UNC HEALTH CARE

Implementation of an Event Reporting and Learning System Leads to Improvements in Patient Safety Culture at UNC Medical Center

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Agenda

- Overview of Culture of Safety improvement within UNC Radiation Oncology
- Culture of Safety Improvement Project at UNC Medical Center
- Next Steps for UNC Medical Center

UNC Medical Center Department of Radiation Oncology

- North Carolina Cancer Hospital in Chapel Hill
- Department treats ~120 patients per day
- Approximately ~110 staff members
  - Nurses
  - Doctors
  - Physicists, Dosimetrists, Therapists
  - Administrative staff
  - Researchers

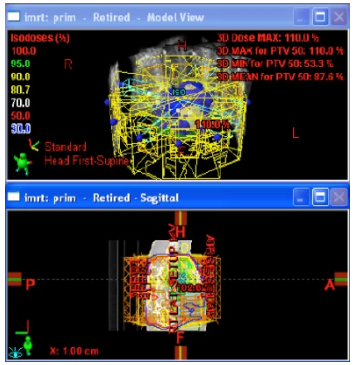
Complex Process

Time-line & Interactions with Computers

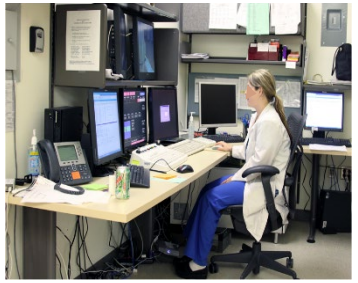
Consultation

Planning

Physics QA

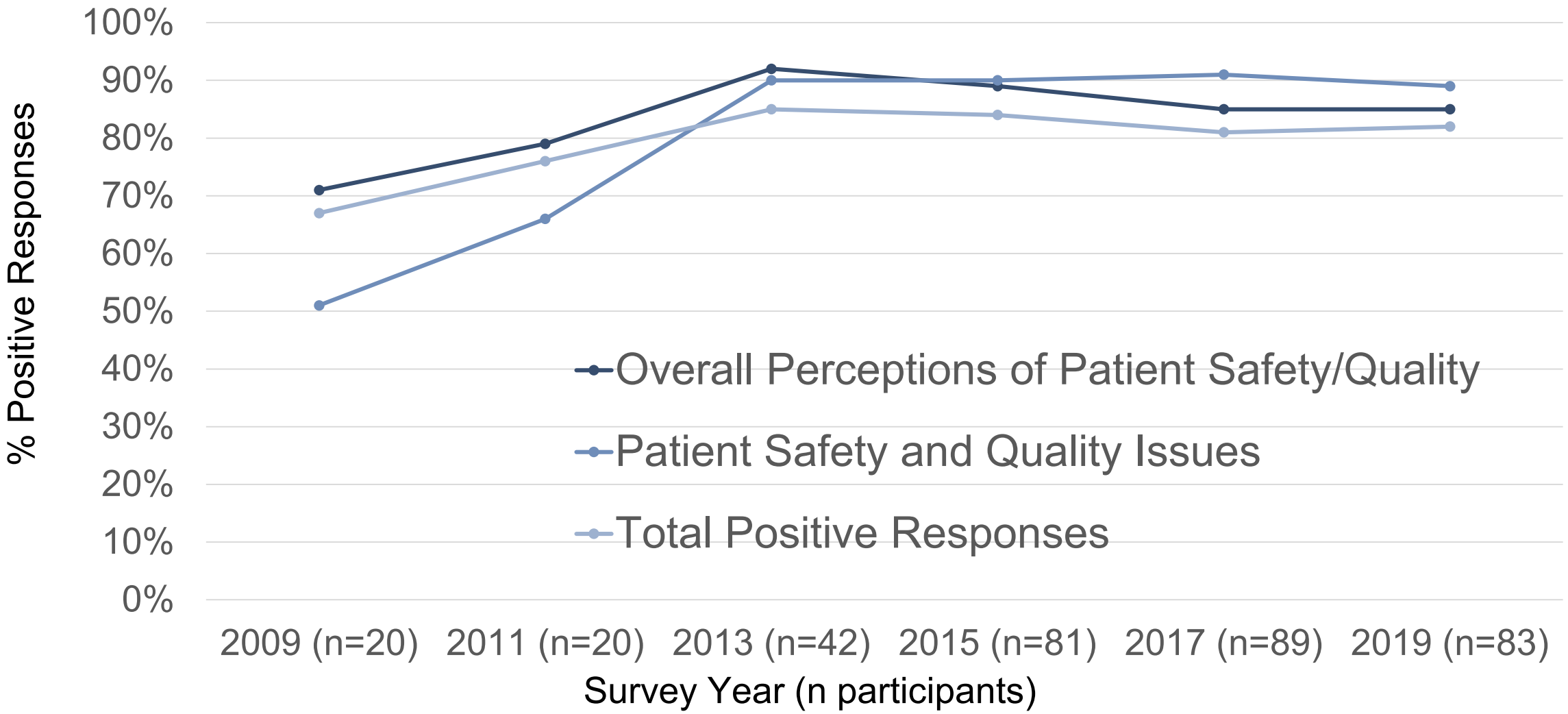


Treatment

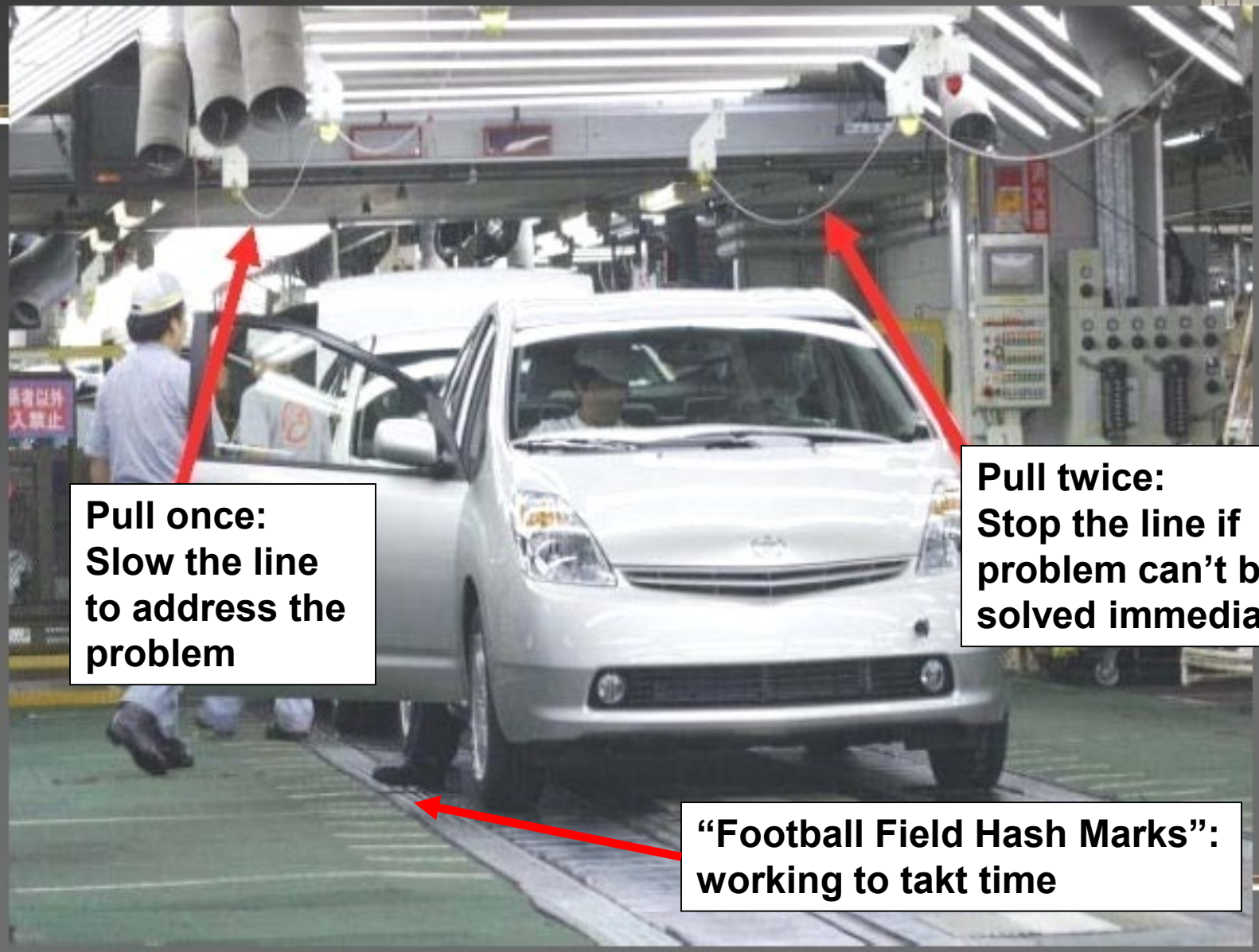


Iterations & Handoffs
IMRT case:
200+ steps,
many hand-offs

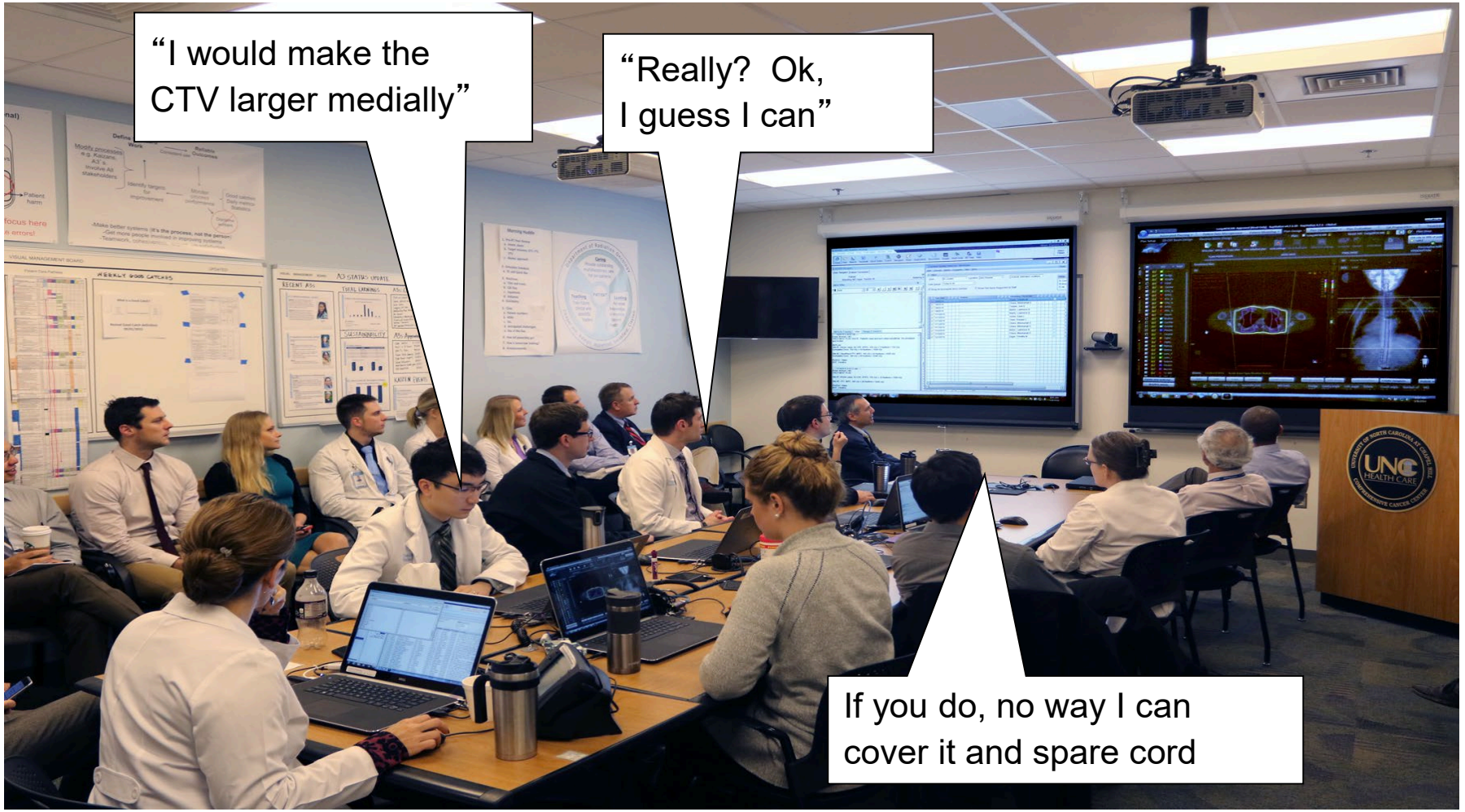
SOPS Results over time: Radiation Oncology



