



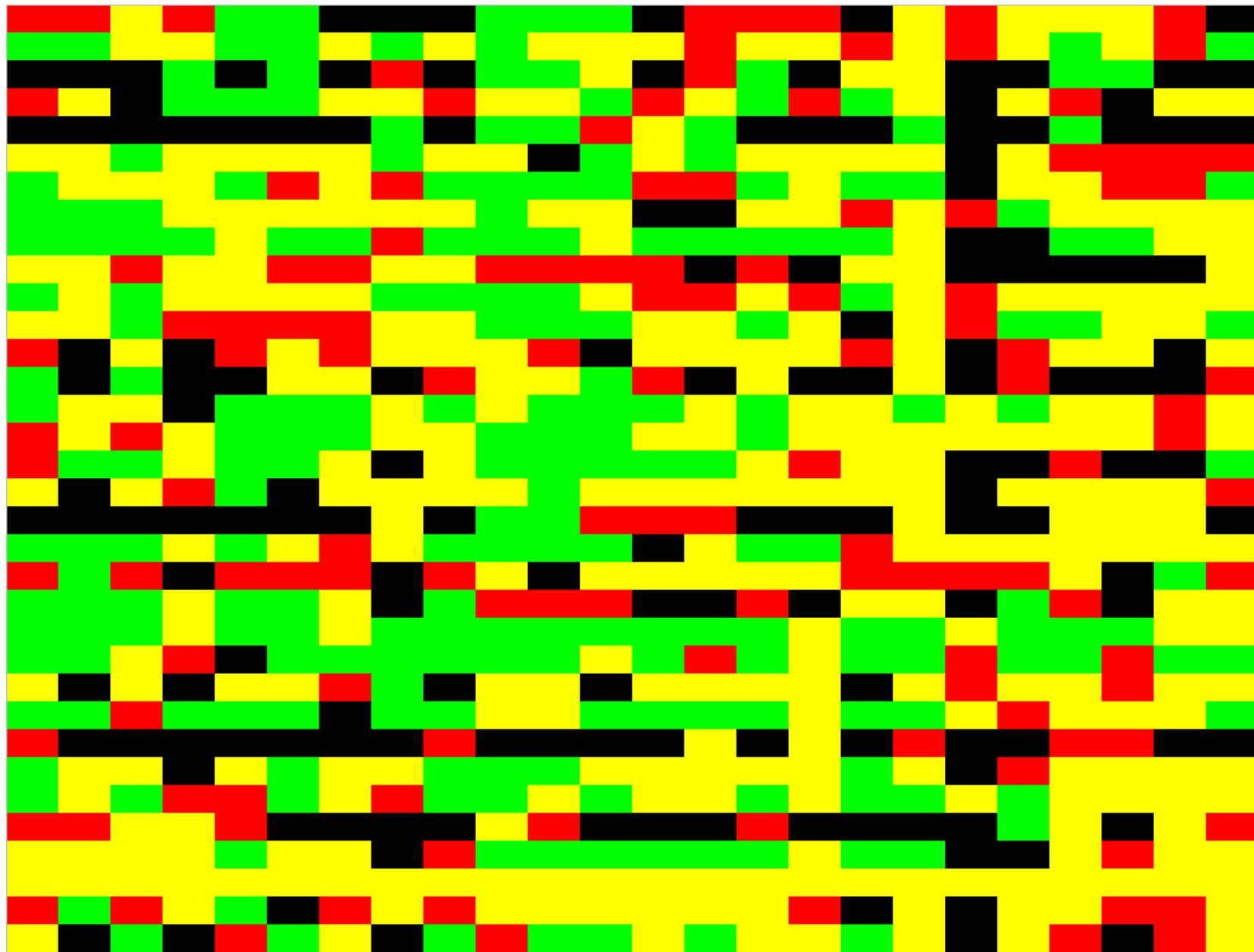
Supporting the Healthcare Workforce - Innovations in OHS

SevenSeventeen

Silent Danger: The Five Crucial Conversations that Drive Safety

Grant Donovan PhD

Perception Map DNA Response Pattern



Memetic Pattern

2 time 2 equals

4

Oh! What a feeling

Toyota

She loves you

Yeah, Yeah, Yeah

The Parent - Child Conversation

Parent: How was school today?

Child: Okay

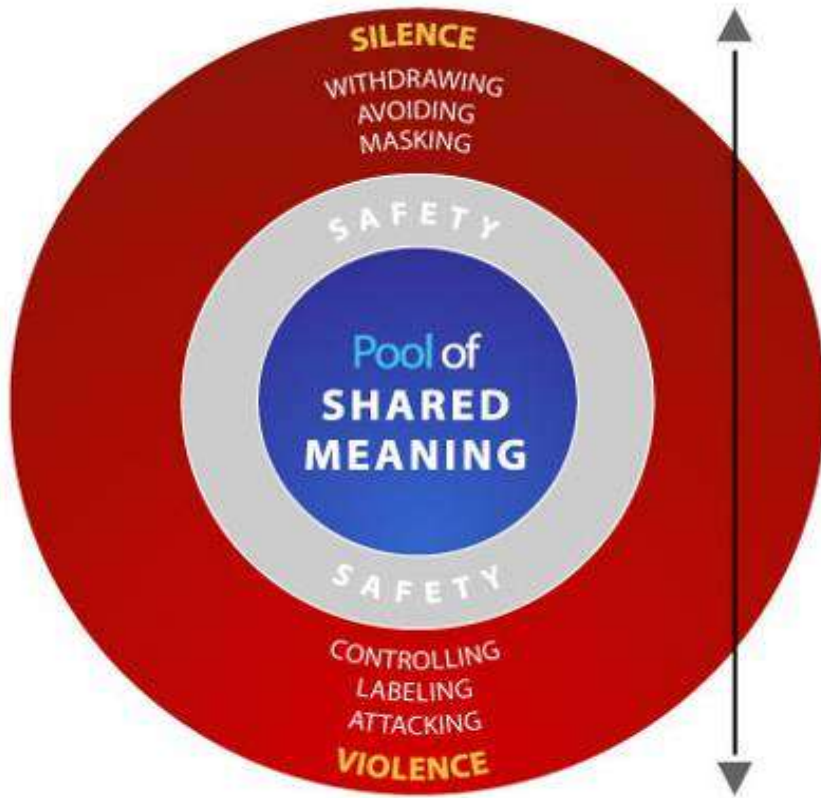
Parent: What did you learn?

