NCPS
Nebraska Coalition for Patient Safety

NCPS Mission: To continuously improve the safety and quality of healthcare delivery in the region.

NCPS Update: June 2024

A Message from the Patient Safety Program Director

Carla Snyder, MHA, MT(ASCP), SBB, CPHQ

Emily and I were fortunate in being able to attend the Nebraska Hospital Association & Nebraska Rural Health Association Rural Health Conference in Kearney June 4th. NCPS has many Critical Access Hospitals as members and strong ties to them; having an exhibitor's table at such an event allows us to thank our current members and inform non-members of the value a membership with NCPS would provide to them.

The meeting's keynote speaker, Brock Slabach, COO National Rural Health Association, reminded us of the importance of the provision of quality healthcare in rural Nebraska. He explained how rural areas make up 80% of the land mass in the USA and have roughly 17% of the entire population. Yet they provide the food, fuel, and fiber to power our nation and without access to high-quality health care those important resources are at risk because of poor health outcomes for those living and working in rural America.

NCPS' mission, To continuously improve the safety and quality of healthcare delivery in the region, supports our members in all areas of Nebraska and the surrounding states. Thank you for entering this important partnership with us!

NCPS Shared Learning Resources

For this month's Learning Resource we are drawing your attention to a toolkit created by the Agency for Healthcare Research and Quality (AHRQ) to address the very important patient safety issue of diagnostic error. Research shows that at least 5% of adults in the United States experience a diagnostic error each year in outpatient settings. Recent postmortem examination research spanning decades has shown that diagnostic errors contribute to approximately 10% of patient deaths in the U.S. World-wide this is such an issue that the World Health Organization(WHO) has already announced that their 2024 World Patient Safety Day (September 17th) theme is "Improving Diagnosis for Patient Safety" with the slogan "Get it right, make it safe".

AHRQ's toolkit is called **Toolkit for Engaging Patients To Improve Diagnostic Safety**. It employs a two-pronged approach. First, engaging patients by providing them with a pre-office visit planning worksheet, **Be the Expert on You**; and secondly, informing clinicians of a strategy to help them practice deep and reflective listening, **60 Seconds to Improve Diagnostic Safety**. This toolkit is comprehensive and has been developed so that it can easily be taken directly from AHRQ's website and implemented in any ambulatory setting with minimal time required. Included in the kit are tools to prepare your organization, make a plan, train your team, implement and evaluate. Here is a **link** to this important resource.

Event Reporting Process Upgraded

NCPS is launching our new Event Reporting software June 18th! The fillable pdf, used since the founding of NCPS, has been replaced with a software known as REDCap. This change makes the entry of events less time-consuming and more intuitive for those entering the event. We have recorded a video which explains how to complete the form and also created an Adverse Event Report Resource Sheet. Its accompanying video gives further explanation for the intent of various data fields and explains why several significant changes were made (e.g., moving from the MERP Severity Index which classifies events of harm from A to I based on the harm the patient experienced to AHRQ's taxonomy of Incident, Near Miss, Unsafe Condition).

The link to the downloadable Adverse Event Resource Sheet is located at the top of the Core Report form which is found by going to https://redcap.link/ncps_form.

Links to the videos are below:

Instructions For Entering Events into NCPS' REDCap Form

Why Changes to NCPS Event Reporting Form Were Made as Form Was Moved to REDCap

The form and these recordings will be on our website once our current website "re-fresh" project is completed in July.

Legal Counsel Update

Please visit the case law document [In RE Baycare Medical Group (11th CIR., 2024 W.L. 2150144), detailing protecting deliberations and analysis that is not reported to the PSO under the Deliberations and Analysis Pathway. In addition, the document linked here outlines the case summary.

Learning Opportunities for NCPS Members

NCPS Members TeamSTEPPS® Master Trainer Class

July 17th and 18th 8:00am - 4:30pm each day

TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) is designed to help health care professionals improve patient safety and quality through effective

communication and teamwork skills. TeamSTEPPS® is an evidence-based set of tools and a training curriculum to successfully integrate communication and teamwork principles into any health care system.