Stopping the line



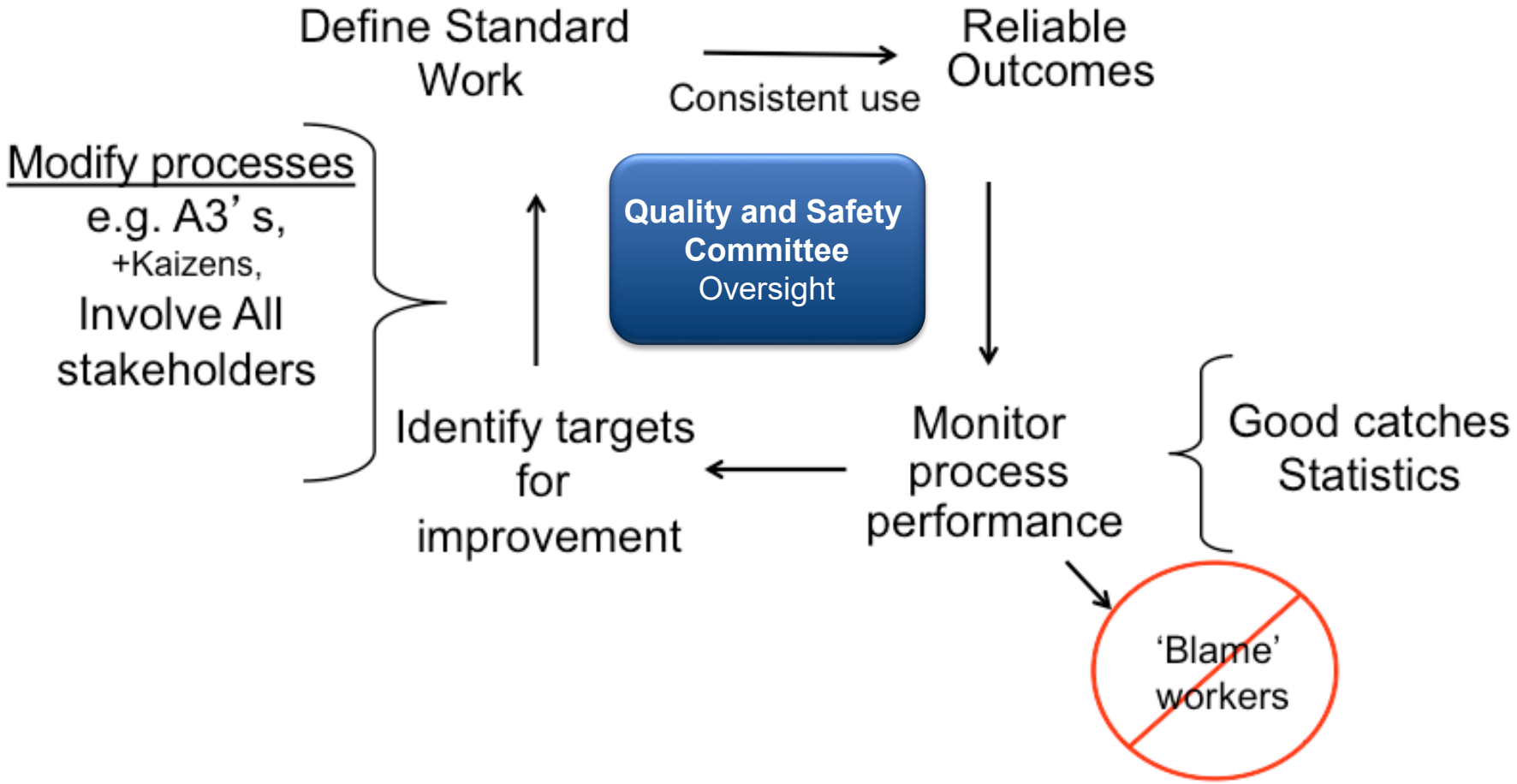
Daily Morning Conference



Psychological Safety

Safety Rounds

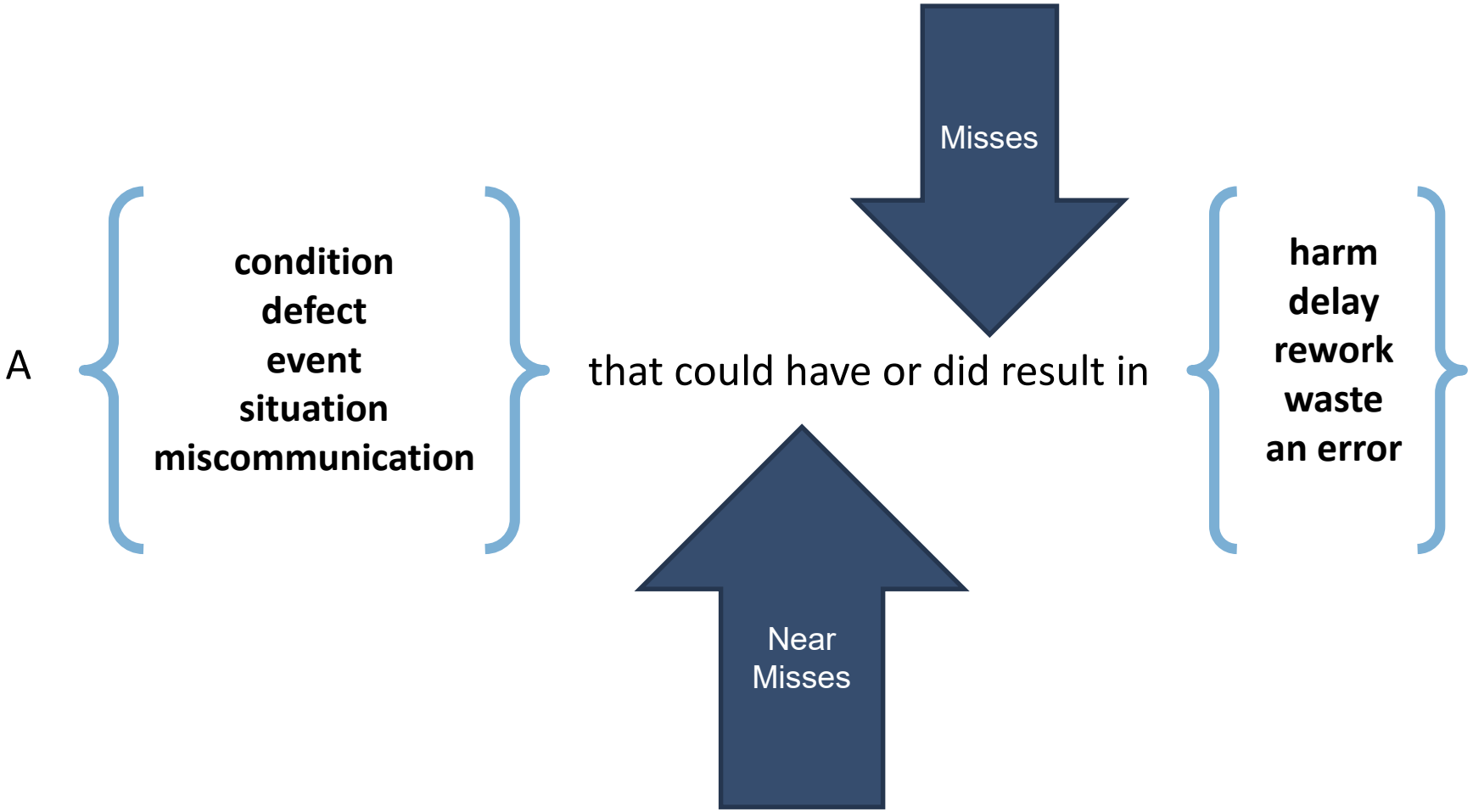
Improvement Cycle



