



**GE HEALTHCARE
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Going from a Culture of Blame and Denial to a Culture of Safety

Summary: Many healthcare organisations face difficulties while managing transition from a culture of blame and denial to a culture of safety. To succeed, leaders should identify obstacles, create an environment of trust and set an example with their own actions.

Healthcare holds traditions in high esteem. The white coat and nursing pin ceremonies to symbolise the transition from student to provider continue through the centuries. These are patterns of behaviours that are upheld even in the face of a changing world.

Sadly, one pattern that also continues is a culture of blame and denial (CoBD). Culture is what you say and do on a daily basis. How errors are analysed,

been rooted deeply within healthcare for centuries: shifting blame to others, not reporting or identifying errors for fear of retaliation, a lack of accountability due to power structures, etc. Incivility in the workplace and a lack of response to behaviours further reinforce cultural influencers of blame and denial. Errors within healthcare have been seen through the lens of individual actions and the need for disci-

and effect of changes. They understand what culture is and that actions are being evaluated to the stated standards of performance and behaviours. All individuals are accountable for improving quality, safety and the culture of the organisation. As outlined in the Patient Safety Movement Foundation's Actionable Patient Safety Solutions (APSS) #1, 'Culture of Safety,' creating such a culture entails fostering a safe and

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discussed and acted upon influences the culture of an organisation. Human error factors can cause negative patient outcomes, but they are not isolated as a cause of harm. Processes, policies and system failures have greater influence over patient outcomes than individuals. Leaders who focus solely on the individual human errors reinforce a CoBD, in which employees tend to not want to be singled out or disciplined. This creates a cycle of employee unwillingness to elevate issues or failures that need addressing.

Prerequisites

The prerequisites for a CoBD have

plinary action to correct behaviours. Leaders who promote a CoBD look for and reinforce individual failures, but do not deal with high-power individuals. Analysis of an error will only consider the surface facts and draw conclusions without deep examination of underlying influencers and contributors. Employees learn to keep their head down, 'just do their job' and not speak up in a CoBD.

In contrast, leaders who are consciously promoting a culture of safety (CoS) understand that organisations are dynamic and complex. Leaders look for failures within systems and processes, not individuals. They utilise tools to analyse both upstream and downstream for the cause

reliable environment of transparency, safety, trust and accountability (PSMF 2018).

Importance of Team Roles

In understanding a CoBD and why it is difficult to move to a CoS, you have to be willing to examine and understand the current culture within an organisation. Typically, organisations have looked at physicians as captains of the ship, giving the orders with everyone rowing even when it is in the wrong direction. The brave ones who speak up are dealt with swiftly. Soon it becomes well understood to not stand out, not speak up and do what you are told. That

power structure, however, leaves the top individual in the role of needing to be perfect in decision-making, execution and communication. We all know that is impossible; humans make errors, especially in complex environments.

In contrast, a CoS understands that everyone has a role that is also mutually respected. The physician's role is thus similar to that of a quarterback in a football game. An important role, but one that is dependent upon others. If

to patient safety as another programme that will fade away with the new leader.

One obstacle we cannot underestimate is the tendency for individuals to be defensive under stress. Currently, preparations for clinical professionals concentrate on medical skills and omit skills to handle high risk/consequence environments. Training to manage one's own response to error-making and to take responsibility is critically missing from medical curricula.

Building trust as a team is a significant contributor to a CoS. Trust begins with creating opportunities to have clear thinking. This is often challenging in the unpredictable, time-constrained health-care environment. So, a commitment to designing the system in alignment with human capacity is paramount to forming a successful CoS. Straight thinking lends liberties to straight talk, listening to truly understand rather than checking boxes, and making commit-

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you analyse successful teams, you see commonalities – clear communication, accountability among team members, role clarity, and agreement on goals and metrics. Team members listen and feel part of a greater whole, not just an individual doing a job. Leaders foster an environment that promotes mutual respect, to keep precision focus on patient safety being the top priority over competing priorities, such as financial and growth goals.

Additionally, a prioritisation of learning is found in a CoS and conversely, mistakes are repeated in a CoBD due to denial. This has a significant impact on patient safety.

Obstacles

Cultural transformation is loaded with complexity, barriers and doubters who do not believe that you can achieve zero harm. Bias creates invisible barriers that influence human behaviours. Bias such as some medical errors cannot be prevented, or the severity of illness influences outcomes more than safety actions. The business of healthcare creates conflicting priorities and confusion within the workforce on what is the top priority today. Layer upon an organisational change, such as a key leader leaving, and it is easy for the organisation to move from true transformation

This dynamic must also be addressed alongside managerial prioritisation of fostering a CoS. It is not enough to support a culture of learning, which in turn supports a CoS. The individuals must develop trust in themselves as they develop trust in each other. Shifting from a CoBD to a CoS must be staffed by people who are both willing to face errors and competent at reversing lifelong mental patterns that not only tend towards blame and denial but also interpret through a lens of shame. This course correction takes more than simply saying 'it's okay to fail' or 'learn from your mistakes.'