Many studies have found that teamwork training can lead to a stronger culture of safety through:
- Positive change in behaviors
- Process efficiencies
- Increased patient satisfaction
- Cost savings
- Improved outcomes
- Enhanced staff satisfaction

You may learn more about this workshop and/or register for it on the NCPS website; or email Emily Barr, embarr@unmc.edu, or Carla Snyder, carlasnyder@unmc.edu,with any questions. (*CEUs for this training are pending).*

NPQIC Substance Use Disorder Webinar Series Final Session

Aug 12, 2024 12:00pm

This fourth and final, no cost webinar provides education about substance use screening practices for maternal and infant populations. Its target audience is nurses and providers. Continuing education credits are pending. Register here.

NPQIC Perinatal Simulation Training

Aug 21, 2024 5:30 - 9:30pm CST Avera St. Anthony's O'Neill, NE

Aug 28, 2024 4:30 - 8:30pm CST Cherry County Hospital, Valentine, NE

This free training is for Providers, Nurses, and Respiratory Therapists. Each session will feature:

- A review of maternal and neonatal topics
  OB emergencies
  Neonatal resuscitation
- Maternal and neonatal simulation and skills experience.

To register for the August 21st session click here (registration ends 8/14); to register for the August 28th session click here (registration ends 8/21). Supper will be provided at both sessions. For more information contact Sydnie Carraher, scarraher@unmc.edu.

Nebraska Healthcare Quality Risk and Safety (NAHQRS)

Consider Becoming a Member of NAHQRS

The stated mission of NAHQRS is "To develop and empower healthcare quality, risk and safety professionals to advocate for and improve patient care in Nebraska". Beyond that, membership in this organization is a great networking opportunity! Members are from towns and cities across the state. The group meets every other month with virtual and in-person options. The in-person options are at a variety of healthcare organizations' settings. The meetings include organizational business and educational topics. Membership in this organization is only $55/year and is a gateway to free CEUs and great friendships with other healthcare quality, risk and safety professionals. Check out

their website or contact one of their officers (listed on the website) for more information or to answer any questions.

Patient Safety Resources

Improving Supervisor Confidence in Responding to Distressed Health Care Employees

Emotional distress and burnout are increasingly common among health professionals. Workplace leaders often lack the tools and direction for appropriately responding to distressed employees. This paper from The Joint Commission Journal on Quality and Patient Safety shows that simple, on-demand supervisor training videos can improve the confidence of supervisors to respond appropriately to distressed employees. The paper may be found here.

Disparities in Patient Safety Voluntary Event Reporting: A Scoping Review

Voluntary Error Reporting (VER) is prone to underreporting which introduces risk of bias. It is important to understand how different groups of patients may be affected by bias in VER so that equitable, high-quality care can be ensured. This scoping review demonstrates disparities by race, language, age and gender as described by current literature. The importance of improving how patient demographic information is collected as part of safety initiatives to aid in the recognition and action planning to address for all patients is shown. The paper may be found here.

Why Talking is Not Cheap: Adverse Events and Informal Communication

A strong safety culture relies on staff formally reporting or speaking up about adverse events (AE), yet valid reasons exist to explain why staff may choose not to. This article argues that although staff may not be using formal channels to report AE, they are engaging in informal communication. Using high-profile adverse events, the authors describe the important role gossip plays in sense-making and how leadership would do well to listen to this informal communication. The article may be found here.

Speaking Up and Taking Action: Psychological Safety and Joint Problem-Solving Orientation in Safety Improvement

Healthcare organizations face stubborn challenges in ensuring patient safety and mitigating clinician turnover. This paper looked at how the role of psychological safety in patient safety can be enhanced with joint problem-solving orientation (JPS). JPS is defined as emphasizing problems shared and viewing solutions as requiring co-production. Their findings point to JPS as a measurable factor that may enhance the value of psychological safety for patient safety improvement. The paper may be found here.

For more information about NCPS and the services we offer, please contact Carla Snyder MT(ASCP)SBB, MHA, Patient Safety Program Director at: carlasnyder@unmc.edu