2021 ANNUAL REPORT

NCPS
Nebraska Coalition for Patient Safety

NCPS

Nebraska Coalition for Patient Safety

Suggested Citation:
Brondum G, Jones KJ, Dawson A. Nebraska Coalition for Patient Safety 2021 Annual Report. Omaha, NE: Nebraska Coalition for Patient Safety; May 2022.

EXECUTIVE DIRECTOR MESSAGE

Dear Patient Safety Advocates:

"The only constant is change" – Heraclitus.

Though considerable progress has been made in improving patient safety over the past 20 years, rapidly advancing technology, staffing issues, provider burnout, increased production demands and the fragmentation of the health care system in the United States continue to contribute to the problem of medical error. The already rapid pace of change in healthcare has accelerated as the COVID-19 pandemic further increased the complexity of providing safe patient care. In this annual report, NCPS explores the impact of the pandemic on patient safety through the analysis of national data and information submitted by members. We recognize the remarkable resilience of healthcare providers in adapting to this quickly changing landscape.

NCPS continues to evolve as we strive to meet the dynamic needs of the healthcare providers we serve. From 2006 through 2017, NCPS achieved stability in operations and significant growth in hospital membership and event reporting. NCPS became the 76th Patient Safety Organization (PSO) in the nation to be listed with the Agency for Healthcare Research and Quality in 2009, gaining federal privilege and confidentiality protections for the Patient Safety Work Product developed by NCPS and its members. The small NCPS workforce delivered pertinent education programs and shared learning resources to members, strengthening the provider-PSO Patient Safety Evaluation System.

In 2017, the Nebraska Medical Association and the Nebraska Academy of Physician Assistants demonstrated innovative leadership by initiating and advocating for development of a Patient Safety Cash Fund to advance patient safety improvement in Nebraska. Beginning in 2020, physicians and physician assistants have contributed to the Patient Safety Cash Fund through a special fee paid at the time of state licensure, effectively doubling the financial resources available to NCPS. As a result, NCPS has added a Patient Safety Program Director to its workforce, has improved its web platform and communications, has increased educational offerings and continuing education credits, and has taken initial steps to transition to electronic event reporting.

As remarkable as our journey has been, NCPS intends to move boldly into the future as we continue to strengthen our infrastructure and expand our capacity to support providers in various settings in patient safety improvement. We welcome new Executive Director, Dr. Emily Barr, OTD, MBA, who will join NCPS in May, bringing strong experience in clinical education, quality improvement, business management and community engagement. We look forward to serving more ambulatory care members in their efforts to improve patient safety, we plan to offer more robust virtual and in-person training programs and we are excited to provide a web-based event reporting system to our members. We hope to move beyond the pandemic but are reminded that change is a constant and we must be nimble to succeed.

It has been my honor to serve as Executive Director of NCPS and I thank you for your partnership and your ongoing work to make healthcare safer for all.

Gail Brondum, LPN, BS
Executive Director

THE VALUE OF NCPS MEMBERSHIP

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

The Institute of Medicine report, To Err Is Human, brought national attention to the problem of preventable medical error in the U.S. In response, Congress enacted the Patient Safety and Quality Improvement Act of 2005 (ACT) to encourage shared learning from events by granting privilege and confidentiality protections to providers who work with listed Patient Safety Organizations (PSOs). Currently, 97 PSOs are listed with the Agency for Healthcare Research and Quality (AHRQ). These 97 PSOs work with healthcare providers across the nation to improve the safety and quality of healthcare. The collaborative work of providers and PSOs, made possible through the protections of the Act, serves as a national learning system for patient safety improvement.

On a state level, the Nebraska legislature passed the Patient Safety Improvement Act in 2005, calling for the formation of a PSO in Nebraska. The purpose of the Nebraska Act was to encourage a culture of safety and quality by providing for legal protection of information reported, aggregation of information about occurrences and sharing of information for improvement. As a result of this legislation, five state professional organizations collectively founded NCPS: Nebraska Academy of Physician Assistants, Nebraska Hospital Association, Nebraska Medical Association, Nebraska Nurses Association and Nebraska Pharmacists Association.

Nebraska Coalition for Patient Safety Founding Organizations

NAPA Nebraska Academy of PAs

NHA Nebraska Hospital Association
The influential voice of Nebraska's hospitals

NMA Nebraska Medical Association

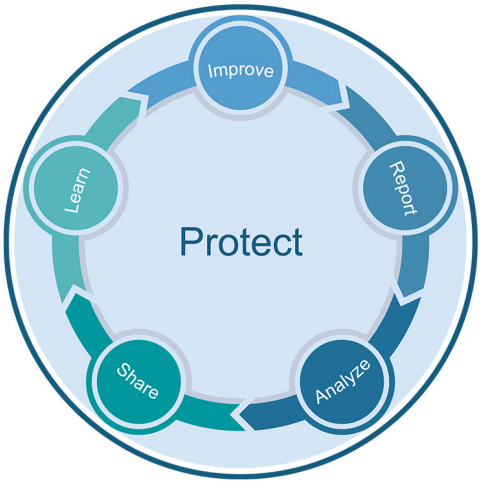
NNA NEBRASKA NURSES ASSOCIATION

NPA Advocate. Educate. Connect. | Nebraska Pharmacists Association

THE VALUE OF NCPS MEMBERSHIP

NCPS has maintained its PSO listing with AHRQ since initial certification in 2009 and complies with Nebraska Statutes pertaining to the Patient Safety Act. As such, healthcare providers who work with NCPS benefit from both federal and state confidentiality and privilege protections so that patient safety and quality improvement activities can be conducted within a safe and protected environment, without fear of legal discovery.

NCPS helps providers to develop patient safety evaluation systems (PSES) in which information about patient safety and quality is **reported**, collected, **analyzed**, and **shared** under the confidentiality and privilege **protections** of state and federal law. The PSES is a "safe space" where providers and the PSO **learn** from patient safety events and **improve** systems of care to decrease the risk of future adverse events and patient harm.



How providers and NCPS work together within the protected Patient Safety Evaluation System:

- **Report:** Providers collect patient safety event and improvement information within their organizations and report it to NCPS in a confidential and secure manner.
- **Analyze:** NCPS aggregates and analyzes event data from multiple providers, allowing for the identification of trends and the detection of rare events which may not otherwise come to the attention of an individual healthcare organization. NCPS staff also assists providers with event investigations and data analysis.
- **Share:** NCPS shares insight into underlying causes of patient safety events and provides members with shared learning reports as part of the feedback loop. De-identified Events, Patient Safety Alerts, Reporting Committee Summaries, and Risk Assessments ask, "Could this happen at your organization?"
- **Learn:** Providers and NCPS partner in a patient safety evaluation system where lessons learned from safety events are used to prevent future events. NCPS offers education about a variety of relevant patient safety topics.
- **Improve:** NCPS assists providers with developing effective approaches to improve patient safety and quality through evidence-based resources and tools, training programs, and safety culture services.

FUNDING OF NCPS

Neither state nor federal funds were allocated to support NCPS when the state and federal patient safety legislation passed in 2005.

Reflecting our grass roots origins, from 2008 through 2021, NCPS had three primary sources of funding: member dues, sponsor donations, and member services such as education and conducting Surveys on Patient Safety Culture. (Figure 1.) The amount NCPS received from member dues has been nearly $180,000 per year over the last five years as membership stabilized at 63 acute care facilities, primarily hospitals.

