

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

---

## **NCPS Update: September 2024**

### **A Message from the Executive Director**

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

September 17th, 2024, acknowledges World Patient Safety Day, which provides us all the opportunity to raise awareness for patients, healthcare workforce and leaders, and policymakers to improve patient safety across the care continuum. The theme for 2024 is “Improving diagnosis for patient safety” with the slogan “Get it right, make it safe!” (World Health Organization)

NCPS continues to explore educational offerings to support efforts to improve diagnostic safety in Nebraska. According to preliminary patient safety event data reported to NCPS in 2023, 22% of events causing death or serious injury were a result of diagnostic error. This percentage stresses the significance of the World Patient Safety Day theme of diagnostic safety. Additional information on reported patient safety data will be published in the 2023 NCPS Annual Report in the near future. Members interested in collaborating with NCPS on projects associated with diagnostic safety improvement can contact Emily Barr, [embarr@unmc.edu](mailto:embarr@unmc.edu).



NCPS is recognizing World Patient Safety Day by hosting a virtual Members Meeting on September 17th from 8:30 AM-12:00 PM. We look forward to hearing from expert presenters on various topics relevant to the patient safety work our members are engaging in. Please visit the NCPS website, [here](#), to register and view full program information. This event is free for member organizations, and CEs will be offered for those able to attend the event live. The event will be recorded.

### **NCPS Shared Learning Resource**

This month's learning resource is a patient safety brief discussing the importance of creating and maintaining order sets in the electronic health record in such a manner to ensure patient safety. An interesting finding is that the extent to which order sets support clinical workflow is not well understood and if structured poorly can cause unintended patient harm. This patient safety brief includes best practices for the creation and maintenance of order sets and other clinical decision support tools. These tools help organizations meet the Five "Rights" of Clinical Decision Support Tools[i]:

**Right Information** - relevant and supported by best evidence available

**Right Person** - targeted to the correct individuals and supportive of their workflow

**Right Format** - presented in such a way that is useful to the task at hand (e.g., alerts, order sets, or info buttons for a particular application)

**Right Channel** - delivered through the most appropriate medium for its goal

**Right Time** - available to the user when it is needed

This resource, Order Sets in the Electronic Health Record, may be found in the Members Only portal of our website in the [Educational Resources tab](#).

[i] Campbell, JR. The "Five" Rights of Clinical Decision Support. *J AHIMA*. 2013;84:42-7.

## Legal Update

### AQIPS September Monthly Meeting

**September 19, 2024**      **1:30pm- 2:30pm CT**

Please join us for the Alliance for Quality Improvement and Patient Safety (AQIPS) Monthly Member Meeting. In this meeting, members share their best practices and patient safety problems they are working to overcome. If you have an agenda item you would like to have added to the meeting, please email it to [pbinzer@allianceforqualityimprovement.org](mailto:pbinzer@allianceforqualityimprovement.org). Peggy Binzer, JD, is AQIPS Executive Director and the meeting host. Email [carlasnyder@unmc](mailto:carlasnyder@unmc) if you are interested in attending and the AQIPS meeting invitation will be forwarded to you.

### AQIPS 4th Quarter Legal Counsel Meeting

**November 14, 2024**      **2:15pm- 3:15pm CT**

In the Legal Counsel Meeting, recent case law and legal principles are discussed. If you have any case law to share or would like to make a presentation, please email [pbinzer@allianceforqualityimprovement.org](mailto:pbinzer@allianceforqualityimprovement.org). This meeting is hosted by AQIPS Executive Director, Peggy Binzer, JD. Email [carlasnyder@unmc](mailto:carlasnyder@unmc) if you are interested in attending and the AQIPS meeting invitation will be forwarded to you.

## Learning Opportunities for NCPS Members

### NCPS Annual Members Virtual Meeting

**September 17, 2024**      **8:30am - 12 noon CT**

The agenda for this members only meeting has a wide variety of topics with at least one that should be of benefit to you in your work in patient safety! Here is a brief outline of the day's agenda:

**Keynote Address: 8:30-9:00 AM**

Joy Doll, OTD, OTR/L

Data Driven Decision Making: Building Capacity for Evidence-Based Practice

**Session 1: 9:00-10:00 AM**

Amy Vacek, MSN, RN

Daily Visual Management Boards for Process Improvement

**Session 2: 10:00-11:00 AM**

Peggy Binzer, JD

Designing PSES Programs, including Patient Disclosure

**Session 3: 11:00 AM - 12:00 PM**

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

NCPS State of the Organization

Members may use this [link](#) to register for the event. CEs will be available for those attending live. The sessions will be recorded and distributed to all who have registered.