-Make better systems (**it's the process, not the person**)
-Get more people involved in improving systems
-Team-work, cohesiveness, respect, job satisfaction

Radiation Oncology Quality and Safety Committee

Good Catch – Broad Definition



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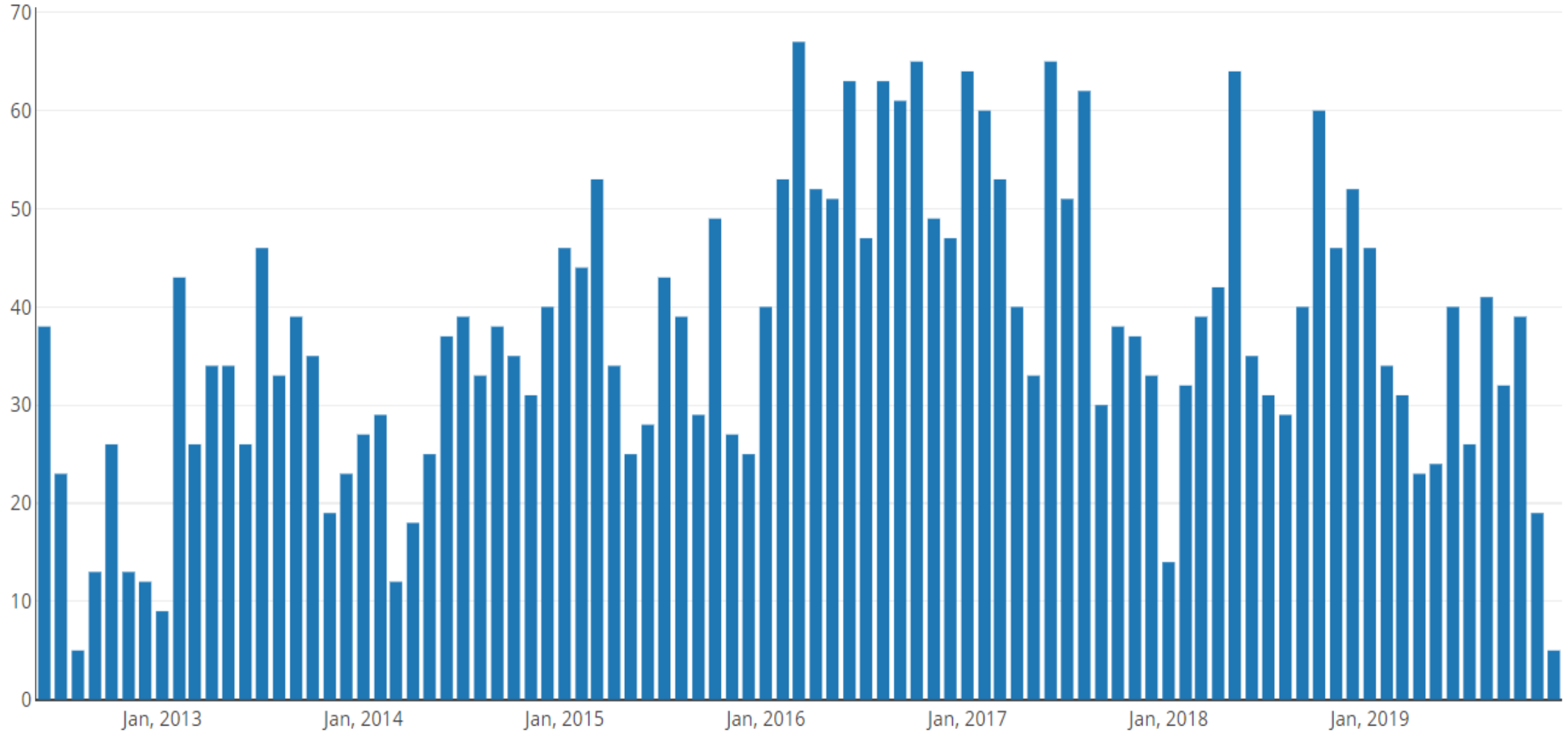
Total Monthly Submission: Radiation Oncology