Mindset of Trust

Leaders must have a preoccupation with system and process failures, looking to create safety nets to assure that individuals can perform with safety in mind. This mindset change must be one of the top priorities for leaders. Starting with a baseline survey analysing the level of trust and truth-telling, leaders then develop strategic action steps to advance their culture from blame to safety. When errors occur, leaders must assure that there is transparency in analysis and reporting. They know that developing trust within an organisation is an outcome based on actions seen by employees, taken by leaders.

ments that recall and align with the professed CoS values.

When walking the talk becomes predictable, team members begin to rely on each other in ways that increase transparency and learning. The trust derived from this environment sets the context for respect, and an environment of positive intent evolves. Put another way, when there is trust and respect, there is a presumption of goodwill, which goes a long way in making it easier to speak up when near-misses happen or errors occur.

Necessary System Changes

The first action to achieve change is an articulation of what the vision for patient safety is and why there is a need to achieve that vision. Telling the stories of where safety failed and the impact to those involved helps to gain understanding of the 'why' behind the needed changes. Utilising methodology to engage employees in developing the vision will accelerate ownership throughout the organisation. Develop communication mapping to assure that all employees feel that they are knowledgeable of the vision and the process of development.

Once the vision for safety is established, analyse the systems and processes that need to be revised to

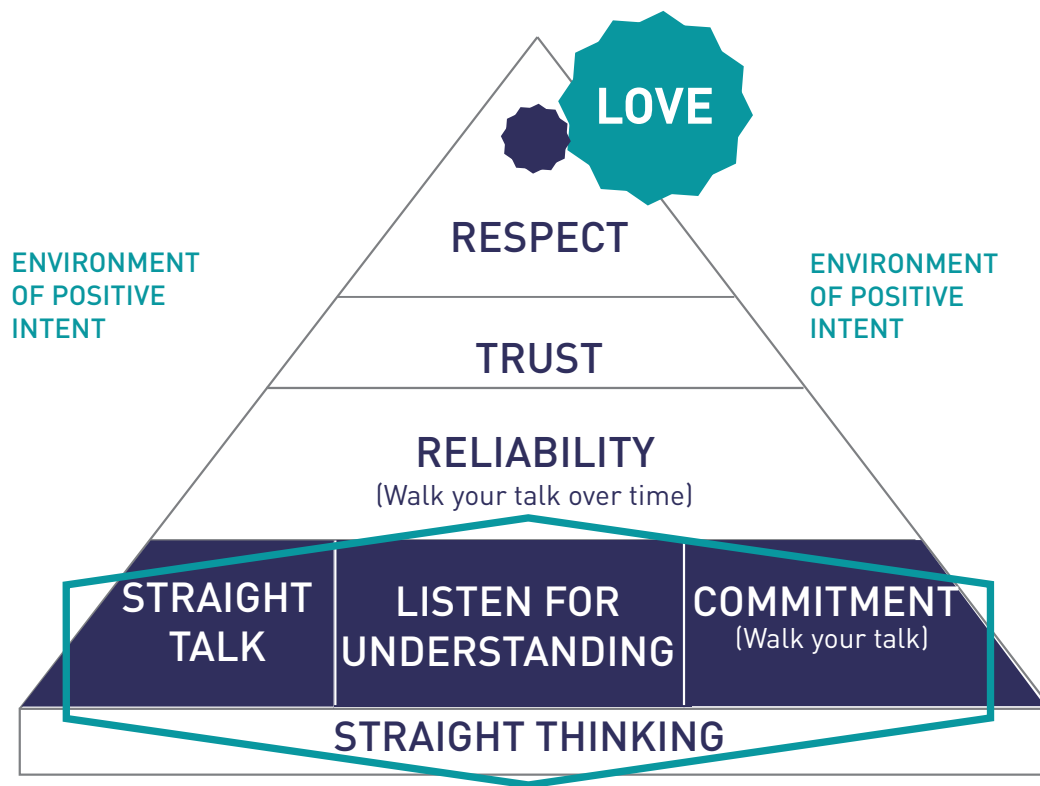


Figure 1. Howard Jackson Trust Model, Modified by Yogiraj Charles Bates.

assure that the vision can be transformative and sustained. How are safety issues communicated? Is it a form online that goes into a database, but employees feel it is a black hole? Do employees know how to call out a safety issue to bring immediate attention to it? How are safety issues reviewed and addressed? Do you conduct safety huddles that are effective in escalating issues? Safety huddles – brief, routine meetings to share information – can be used as a deflection from change when they become routine. In essence, they become another meeting instead of a powerful tool to advance safety. Listen for truth-telling and willingness to discuss difficult issues in huddles. Look for listening and follow up not from the usual volunteers, but all participants.

