California
Patient Safety Action Coalition

CAPSAC

PRESS RELEASE

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California Patient Safety Action Coalition (CAPSAC) Charts New Path in Preventing Medical Errors

There is a better way to reduce medical errors says new coalition of patient safety experts.

Newport Beach, Calif. — On the heels of a groundbreaking meeting of health care industry stakeholders held last month in Southern California, the California Patient Safety Action Coalition (CAPSAC) – a newly formed group of leading health care organizations and patient safety experts – is engaging medical centers, physician groups and a broad range of community health care providers this month with information and workshops on a new approach to preventing medical errors. The workshops will be held at 15 regional locations between October 22 and November 13, 2008.

"California has strict state laws that require the reporting of medical errors and a strong legal system that holds health care providers accountable for mistakes, but system errors are still occurring at an unacceptably high rate," said Theresa Manley, R.N., chair of CAPSAC. "We believe it is time for California's health care providers and regulators to lead the way and learn from other industries that have successfully reduced errors through a collaborative, cultural change in understanding the nature of how mistakes happen."

By the end of 2008, CAPSAC plans to have trained 1,000 senior health care leaders on this new approached called "Fair and Just Culture." In a "Fair and Just Culture" the emphasis is on preventing future errors through learning from mistakes, regardless of whether the mistake caused harm or not.

"Our current system of accountability for medical errors is 'no harm, no foul,'" said David Marx, a lawyer and systems engineer who developed the "Just Culture" human error prevention methods for the airline industry and has played a key role in its adoption in the health care systems of states such as Minnesota and North Carolina. "Severity of harm drives action in our culture, so a human mistake that causes significant harm will be punished more severely than reckless behavior that does not cause harm."

In trying to punish medical errors we actually discourage improving safety by creating an incentive to not report errors or near misses that do not cause harm, Marx added. He advocated moving beyond looking at outcomes of errors and instead looking at how and why errors happen. "We cannot expect humans to be perfect, and when we write rules requiring perfection, it is counterproductive," he said. "We need to assume that humans will make mistakes and create a system that intervenes before harm occurs."

S.B. 1301, a new state law that requires mandatory reporting of adverse medical events, is designed to improve health care quality in California, but for it to be effective, it needs to be implemented in a way that makes the state and health care providers partners in the goal of improving safety for patients, stated Kathy Billingsley, head of the Center for Health Care Quality, which enforces the provisions in S.B. 1301, at last month's CAPSAC conference.

"Enforcement and partnerships are both paths to improving quality," she said. "You can conduct enforcement in a way that is not adversarial."

This includes the liability area of health care, explained Maureen Archambault, RN, MBA, CPHRM, a senior vice president at Marsh Risk and Insurance Services "Our legal system allows plaintiffs' attorneys to use details of an error you share outside of your organization against you," she said. "By bringing all health care stakeholders together, we can start to tear down some of these barriers to trust that prevent the sharing of information across organizations."

One of the early adopters of "Just Culture" is the Los Angeles County Department of Health Services (DHS), which cares for 10 million people and is the second largest public health care provider in the United Sates.

"We believe that the 'Just Culture' model will provide a method of appropriate accountability that will enhance the reporting, transparency and productive response to errors, and that this will lead to system changes that will reduce the likelihood of patient harm," said Kenneth E. Aaron, M.D., DHS's corporate patient safety officer. "The L.A. County DHS is working to implement 'Just Culture' to show that it can be successfully introduced into a large, complex, publicly visible system."

CAPSAC is sponsoring regional training sessions throughout the state on how to apply a "Fair and Just Culture." For more information or to register, visit www.capsac.org. Current dates include:

Date	Location
10/22/08	India Community Center 525 Los Coches Street Milpitas, CA 95035
10/24/08	REGULATORS INVITED Sacramento Cancer Center 2800 L Street Sacramento, CA 95816
10/29/08	Commonwealth Club 595 Market Street, #2 San Francisco, CA 94105
10/29/08	Loma Linda University Medical Center 11234 Anderson Street Loma Linda, California 92354
10/29/08	St. John's Regional Medical Center 1600 N. Rose Ave. Oxnard, CA 93030
10/30/08	The Sheraton Palo Alto 625 El Camino Real Palo Alto, CA 94301
11/5/08	Long Beach Memorial 2801 Atlantic Ave. Long Beach, CA 90806
11/5/08	Good Samaritan Hospital 1225 Wilshire Boulevard Los Angeles, CA 90017
11/6/08	Wesley Palms 2404 Loring Street San Diego, CA 92109
11/7/08	REGULATORS INVITED Sacramento Cancer Center 2800 L Street Sacramento, CA
11/11/08	Washington Hospital 2000 Mowry Avenue Fremont, CA 94538
11/12/08	Hollywood Presbyterian 1300 N. Vermont Avenue Los Angeles, CA
11/13/08	Kaiser Permanente 300 Lakeside Drive Oakland, CA 94612
11/13/08	Wesley Palms 2404 Loring Street San Diego, CA 92109

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