Leadership and Healthcare Safety

A recent *study* by Johns Hopkins University now indicates that Medical Errors are the third leading cause of death. Why is this? More importantly, how did it happen? Clearly it did not occur overnight. In healthcare, quality and safety are supposedly mainstream and even tied to reimbursement. With so many safety initiatives, solutions and committees to prevent this result, what happened. Part of the research showed that it was the lack of standardization in processes and protocols and other indications were the lack of reporting.

Radiation Oncology is no different there are numerous threats to patient and employee safety daily. Radiation Oncology gained negative attention regarding radiation safety in the *2010 New York Times Articles*. In radiation oncology, we have secondary checks, signature sheets, safety meetings, training etc., but accidents still happen. Even something as small as the wrong head holder, could be potential for an error. Front end errors or oversights can occur when verifying insurance information that prevent us from being paid or paid on time.

The question is how many of these errors reported/found and how many are swept under the rug. The answer to this question is the same answer that Johns Hopkins is looking for. Fortunately, the research for the main culprit has been done and discovered in radiation oncology and continues to be researched.

The answer is **culture**. All of the greatest tools and solutions are rendered ineffective if deployed in a toxic work culture. Defining a *toxic work*

culture is lengthy, but overall it is one of silos, fear, hidden agendas, high stress, self-serving initiatives etc. In these environments mistakes are often not reported due to fear of embarrassment, retaliation or retribution. The stress of staff, physicians and management at all levels about who is watching them and which deadline needs to be met becomes the focus. This loss of focus on the clinical operations are when mistakes occur. *ASTRO* has made incredible steps with its "Safety is No Accident: A Framework for Quality Radiation Oncology.

Tolerance and ***accountability*** are other topics that lead to an environment which may be more prone to workplace errors. Often times there are different rules for different people, which leads to varying levels of accountability when mistakes or "near misses" occur. Departments and healthcare systems are often plagued and weighted down by the tolerance and dangers or inappropriate behavior such as workplace bullying. The staff, physicians and administration wonder why the talented individuals often leave. There seems to be just as much time being spent on who to blame as there does simply taking ownership, fixing the process and moving forward. Communication is one of the greatest tools we have to prevent errors in our departments and service lines. What if people feel as though they cannot speak up?

The Johns Hopkins study identifies the end result that there are more medical accidents resulting in deaths. The important thing is what is leading to this. The solution can be found in education and assessment. For this to happen departments, service lines and systems must have open minds to new ideas and be able to accept constructive criticism. The core issues did not develop overnight and take time to be corrected. Fear and change are what hold most

back. Often a toxic work culture is the result of cyclic behavior. This study further reinforces the need to break the cycle.

The statistics will continue until we see a paradigm shift away from hierarchical, top-down approaches and see more true leadership out of the current environment. The *Quality Payment Program implemented by CMS will expose more of the weak links as we move forward.* **Being proactive is key.** Contact us to comment or learn more about the strategies and solutions to assess and overcome this epidemic at **318-537-1509.**