

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

NCPS Update: July 2023

A Message from the Patient Safety

Program Director

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The United States' opioid epidemic began in the mid-1990's and unfolded in phases. A brief timeline with key milestones may be found on the American

Council on Science and Health's [website](#). One notable milestone in that timeline is the tripling in opioid prescriptions between 1991 and 2011. Much work to decrease the rate at which opioids are prescribed has occurred over the past 20 years; a recent search on the Agency for Healthcare Research and Quality [website](#) returned over 10,000 records when the word "opioid" was entered in the search box. The Nebraska Department of Health and Human Services, the Nebraska Hospital Association, the Nebraska Medical Association, the Nebraska Pharmacist Association, and the Nebraska Association of Physician Assistants have all acted to provide tools to aid providers in the management of opioid prescriptions in our state. This includes the [Stop Overdose Nebraska program](#), [Safe Prescribe](#), [NHA Opioid Toolkit](#), and the [Prescription Drug Monitoring Program](#) to name just a few.

Much work is still needed and a recent story on CBS News highlighted an innovative program to treat and prevent drug overdoses for persons in Camden, NJ. It was developed by Cooper University Healthcare in response to the high rate of drug overdoses found in their community; their hospital emergency department and local emergency medical services were being overwhelmed by persons experiencing drug overdoses. Working collaboratively, they have developed a program which includes providing paramedics not only naloxone but also with buprenorphine and training to help get persons revived by naloxone into drug treatment. You can watch the story [here](#).



NCPS Shared Learning Resources

This month's Learning Resource is the 2023 Quarter 2 Reporting Committee Summary. The NCPS Reporting Committee is an interprofessional group which includes several physicians, nurses, a pharmacist, a physician assistant, and several allied health professionals. Each member receives a specific case to review. The case is within their clinical subject matter expertise and has been reported to NCPS by a member organization. Each member presents

their case to the committee and interesting discussion follows since each member has a slightly different lens of understanding due to differences in training and work experience. This quarter's summary is of an incident when a tracheostomy tube became dislodged. This resource may be found on the NCPS website in the Education Resources on the [Members pages \[t.e2ma.net\]](#).

Legal Counsel Updates

NCPS is pleased to introduce a new section of the newsletter to highlight legal counsel updates. Quarterly, the Alliance for Quality Improvement and Patient Safety (AQIPS) conducts a virtual legal counsel meeting that is available to all member Patient Safety Organizations (PSO) and their affiliated member organizations. As an NCPS member, the meeting materials are available to your teams to provide updates regarding current case law and other relevant topics related to the Patient Safety and Quality Improvement Act, and best practices for PSO and Patient Safety Evaluation System (PSES) operations. The 2nd Quarter meeting slide deck can be found [here](#). The next legal counsel meeting is scheduled for **Thursday, September 14th 12:00-1:00 PM CT**. Please contact Emily Barr at embarr@unmc.edu for a Webex invitation.

Additionally, NCPS has been working with AQIPS to clarify best practice related to learning from and protecting digital/video recordings as Patient Safety Work Product. This [document](#) is a best practice guideline for protecting recordings and using for purposes to conduct patient safety activities. NCPS encourages member organizations to review this document and current PSES policies and procedures to review for compliance. Please contact Emily Barr at embarr@unmc.edu if you have questions regarding digital/video recordings or any other PSES related questions.

Learning Opportunities for NCPS Members

Agricultural Health and Safety Course For Medical and Safety Professionals

Tuesday, July 18th - Friday, July 21st

The University of Nebraska Medical Center's Center for Continuing Education is offering this course free of charge. Each day has a full agenda of timely topics. Additionally there are on-line modules to complete if you want CEs. Check out each day's agenda and register [here](#).

National Action Alliance Webinar Series:

Two webinars from the National Action Alliance To Advance Patient Safety are still available for your registration to attend.

1. Involving Patients and Families in Safety

Tuesday, July 25th from 12:00 - 1pm

Speaker to be announced. Register [here](#).

2. Engaging Boards and Executive Leadership in Safety

Tuesday, August 22nd from 12:00 - 1pm

Speaker to be announced. Register [here](#).

NCPS Sponsored Webinar: Practical Considerations for Medication Safety

The recording of this June 28th webinar may now be found on the [NCPS website](#).

If you were unable to join us for this excellent presentation by medication safety subject matter experts, Sloane Hofer, PharmD, BCPS and Stacie Ethington, MSN, RN, from Nebraska Medicine, please check out the recording and handout. Both are found in the member's portal under Educational Resources/Webinars. In it, they address three new best practices from ISMP's 2022-023 listing. This includes: Safeguard Against Errors With Oxytocin Use; Maximize the Use of Barcode Verification Prior to Medication and Vaccine Administration by Expanding Use Beyond Inpatient Areas; Layer Numerous Strategies Throughout the Medication-Use Process to Improve Safety With High-Alert Medications. ISMP also has developed a Community Pharmacy Best Practice which is concerned with Preventing Wrong Patient Errors When Filling Prescriptions, Responding to Questions, and Administering Vaccines. Also included in their talk is discussion of safety considerations for IV pumps.

Patient Safety Resources

Imagining the future of diagnostic performance feedback

Diagnostic error is an area of great interest in patient safety with an estimated 12 million people each year in the U.S. alone affected by it. A recent publication in *Diagnosis* explores the value of peer feedback and proposes solutions to overcome the barriers found in providing diagnostic performance feedback. The paper is available at:

<https://www.degruyter.com/document/doi/10.1515/dx-2022-0055/>

Normalization of deviance is contrary to the principles of high reliability

Despite efforts to reduce the risk of patient safety events in the OR such events continue to occur. A paper in AORN Journal explores two factors which help prevent the normalization of deviance in the OR, nurse engagement and supportive managerial relationships. Normalization of deviance and its oppositional force to safety and high reliability are discussed as well as possible solutions. 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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