NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: October 2023

A Message from the Patient Safety Program Director

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

I am pleased to announce that in December, NCPS will be offering a webinar series, ***Improving Your RCA2 Processes***. In the event reports submitted to us, we sometimes see gaps in members' investigations and RCAs performed. Not all root causes may have been identified or there are disconnects in the determination of cause-and-effect relationships. These gaps lead to incomplete corrective actions which could allow a similar event of patient harm to reoccur. Our goal in providing this training opportunity is to help members develop their own processes that are timely, actionable, and inclusive; and equally as important, processes that are streamlined and less stressful to facilitate as compared to what their current processes may be.

This series will consist of three sessions on Wednesdays in December (December 6, 13, and 20) from 1:30-2:30pm. Topics to be covered include:

- Prioritizing Events for Review
- Learning from a System-Level View
- Who Should Be on an RCA2 Team
- Engaging the Patient
- Finding and Mapping the Facts
- Causal Statements to Facilitate Action
- Actions to Build Safter Systems
- NCPS RCA Quality Audit Tool

Optional homework will be offered to aid you in your learning and virtual office hours scheduled for the Monday afternoon (1:30-2:30pm) and Tuesday morning (9:30-10:30am) following the live Wednesday sessions. This will allow participants who have questions about the content included in the previous Wednesday's session or the optional homework to have them answered.

On January 10, 2024, we will conclude the series with a Safe Table where participants can share their experiences and learnings. Safe Tables are not recorded and a Safe Table Confidentiality agreement is included in your registration for this session.

The resources used in these sessions are drawn from the Institute for Healthcare Improvement, the Veterans Health Administration National Center for Patient Safety, and actual events reported to NCPS.

Please go to the NCPS website's Event Calendar to register for the sessions. Registering there will trigger an automated email to be sent to you which contains the correct zoom link for the session or virtual office hours for which you registered. The Wednesday sessions will be recorded for those who have scheduling conflicts and are unable to attend the "live" sessions. CEUs will be available for persons attending the live sessions.

If you do not currently have a NCPS membership login, please go to www.nepatientsafety.org and click on Members on the page's header or click here. Either method will allow you to access the Member request sign-on. We will get your sign-on set up so you can then register for this important training opportunity!

NCPS Shared Learning Resources

This month's Learning Resource is a de-identified event of harm where a patient on BIPAP for respiratory management had the BIPAP removed and replaced with 3 liter of oxygen by nasal cannula for transport to the Radiology suite for a CT scan. Several gaps in the established workflow resulted in staff not recognizing the patient's subsequent difficulty in breathing and eventual coding. This resource, ***Intrahospital Transport of Patients on O2***, may be found on the NCPS website in Education Resources\De-identified Events on the Members pages [t.e2ma.net].

Legal Counsel Updates

Last month, the President's Council of Advisors on Science and Technology (PCAST) released a report with recommendations on transforming patient safety in the United States. PCAST made several recommendations in the report to President Biden including establishing federal leadership to place patient safety as a national priority, increased collaboration with patients to reduce disparities in medical errors, mandatory event reporting towards a national repository, and advancing research practices and technologies. While Patient Safety Organizations have worked for years with members to create a learning ecosystem to support patient harm reduction, the report calls for a national focus on gathering and disseminating adverse safety events and building upon the existing work of PSOs to improve data transparency and evidence-based solutions. These proposed actions could have a significant impact on Patient Safety Organizations. At this time, we are uncertain of all that this proposed action could mean and so NCPS will continue to monitor the status of the PCAST report and further federal action to share with our members and other stakeholders. The full report can be found here.

Please contact Emily Barr at embarr@unmc.edu if you have questions or thoughts regarding the PCAST report.

Learning Opportunities for NCPS Members

NAHQ Healthcare Quality Week 2023 Webinars

In celebration of National Healthcare Quality Week, Oct 15 - 21, the National Association for Healthcare Quality is providing complementary webinars each weekday.

Tuesday's offering is the 2018 HBO Documentary, Bleed Out. This is a medical error/patient safety story told by the son of a patient who suffered a catastrophic event of harm when undergoing a routine hip pinning.

Wednesday, a panel of safety and quality leaders, as well as the patient's son who was the writer, director, and producer of the documentary, will discuss the documentary and its larger concerns about patient safety and state of healthcare in the United States.

Friday's presentation is Ethical Leadership: Creating Psychological Safety at All Levels of the Organization. This topic is of importance for a culture of reporting which we know is foundational to creating an organization's culture of safety.

Use this link to review the schedule of events and to register for any which you would choose to attend.

Patient Safety Resources

Study finds racial and ethnic bias in healthcare algorithms

Algorithms are commonly used in electronic health records, clinical guidelines and healthcare decision tools. This is a concern for patient safety and quality of care because these algorithms may introduce bias into care delivery and outcomes. This study shows the need for standardized and rigorous approaches for algorithm development and implementation to mitigate racial and ethnic inequities. The paper is available at: https://www.degruyter.com/document/doi/10.1515/dx-2022-0055/

Understanding and preventing vaccination errors

Vaccine errors can limit the effectiveness of immunization efforts. Based on survey data from 227 health professionals in France, this study identified several areas for improvement related to knowledge of vaccine-related errors, such as contraindications during pregnancy, vaccine storage, age-related vaccine schedules, and vaccine administration. The paper may be found here.

Racial and ethnic discrepancy in pulse oximetry and delayed identification of treatment eligibility among patients with COVID-19.

Black and brown patients have experienced disproportionately poorer outcomes from COVID-19 infection as compared with white patients. This study found that patients who identified as Asian, Black, or Hispanic may not have received timely diagnosis or treatment due to inaccurately measured pulse oximetry (SpO2). These inaccuracies and discrepancies should be considered in COVID outcome research as well as other respiratory illnesses that rely on SpO2 measurement for treatment. 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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