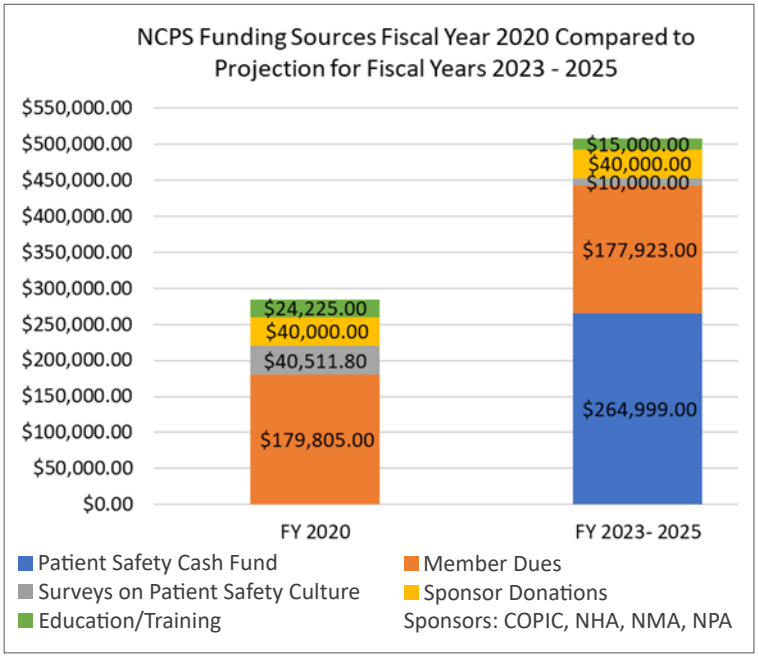


Figure 1. NCPS Funding Sources

Four sponsors have consistently donated a collective $40,000 per year to NCPS since 2007. These sponsors include COPIC, the medical liability insurer, and three of our five founding associations. These three are: The Nebraska Hospital Association (NHA), the Nebraska Medical Association (NMA), and the Nebraska Pharmacist Association (NPA).

On March 13, 2019 Legislative Bill 25 (LB 25) was signed into law by Governor Ricketts. This legislation created the Patient Safety Cash Fund. The Nebraska Medical Association and the Nebraska Academy of Physician Assistants initiated and advocated for this legislation, which adds fees to initial issuance or renewal of licensure to practice as a physician, an osteopathic physician, or a physician assistant in Nebraska. As a result, physicians pay an additional $50, and physician assistants pay an additional $20, every two years when they renew their licenses. The revenue generated by these fees is allocated to the Patient Safety Cash Fund, which can only be used to support a Patient Safety Organization in Nebraska. NCPS currently receives about $265,000 per year from the Patient Safety Cash Fund. NCPS began receiving funds from the Patient Safety Cash Fund in April 2021. As Figure 1 illustrates, income from the Patient Safety Cash Fund nearly doubles our annual operating budget. NCPS has used this additional income to add two major resources to serve members: a full-time Patient Safety Program Director and the Press Ganey Electronic Reporting Platform.

NCPS is grateful to its members and sponsors who have consistently supported our patient safety activities since 2007. We want to extend our gratitude further to each physician and physician assistant licensed in Nebraska who pay $50 and $20 every two years respectively to support the Patient Safety Cash Fund.

NCPS ORGANIZATIONAL MEMBERS

We would like thank and acknowledge our 63 hospital and ambulatory surgery center members for their support in 2021. We welcome new ambulatory care practices as members for 2022.

LARGE HOSPITALS AND MEDICAL CENTERS

Bryan Medical Center
CHI Health Creighton University Medical Center Bergan Mercy
CHI Health Immanuel
CHI Health St. Elizabeth
Nebraska Methodist Hospital
Nebraska Medicine - Nebraska Medical Center

COMMUNITY HOSPITALS

CHI Health Good Samaritan
CHI Health Lakeside
CHI Health Mercy Council Bluffs
CHI Health Midlands
CHI Health St. Francis
Columbus Community Hospital
Faith Regional Health Services
Great Plains Health
Kearney Regional Medical Center
Mary Lanning Healthcare
Methodist Fremont Health
Nebraska Medicine - Bellevue Medical Center

SPECIALTY HOSPITALS

CHI Health Nebraska Heart Hospital
Lincoln Surgical Hospital
Methodist Women's Hospital
Midwest Surgical Hospital
Nebraska Spine Hospital
OrthoNebraska

CRITICAL ACCESS HOSPITALS

Antelope Memorial Hospital
Avera Creighton Hospital
Avera St. Anthony's Hospital
Beatrice Community Hospital
Boone County Health Center
Box Butte General Hospital
Brodstone Memorial Hospital
Butler County Health Care Center
Chadron Community Hospital & Health Services

CRITICAL ACCESS HOSPITALS (continued)

Cherry County Hospital
CHI Health Mercy Corning
CHI Health Missouri Valley
CHI Health Plainview
CHI Health Schuyler
CHI Health St. Mary's
Community Hospital (McCook)
Community Medical Center (Falls City)
Cozad Community Health System
Crete Area Medical Center*
Fillmore County Hospital
Franciscan Health Care (West Point)
Harlan County Health System
Howard County Medical Center
Jefferson Community Health & Life
Kimball Health Services
Lexington Regional Health Center
Memorial Community Hospital & Health System (Blair)
Memorial Health Care Systems (Seward)
Merrick Medical Center
Nemaha County Hospital
Osmond General Hospital
Pawnee County Memorial Hospital
Pender Community Hospital
Saunders Medical Center
Syracuse Area Health
Thayer County Health Services
Tri Valley Health System
West Holt Medical Services

AMBULATORY SURGICAL CENTER

CHI Health Ambulatory Surgery Center at Midlands

AMBULATORY CARE PRACTICES

Bryan Heart*
Bryan Physician Network*
CHI Health Clinic
Nebraska Medicine Physicians

*New in 2022

NCPS SPONSORS

PLATINUM

COPIC®
Better Medicine • Better Lives

GOLD

NHA Nebraska Hospital Association

NMA
Nebraska Medical Association

SILVER

NPA
Advocate. Educate. Connect.

Nebraska Pharmacists Association

NCPS & UNMC CAPTURE FALLS ANNOUNCE NEW RELATIONSHIP

In November 2021, NCPS and the University of Nebraska Medical Center (UNMC) CAPTURE Falls program entered into a collaborative agreement. The primary purpose of this relationship was to extend the protections of the Federal Patient Safety and Quality Improvement Act (Act) of 2005 to CAPTURE Falls and the hospitals involved in that program.

What is UNMC CAPTURE Falls?

The **C**ollaboration **a**nd **P**roactive **T**eamwork **U**sed to **Re**duce (CAPTURE) Falls program is a quality improvement and research initiative to improve inpatient fall-risk reduction programs in Nebraska Critical Access Hospitals. It began in 2012 under the leadership of Katherine Jones, PT, PhD, current President of the NCPS Board of Directors, while she was on faculty in the UNMC College of Allied Health Professions. It has continued since her retirement from UNMC under the guidance of Dawn Venema, PT, PhD, Victoria Kennel, PhD, and Anne Skinner, MS, RHIA, also faculty within the UNMC College of Allied Health Professions. The CAPTURE Falls program has been funded by the Agency for Healthcare Research and Quality (2012-2017) and the Nebraska Department of Health and Human Services Office of Rural Health Medicare Rural Hospital Flexibility Program (2015-present). To date, over 30 Nebraska Critical Access Hospitals have participated in the CAPTURE Falls program.

Hospitals who engage in the CAPTURE Falls Program receive educational and consultative support on best practices for hospital fall and fall injury risk reduction. Hospitals also have access to Know Falls, a secure online reporting system and database to facilitate learning from fall events and benchmarking fall rates specific to Critical Access Hospitals.

Additional information about CAPTURE Falls is available at:
www.unmc.edu/patient-safety/capturefalls

Why is this new relationship between NCPS and UNMC important?

There are several important benefits of this new relationship:

» This agreement will extend the protections of the Act to CAPTURE Falls and participating hospitals. Federal confidentiality and privilege protections apply to certain information (called Patient Safety Work Product) which is developed when a provider works with a Patient Safety Organization (PSO) to improve quality and patient safety. Under this new agreement, UNMC CAPTURE Falls will function as a component of the NCPS PSO, extending the federal privilege and confidentiality protections to the Patient Safety Work Product that is developed through hospitals' participation in the CAPTURE Falls program.

» It will reduce reporting burden for hospitals who report both to CAPTURE Falls and NCPS, because fall events submitted to CAPTURE Falls can be considered submitted to NCPS.

» It will enhance learning from fall events reported to CAPTURE Falls and/or NCPS as the organizations work together to support providers in their efforts to reduce harm from falls.

What are the next steps? Hospitals who participate in CAPTURE Falls will receive additional communication from UNMC about this collaboration soon.

This new agreement between NCPS and UNMC CAPTURE Falls provides an example of how organizations can work together to improve the quality and safety of healthcare by removing barriers to sharing information about adverse events.

