Louisiana Hospital Association

WEBINAR

Just Culture and Non-Punitive for Healthcare Errors

Tuesday, July 9, 2013

9:00 a.m. – 10:30 a.m. (Central Standard Time)

Purpose:
Preventable medical errors are actually on the rise by 1% per year according to the National Quality Forum 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 dollars in excess care. A November 2010 Office of Inspector General (OIG) study found that 15,000 Medicare patients every month experience an adverse event during healthcare delivery that results in death. One of every seven discharges (13.5%) results in an adverse event. This webinar will cover the patient safety issues along with CMS Hospital CoP, on punitive environment and reporting of medication errors, adverse events and drug incompatibilities and the Joint Commission requirements on patient safety and a non-punitive environment. The 2013 toolkit on Just Culture by AHRQ will also be discussed. CMS will start reporting each hospital's scores and reduce payments by 1% to hospitals with the highest rate of medical errors and infections in 2015. Hospitals should start evaluating ways to proactively reduce errors and adverse events.

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 **Failure Mode and Effect Analysis** (FMEA) must be done every 18 months
- Recall that the 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 environment for system failures
- Discuss what is meant by Just Culture

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.

Who Should Attend:
Patient Safety Team Members, Patient Safety Officer, Quality Management Coordinator, Joint Commission Coordinator, Nurse Educator, Chief Nursing Officer, Nurse Managers, Nurse Educators, Risk Manager, Hospital Legal Counsel, Physicians, VP of Medical Staff, Consumer Advocate, Nurse Managers, Nurse Supervisors, Clinic Managers, Nurses, CEO, Chief Operating Officer, Patient Safety Committee Members, Department Directors, Compliance Officer, Pharmacist, Pharmacy staff, Compliance Officer and anyone else involved in improving patient safety in healthcare facilities.

Faculty:
Sue Dill Calloway, RN, Esq. CPRHM, AD, BA, BSN, MSN, JD, Attorney at Law
President of Patient Safety, Healthcare Consulting and Education Company
Sue Dill Calloway has been a nurse attorney and consultant for more than 30 years. Currently, she is President of Patient Safety and Healthcare Education and Consulting and also the Chief Learning Officer for the Emergency Medicine Patient Safety Foundation. Prior to Sue's current role, she was the director of hospital patient safety for The Doctors' Company and OHIC Insurance Company. She has done many educational programs for nurses, physicians, and other healthcare providers. Sue has authored over 100 books and numerous articles. She is a frequent speaker and is well known across the country in the area of healthcare law, risk management, and patient safety. **The speaker has no real or perceived conflicts of interest that relate to this presentation and there will be no discussion of unlabeled uses of drugs/devices.*

Contact Hours:
Nursing participants: This webinar has been approved for 1.8 contact hours by the Iowa Board of Nursing Approved Provider Number 339. Completion of offering required prior to awarding certificate.
All other participants: Must attend the entire Webinar and complete a Webinar critique to receive a 1.5 Hour Attendance Certificate for each program.

Instructions will be given at the conclusion of the webinar on how to obtain your contact hour.

Webinar Topics:

- CMS hospital CoP standard on non-punitive environment
    - Requirement for voluntary non-punitive environment
    - CMS memo March 2013 on reporting to PI program and AEs
    - AHRQ Common Formats
    - Standard revised Tag 508 in 2011 and 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 and LD chapter requirements
    - External reporting of significant adverse events
- National Quality Forum 34 Safe Practices for Better Healthcare standard on culture of safety
    - Leadership structures and systems
    - Patient safety program, patient safety officer and patient safety committee
    - Board responsibility in patient safety
    - Two toolkits for leadership on walk-abouts and culture measurement
- Just Culture theory as a balance
    - AHRQ 2013 toolkit
    - Just culture principles
- OIG Study on adverse events with Medicare patients
- CMS reduction of 1% for hospitals with highest rate of medical errors and infections
- The IOM Study on Medical Errors
- Patient Safety Issues
- Definition of Patient Safety
    - AHRQ definition
- 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
- System Approach
- Human factor engineering
- Root cause analysis
    - CMS Worksheet and 3 RCAs for hospitals
- Active verses latent conditions
- Errors at the sharp end verses the blunt end
- Slips verses mistakes
- Patient safety outcomes
- Human error
- Culture of safety components
- Developing a culture of safety
- High reliability organizations
- Patient safety rounds or walk abouts

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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 $250.00.

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