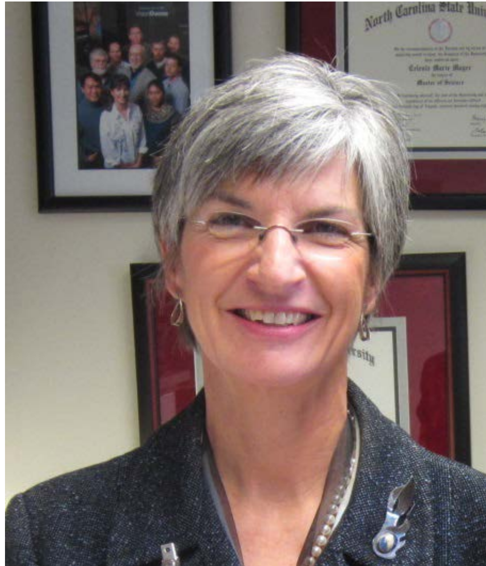
University of North Carolina Health System

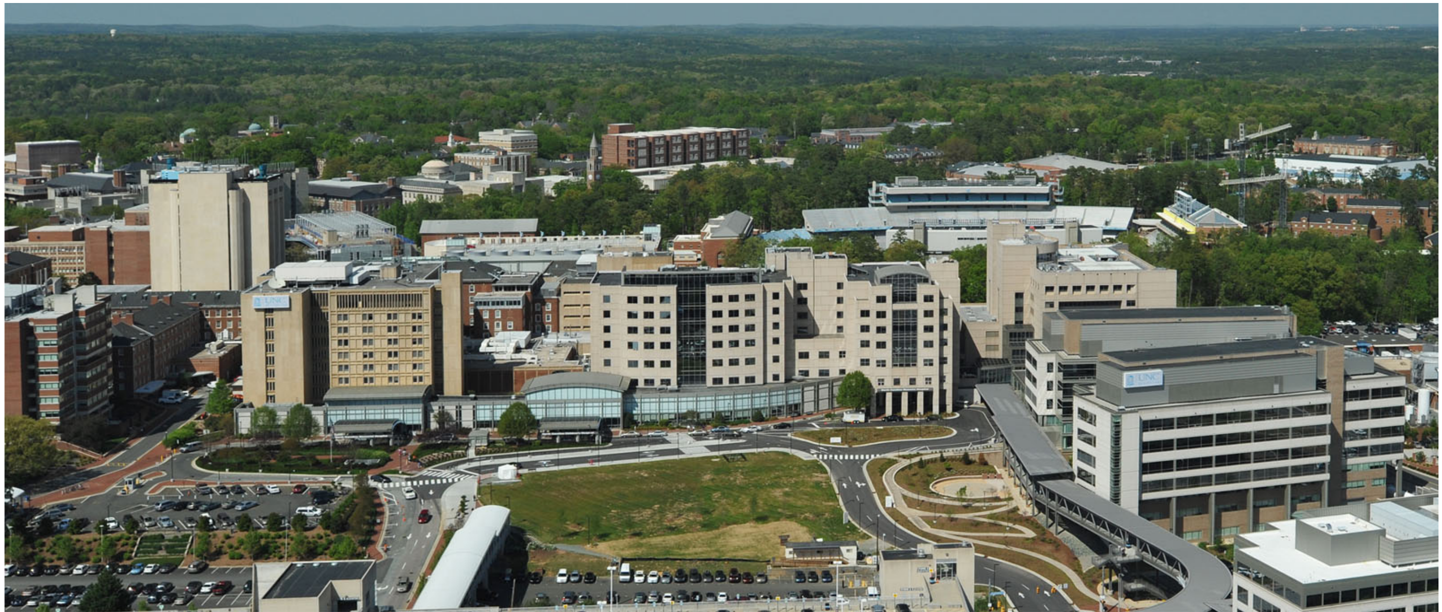


Celeste Mayer, PhD

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
  - – VP for Quality – 2003 - 2007
  - – Chief of Staff – 2007 - 2014
  - – General Counsel – 2014 - present

Non-punitive Response to Error Survey Results over Time

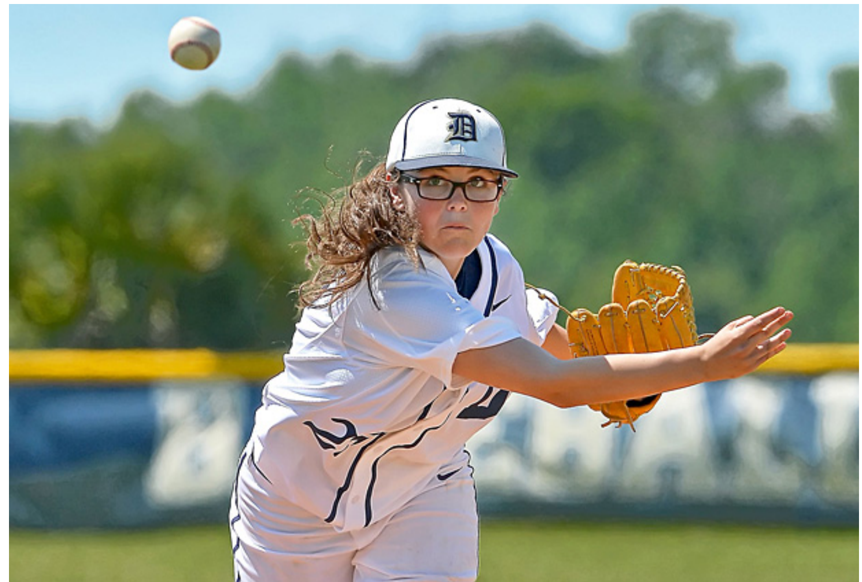
Survey Administration Period	UNC Medical Center Average % Positive	Database Teaching Hospitals Average % Positive
2006 July	36%	41% (2007)
2008 June	39%	42% (2009)
2009 December	46%	42% (2011)
2011 October	48%	41% (2012)
2013 December	51%	42% (2014)
2015 October	53%	43% (2016)