REPORT

Coming Soon: Electronic Reporting

NCPS is using resources from the Patient Safety Cash Fund to implement an electronic reporting program. Electronic reporting will overcome barriers to manual reporting for members and improve the efficiency of analyzing patient safety event data for NCPS workforce. Improving the structure of reporting from a manual to electronic process will significantly improve our ability to learn about the nature and scope of the risks and hazards to patient safety in our region.

NCPS recently entered into an agreement with Press Ganey Associates, Inc. to use their Patient Safety Organization (PSO) Platform to collect, manage, and analyze patient safety event reports. After training, NCPS workforce will use a phased approach to implement the reporting platform with member organizations who are interested in participating.

Facility members currently report to NCPS by completing a fillable pdf document and submitting it via encrypted email. NCPS workforce review each report submitted and enter information from each of the data fields into an Access database. Ashley Dawson, Patient Safety Statistician, uses statistical and data analytic methods to run queries and reports from the database.

The Press Ganey PSO Platform will allow authorized users from NCPS member facilities to access the secure web-based software system to report an individual event or to upload files that contain information about multiple events from their internal patient safety evaluation system. Members will have direct access to pre-configured dashboard reports and comparative aggregate data from seven other PSOs who use the Press Ganey PSO Platform.

If you have questions or would like more information, please contact Carla Snyder, Patient Safety Program Director at carlasnyder@unmc.edu.

ANALYZE

Effect of the Pandemic on Patient Safety among NCPS Members: Triangulating Multiple Data Sources

The COVID-19 pandemic began in the U.S. during Quarter 1 of 2020.[1] The initial surge occurred during Quarter 2 2020 (high of 9.9/100,000 pop.) with subsequent peaks in Quarter 4 2020 (high of 19.6/100,000 pop.), Quarter 1 2021 (high of 20.7/100,000 pop.), Quarter 4 2021 (peak of 23.8/100,000 pop.), and Quarter 1 2022 (high of 31.8 per 100,000 population). Hospitalizations declined rapidly throughout Quarter 1 2022 to 1.6 per 100,000 population at the end of the quarter. Surges in hospitalizations in Nebraska hospitals generally reflected the national pattern (Figure 2).[2]

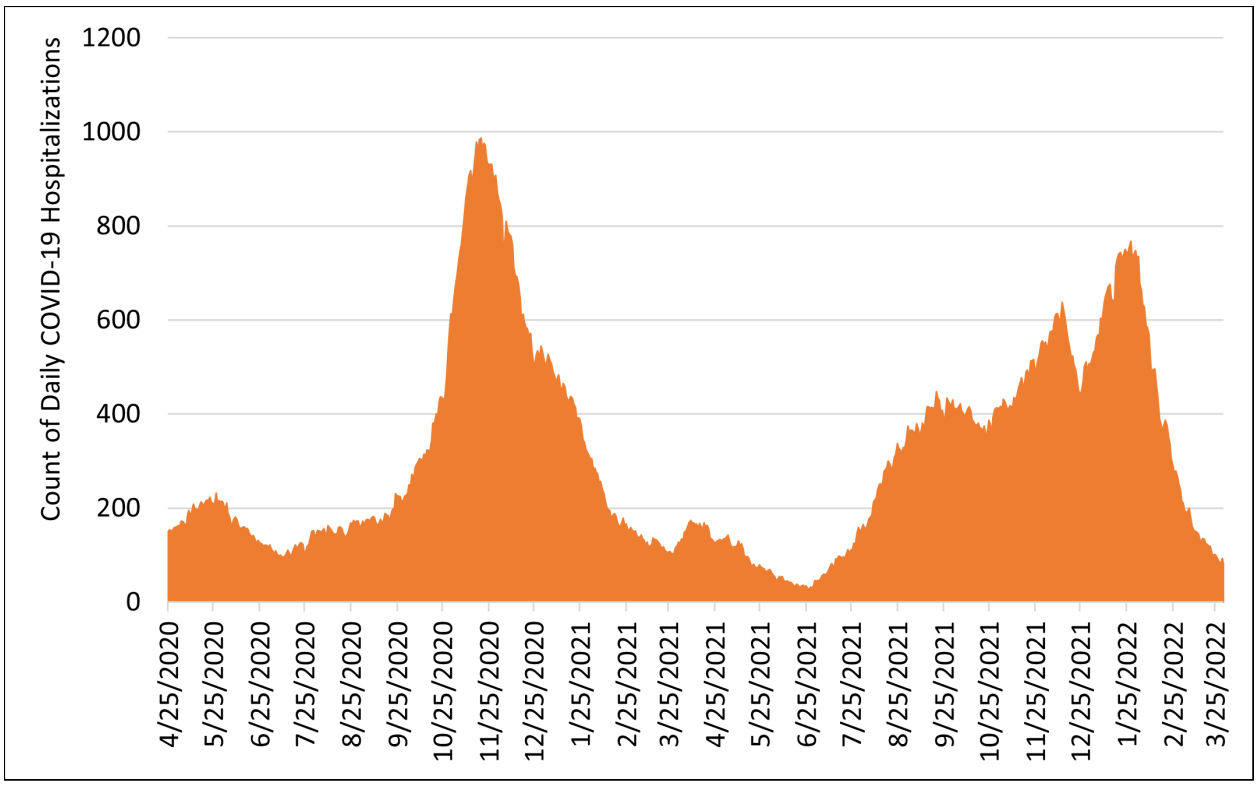


Figure 2. Nebraska COVID-19 Active Hospitalizations 4/25/2020 - 3/31/2022

Member hospitals voluntarily choose the events they report to NCPS, which prevents tracking the true incidence of events over time. However, we can triangulate multiple sources of data to draw meaningful conclusions. To assess the impact of the COVID-19 pandemic on member hospitals, we triangulated four sources of data: (1) NCPS Annual Member Survey, (2) NCPS Event Database, (3) fall rates by year from the National Database for Nursing Quality Indicators, and (4) Pilot Study Results from the AHRQ Surveys on Patient Safety Culture Workplace Safety Supplemental Items for Hospitals.

Source:

[1] Centers for Disease Control and Prevention. COVID-NET. Laboratory-Confirmed COID-19-Associated Hospitalizations. Accessed April 2, 2022. Available at: https://gis.cdc.gov/grasp/COVIDNet/COVID19_3.html

[2] Nebraska Department of Health and Human Services. Nebraska Public Health Atlas. Nebraska Hospital Capacity & Respiratory Illness Dashboard. Accessed April 2, 2022. Available at: https://atlas-dhhs.ne.gov/Atlas/Respiratory_Illness

Triangulating Multiple Data Sources:

NCPS Member Survey

Annually, NCPS surveys members to confirm hospital characteristics, identify changes in contact information, and determine needs for patient safety resources and education. Of the 63 organizations belonging to NCPS in December 2021, 29 (46%) responded to the survey conducted in January 2022. Of those 29, 17 (59%) responded to questions about how the COVID-19 pandemic impacted patient care and patient safety within their hospital. We used qualitative methods to code 54 themes among the 17 hospital responses and identified four over-arching themes:

- 63% of the 54 themes described safety concerns related to COVID-19
- 13% of the 54 themes described how members were adapting to COVID-19
- 9% of the 54 themes described how members were maintaining safety during COVID-19
- 6% of the 54 themes described how members perceived that safety/quality initiatives had stalled during COVID-19

Table 1. summarizes the frequency of these main themes and associated subthemes and provides a representative quote for each subtheme.

Table 1. Impact of the COVID-19 Pandemic on Patient Care and Patient Safety among NCPS Members

Themes and Subthemes	Proportion of Themes (n=54)	Representative Quote(s)
Safety Concerns related to COVID-19	**63%**	
Staff limited due to caring for increased volume of isolated patients	19%	"Nurses are spread thin at times with trying to care for a whole new section of isolated patients."
Staff burned out due to fatigue, stress due to mandates, angry patients/families	11%	"Our staff is tired and burned out. The vaccine mandate has put enormous stress on many staff members, especially Leadership in trying to figure out how to comply and keep our hospital open." "Burn out due to difficulty dealing with angry patients and families."
Staff need time to don PPE	7%	"The time it takes to place PPE on limits how soon the nurse can get into a patient room to assist the patient from a fall."
Staff limited due to self-quarantine	4%	"Also, staffing levels have fluctuated due to quarantine and isolation cases amongst staff."
Staff not donning/ wearing PPE correctly	2%	"Getting everyone trained on proper PPE and keeping staff accountable for wearing it has been challenging, especially the eye protection."