Child: Nothing

Parent: So why are we sending you to school?

Child: I don't know (because you're stupid?)

Toggling between Silence and Violence



Silence doesn't work, so we get frustrated

When we get *too* frustrated, we jump to violence

VitalSmarts Silent Danger Research Study

Sample Size: 1600 employees from 30 different organizations

Result: Five workplace safety threats beyond education and technology

Get It Done

Unsafe practices justified by tight deadlines

Undiscussable Incompetence

Unsafe practices from skill deficits that can't be discussed

Just this Once

Unsafe practices justified as exceptions to the rule

This Is Overboard

Unsafe practices that bypass precautions considered excessive

Are You a Team Player?

Unsafe practices justified for the good of the group

VitalSmarts Silent Danger Research Study

Key Findings

1. 93 percent of the 1,600 employees surveyed had at least one team member who regularly used one or more of the five justifications for unsafe practices
2. Nearly half were aware of an injury or death caused by these practices
3. When employees see one of these five threats, only one in four speak up
4. Workplace silence is a primary cause of why safety risks persist in industries that already spend millions annually on standard safety training and audits

Known Cultures of Silence in Healthcare

1. Silence contributes to two million hospital-induced infections each year resulting in tens of thousands of unnecessary patient deaths
2. People remain silent as their colleagues fail to follow standard protocols
3. CDCP found healthcare professionals wash their hands only about half the number of times that policies require—a key factor in the spread of infections..... When the lead person set a bad example, not only did nurses, residents and others not speak up, they also failed to wash their hands as well

Mary G. Lankford et al., “Influence of Role Models and Hospital Design on Hand Hygiene of healthcare Workers,” *Emerging Infectious Diseases*, Vol. 9, No. 2, February 2003

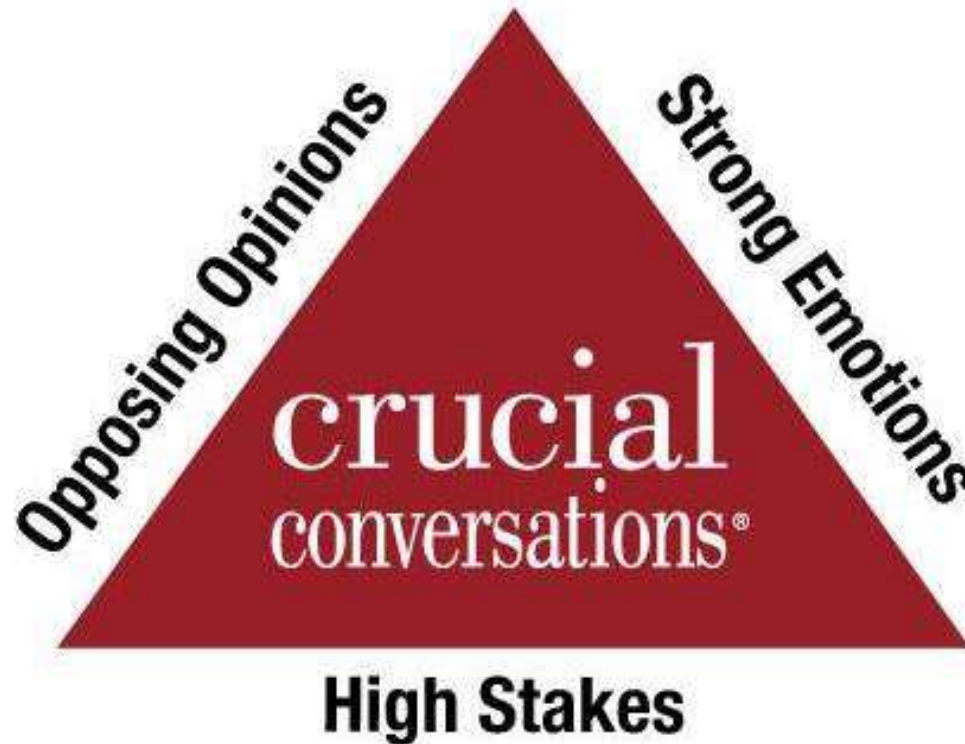
Silence Kills – VitalSmarts Healthcare Study

Study Sample: 1,700 nurses, physicians, clinical-care staff and administrators across thirteen urban, suburban, and rural US hospitals

1. Over 50 percent had witnessed co-workers break rules, make mistakes, fail to support colleagues, demonstrate incompetence, show poor teamwork, disrespect peers, micromanage and cut corners without being held to account
2. 20 percent of physicians said they had seen harm come to patients as a result of these practices
3. 23 percent of nurses said they were considering leaving their units because of these practices

NOTE: Over 190,000 people die each year in U.S. hospitals because of medical mistakes

What Is a Crucial Conversation?



Case Studies

1. Spectrum Health
2. [Maimonides Medical Centre](#)
3. Maine General Hospital

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