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

Practice into Policy

Two years to change the Corrective Action Policy

Policy into Practice

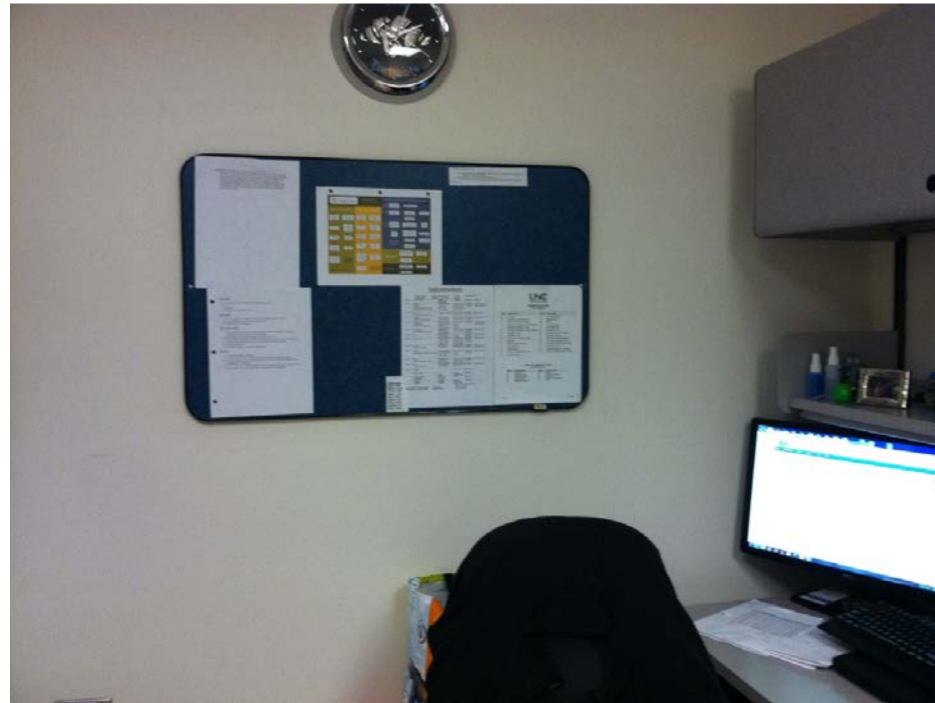
- Clear expectation for use of the Just Culture Algorithm
- Mandatory training for new managers
- Visibility to all staff
- Requirements for documentation
- Employee Relations involvement

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



The Algorithm

The Just Culture Algorithm

Simplified Version

www.justculture.org

The Duty to Produce an Outcome (system under control of employee)

- Was the duty to produce an outcome known to the employee? — No → Investigate circumstances leading to failure to know of duty
- Yes → Was it possible? — No → Investigate circumstances leading to impossibility
- Yes → Did the benefit outweigh the risks? ◢ — Yes → Support employee in decision
- No → Is the employee at an acceptable level of performance? — Yes → Accept outcome
- No → Assist employee in producing better outcomes, or consider punitive action

Note: This test applies when the employee controls the system and is responsible for the output of the system.

◢ Burden of production falls on employee

The Duty to Follow a Procedural Rule (system controlled by the employer)

- Was the duty to follow a rule known to the employee? — No → Investigate circumstances leading to failure to know of duty
- Yes → Was it possible? — No → Investigate circumstances leading to impossibility
- Yes → Did the employee knowingly violate the rule? — No → Console employee and conduct human error investigation
- Yes → Did the benefit outweigh the risks? ◢ — Yes → Support employee for decision to violate rule
- No → Did the employee have a good faith but mistaken belief that the violation was insignificant or justified? ◢ — Yes → Coach employee and conduct at-risk behavior investigation
- No → Consider remedial/ punitive action

Note: This test applies when the employee works within a system and is responsible for being a reliable component within that system.

The Duty to Avoid Causing Unjustifiable Risk or Harm

- Note: Harm not required – only the purpose to cause harm. Was it the employee's purpose to cause the harm? — Yes → Consider punitive action
- No → Note: Harm is practically certain to occur. Did the employee knowingly cause the harm? — Yes → Was the harm justified as the lesser of two evils? — Yes → Support employee in decision; No → Consider remedial/ punitive action
- No → Note: Evaluated against potential harm (i.e., risk). Did the behavior represent a substantial and unjustifiable risk? — No → Do not consider employee action
- Yes → Did the employee consciously disregard this substantial and unjustifiable risk? — Yes → Consider remedial/ punitive action
- No → Given this, should the employee have known they were taking a substantial and unjustifiable risk? — No → Do not consider employee action
- Yes → Did the employee choose the behavior? — No → Console employee and conduct human error investigation
- Yes → Coach employee and conduct at-risk behavior investigation

Note: A substantial and unjustifiable risk is one where the risk of harm outweighs the social utility of the behavior.

Repetitive Errors or At-Risk Behaviors

- Does the source of the series of human errors or at-risk behaviors reside within the system? — Yes → Investigate circumstances leading to system risk
- No → Consider remedial/ punitive action

System Test

- Does the system appear designed to achieve the results you intend? — Yes → No further action required
- No → Redesign system

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Requirements for Documentation

Employee Counseling Session

10/26/2016

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

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

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