NCPS Member Survey (Continued)

Themes and Subthemes	Proportion of Themes (n=54)	Representative Quote(s)
Shortages of PPE, medications, sitters, supplies/equipment, maintenance	9%	"We have had instances where we have lacked PPE and this is not safe for the staff more than the patients." "I think the biggest care issues have been not ... having the equipment at our facility, such as bipap/ventilation/etc." "Need more sitters with confused covid patients but staffing too tight not always able to provide, medication shortages."
Delayed transfer of critical patients	6%	"Staff are still giving 100% but there is no place to transfer critical patients and they are not receiving the care they would have prior to pandemic."
Lack of patient advocacy due to limited visitation	4%	"Visiting polices changed....increasing load on IP staff."
Increased frequency of near misses	2%	"We have seen increase of near misses."
Adapting to COVID-19	**13%**	
Adapting to increased demands by limiting non-COVID care	9%	"Quarantine and isolation requirements have been a nightmare for staffing and has made it difficult to keep some departments operational. We have had to cancel surgeries and procedures, both due to mandates and due to staffing."
Adapting by managing COVID	9%	"We have 1 true negative pressure room, then built 2 more, then added 3 more after that. So, we made it work, but wasn't ideal. No negative pressure in our ER and treatment rooms either, so then we were closing down rooms for 1+ hours for the proper ventilation."
Adapting by cross training staff	2%	"Cross training employees is very important so we can float staff from IP to OP to Clinic or long-term care."
Adapting using Network Hospital support	2%	"We do not have an ICU - our network hospital has been a great resource."
Maintaining Safety - Using effective processes	**9%**	"Infection Control has done an excellent job with this, as well as our staff, ensuring employees, patients and visitors are following procedures."
Safety/Quality Initiatives Stalled	**6%**	"Many of the great initiatives we had started have been put on hold due to lack of time. Staff who normally focus on patient safety have spent a majority of their time on dealing with COVID."

NCPS Event Database

Number of Reported Events (Figure 3). In voluntary reporting systems, the stronger the culture of safety, the more staff value learning about system sources of error, and the more likely they are to report patient safety events. The annual number of events reported to NCPS peaked at 180 in 2016 and then decreased 24% to 136 in 2019. Discussions with members revealed two reasons for this decrease: (1) the manual reporting process and (2) turnover among hospital staff who were accountable for reporting to NCPS. The onset of the COVID-19 pandemic was associated with a 24% decrease in the number of events reported from 136 in 2019 to 103 in 2020.

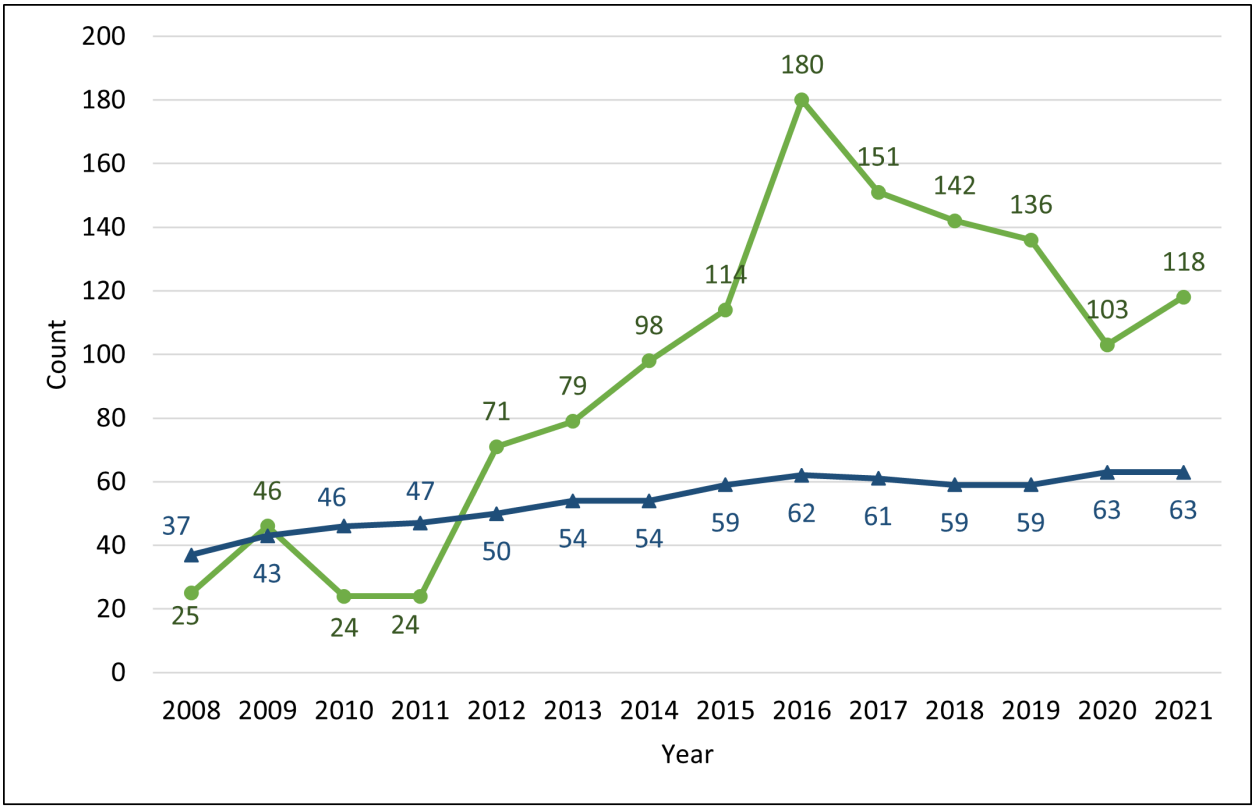
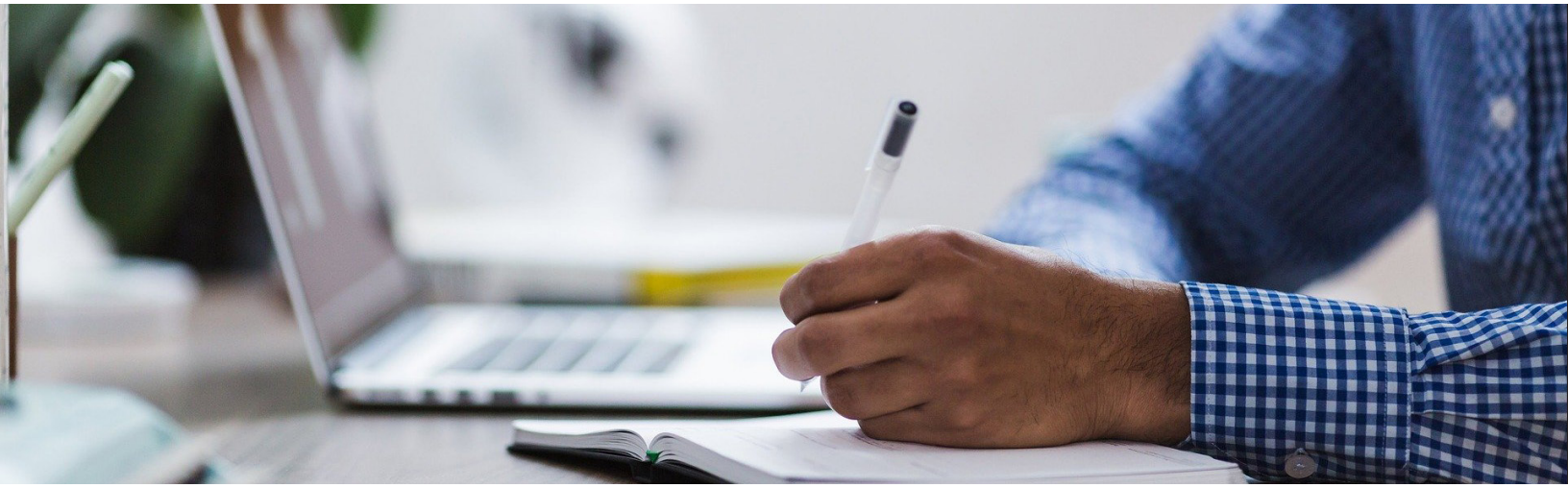


Figure 3. Count of Members and Reports Voluntarily Submitted to NCPS by Year



NCPS Event Database (Continued)

Severity of Reported Events (Figures 4 and 5). The relative severity of reports did not change significantly during the COVID-19 pandemic. Specifically, errors that reached the patient and caused harm (severity categories E – I) accounted for 58% of reported events during both time periods, non-harmful errors that reached the patient (severity categories C and D) accounted for 36%, and near misses/potential for error (severity categories A and B) accounted for about 5% of events.

