



California Patient Safety Action Coalition (CAPSAC)

www.capsac.org

***California's Pathway to Patient
Safety
Through a Fair and Just
Culture***

California
Patient Safety Action Coalition

CAPSAC



Objectives for today

At the end of this presentation you will be able to:

- Describe the mission of the California Patient Safety Action Coalition (CAPSAC)
- Discuss three key concepts of Just Culture
- Explain how Just Culture is spreading in CAPSAC member organizations



Roundtable Meeting, June 20, 2007

California Leaders Network Alumni – Patient Safety Task Force

- Los Angeles County
Department of Health Services
- California Department of Public
Health
- Catholic Healthcare West
- HealthCare Partners
- Palo Alto Medical Foundation
- Sutter Health
- The Woodland Clinic
- Brightline/Beacon
- California Hospital Association
- California Medical Association
- Kaiser Permanente
- Lumetra
- The Doctor's Company



July 2008 Convening

A Call to Action....

California
Patient Safety Action Coalition

CAPSAC

OUR DIFFERENTIATING
VALUE-ADDED STRATEGY
IS TRANSFORMATIONAL
CHANGE.





CAPSAC Mission

To enhance patient safety and increase reporting of near misses and medical errors through promoting a Fair and Just Culture across the continuum of health care in California.

California
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CAPSAC: *VALUE PROPOSITION*

- *A common voice for a Fair and Just Culture*
- *Protection of the public from unsafe practitioners and unsafe systems*
- *Build systems for accountability for human and system errors*

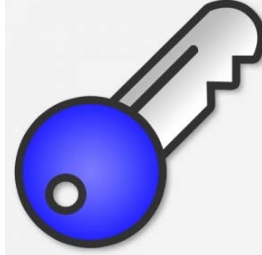
California
Patient Safety Action Coalition

CAPSAC



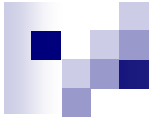
To err is human

Human Behavior



Recognize human fallibility

- Humans will make mistakes
- Humans will drift away from what we have been taught



YOU WILL NEED THE FLASH 6 PLUG-IN 

Jacques Perrin presents
WINGED MIGRATION

> ENTER

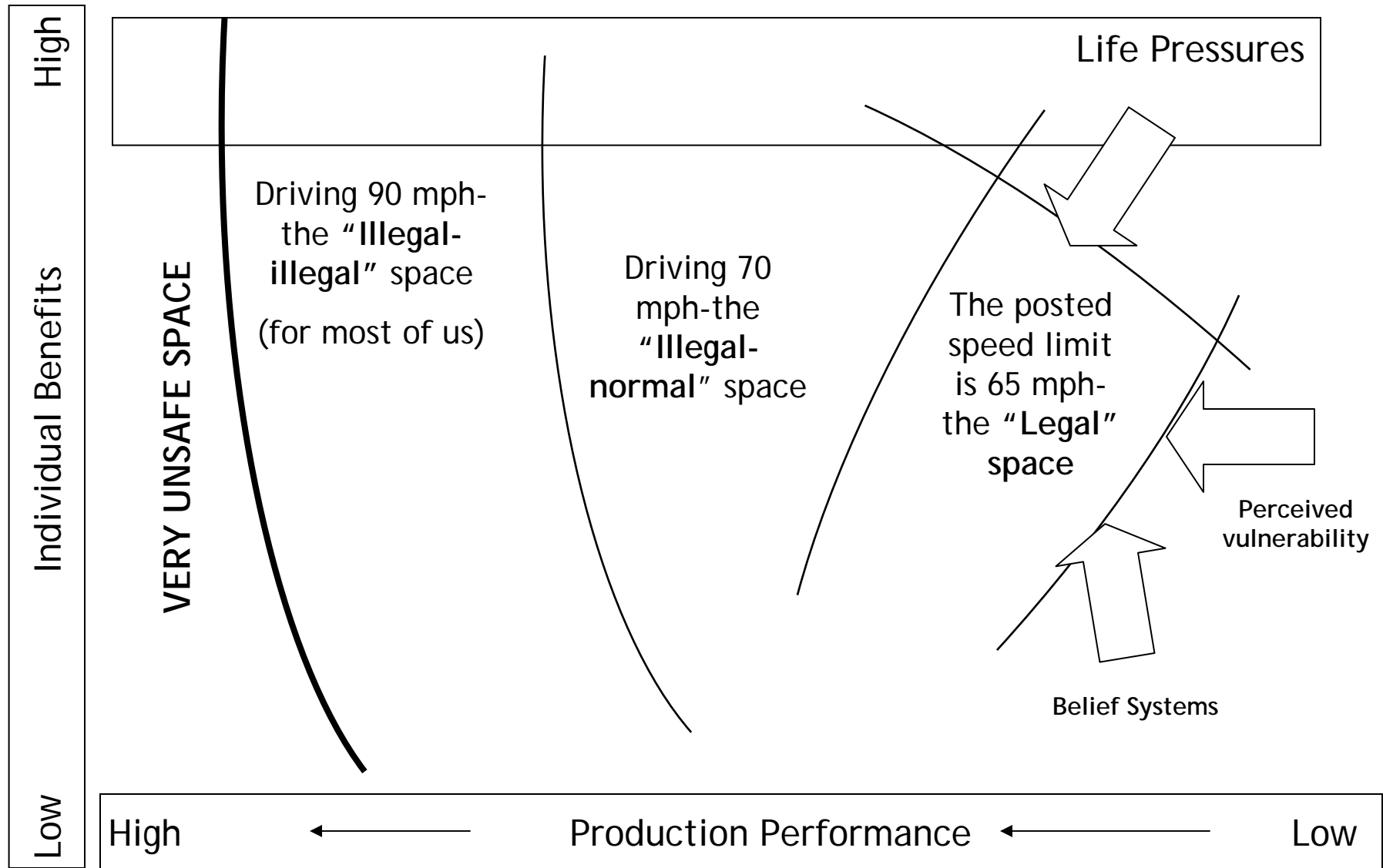
We have detected that you already have Flash

SONY PICTURES
CLASSICS

G GENERAL AUDIENCES
All ages Admitted 

SITE DESIGN AND PROGRAMMING :: THE CHOPPING BLOCK

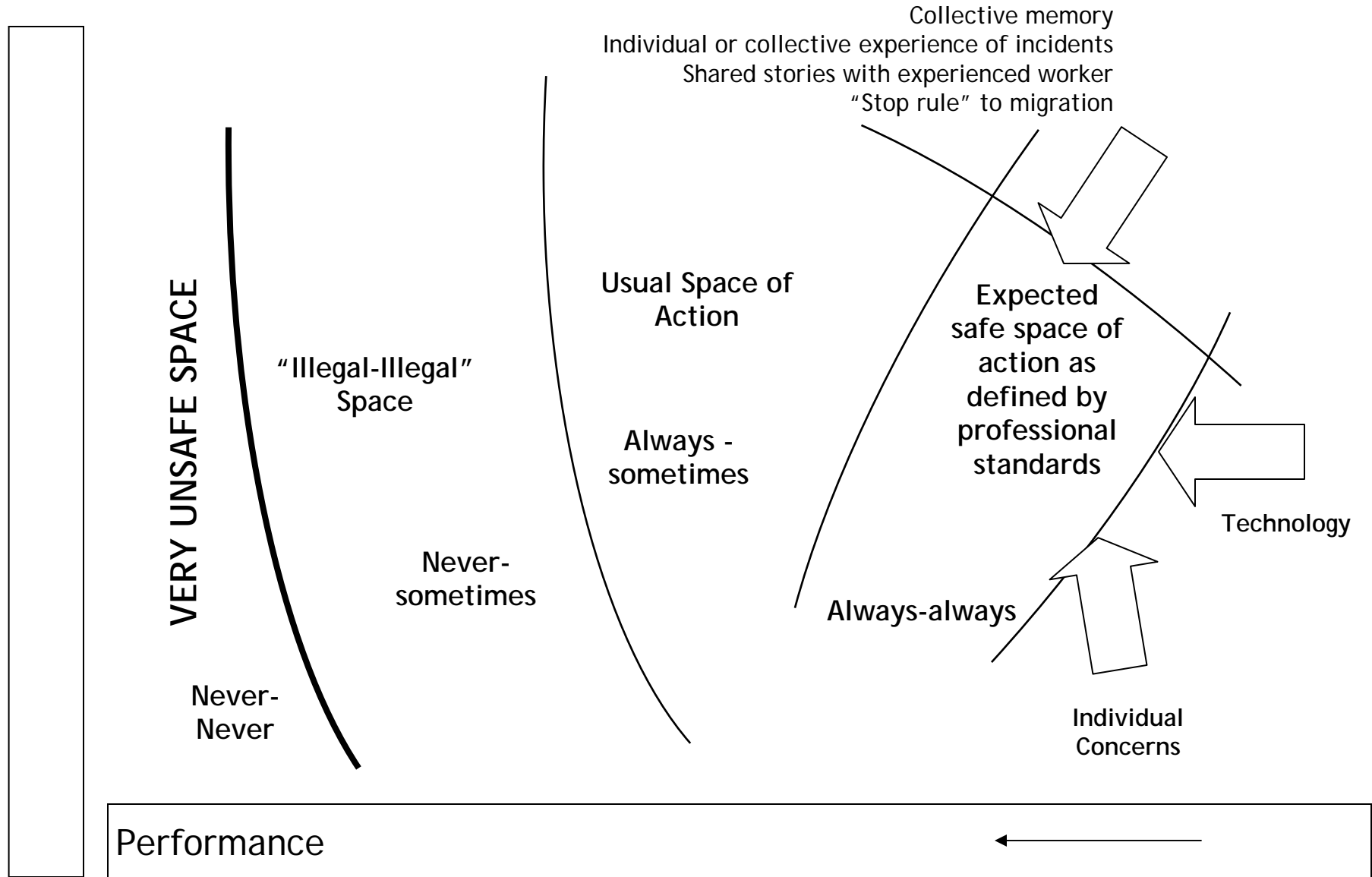
Systemic Migration to Boundaries





Road-rage speedometers

Managing Migrations and Malpractices





U.S. Hospitals: Still Unsafe and Too Often Deadly

Friday, January 09, 2009 by:

Sherry Baker, Health Sciences Editor

Cover Story

Bad Medicine



David Whelan 02.14.08, 6:00 PM ET

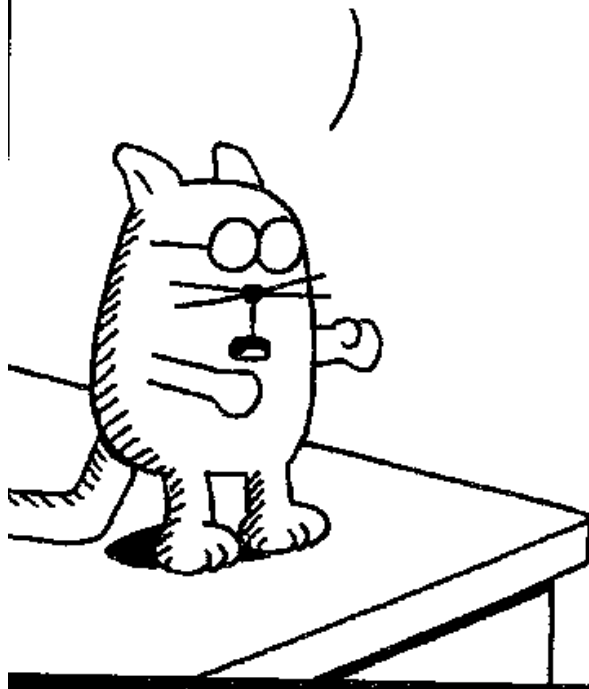
Forbes Magazine dated March 10, 2008

HOSPITALS are still the heart of the health care industry, consuming a third of the \$2 trillion annual U.S. health care bill. Some are very good. But many are not, brimming with infectious bugs, systemic errors and negative hospitality. And because the hospital industry does all it can to thwart competition, many communities are stuck with the hospitals they have. Why quality care may be better left to the emerging specialty hospitals

Design of the Socio-Technical System



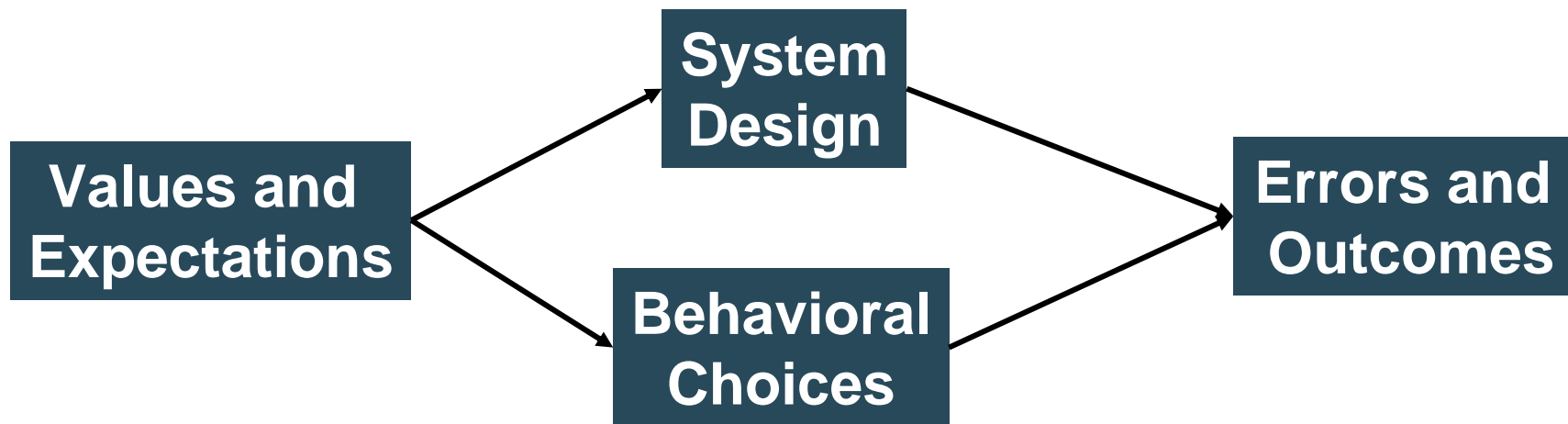
I FORGET - WHAT'S THE
WORD FOR PRETENDING
THAT PEOPLE CAN
CHANGE THEIR BASIC
NATURE?



MOTIVA-
TION?



Inputs and Outputs





The Two Key Elements of a Socio-Technical System

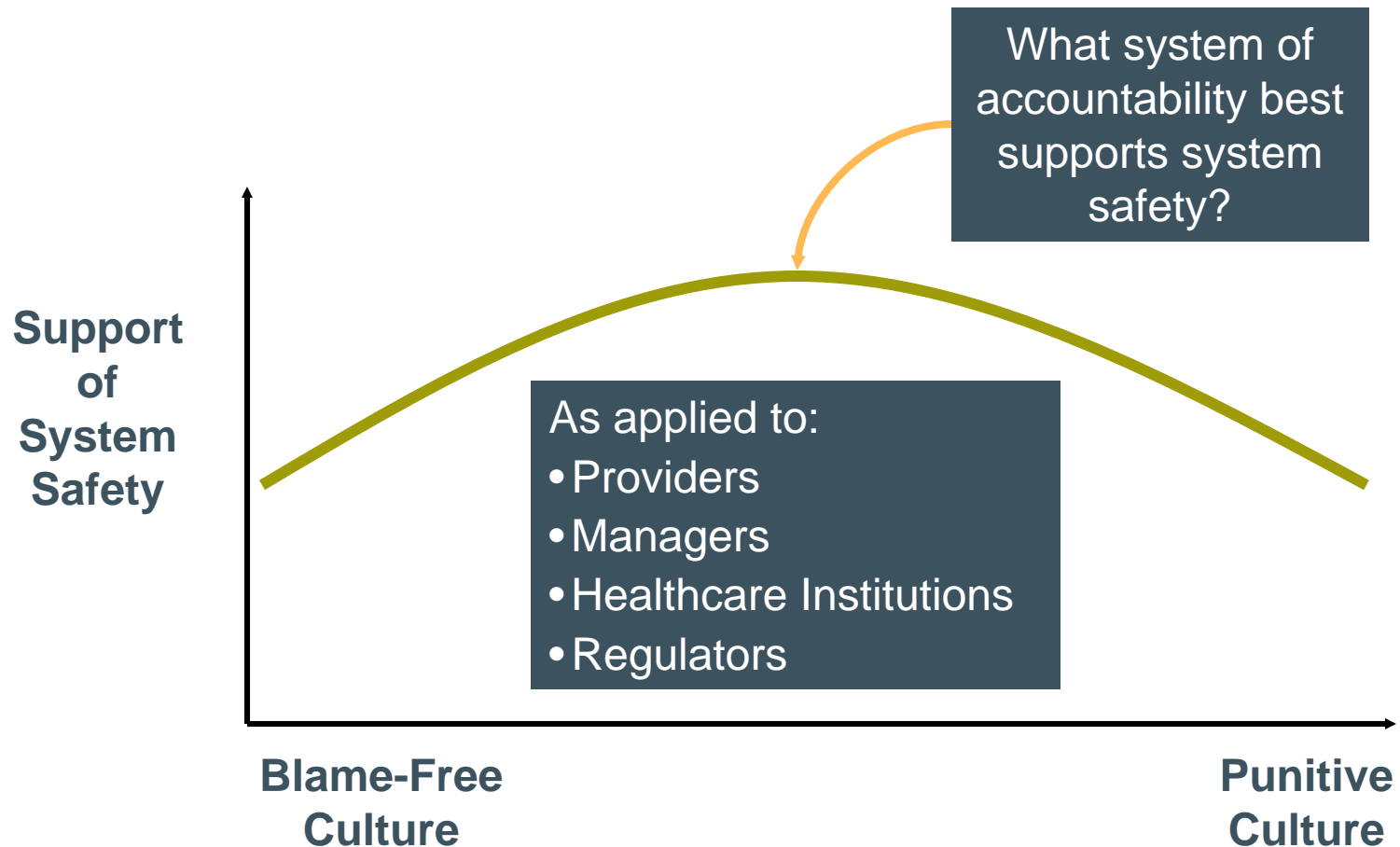
■ System Design

- Performance Shaping Factors
- Barriers
- Recovery
- Redundancy

■ The Behavioral Choices of Components within the System

- Producing outcomes
- Following procedures
- Doing the “right thing”

The Problem Statement





Justice, Accountability,
System Safety



Our Response — Human Error

- Human Error — inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake.

Console

Learn



Our Response — At-risk Behavior

- At-risk Behavior — behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.

Coach

Learn



Our Response — Reckless Behavior

- Reckless Behavior — behavioral choice to consciously disregard a substantial and unjustifiable risk.

Discipline

The Three Behaviors

<p>Human Error</p> <hr/> <p><i>Inadvertent action: slip, lapse, mistake</i></p> <p>Manage through changes in:</p> <ul style="list-style-type: none">• Processes• Procedures• Training• Design• Environment	<p>At-Risk Behavior</p> <hr/> <p><i>A choice: risk not recognized or believed justified</i></p> <p>Manage through:</p> <ul style="list-style-type: none">• Removing incentives for at-risk behaviors• Creating incentives for healthy behaviors• Increasing situational awareness	<p>Reckless Behavior</p> <hr/> <p><i>Conscious disregard of unreasonable risk</i></p> <p>Manage through:</p> <ul style="list-style-type: none">• Remedial action• Punitive action
<p>Console</p>	<p>Coach</p>	<p>Discipline</p>

Outcome bias...

- *No harm ... no foul*
- *Professional bias.....*





Just Culture Model

- Event investigation—closing the gap
 - Direct cause
 - Cause of behavioral choice
 - Cause of human error
- Just Culture Algorithm
- Managers Training
- Executive/Champion training
- Staff training



3. Each human error has preceding cause

Safe Choice Edit

Click here to find Name Person (Consoled/Coached/Counseled): Phone:

Type:
Human Error
At Risk Behavior
Knowingly Unsafe Behavior

Safe Choices Manager Action

No Action Taken
 Consoled, further action required
 Consoled, no further action required

Factors increasing the likelihood of human error:

- Staff knowledge or skill
- Other staff performance shaping factors (e.g. stress, fatigue)
- Unaware of procedure or protocols (e.g. medication administration)
- Communication (e.g. between staff, between shifts)
- Equipment or tools (e.g. complex, confusing)
- Clinical products (e.g. drugs, stint)
- Patient factors (e.g. physiology, compliance)
- Environment/facilities (e.g. room availability)

Short description of the human error:

Rule 3 – each human error must have a preceding cause

4. Each violation has a preceding cause

Safe Choice Edit

Click here to find Name Person (Consoled/Coached/Counseled): Phone:

Type:
Human Error
At Risk Behavior
Knowingly Unsafe Behavior

Safe Choices Manager Action

No Action Taken
 Coached, further action required
 Coached, no further action required

Factors involved in the at-risk behavior:

- Low perception of risk
- Difficult to comply with rule
- Other priorities contributing to the non-compliance with

Frequency of the at-risk behavior:

- Individual Norm
- Common practice/local group norm

Short description of the at-risk behavior:

Rule 4 – each violation must a preceding cause



Webinars

<http://futurehealth.ucsf.edu/Program/Default.aspx?alias=futurehealth.ucsf.edu/Program/chcf>



CAPSAC Today

- Association of California Nurse Leaders
- Barton Memorial Hospital
- Brightline/Beacon
- BETA Healthcare
- California Children's Hospital Association
- California Department of Managed Health Care
- California Department of Public Health
- California HealthFirst Physicians
- California Hospital Association
- California Hospital Patient Safety Organization (CHPSO)
- California Leaders Network Alumni-Patient Safety Task Force
- California Medical Association
- California Primary Care Association
- California Society of Pediatric Dentistry
- CAPG
- Catholic Healthcare West
- Cedar Sinai Medical Center
- Children's Hospital Central California
- Children's Hospital Los Angeles
- City of Hope
- Clovis Community Medical Center
- Community Clinics of Santa Clara and Contra Costa Counties
- Community Health Councils
- Community Medical Centers
- County and Safety-Net Provider Organizations
- The Doctor's Company
- El Centro Regional Medical Center
- Glendale Adventist Medical Center
- Good Samaritan Hospital San Jose
- HealthCare Partners
- Hoag Memorial Hospital Presbyterian
- Hospital Association of San Diego and Imperial Counties
- Hospital Association of Southern California



CAPSAC Today (continued)

- Hospital Council
- Hospital Council of Northern and Central California
- Kaiser Permanente
- Kaweah Delta Health
- Little Company of Mary Hospital
- Long Beach Memorial Medical Center
- Los Angeles County Department of Health Services
- Los Angeles County Rancho Los Amigos National Rehabilitation Center
- Lumetra
- Marsh Risk and Insurance Services
- Methodist Hospital
- Motion Picture & Television Fund
- O'Connor Hospital
- Office of the Patient Advocate
- Palo Alto Medical Foundation
- Patients First Consulting
- Petaluma Valley Hospital
- Redlands Community Hospital
- Salinas Valley Memorial Healthcare System
- San Francisco General Hospital
- Santa Rosa Memorial Hospital
- Scripps Healthcare
- Sharp Healthcare
- St. Francis Medical Center
- St. Joseph Health System
- Stanford Hospital and Clinics
- Sutter Health
- Sutter VNA and Hospice



CAPSAC 2009-2010 Goals

- Continue to spread Just Culture
 - Regional trainings late summer/early fall
 - Signed statement of support for a statewide culture of learning justice and accountability
- Engage physician organizations
- Outreach to the public/media



CAPSAC Member Organizations and Just Culture Implementation

- St. Joseph Healthcare System
- Catholic Healthcare West (CHW)
- Scripps Health
- Sharp Health
- Palo Alto Medical Foundation
- Sutter Health



More information

- www.capsac.org

California
Patient Safety Action Coalition

CAPSAC

I'M GOING INTO
THE FALSE HOPE
BUSINESS.

