NCPS
Nebraska Coalition for Patient Safety

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

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# NCPS Update: March 2024

## A Message from the Executive Director

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

March 10-16, 2024 marks the annual recognition for Patient Safety Awareness Week, serving as a dedicated time to observe and bring awareness to improve the safety of the health care system for patients and the workforce. Several studies have estimated that 134 million adverse events occur each year, resulting in approximately 2.6 million deaths (World Health Organization). One patient safety topic highlighted throughout this year regards diagostic safety. The NCPS 2022 Annual Report features information on diagnostic safety from member-reported events, including that 122 of the 13,063 events with known severity resulted in permnant harm or death, with 49 (40%) of these events resulting from diagnostic error (Annual Reports : About : Nebraska Coalition for Patient Safety (nepatientsafety.org). NCPS continues to expand data collection methods and analysis to support member organizations and providers with diagnostic safety efforts. To commemorate Patient Safety Awareness Week, please consider viewing a free webinar offered through the Institute for Healthcare Improvement on March 14th at 10:00 AM CT titled, Diagnostic Excellence. Registration information can be found here.

NCPS also wants to draw your attention to a couple of updated announcements regarding future events and member service offerings.

- First, due to unforeseen circumstances, NCPS will be postponing the scheduled Patient Safety Conference originally scheduled for Friday, April 26th. The new date is still to be determined but will likely occur sometime in September, and will be a completely virtual, ½ day offering of continuing education on important patient safety topics. We look forward to providing more details in the near future.
- Second, the transition to the new NCPS event report form began this week with the initial pilot testing with a group of member organization volunteers. The purpose of the pilot group is to test the features of the form and the tutorial instructions to ensure a smooth transition for future event reporting. It is anticipated the pilot testing period will be open for approximately 4 weeks, so please stay tuned for further information on next steps for your organization.

In recognition of Patient Safety Awareness Week, NCPS thanks you and your teams for making patient safety a priority!

## NCPS Shared Learning Resource

This month's learning resource is a Patient Safety Alert, **Improving Communication with Deaf and Hearing-Impaired Patients**. The aging U.S. population with age-related hearing loss

(ARHL) and busy, noisy healthcare settings can collide resulting in serious patient harm events or less positive health outcomes due to miscommunications. The National Deaf Center states that in the 2021 American Community Survey (ACS), about 3.6% of the U.S. population, or about 11 million individuals, consider themselves deaf or have a serious difficulty hearing.(i)

A recent Viewpoint article published in the American Medical Association's online journal, JAMA Internal Medicine titled **"Communicating With Patients With Hearing Loss or Deafness - Can You Hear Me?"**(ii)**,** prompted our review of best practices and strategies to overcome this significant patient health and safety issue; and the creation of this month's resource with practical tools/considerations for health care providers. Our resource may be found on the NCPS website within the Educational Resources, Patient Safety Alert in our members only portal.

i. National Deaf Center on Post Secondary Outcomes; 2023. https://nationaldeafcenter.org/faq/how-many-deaf-people-live-in-the-united-states/

ii. O'Leary, D., O'Leary, T. Communicating With Patients With Hearing Loss or Deafness - Can Your Hear Me? JAMA Internal Medicine. Published online February 26, 2024.

## Learning Opportunities for NCPS Members

### Rural Maternal Health Series: Implementing Patient Safety Bundles in Rural Hospitals

**April 9 1:00 pm - 2:00pm CST**

Standardizing clinical care is a foundational element of improving safety and quality in healthcare. The AIM bundles, developed by the Alliance for Innovation on Maternal Health, are a set of processes that hospitals can implement to make complex care and teamwork more effective. In a presentation especially relevant for hospital leaders who want to move forward in this work but don't know where to start, speakers will address examples specific to rural and small hospitals, acknowledging the limited staffing and other constraints that these facilities often face.

Registration for this webinar may be found here. If you have questions or problems with the registration process, please contact RHIhub Webinars at webinars@ruralhealthinfo.org.

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## Patient Safety Resources

### A qualitative study of systems-level factors that affect rural obstetric nurses' work during clinical emergencies

Severe maternal morbidity continues to be a patient safety challenge. In this study, obstetric nurses and physicians describe unique system factors that affect obstetric nurses when their patients experience clinical deterioration. Lack of resources included physical necessities such as a blood bank as well as human resources in the form of staff practicing "at the top of their game". The researchers describe a need for context specific policies and procedures for rural hospitals. The full free text article may be found here.

### Exploring clinical lessons learned by experienced hospitalists from diagnostic errors and successes

Diagnostic errors cause significant patient harm and the achievement of diagnostic excellence can be accomplished by learning from both errors and successes in patient care. Clinically experienced hospitalists were interviewed to examine the clinical lessons they have learned from diagnostic errors and successes. Five themes were identified: excellence in clinical reasoning as a core skill; elucidating insights from patients and other care team members; reflecting on the diagnostic process; commitment to a growth mindset, and prioritizing self-care and well-being. You can find the study here.

### Use of professional interpreters for patients with limited English proficiency undergoing surgery

Though evidence shows the use of professional interpreters reduces disparities in care, they are not always utilized. This study investigated the use of professional interpreters on patients with limited English Proficiency (LEP) undergoing surgical procedures. These researchers emphasized hospital discharge as an important area to improve rates of interpreter use. You can find the paper here.

### Exploring the factors that drive clinical negligence claims: stated preferences of those who have experienced unintended harm

This study aimed to assess the relative important of factors that influence those who have experienced a patient safety incident (PSI) to make a claim for compensation. The actions taken by the health service after a PSI, and people's perceptions about the probability of success and the size of the potential reward, can influence where a claim is made. Study results show the importance of giving an appropriate apology and conducting a satisfactory investigation. This stresses the importance around how patients are treated after a PSI in influencing negligence claims that are made. This original research paper may be found here.

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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