**PSA Hosted Webinar: "Success Cause Analysis" as a Strategy to Promote Learning and Staff Engagement****Wednesday, September 18, 2024      11:00am - 12noon CST**

Historically the most common approach to improve safety in healthcare has been to study adverse outcomes to identify system weaknesses and correct them. While this approach is useful, it has limitations. Additionally patient safety professionals can experience stress and may view their systems and teams as unsafe. Quality professionals, both physician and nurses, from several well-known health systems will articulate the value of Success Cause Analysis (SCA) in promoting learning and organizational culture change. They will describe SCA considerations for each component of traditional event analysis, how they established SCA within their organizations, and how you can deploy SCA in your facility. Additionally, participants will learn how to mitigate "third victim syndrome" for safety professionals analyzing only errors and how to involve patients and families in patient safety and quality process reviews. Click [here](#) to go to the Patient Safety Authority (PSA) website to learn more about this webinar and to register for it.

**PSQH Hosted Webinar: Regulatory Update - What You Need to Know About the Latest Changes Affecting Patient Safety****Tuesday, September 24, 2024      12:00noon - 1:00PM CST**

In this webinar, Jen Cowel, Executive Vice President of Accreditation Regulatory Compliance, Patton Consulting, explains everything you need to know about the latest regulatory and compliance changes affecting patient safety and healthcare quality. Use this [link](#) to register for this free webinar hosted by Patient Safety & Quality Healthcare (PSQH).

**NAHQ: CPHQ Virtual Instructor-Led Review Course****Course Schedule: October 4 - October 18**

October 4                      3-4 PM

October 7 -11                3-5 PM

October 14 - 18            3-5 PM

This course is designed to support those planning to take the Certified Professional In Healthcare Quality (CPHQ) Certification. Based on the current CPHQ content outline, this course provides a review of essential healthcare quality concepts and offers valuable tips on how to best prepare for the exam. More information on this educational offering may be found on the [NAHQ website](#).

## **Older adults are often misdiagnosed. Specialized ERs and training clinicians can help.**

Missed or delayed diagnosis in older people is a problem fed by clinical and social complexities. This story, aired on National Public Radio in July of 2024, discusses the need for geriatricians, geriatric emergency rooms, or special training for physicians in caring for older patients. You can access the story [here](#).

## **Association of patient photographs and reduced retract-and-reorder events.**

Patient misidentification can lead to serious patient safety risks. In this study, conducted at one pediatric hospital system, the presence of a patient photograph in the electronic health record (EHR) associated with a 40% reduction in the odds of retract-and-reorder events, a surrogate measure of wrong-patient order entry. The paper may be found [here](#).

## **What I Wish I Had Known - A Chief Quality Officer reflects on 25 years as a healthcare safety leader**

In this article by Dr. Tejal Gandhi, the Chief Safety and Transformation Officer at Press Ganey, she outlines the important things she's learned in the course of her work in patient safety. She specifically addresses seven things she would "impart to her younger self". They are: 1). We need to address emotional harm, too. 2). Patients' perceptions of safety shape their experience. 3). Care is only truly safe if it's also equitable. 4). Workforce safety is a precondition of patient safety. 5). Safety culture and employee engagement are mutually reinforcing. 6). Bring together people, process, and technology to fortify the system and strengthen the skills of people in the system. 7). Safety is the foundation of healthcare. The complete article 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](mailto:carlasnyder@unmc.edu)

Share this email:



[Manage](#) your preferences | [Opt out](#) using TrueRemove®

Got this as a forward? [Sign up](#) to receive our future emails.

View this email [online](#).

986055 NE Medical Center  
Omaha, NE | 68198 US

This email was sent to .

*To continue receiving our emails, add us to your address book.*

[Subscribe](#) to our email list.