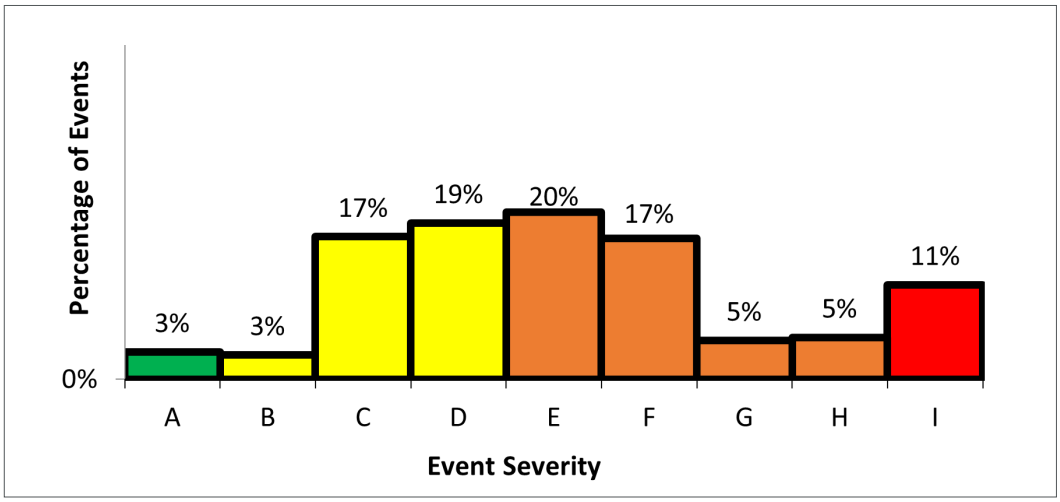


Figure 4. Severity of Events Prior to COVID-19 2008 - 2019 (n=1,095)

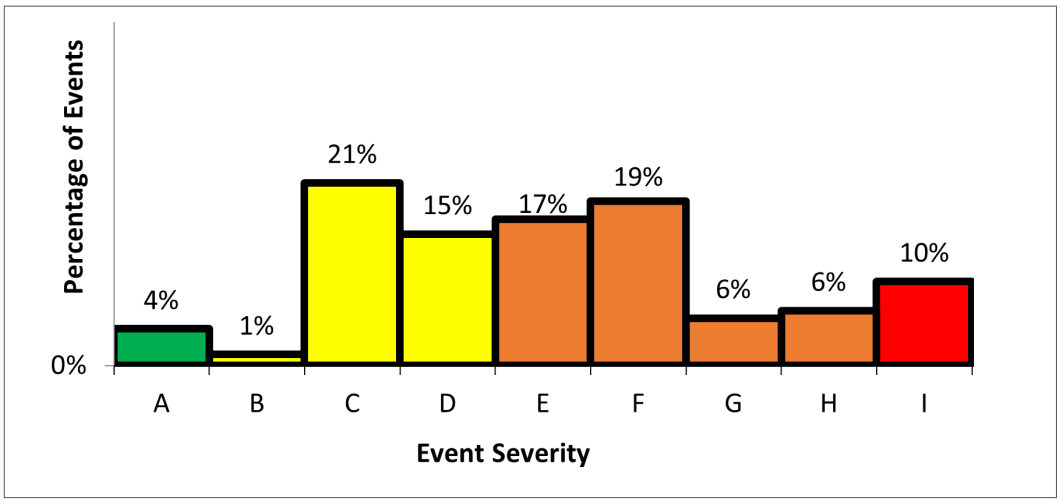


Figure 5. Severity of Events Reported to NCPS During COVID-19 2020 - 2021 (n=235)

NCPS Event Database (Continued)

Staffing as a Contributing Factor. From 2008 – 2019, prior to COVID-19, NCPS members reported that staffing-related factors such as staff floating, being inexperienced, working alternate hours or being insufficient contributed to 10.8% of reported events. In contrast, from 2020 – 2021, during COVID-19 staffing-related factors contributed to 14.0% of reported events.

Type of Reported Events. NCPS categorizes events into one of 47 types (Figure 5). We compared the proportions of event types reported during seven quarters prior to the onset of the pandemic to those same proportions for seven quarters after the onset of the pandemic. There were four event types whose proportions differed by more than 3% pre-pandemic as compared to during the pandemic (Figure 6). As compared to before the onset of COVID-19, falls and failure/delayed response to change in condition were more likely to be reported during COVID-19 while medication errors were less likely to be reported.

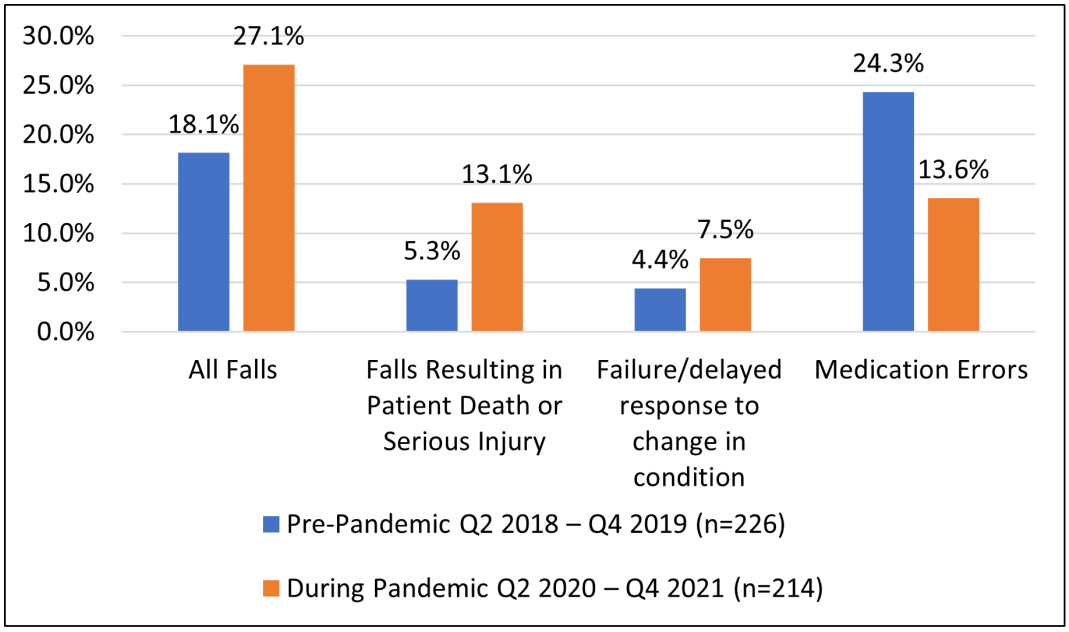


Figure 6. Changes in Proportion of Event Types Reported to NCPS Associated with Onset of COVID-19

National Database for Nursing Quality Indicators®

The National Database for Nursing Quality Indicators ® (NDNQI®) is a proprietary database of nursing sensitive quality measures. NDNQI® is now part of the portfolio of patient safety products owned by Press Ganey. According to NDNQI data:

- Throughout 2020, the rate of inpatient falls increased among medical, med-surg, surgical, and step-down patient care units;
- During Quarter 4 of 2020, the rate of stage 2 hospital-acquired pressure injuries increased across all unit types; and
- During Quarter 2 through Quarter 4 2020, central-line associated blood stream infections increased in high acuity units. [3]

Figure 7. demonstrates the increase in fall risk among medical adult nursing units associated with national surges of COVID-19 hospitalizations in Quarters 2 and 4 2020. [4]