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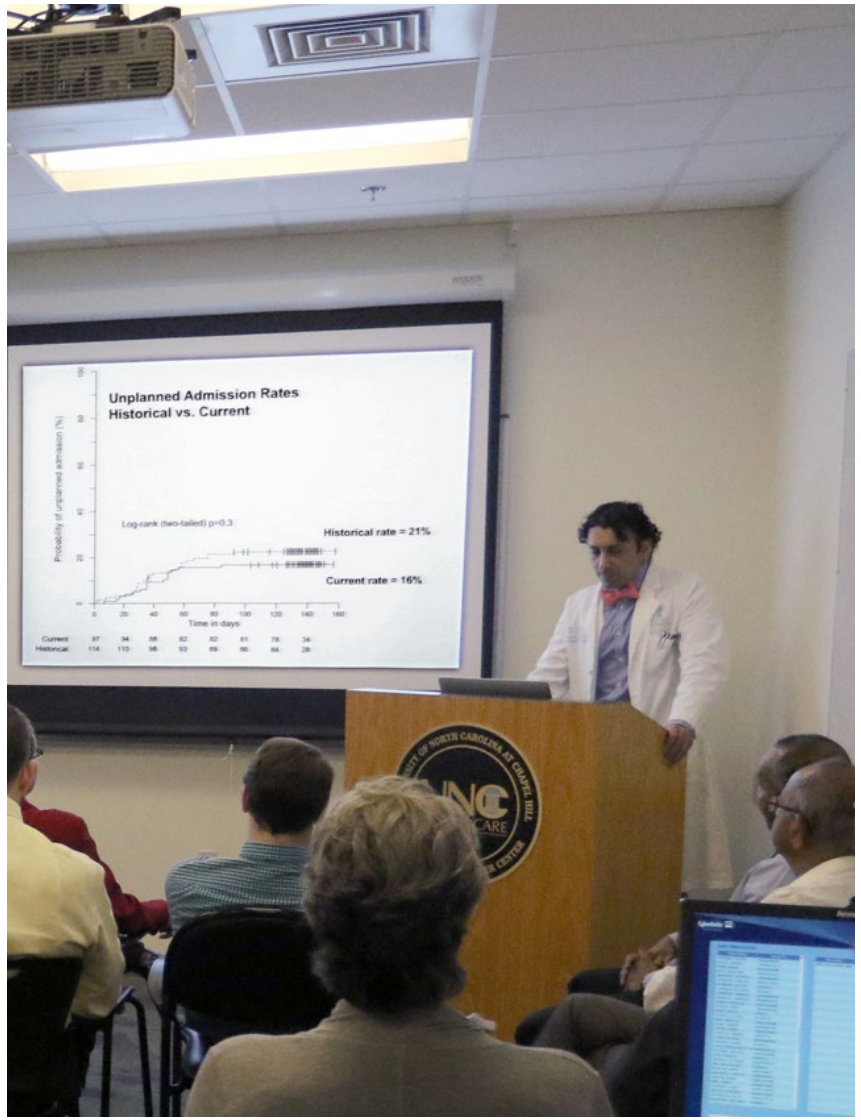
Monthly QA Meetings



Summary -- Key Components

- Dr. Marks's (Chair of the Department) vision and support
- Culture of "Stop-the-Line" (Good Catches)
- Provide psychologically safe environment and feedback
- Local *Quality and Safety Committee* with physician engagement and leadership
- Allocate time for improvement activities
  - Dedicated improvement coaches
- Celebrate improvement activities, rewards & recognition,
- Lead by example