NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: April 2024

A Message from the Patient Safety Program Director

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

The Agency for Healthcare Research and Quality (AHRQ) was formed in 1989 and is celebrating its 35th Anniversary this year! The motto for their year of celebration is *Today's Research, Tomorrow's Healthcare*. The agency's goal is to advance the quality of healthcare and shape the future of healthcare policy through rigorous research and innovation. AHRQ's **website** outlines the significant milestones achieved in the past 35 years and acknowledges the various persons that have led the organization during its first 35 years.

In 2005, AHRQ initiated the **Patient Safety Network**. This valuable resource provides access to the latest news, research findings and publications; pertinent legislation; conferences; and tools related to patient safety. The evidence-based research and protocols we at NCPS cite in our Shared Learning Resources and other trainings often have been obtained through AHRQ. There is no fee to gain access to either the AHRQ or PSNet website and newsletter distribution lists so I would encourage you to act to obtain a member login.

The work AHRQ performs aligns with and supports the work of a patient safety organization (PSO). A basic AHRQ tenet is that improving healthcare outcomes is a collective endeavor which requires the engagement and cooperation of an entire community (i.e., co-funders, partners, grantees, stakeholders, staff, and alumni). This parallels the commitment and work patient safety organizations and their members perform. A culture of safety is a shared value and responsibility within the healthcare community. By reporting events of harm occurring in your practice setting you are improving the safety for patients in all healthcare settings. Reporting events of harm or near misses allows NCPS to de-identify them and then share them with all members. Members can then objectively evaluate their own processes and mitigate similar events in their practice setting. Additionally, the trainings and services provided by NCPS (e.g., TeamSTEPPS, Just Culture, Survey on Patient Safety, etc.) assist teams and their organizational leaders in establishing a culture of safety in their organization.

We appreciate you being an active member of the patient safety movement through your membership in NCPS and by your organization's reporting of events of patient harm or near misses to us. Working together we can make a difference and deliver on the **NCPS Mission: To continuously improve the safety and quality of healthcare delivery in the region.**

NCPS Shared Learning Resources

This month's Learning Resource is the summary of an event reviewed by NCPS' Reporting Committee. The event was a medication error caused by the incorrect medication being loaded into an Automated Dispensing Cabinet (ADC). A review of best practices for the safe use of ADCs as well as Reporting Committee members comments and observations for this case are included in the resource. The resource may be found on the NCPS website in Education Resources\Reporting Committee Summary on the Members pages [t.e2ma.net].

Legal Counsel Update

The legal update this month regards a recent case, SunRise Hospital v. Grace, in which the Nevada Supreme Court found that the Patient Safety Quality Improvement Act (PSQIA) privilege cannot be waived and is determined to be absolute. A summary is provided here, written by Peggy Binzer from the Alliance for Quality Improvement and Patient Safety, the professional association for Patient Safety Organizations. Please reach out to Emily Barr at embarr@unmc.edu if you have questions or comments regarding the case.

Learning Opportunities for NCPS Members

NPQIC Substance Use Disorder Webinar Series

April 22, 2024 12:00pm
May 6, 2024 12:00pm
June 10, 2024 12:00pm
Aug 12, 2024 12:00pm

This no cost 4-part webinar series will provide 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.

Patient Safety Evaluation System 2024 Virtual Summit

May 21 & 22, 2024 10am - 2pm CT

Discover how to leverage your Patient Safety Evaluation System (PSES) to transform health care into a learning structure. This innovative summit will teach you how to break barriers and solve what keeps us up at night. It will provide information to help you to communicate better (internally and with patients) and strengthen patient care delivery. Presenters will address how to improve patient care design, and discuss innovative programs that reduce costs, accelerate efficiency, and enhance reliability.

Held over two half-days, the PSES 2024 Virtual Summit will include national safe-table discussions, topic-focused breakout sessions, and an amazing keynote presenter – all centered around health care innovation and patient safety evaluation systems. Register here.

Patient Safety Resources

Successfully Integrating Age-Friendly Care in a Geriatric Emergency Department

This case study from Sharp Grossmont Hospital demonstrates the value of the Age-Friendly programs. Results for this particular healthcare organization included decreased readmissions for older adults and improved job satisfaction for nurses. If you are interested in learning more about the Age-Friendly program, please contact Matt Lentz, RN, MSN, Quality Consultant at the Nebraska Hospitals Association. He may be reached at mlentz@nebraskahospitals.org

Analysis of intervention employability in pharmacy-related medication safety reports at a tertiary medical center

The Institute for Safe Medication Practices (ISMP) hierarchy of effectiveness of risk-reduction strategies ranks interventions from the least to most effective. Researchers evaluated the actionability of 665 pharmacy-related medication safety reports at one hospital. Three-quarters of the reports were only actionable at the least effective levels (e.g., suggestions to "be more careful", educational programs). The researchers suggest events that lent themselves to more effective levels of intervention were acted upon and, therefore, recurred less frequently. The paper may be found here.

Racial implicit bias and communication among physicians in a simulated environment

Clinicians' implicit racial bias can result in poor communication, poor patient care, and patients not returning for follow up. In this study, physicians participated in a simulated online patient visit, randomized to either a Black or White standardized patient (SP). Both the physician and SP were blinded to the true purpose of the study, which was to explore the association between the physician's implicit bias and the SP's rating of the physician's communication skills. Results show a significant association between physician bias and communication scores. The paper may be found here.

Organizational learning in the morbidity and mortality conference

Morbidity and mortality (M&M) conferences have evolved from focusing on individual clinicians to systems errors. In this study, researchers observed M&M conferences, interviewed leadership, and reviewed M&M policies at three Canadian hospitals to describe how organizational learning is enacted. Although the hospitals differed in policies and processes, all three acknowledged the importance of recognizing organizational trends and learning from errors at both the individual and system levels. The research 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

986055 NE Medical Center
Omaha, NE | 68198 US