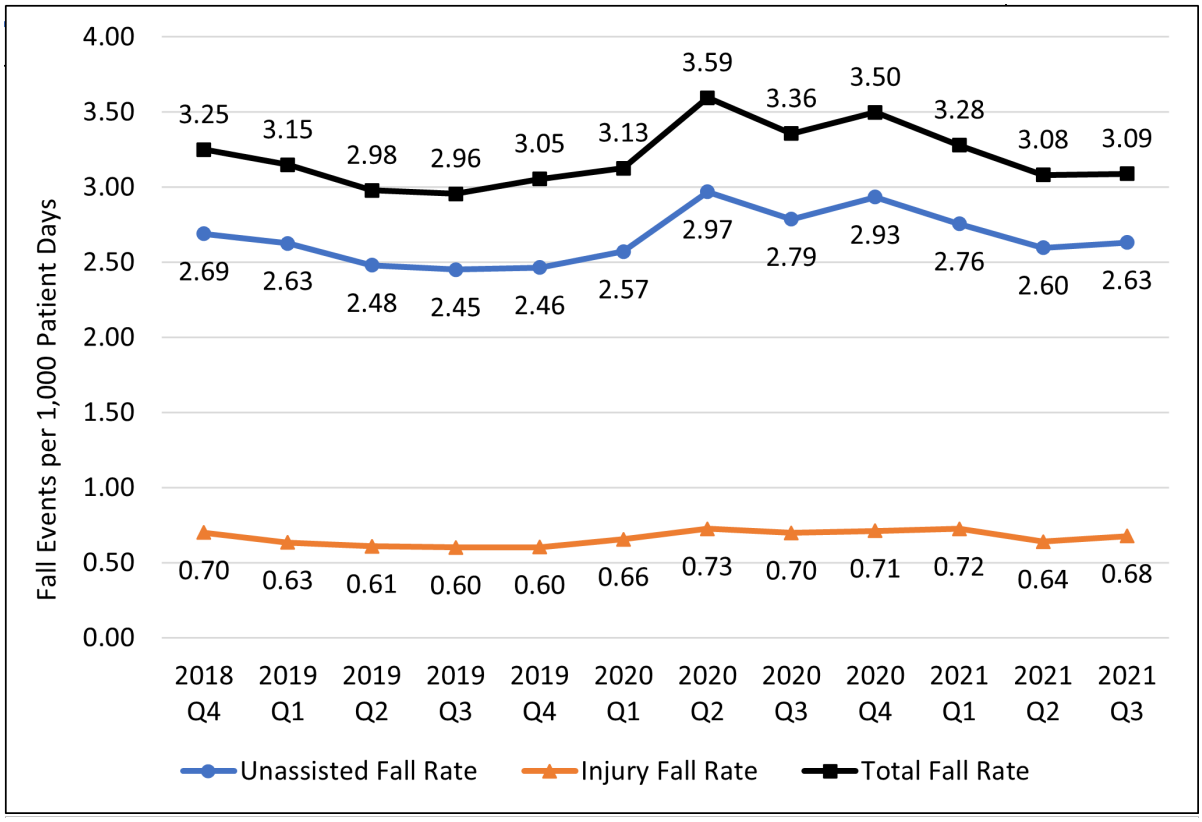


Figure 7. National Database of Nursing Quality Indicators Medical Adult Nursing Unit Fall Rates Q4 2018 - Q3 2021

Source:

[3] Press Ganey. New Press Ganey findings show healthcare safety scores fell amid the pandemic. Accessed April 2, 2021. Available at: www.pressganey.com/about-us/news/new-press-ganey-findings-show-healthcare-safety-scores-fell-amid-pandemic

[4] Personal Communication. Nancy Dunton, Kansas University School of Nursing NDNQI Primary Investigator for contract with Press Ganey.

Triangulating Multiple Data Sources:

Pilot Study Results from the AHRQ Surveys on Patient Safety Culture Workplace Safety Supplemental Items for Hospitals

Safety culture is the shared beliefs and behaviors taught by organizational leaders that define how to think and feel about patient safety, including the relative importance of patient safety as compared to other organizational goals such as productivity. The Agency for Healthcare Research and Quality (AHRQ) has developed surveys to assess safety culture in five settings: hospital (HSOPS), medical office (MOS), nursing home (NHSOPS), community pharmacy, and ambulatory surgery center. Workplace Safety supplemental items can be added to the HSOPS or MOS and include 22 items that assess perceptions of the extent to which an organization's culture supports workplace safety for providers and staff in their particular setting.

Results from the AHRQ Pilot Study of Workplace Safety conducted among 28 hospitals and 7,037 respondents during the pandemic in May – June 2021 revealed the following: [5]

- 30% of respondents reported symptoms of burn-out
- 25% of respondents reported that they were considering quitting their current position
- 21% of respondents reported that verbally aggressive patients and visitors were a problem
  36% of respondents reported that there was not enough staff available to help move, transfer, or lift patients

Conclusion: Impact of COVID-19 on Patient Safety

By triangulating information from NCPS members' perceptions of the impact of COVID-19, the NCPS event database, the National Database of Nursing Quality Indicators, and AHRQ's Pilot Study of Workplace Safety, we can conclude that the primary stressor on hospitals during the COVID-19 pandemic was an increase in the number of sicker patients who also needed to be isolated. Increasing the workload without increasing resources increased the likelihood that:

- staff experienced symptoms of burnout such as emotional exhaustion and
- risks and hazards reached patients due to limited numbers of staff, isolation of staff, staff feeling burned out, and staff delays in reaching patients due to the need to don personal protective equipment (Figure 8).

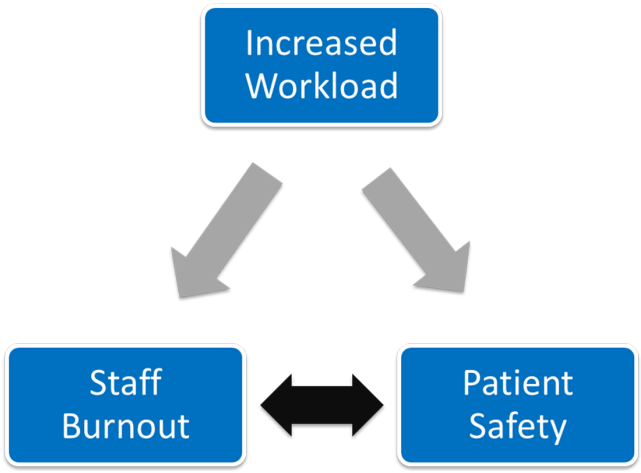


Figure 8. Association between Increased Workload, Staff Burnout, and Patient Safety

Source:
[5] Famolaro T, Yount N, Sorra, J, et al. Pilot Study Results From the AHRQ Surveys on Patient Safety CultureTM (SOPS®) Workplace Safety Supplemental Items. (Prepared by Westat, Rockville, MD, under Contract No. HHSP233201500026I/HHSP23337004T.) Rockville, MD: Agency for Healthcare Research and Quality; November 2021. AHRQ Publication No. 22-0008.

Conclusion (Continued)
Consistent with staffing limitations, during the COVID-19 pandemic member hospitals reported fewer events, and they were more likely to report two types of event types that require staff to intervene and coordinate care in a timely fashion: falls and failure/delayed response to a change in condition.

Recommendations
To fully understand the impact of COVID-19 in your organization, NCPS recommends conducting the Hospital Survey on Patient Safety Culture with the supplemental Workplace Safety Items in the next 12 months. Survey results will help organizations to prioritize the resources needed to implement safety culture interventions such as TeamSTEPPS Training, Just Culture Training, and Employee Well-Being that improve organizational resilience. Organizational resilience is the ability to manage complexity and adapt to change.[6]

Research demonstrates that organizational resilience is positively associated with effective teamwork practices that can be conducted during team briefs, huddles, and debriefs such as:

- Exchanging information between novices and experts,
- Integrating different perspectives to create a shared mental model, and
- Use of protocols and checklists[7]

In fact, research has demonstrated that using structured debriefs to learn from unusual events can improve team performance by 25%.[8]

Because of the impact of COVID-19 on the healthcare workforce NCPS would like organizations to specifically consider assessing staff perceptions of Workplace Safety in the next 12 to 18 months.