Use stories to communicate why safety is important. Storytelling helps employees to identify, feel empathy and understand why changes are needed. Employees become engaged and more

willing to give discretionary energy to advance patient safety.

Personal Experience

Vonda Vaden Bates' husband, Yogiraj Charles Bates, died in a Minnesota hospital following brain surgery in 2012. Many people have contacted her to say that hearing his story influences their actions on behalf of patient safety. She believes that one reason people are impacted by their experience is that a CoBD was a factor in his death. This became evident as she approached the hospital with questions about the shocking outcome; an overlooked blood clot, which resulted in a fatal pulmonary embolism. It's estimated that over 45,000 people die from hospital-associated blood clots in the U.S. each year. Reports suggest that as many as 70% of cases of HA-VTE in patients could be prevented (Centers for Disease Control and Prevention 2019).

Like many others, Vonda walked back into the hospital where Yogiraj Charles

died assuming that the administration and clinicians would be interested in thoroughly reviewing his care with her 24/7 experience to identify what happened. She presumed that the priority would be to ensure lessons were learned so others would not suffer the same fate. She was horrified to find a CoBD. It began to be apparent that denial and defensiveness contributed to his death by neglecting to educate everyone in the hospital about how to address one of the most common preventable hospital-acquired conditions in the U.S.

Organisational Experience

As one organisation Martie worked with started to understand what a CoS truly meant, small tests were made to see if leadership was sincere about this body of work and change. Tests such as bringing up a small issue to see if there would be a response. The toughest test was dealing with disruptive behaviour of top volume producing

physicians and employees with seniority whose behaviours had been normalised. Knowing that negative disruptive behaviour causes harm and hurt to patients, they had addressed what was to be the standard of expected behaviours and dealt with individuals when they did not meet those expectations and values.

One of the top volume producing physicians informed the employees that a culture of safety did not apply to him. The line in the sand was drawn. Employees would trade shifts, pay each other and call in sick to avoid working with him in the operating room. The less senior employees were routinely assigned his room and would leave the cases crying or so upset that they could not think clearly. His rooms had more errors than others, yet it had been tolerated and discounted as individual performance of the staff – not a systemic issue of safety.

His behaviour and others' were dealt with in a fair but clear manner. Expectations of behaviours and why those expectations were being enforced were clearly articulated. He continued in his behaviour feeling that he did not have to comply with the expected performance and behavioural standards. Each time, each instance they had to address it. It was a defining moment for the organisation. Evidently the physician made the decision to take his cases to the competitive hospital. It impacted them financially, but in the long run was the defining moment within the organisation that communicated loudly the commitment to assuring the safest care possible for the patients.

Leadership Behaviour

Leadership behaviour will make or break cultural transformation within an organisation. Employees many times play the game of Clue (a popular murder-mystery board game) when it comes to watching leaders and looking for what is happening next or what is expected of them. That is why it is imperative for a leader to pause and self-reflect on their own values, beliefs and motives. This can be extremely difficult to do

as a leader. Reflection opens up the mind's ability to understand the cost to humanity, the degree of moral and ethical distress felt and faced when safety fails. It feels overwhelming, and many times leaders will deal with the significance by making safety a tactical action only.

Safety needs to be both. Tactical actions need to occur to assure the organisation self-examines and pushes to perform at higher standards. Yet, the leader cannot devoid themselves of the deeper calling of patient safety. It is the countless faces of individuals who trust, rely and depend upon their leadership and commitment to being relentless in elevating patient safety throughout their organisation. It is that behaviour that is the most important of a leader. When a leader feels passionate about their work, others will follow living the same passion through their actions. ■

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Key Points

- A culture of blame and denial is a continuing pattern.
- Instead of focusing solely on the individual human errors, leaders look for failures within systems and processes. Safety nets should be created to assure that individuals can perform with safety in mind.
- Obstacles to cultural transformation are many, including complexity, doubters, various biases and the tendency for individuals to be defensive under stress.
- For culture of safety, examining the current culture is needed as well as understanding that everyone has a role that is also mutually respected.
- Building trust is an important element of a culture of safety. It fosters respect and positive intent.
- Articulate the vision for patient safety and the ways to achieve it. Develop communication mapping. Conduct safety huddles that are effective. Storytelling can help staff to identify, feel empathy and understand why changes need to occur.

REFERENCES

- Centers for Disease Control and Prevention [2019] Learn About Healthcare-Associated Venous Thromboembolism. Available from iii.hm/11fe
- Patient Safety Movement Foundation [2018] Actionable Patient Safety Solution (APSS) #1: Culture of Safety. Available from iii.hm/11i8