

## Creating A Culture of Clinical Accountability

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### What Is Culture?

“...the set of habitual and traditional ways of thinking, feeling and reacting that are characteristic of the ways a particular society meets its problems at a particular point in time.”

Clyde Kluckhohn, Anthropologist

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### Key Components of Culture

- Personal accountability for our actions
- Speaking candidly to each other about our concerns
- Transparency
- Open dialogue about medical mistakes

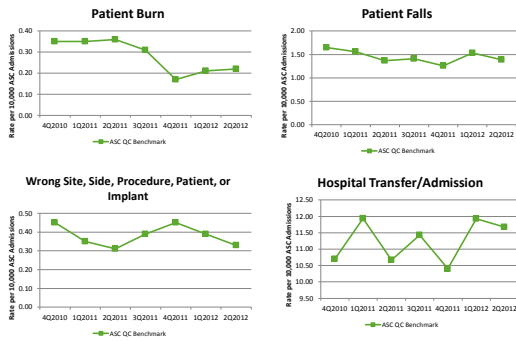
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## Facts

- Medical mistakes kill enough people each week to fill six jumbo jets
- If medical errors were a disease, they would be the sixth leading cause of death in America
- 1.3 million people are injured by and approximately 7,000 deaths occur each year in the U.S. secondary to medication errors

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## Quality Metrics Industry Trends



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It's About People

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When It Comes to Healthcare Harm,  
Good Is Not Enough

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### Why Are We Here Today?

- What does a robust culture of accountability look like?
- What barriers do we face?
- What will we specifically do to drive a culture of accountability and patient safety, as individuals and within our team?

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## Robust Culture of Accountability

- Teammates speak up
- No shortcuts
- Teamwork
- Continuous improvement
- Measurement and transparency

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## Barriers to a Culture of Accountability & Patient Safety



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“A culture that prevented effective communication of critical safety information and stifled professional differences of opinion.”

NASA

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## Silence

- Mistakes
- Broken rules
- Shortcutting
- Poor teamwork
- Incompetence

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## Incompetence

- 53% of nurses have concerns about a peers competence
- Only 12% have spoken to their peer about it
- 34% of nurses are concerned about a physician's competence
- Less than 1% have spoken to them about it

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## Why Are We Silent?

- Primary obstacles
  - Lack of ability
  - Time
  - Fear of retaliation
  - Belief that it is “not my job”
  - Low confidence that it will do any good
- Overall belief
  - Crucial conversations will lead to disaster

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## When We Do Talk

- Talk to coworkers or manager
- Goal is not to solve the problem
  - Work around them
  - Warn others about them
  - Blow off steam

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## The Results

- Unavoidable errors
- High turnover
- Decreased morale
- Reduced productivity

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## Taking It to the Next Level

- Safety culture survey
- Focused communication
- Leadership accountability

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## Safety Culture Survey

- Active participation by all team members
- Honest feedback
- Open communication on barriers to patient safety
- Example survey questions
  - I am comfortable addressing a concern about patient safety during their course of care
  - I feel I will experience retaliation if I address when something does not seem right

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## Focused Communication: Stand Down

- Best practice
- Serious situations
- Pull team off battlefield
- Domestic violence

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## What Is Patient Safety Stand Down?

- Engagement of the leader, teammates and physicians
- Held in the facility or hospital during cease in patient care
- Focus on culture of accountability and how to keep our patients safe
- Making a commitment to preventing healthcare harm

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## Leading in a Culture of Accountability

- Open communication
- Measurement and transparency
- Clear expectations
- Ownership
- Follow-up

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## Measure of Facility Success

- Zero wrongs
- Zero falls
- Zero burns
- Zero medication errors

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“We choose this, not because it is easy, but because it is hard, because this goal will serve to organize and measure the best of our energies and skills, because this challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win.”

John Fitzgerald Kennedy

THANK YOU

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