Source:
[6] Hollnagel E, Woods DD, Leveson NC. Resilience engineering: concepts and precepts. Aldershot: Ashgate; 2006.
[7] Iflaifel M, Lim RH, Ryan K, Crowley C. Resilient Health Care: A systematic review of conceptualizations, study methods and factors that develop resilience. BMC Health Services Research. 2020;20:324. https://doi.org/10.1186/s12913-020-05208-3
[8] Tannenbaum SI, Cerasoli CP. Do team and individual debriefs enhance performance? A meta-analysis. Human Factors. 2013;55:231-245.

SHARE

Shared Learning Reports: NCPS gains insight into underlying causes of patient safety events through review and analysis of reported events. Lessons learned are shared with NCPS members to assist with risk mitigation to prevent future patient safety events. These monthly Shared Learning Reports include de-identified events, patient safety alerts, patient safety briefs, and reporting committee summaries. Each shared learning report contains evidence-based best practice recommendations and an organizational self-assessment tool which asks, *"Could this happen in your organization?"*

Shared Learning Reports 2021:

Month	Type of Resource	Topic
January	Reporting Committee Summary	Independent double checks
February	Patient Safety Brief	Reporting patient safety events
March	Patient Safety Brief	Nurse fatigue
April	Reporting Committee Summary	Critical laboratory values
May	Patient Safety Brief	Medication reconciliation
June	Patient Safety Brief	Verbal orders
July	Reporting Committee Summary	Patient Identification, Standard Pre-Procedure Protocols, Wrong Patient/Wrong Procedure
August	De-identified Event	Patient Falls with Serious Injury – Focus on Hip Fractures
September	Patient Safety Alert	Mitigating Risks Associated with Administering Potassium and/or Managing Serum Levels
October	Reporting Committee Summary	Culturally and Linguistically Appropriate Services, Limited English Proficiency, Medical Interpreters
December	Patient Safety Alert	Patient Falls in Ambulatory Care Settings

Shared Learning Reports are a "members only" benefit and are part of the feedback loop of the provider-PSO patient safety evaluation and learning system. The Member Resources portal of the NCPS website contains a library of Shared Learning Reports covering a wide variety of patient safety topics.

Safe Tables: A Safe Table provides a confidential and privileged space for providers to gather to share patient safety concerns and to collaborate about best practices. NCPS is planning to host regular Affinity Group Safety Huddles for NCPS members to engage in dialogue about pertinent patient safety topics using the Safe Table model. Information discussed during a Safe Table is considered Patient Safety Work Product within the NCPS Patient Safety Evaluation System. An Affinity Group is a group formed around a shared interest or common goal, and is intended to provide benefit from interactions with people who share common identities or experiences. NCPS will begin by scheduling Safety Huddles for the following Affinity Groups: Critical Access Hospitals, Community and Specialty Hospitals, and Large Academic/Teaching Hospitals. Additional groups may be developed over time.

"Could this happen at your organization?"

LEARN

NCPS offers its members virtual education programs about a wide variety of patient safety topics identified from analysis of reported events as well as from the suggestions of our members. Live webinars award continuing nursing education credit. Continuing medical education credit is available for select live and recorded webinars.

Continuing Education Contact Hours awarded by Iowa Western Community College, Iowa Board of Nursing Provider #6.

Nebraska Medical Education Trust awards Continuing Medical Education Credits.

Virtual Education Offerings:

Suicide Risk Assessment and Safety Planning (Webinar followed by a Safe Table)
Presenter: David Cates, PhD
Director, Behavioral Health, Nebraska Medicine
Vice Chair of Clinical Operations, Department of Psychiatry, University of Nebraska Medical Center

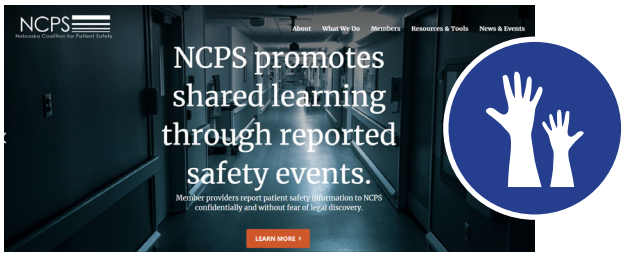
Taking a Case Study Approach to Using Data for Patient Safety Improvement Efforts
Presenter: Anne Skinner, RHIA, MS
Assistant Professor, College of Allied Health Professions
University of Nebraska Medical Center

Patient Safety Organizations 101: PSWP Privilege in the Context of PSOs
Presenter: Michael R. Callahan
Senior Counsel, Katten Muchin Rosenman LLP

Interventions for Hospital Fall Risk Reduction
Presenter: Dawn M. Venema, PT, PhD
Associate Professor, Division of Physical Therapy Education
College of Allied Health Professions, University of Nebraska Medical Center

Patient Safety Organizations: What Every Ambulatory Care Provider Needs to Know (CME also available for the recorded webinar)
Presenter: Michael R. Callahan
Senior Counsel, Katten Muchin Rosenman LLP

Did you miss one or more of these live webinars? All webinars are recorded and available in the Members Resources portal of the NCPS website.



NCPS members have access to shared learning materials through the Members Resources portal on our website.

IMPROVE

NCPS assists providers to improve patient safety and quality by using evidence-based resources and tools, training programs, and services to evaluate and improve safety culture.

Based on the work of James Reason[9], we think about safety culture as being made up of four key components, which are interactive and dynamic.

1. **Just** – there is a fair, transparent, consistent system of managing events, demonstrating a shared accountability between system design and behavioral choices
2. **Reporting** – staff feel safe to freely report errors and unsafe situations; they understand how the information is used
3. **Learning** – information from reports is used to understand risk in the organization and how systems and processes can be improved
4. **Flexible** – team communications are optimized; there is psychological safety to speak up about safety related information; the organization changes processes and systems to improve

As these components of safety culture are strengthened, the organization moves toward becoming a safe, informed, highly reliable organization.

SAFETY CULTURE ASSESSMENT

The Joint Commission calls upon leaders to conduct a baseline assessment of safety culture, develop action plans for improvement, and reassess safety culture every 18 – 24 months to monitor progress.

NCPS has expertise in conducting, analyzing, and interpreting the Agency for Healthcare Research and Quality's (AHRQ's) Surveys on Patient Safety Culture (SOPS). AHRQ has developed surveys to assess safety culture in five settings: hospital (HSOPS), medical office (MOS), nursing home (NHSOPS), community pharmacy, and ambulatory surgery center.

We have conducted surveys among NCPS members in Nebraska and non-members located in the states of Alaska, Louisiana, and Washington.

AHRQ has developed supplemental items that can be added to the HSOPS and the MOS or used separately. These items include:

- Health Information Technology - 15 items assess perceptions of the impact of health IT on patient safety in the hospital setting.
- Value and Efficiency - 25 items assess perceptions of the extent to which an organization places a priority on and adopts practices to promote efficiency, waste reduction, patient centeredness, and high-quality care at a reasonable cost in the hospital or medical office setting.
- Diagnostic Safety - 12 items assess perceptions of the extent to which a medical office supports the diagnostic process, accurate diagnoses, and communication around diagnoses.
- Workplace Safety - 22 items assess perceptions of the extent to which an organization's culture supports workplace safety for providers and staff in the hospital or medical office setting.

Source:
[9] Reason, J. Managing the Risks of Organizational Accidents. Hampshire, England: Ashgate Publishing Limited; 1997.

IMPROVE

IMPROVING PATIENT SAFETY CULTURE

Debrief Collaborative

Four organizations in Nebraska partnered to develop the Nebraska Debrief Collaborative. These organizations included the Nebraska Coalition for Patient Safety, the Nebraska Perinatal Quality Improvement Collaborative, the Nebraska Association for Healthcare Quality Risk and Safety, and the Nebraska Hospital Association. The Nebraska Coalition for Patient Safety provided the planning and execution for the collaborative, which was funded by the Nebraska Department of Health and Human Services (NE DHHS), Division of Public Health, Office of Rural Health. Critical Access Hospital Network Coordinators for CHI Health Nebraska and Bryan Health provided input and guidance for the project.

Katherine Jones, PT, PhD, led the Debrief Collaborative, whose program objectives were to: (1) develop a publicly available online toolkit that healthcare professionals can use to improve their knowledge and skills related to conducting debriefs for learning and improvement and (2) deliver training to healthcare organizations seeking to implement and sustain conducting debriefs to improve systems of care.

