NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: June 2023

A Message from the Executive Director

Emily Barr, OTD, MBA, OTR/L, BCG

According to the National Academy of Medicine, diagnostic error can be a blind spot within patient safety[i]. Each transition of care across the continuum has underlying context-specific factors that can contribute to diagnostic errors, ultimately increasing potential risk for patient adverse events. Due to the high-risk nature of care transitions, it is imperative that communication is effective within the interdisciplinary team and with patients and families throughout the process. While transitions of care have been a well-studied area, there has not been a significant focus on strategies in reducing diagnostic error. This month, the Agency of Healthcare Research and Quality issued a brief titled, “Diagnostic Safety Across Transitions of Care Throughout the Healthcare System: Current State and a Call to Action” to support providers with diagnostic safety. The brief examines multiple transition points across the continuum and (1) context-specific contributors, (2) handoff or transition-specific contributors, and (3) recommended strategies to prevent and mitigate diagnostic errors and uncertainty.[ii] A recurring mitigating strategy outlined in the brief is the standardization of communication tools. While not specifically mentioned within the brief, TeamSTEPPS® tools such as “SBAR”, “Debriefs”, and “Huddles” can be effective communication tools to support improvements in reducing diagnostic error. The full brief can be found here. For additional resources on diagnostic safety or TeamSTEPPS® tools please reach out to the NCPS team at ncpssupport@unmc.edu.

[i] National Academies of Sciences, Engineering, and Medicine, Institute of Medicine, Board on Health Care Services, Committee on Diagnostic Error in Health Care. Improving Diagnosis in Health Care. Washington, DC. National Academies Press; 2016. https://www.ncbi.nlm.nih.gov/books/NBK338596/.

[ii] Santhosh L, Cornell E, Rojas JC, Lyons P. Diagnostic Safety Across Transitions of Care Throughout the Healthcare System: Current State and a Call to Action. Rockville, MD: Agency for Healthcare Research and Quality; June 2023. AHRQ Publication No. 23-0040-1-EF.

NCPS Shared Learning Resource

This month's learning resource is a de-identified event, a Transfusion to the Incorrect Patient. The de-identified event may be found on the NCPS website within the Educational Resources

in our members only portal.

Learning Opportunities for NCPS Members

CIRCO Cybersecurity Webinar

June 21 11am-12noon CT

In 2021, 45 million individuals were affected by health care cyber-attacks, that number has tripled in the past three years. In 2022 cybersecurity attacks topped the ECRI list of the Top 10 Health Technology Hazards. The current environment necessitates healthcare systems to not only address their own cyber security strategies, but also to be aware and involve any third-party vendors with access to networks.

Do you understand the risks? Is your organization prepared to respond to a cyber security threat? In 2022 the Academic Medical Center Patient Safety Organization (AMC PSO) convened a task force to develop a consensus-supported set of best practices to mitigate cyber security risks. The goal of this activity is to learn from experts who developed these best practices and patient safety risks related to cyber security and recovery in health care. Presenters will provide an overview of risks and will also describe practical takeaways to reduce risk related to cyber security and recovery. Register **here**.

NCPS Sponsored Webinar: Practical Considerations for Medication Safety

June 28 noon - 1pm

Medication events are the largest number of events reported to NCPS. Medication safety subject matter experts, Sloane Hoefer, PharmD, BCPS and Stacie Ethington, MSN, RN, from Nebraska Medicine will discuss strategies for several of the new Best Practice Guidelines from the Institute for Safety Medication Practices (ISMP). These include Safeguard Against Errors With Oxytocin Use; Maximize the Use of Barcode Verification Prior to Medication and Vaccine Administration by Expanding Use Beyond Inpatient Areas; and Layer Numerous Strategies Throughout the Medication-Use Process to Improve Safety With High-Alert Medications. Also included will be discussion of ISMP's Community Pharmacy Best Practice Guidelines and safety considerations when using IV pumps. NCPS Members may register **here**.

AQIPS 2023 Q2 Legal Counsel Meeting

June 29 12noon - 1pm CT

The Alliance for Quality Improvement and Patient Safety (AQIPS) provides a legal counsel meeting each quarter for their members. NCPS is an AQIPS member and so NCPS members are also invited to attend this quarterly Legal Counsel Meeting. Robin Nagele, Senior Counsel at Post & Schell, P.C., will be the speaker. She has extensive experience and legal expertise with Patient Safety Organizations and Participating Providers regarding legal compliance and privilege protection under the federal Patient Safety Quality Improvement Act. Your organization's legal counsel is also invited/encouraged to attend. Please forward this Cisco webex invitation to your organization's legal counsel. Join from the meeting link:

https://aqips.my.webex.com/aqips.my/j.php?MTID=m977229918a63af8393b93c39a495a5a3

Patient Safety Resources

Identification of Patient Safety Threats in a Post-Intensive Care Clinic

Because patients discharged from the intensive care unit (ICU) are at increased risk for readmission and post-ICU adverse events, some hospitals have opened post-ICU clinics. This article describes safety threats identified by post-ICU clinic staff. Medication errors and inadequate medical follow-up made up nearly half of identified safety threats. More than two-thirds were preventable or ameliorable. The abstract may be found **here**.

AHRQ Announces New Challenge Competition to Highlight the Impact of Its Patient Safety Tools

AHRQ has announced a new challenge competition which is intended to demonstrate how the use of the agency's patient safety tools has resulted in safer healthcare. Up to 10 winners who describe how the use of patient safety resources resulted in measurable improvement will receive $10,000 each. Challenge submissions are due October 5, 2023 and can be from any of fourteen categories of quality improvement projects. Further information on this challenge may be found **here**.

COVID- 19 Resources & Research

One in 10 People Who Had Omicron Got Long COVID

A recently published Medscape article informs that a study recently published in *The Journal of the American Medical Association* found about 10% of people infected with Omicron reported having long COVID. This is a lower percentage than what was estimated for people with earlier strains of the coronavirus. Also reported in the article are results from the National Institute of Health which found people who were unvaccinated or got COVID before Omicron were more likely to have long COVID and more severe cases. The article may found **here**.

Development of a Definition of Postacute Sequelae (PASC) of SARS-CoV2 Infection

The National Institute of Health's Researching COVID to Enhance Recovery (RECOVER) Initiative has published findings from their initial project to develop a definition of PASC, also know as *long COVID.* The study also aimed to describe PASC frequency across cohorts, vaccination status, and number of infections. The RECOVER Initiative seeks to understand, treat, and prevent PASC. 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

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