University of North Carolina Health System

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University of North Carolina Health Care System, Chapel Hill, NC
UNC Medical Center

• Public Academic Medical Center
• Memorial, Children’s, Neurosciences, Women’s and Cancer Hospital
• ~850 beds
• Chapel Hill, NC
My Role

• Patient Safety Officer since 2003

• At UNC since 1988

• Reporting structure
  – Chief of Staff – 2007 - 2014
  – General Counsel – 2014 - present
## Non-punitive Response to Error Survey Results over Time

<table>
<thead>
<tr>
<th>Survey Administration Period</th>
<th>UNC Medical Center Average % Positive</th>
<th>Database Teaching Hospitals Average % Positive</th>
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</thead>
<tbody>
<tr>
<td>2006 July</td>
<td>36%</td>
<td>41% (2007)</td>
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<tr>
<td>2008 June</td>
<td>39%</td>
<td>42% (2009)</td>
</tr>
<tr>
<td>2009 December</td>
<td>46%</td>
<td>42% (2011)</td>
</tr>
<tr>
<td>2011 October</td>
<td>48%</td>
<td>41% (2012)</td>
</tr>
<tr>
<td>2013 December</td>
<td>51%</td>
<td>42% (2014)</td>
</tr>
<tr>
<td>2015 October</td>
<td>53%</td>
<td>43% (2016)</td>
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North Carolina Just Culture Collaborative 2006/2007

• What it was – Partnership between the NC Quality Center and Outcome Engineering

• How I got involved – saw the opportunity

• Proposed the idea for participation to the Chief of Staff

• 10 NC Hospitals participated in a year-long learning and sharing experience - July 2006 to April 2007
How I pitched this to my boss

• Inexpensive consulting
• We were measuring
• Foundational, next step work
Fortuitous Serendipity
The UNC Collaborative Team

- Patient Safety Officer
- Director for Risk Management
- Attorney from the Legal Department
- Director for Employee Relations
- Human Resources Associate
- Director for Nursing Education
- Two Nurse Managers
- Pediatrician
- Anesthesiologist
The Collaborative

• Prework
  – RCA Event documentation
  – Employee Corrective Action Reports
  – Patient Safety Activity Documentation
  – Policies; Corrective Action, Sentinel Events, Adverse Event Reporting
  – Patient Safety Plan
  – Code of Conduct, Employee Handbook, Medical Staff Bylaws

• In-Person Learning/Sharing – 3 Days

• Monthly conference calls
Creating Change

• Acknowledge the shift

• Many formal communications

• Used visible support from high-profile leaders and organizations

• Education

• Weaving into the fabric of the organization

• Policy Change
Two years to change the Corrective Action Policy
Policy into Practice

• Clear expectation for use of the Just Culture Algorithm
• Mandatory training for new managers
• Visibility to all staff
• Requirements for documentation
• Employee Relations involvement
Training

• Manager and all comer training near the end of the collaborative (Feb/March 2007)
• David Marx lead training for leadership and managers (May 2007)
  – Serendipity again – Organizational “Commitment to Caring” kickoff and folding Just Culture into the strategic plan
  – Offered Continuing Nurse Education credit for managers
  – Created a “cascade learning” document for managers to guide the sharing with staff
• And since then Employee Relations leads training for all new managers
  – 1 hour concepts
  – Application practice using a case
• Frontline staff experience Just Culture
Visibility to Staff

• The algorithm – can be found displayed in most managers’ offices
Employee Counseling Session

Employee's name ________________________________ EID ________________________________

Employee's Department __________________________ Dept. No. __________________________

Employee/Supervisor Counseling Session Documentation – THIS DOES NOT CONSTITUTE CORRECTIVE ACTION.

Enter date of counseling: ________________
Enter date of incident: ________________

☐ Unacceptable personal conduct
☐ Unsatisfactory job performance

Please check all that apply: ☐ Human Error ☐ At-Risk Behavior ☐ Reckless Behavior

If you (the supervisor) believe a system problem contributed to the Human Error or At-Risk Behavior, you are obligated to submit a report to the Patient Occurrence Reporting System. If applicable, please initial here to indicate this has occurred. ___
### Sustainment Today

- Regular measurement and Focus
- Added 5 additional questions in 2015

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<td>1.</td>
<td>My supervisor emphasizes learning rather than blame when staff make mistakes.</td>
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<td>2.</td>
<td>When staff take shortcuts that put patient safety at risk, supervisors or managers work with them to change their behavior.</td>
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<tr>
<td>3.</td>
<td>Staff who see other staff doing something unsafe for patient care tell them it is unsafe.</td>
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<tr>
<td>4.</td>
<td>Regardless of a person's job position, management applies the same disciplinary policy to everyone working in this hospital, including physicians.</td>
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<tr>
<td>5.</td>
<td>When a patient safety event happens, hospital management looks at more than staff actions to determine what led to the event.</td>
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What Was and Is Most Important

- Supportive and influential leader
- The perfect learning collaborative opportunity
- Incorporating Just Culture Principles into the Corrective Action policy
- Incorporating Just Culture Principles into Counseling/Corrective action documentation
- Regular measurement and sharing