Dr. Jones developed and presented two virtual training programs followed by two implementation support calls. NCPS offered Continuing Education Contact Hours* for nurses and Continuing Medical Education* credits for the debrief training webinars.

- Debriefs: An Evidence-based Team Leadership Tool to Improve Performance and Patient Safety Webinar: May 26, 2021
- Strategies to Conduct Effective Debriefs: June 9, 2021
- Debrief Implementation Support Call #1: July 14, 2021
- Debrief Implementation Support Call #2: August 11, 2021

Open-ended comments from the Program Evaluation Survey are representative of how hospitals plan to use the resources provided by the collaborative:

- "The debrief collaborative expanded the horizon for when to use debriefs."
- "We feel much more confident in conducting debriefs thanks to the collaborative and the resources provided."
- "We now have the right tools; just need to get leadership on board with the process."

NCPS hosted a virtual Safe Table on January 27, 2022 to provide a forum for healthcare providers to learn about progress and challenges in developing structures and processes for conducting debriefs. Katherine Jones, PT, PhD facilitated discussion among 24 participants representing various healthcare organizations across the region. Safe Table attendees shared successes, barriers, stories and practices related to conducting debriefs in their organizations.

The Nebraska Debrief Collaborative Toolkit includes a variety of helpful resources, such as Debrief educational webinar recordings, templates for team charters and policies, a Debrief Pocket Guide, and links to other evidence-based resources. The toolkit is publicly accessible on the Resources/Tools section of the NCPS website.

* Continuing Education Contact Hours awarded by Iowa Western Community College, Iowa Board of Nursing Provider #6.
* Nebraska Medical Education Trust designated this webinar for 1.0 AMA PRA Category 1 Credit

IMPROVE

TeamSTEPPS® Training

Conducting an effective debrief is a key component of TeamSTEPPS®, an evidence-based teamwork system to improve communication and teamwork skills among health care professionals. TeamSTEPPS® stands for Team Strategies & Tools to Enhance Performance and Patient Safety a training curriculum developed by AHRQ and the Department of Defense to successfully integrate teamwork principles into all areas of a health care system. It is used to improve collaboration and communication, and to optimize team performance. Patient safety experts agree that communication and other teamwork skills are essential to the delivery of quality health care and to preventing and mitigating medical errors and patient harm. NCPS offers initial and refresher courses for TeamSTEPPS® training, including a two-hour Essentials course, a one-half or a full-day Fundamentals course, and a two-day Master Trainer course.

Just Culture Training:

A fair, transparent, and consistent system of workplace justice, or just culture, is a foundational component of a robust culture of safety. A just culture is a learning culture that takes a systems approach to holding individuals and the organization accountable for patient safety.

By developing a just culture, organizations can move past a focus on outcomes (severity bias) and blame, to learning about the system and human factors that led to the outcome. NCPS offers customized Just Culture training for healthcare leaders in a variety of formats, using the Outcome Engenuity Curriculum. Training sessions include a two-hour Introduction/Overview, a half-day workshop, and a full-day workshop.

Root Cause Analysis (RCA) Support:

The goal of an RCA is to understand system and human factors that may have caused or contributed to a patient safety event, so that sustainable improvements can be made. Conducting and communicating the results of effective RCAs are fundamental to building a learning culture and becoming a high reliability organization. When staff members understand how patient safety event reports are used for improvement, trust and engagement improve, leading to increased reporting and more reliable safety systems.

The NCPS workforce uses a Root Cause Analysis and Action (RCA2) approach to reviewing events and investigations submitted by member organizations, providing virtual or in-person support in conducting RCAs or review and feedback related to submitted RCAs. This approach emphasizes identifying system causes and actions that may be taken to mitigate the risk of event reoccurrence.

NCPS partnered with the Midwest Alliance for Patient Safety PSO to present "Conducting RCAs in Rural and Critical Access Hospitals" for the National RCA VIrtual Summit on April 14, 2021. Coming in 2022: RCA2 virtual training modules.

Please contact Carla Snyder at carlasnyder@unmc.edu for more information about NCPS safety culture improvement services.

NCPS BOARD OF DIRECTORS

The Nebraska Coalition for Patient Safety is governed by a 12-15 member Board of Directors that includes representation from each of the founding organizations and at least one consumer member. Current board directors include:

Katherine J. Jones, PT, PhD, President (Consumer)
Adjunct Associate Professor, Health Services Research and Administration
College of Public Health
University of Nebraska Medical Center
Omaha, NE

Daniel J. Rosenquist, MD, Vice President (NMA)
Columbus Family Practice Associates and COPIC Consultant
Columbus, NE

Douglas V. Elting, Treasurer (Consumer)
TRANSCEND Health Consultants
Lincoln, NE

Nicole Blaser, MSN, RN, Secretary (NHA)
Director of Quality and Compliance
Columbus Community Hospital
Columbus, NE

Pamela Dickey, MPAS, PA-C (NAPA)
Assistant Professor
Physician Assistant Education
University of Nebraska Medical Center
Kearney, NE

Mike German, PharmD, BCPS (NPA)
Pharmacy Clinical Services Coordinator
CHI Health St Francis
Grand Island, NE

Shaun Horak, DMSc, PA-C (NAPA)
Assistant Professor
University of Nebraska Medical Center
Omaha, NE

Kenneth Kester, PharmD, JD (NPA)
System Director of Telepharmacy Pharmacy Operations and Clinical Services CommonSpirit Health®
Lincoln, NE

Brian Martin, MBA, FACHE (NHA)
Chief Executive Officer
West Holt Medical Services
Atkinson, NE

Michael Rapp, MD, FACS (NMA)
Vice President Medical Operations
CHI Health St. Elizabeth
Lincoln, NE

Jennifer Rystrom, RN, MSN (NONL)
Chief Nursing Officer
West Holt Medical Services
Atkinson, NE

Britt Thedinger, MD (NMA)
Physician
Ear Specialists of Omaha
Omaha, NE

Carol Wahl, DNP, RN, MBA, NEA-BC, FACHE (NNA)
Assistant Professor
University of Nebraska Medical Center College of Nursing
Kearney, NE

NAPA: Nebraska Academy of Physician Assistants
NHA: Nebraska Hospital Association
NMA: Nebraska Medical Association
NNA: Nebraska Nurses Association
NONL: Nebraska Organization of Nurse Leaders
NPA: Nebraska Pharmacists Association

NCPS PARTNERSHIPS

We are grateful for continued collaboration with regional and national organizations toward our mutual goal of improving the quality and safety of healthcare delivery:

- ✓ Agency for Healthcare Research and Quality (AHRQ)
  www.ahrq.gov
- ✓ Alliance for Quality Improvement and Patient Safety (AQIPS)
  www.aqips.org
- ✓ Association of Healthcare Emergency Preparedness Professionals (AHEPP)
  www.ahepp.org
- ✓ National Alliance of Patient Safety Organizations (NAPSO)
  www.chpso.org/nationwide-alliance-patient-safety-organizations
- ✓ Nebraska Association for Healthcare Quality, Risk, and Safety (NAHQRS)
  www.nahqrs.org
- ✓ Nebraska Perinatal Quality Improvement Collaborative (NPQIC)
  www.npqic.org
- ✓ University of Nebraska Medical Center, College of Allied Health Professions, CaptureFalls (UNMC-CAHP)
  www.unmc.edu/patient-safety/capturefalls/index.htm l
- ✓ University of Nebraska Medical Center, College of Public Health (UNMC-COPH)
  www.unmc.edu/publichealth

NCPS STAFF

Gail Brondum, LPN, BS
Executive Director
gail.brondum@unmc.edu
(402) 559-8421

Carla Snyder, MT (ASCP), MHA, CPHQ
Patient Safety Program Director
carlasnyder@unmc.edu
(402) 559-8946

Ashley Dawson, MS
Patient Safety Statistician I
ashley.dawson@unmc.edu
(402) 552-7254

Ron Belyan, MPA
Patient Safety Project Coordinator
ron.belyan@unmc.edu
(402) 552-7254

www.nepatientsafety.org

NCPS

Nebraska Coalition for Patient Safety