

Culture of Safety: Moving to Accountability

8-Part Audio Conference Series

Often overlooked, patient safety has far-reaching implications to the modern hospital. Adverse events impact families, staff, reputations and may result in lengthy legal battles. The Joint Commission has made addressing the problem of a “blame free” culture a priority and CMS is no longer reimbursing certain hospital-acquired conditions.

Nov. 2009 was the 10th anniversary of the Institute of Medicine’s report *To Err Is Human*. This seminal report launched the modern patient safety movement. Many organizations are evaluating their patient safety efforts and results and are moving from a strict “blame free” culture toward a culture of accountability.

This series is filled with helpful guidelines and ideas to help your hospital improve its patient safety processes.

Objectives

The series of teleconferences will build upon each other to cover many aspects of how accountability may affect patient safety.

1. The participant will be able to describe the differences between “blame free” and accountability in the culture of safety.
2. The participant will develop an understanding of legal liabilities associated with hospital-acquired conditions.
3. The participant will be able to identify multi-disciplinary strategies to ensure accountability when implementing patient safety processes.

Intended Audience

Individuals involved or responsible for nursing, case management, social work, physicians, patient safety, pharmacy, risk and/or quality management.

Registration

Special offer: buy the series and get 24/7 On Demand access to the whole series for 8 months after the last program airs!

Registration fee is \$199 per session/per line or \$1499 for all eight sessions. One or more individuals from the same institution may participate for the same fee. The registration fee is charged per phone line occupied. You can access the online registration form at:

<http://www.ohanet.org/Events>

Cancellation

A refund of registration fees will be made to those registrants notifying OHA of cancellation at least three (3) working days prior to program date. A \$40 processing fee will be assessed against each refund. No refunds will be made after this date.

Continuing Education

The Ohio Hospital Association Research and Educational Foundation (OLN-0017-P) is approved as a provider of continuing education by the Ohio Board of Nursing through the approver unit at the Ohio League for Nursing (OBN-006-92) and provider unit approval is valid through May 31, 2011.

Schedule

Each session will be one hour in length beginning at 11:30 a.m. Eastern Time. While intended to be viewed as a series, sessions will still be valuable if viewed individually.

Overviews on page two

Series Dates/Topics/Speakers

February 10, 2010

Culture of Safety: Moving to Accountability

Lisa Klenke, MBA, RN

March 10, 2010

Contributing to a Culture of Safety by Preventing Ventilator Associated Pneumonia

Jody Mullen, MS, RN, BC, CCRN, CCNS
Karen Beekman, RNC-NIC, BSN

April 14, 2010

Diagnostic Errors: Communication of Test Results

Susan Blasik Miller, JD

July 14, 2010

Minimizing Radiation Risk/Overuse

R. Edward Hendrick, PhD.

August 11, 2010

Relating Safety Culture to Medication Errors

Kelly Stanforth, Pharm.D., FISMP

September 8, 2010

Pressure Ulcers

Patricia Rondaris Danzey, RN, MSN, MBA

October 13, 2010

Moving the Culture of Accountability in the Prevention of Central Line Associated Blood Stream Infections

Amy Imm, MD, MMM, FCCP

November 10, 2010

High Risk Medications or High Risk Behaviors?

Kathy Crea, Pharm.D., BCPS

Brief Summaries of Programs

Culture of Safety: Moving to Accountability

Lisa Klenke will speak to the culture of accountability as an overview and provide several practical examples. Attendees will be able to define accountability and how it applies to every level of healthcare service and every provider. Attendees will understand why a culture of safety includes accountability as well as system changes.

Contributing to a Culture of Safety by Preventing Ventilator Associated Pneumonia within the PICU and NICU

Karen Beekman and Jodi Mullen will discuss specific examples and cite best practices for reducing or eliminating Ventilator Associated Pneumonia within the NICU. Attendees will be able to identify multidisciplinary strategies for implementing a safety improvement process and will be able to describe a patient care initiative to decrease VAP.

Diagnostic Errors: Communication of Test Results

Susan Blasik Miller will give a background on Ohio law pertaining to the dissemination of test results to patients. She will tie the topic to accountability for all health care professionals when communicating with patients. Attendees will understand the legal liability associated with failure to properly communicate test results to patients.

Minimizing Radiation Risk/Overuse

R. Edward Hendrick will discuss the use of radiation in today's medical practice and the accountability professionals should hold when ordering or administering imaging tests. Attendees will be able to describe the doses and risks of medical imaging procedures that use radiation and to place those risks in perspective of other risks encountered in daily life. Attendees will be able to discuss options for reducing dose and use of ionizing radiation and lowering radiation risks without sacrificing quality in medical practice.

Relating Safety Culture to Medication Errors

Kelly Stanforth will share with participants the risks medication errors present to professionals and best practices of reducing errors using interdisciplinary techniques. Attendees will understand the concepts of a Just Culture as it relates to investigation of medication errors and fair treatment of the clinicians involved in errors. Attendees will also learn how to use results of a department level safety culture survey with the goal of improving results.

Pressure Ulcers: Accountability of health professionals in eliminating Pressure Ulcers

Patricia Rondaris Danzey will explain key techniques to reduce/eliminate unnecessary pressure ulcers from participants' medical practice. Participants will be provided with examples of non-reimbursable CMS events pertaining to pressure ulcers. Attendees will be able to explain a multidisciplinary best practice implementation technique for reducing pressure ulcers in their clinical environment

Moving the Culture of Accountability in the Prevention of Central Line Associated Blood Stream Infections

Amy Imm will focus much of the time on implementing performance metrics to build a culture of accountability in response to the need for reduction of CLABSI house wide. She will emphasize the need for reduction in vulnerable patient populations outside the ICU. Attendees will review the evidence based elements of care associated with reductions in hospital wide CLABSI. They will also review methods of assuring compliance by the development of performance metrics in the reduction of CLABSI.

High Risk Medications or High Risk Behaviors?

Kathy Crea will provide participants with examples of human factors that go into medication errors. She will explain how reductions can be made via performance and accountability measures. Participants will understand how high risk behaviors and human behaviors contribute to medication errors. Attendees will discuss how principles of a High Reliability Organization relate to prevention of medication errors.