if not eliminated — by resources, commitment and human-centered leadership.

With this research we set out to understand what it means to be and feel safe in healthcare and to determine if the three pillars (physical safety, psychological and emotional safety, dignity and inclusion) resonate with both leaders and bedside team members. The answer is yes. The three pillars of safety are not only essential, they are interconnected. In the words of one inpatient bedside nurse, "All types of safety go hand in hand. When we feel emotionally safe, we are in a better place to make sure we are practicing safely and advocating in other situations, etc. All types need to be present."

To support a thriving healthcare workforce the Heart of Safety Declaration of Principles outlines a holistic, 360 approach to protect the psychological and emotional safety, dignity and inclusion, and physical safety of all who work in healthcare. An expanded definition of care team safety that includes all three pillars, illuminated by six principles, is needed for a better and safer future. There is zero time to waste.

> "All types of safety go hand in hand. When we feel emotionally safe, we are in a better place to make sure we are practicing safely and advocating in other situations, etc. All types need to be present."
>
> ~ Inpatient bedside nurse

3 pillars | **6** principles | **0** time to waste

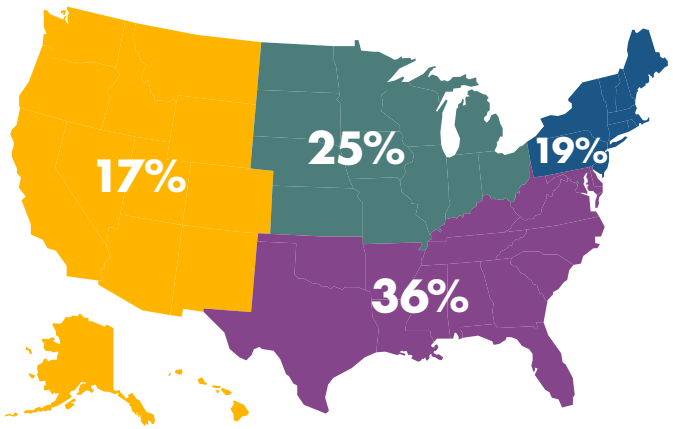
> "Protecting healthcare workers requires more than just resources and communication. It needs a comprehensive approach that addresses burnout, violence and discrimination, fosters a supportive work environment, invests in individual wellbeing and continuously improves practices. This ensures workers feel valued, respected and empowered to deliver quality patient care."
>
> ~ Inpatient bedside nurse

About the survey

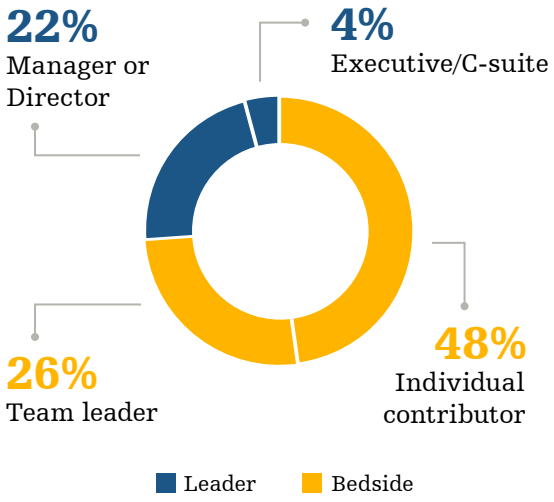
We are grateful to all the healthcare professionals who gave their time to share their perspectives and insights. The survey was fielded in July, August, November and December 2024. The following characteristics are represented in the data set:

407 healthcare respondents

Region



Organizational level



Clinical background

- **45%** **Nursing professional** (RN, LPN, PCT, CNA, etc.)
- **30%** **Physician** (MD, DO, etc.)
- **10%** **Advanced practice provider** (NP, PA, etc.)
- **9%** **Behavioral health** (MD, PsyD, PhD, MSW, etc.)
- **4%** **Pharmacy** (PharmD, BCOP, BCACP, etc.)
- **2%** **Therapist** (PT, OT, RT, etc.)

Demographics

Female	**53%**	Hispanic	**6%**
Male	**44%**	Black, Indigenous or person of color (non-Caucasian)	**10%**
Non-binary/gender not reported	**3%**	Born outside the U.S.	**14%**
LGBTQIA+	**7%**	Identifying as a person with a physical, neurological or psychological disability	**6%**
40+ years of age	**38%**		
Caregiver for an aging parent or loved one	**12%**		

Care settings

- **47%** Inpatient hospital
- **17%** Outpatient hospital
- **35%** Outpatient clinic, pharmacy, etc.

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Executive Strategist
Heart of Safety Coalition
Stryker

About the **Heart of Safety Coalition**

The Heart of Safety Coalition places care team member safety at the heart of healthcare. This national community of industry leaders, learners and advocates ensures that voices are heard, connections are made, and standards are raised to inspire systemic, team and individual change that improves working and healing environments. The Coalition's three pillars of care team safety advance the Heart of Safety Declaration, which intersects the essential wellbeing principles of dignity and inclusion, physical safety, and psychological and emotional safety. Driven by its mission to make healthcare better, Stryker supports and manages the Coalition. Learn more at www.HeartofSafetyCoalition.com.

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