Abstract title: Safety Learning System: reporting work, health and safety in a patient safety system

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Introduction:

WHS legislation requires that officers ensure there are appropriate processes for receiving and considering information regarding incidents, hazards and risks and responding in a timely way to that information. In the health care industry, however, ‘safety’ is most often understood as referring to patient safety with relatively little attention given to worker health and safety issues.

This paper explores the introduction and first twenty months of operation of a single reporting system for SA Health, the South Australian statewide public health system and largest state employer with 38,000 staff and over 600 sites. It explores the challenges and benefits of taking a system wide approach and identifies features that have contributed to successful uptake. Data is presented that illustrates hazard and incident events and perception amongst the health workforce.

Practice innovation:

The project team capitalised on work already undertaken in Patient Safety and Quality to align risk management for both patients and workers in the health care setting and promote work health and safety to an audience that is overwhelmingly focused on 'the patient'.

The development of question sets specific to the health care environment have facilitated identification and deeper understanding of contributing factors and system challenges.

Sources of information:

The information on the development of the reporting system has been drawn from the project plan and reports. The Safety Learning System itself provides the data on number and trends in whs hazard and incident reporting in SA Health. Data has also been drawn from published data in other states for national benchmarking.

Findings:

The use of an existing system focused on patient safety has resulted in excellent uptake of the single reporting system.

The development of a bespoke system allowed for the inclusion of hazards particularly relevant to health to be reflected to the users. This has resulted in improved reporting for hazards such as 'challenging behaviour' and fatigue and tracking for target areas such as manual tasks with bariatric patients.

Discussion:

For progress on safety, organisations must monitor and understand the reasons behind the gap between procedures and practice. (Dekker 2012). In health care this requires understanding of
safety climate as it affects both patient and worker. The Work Health and Safety addition to the patient focused SA Health Safety Learning System facilitates that shift.

References:
