

Louisiana Hospital Association

WEBINAR

Patient Safety and the "Just Culture:" A Primer for Health Care

Wednesday, October 6, 2010 9:00 a.m. – 10:30 a.m. (Central Standard Time)

Purpose:

Preventable medical errors are actually on the risk by 1% per year according to the 2010 revised National Quality Forum (NQF) publication on 34 Safe Practices for better healthcare. There are 18 types of medical errors that account for \$2.4 million extra hospital days and \$9.3 billion in excess care. This Webinar will cover the patient safety issues along with CMS Hospital Conditions of Participation (CoP) and the Joint Commission requirements on patient safety, what hospitals need to do to create a patient safety culture, the balance of a non-punitive environment for medical errors with the Just Culture theory. Also covered will be the patient safety recommendations of the revised 2010 NQF 34 Safe Practices.

Target Audience:

Patient Safety Team Members, Patient Safety Officer, Quality Management Coordinator, Joint Commission Coordinator, Nurse Educator, Chief Nursing Officer, Nurse Managers, Risk Manager, Hospital Legal Counsel, Physicians, VP of Medical Staff, Consumer Advocate, CEO, Compliance Officer, Pharmacist and anyone else involved in improving patient safety in healthcare facilities.

Fee:\$225.00 LHA Member Rate\$275.00 Non-Member Rate(includes one phone line per site)(includes one phone line per site)Additional phone lines will be billed at the LHA Member/ Non-Member rate.Advance registration is REQUIRED to ensure delivery of instructional materials.

Objectives

- Describe the CMS hospital CoP requirements including that near misses must be included in the definition of what constitutes a medication error.
- Discuss the Joint Commission requirements for the patient safety program including that a FMEA must be done every 18 months.
- Recall that the 2010 34 Practices for Better Healthcare recommendations including that a culture survey should be done.
- Recall that AHRQ has published 10 patient safety tips for hospitals.
- Discuss the system analysis theory and that there should be a non-punitive system for system failures.
- Discuss what is meant by Just Culture.

<u>Faculty</u>

Sue Dill Calloway, MSN, JD, RN, Director of Hospital Patient Safety, The Doctors Company. Sue Dill Calloway earned an Associate Degree, BSN and MSN in nursing (summa cum laude), a BA degree, and a law degree (Juris Doctor with honors from Capital University. In addition to being a licensed attorney, Mrs. Dill has been an adjunct professor with the College of Nursing for 17 years, has many years of experience as an emergency department nurse and nurse manager of multiple hospital departments, has been VP of Legal Services for a community hospital, and served as the Director of Risk Management for the Ohio Hospital Association. She has been a consultant with many state hospital associations and national organizations. Mrs. Dill also provides for-profit services for hospitals, writes numerous newsletters, and develops resources for ambulatory surgery facilities.

Webinar Topics

- CMS hospital CoP standard on non-punitive environment
 - Requirement for voluntary non-punitive environment
 - o Medication errors and adverse drug events
 - Must include near misses or close calls
 - Corrective actions to prevent reoccurrences.
- TJC leadership standards on non-punitive behavior and organization safety standards, system performance and culture survey
 - Patient safety program requirements
 - Near misses or close calls
 - FMEA and RCA requirements
 - Patient safety plan and scope of the program
 - System or process failures
 - Sentinel event requirements
 - External reporting of significant adverse events
- National Quality Forum 2010 34 Safe Practices for Better Healthcare standard on culture of safety
 - Leadership structures and systems
 - o Patient safety program and patient safety officer
 - Patient safety committee
 - o Board responsibility in patient safety
 - Two toolkits for leadership on walk abouts
 - Culture measurement
 - Just culture theory as a balance
- The IOM Study on Medical Errors
- Patient safety issues
- Other names for medical error
- Error prevention and just culture
- Establishing a culture of safety
- High reliability organizations
- Key features of culture of safety (AHRQ)
- AHRQ Patient Safety Primer on Safety Culture
- 10 domains of patient safety
- AHRQ 10 Patient Safety Tips for Hospitals
- Human factor engineering
- Root cause analysis
- Active vs. mistakes
- Patient safety outcomes
- Culture of safety components
- Developing a culture of safety
- High reliability organizations

Nursing Contact Hours

1.8 Nursing Contact hours will be awarded upon completion of this webinar.

Instructions will be given at the conclusion of the Webinar on how to obtain certificate.

Note:

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Sign in/Log on instructions will be sent to the registrant several days prior to the Webinar.



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WEBINAR REGISTRATION

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	\$275.00 Non-Member Rate (includes one phone line per site) Additional phone lines will be billed at \$249.00.
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Make check p	payable and mail to: Louisiana Hospital Association Management Corp. 9521 Brookline Avenue, Baton Rouge, La 70809-143 ⁻ Phone: (225) 928-0026 Fax: (225) 923-1004

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