2019 ANNUAL REPORT

NCPS

Nebraska Coalition for Patient Safety

APRIL 2020

EXECUTIVE DIRECTOR MESSAGE

Dear Patient Safety Advocates:

Welcome to the Nebraska Coalition for Patient Safety (NCPS) Annual Report for 2019! It is my privilege to provide you with this update of the patient safety activities conducted during and through the past year.

Since its inception in 2006, NCPS has been engaged with hospitals and surgical centers across Nebraska and western Iowa. We now have an exceptional opportunity to increase our reach to additional providers across the continuum of care and to expand the services we provide. The Nebraska Medical Association (NMA) and the Nebraska Academy of Physician Assistants (NAPA) advocated for the enactment of LB25 to create a patient safety cash fund to support the activities of NCPS. This additional funding, collected via patient safety fees for physicians and physician assistants at the time of licensure, will enable NCPS to increase its capacity to support healthcare providers in improving the safety and reliability of care delivery. We are grateful for the leadership NMA and NAPA have demonstrated, for the trust they have placed in us, and for empowering NCPS with the resources to advance patient safety improvement in our region.

As we look back on the past year, we are reminded how far we have come. We have made a conscious decision to focus on the foundational elements of safety culture evaluation and development in the education and services we provide. The upcoming year promises to be transformational! We are excited to welcome Regina Nailon, PhD, RN to NCPS in the new position of Patient Safety Program Director! Stay tuned as we work to update our reporting system, develop new educational offerings, expand our reach, and enhance our communications.

Thank you for your partnership and your unrelenting commitment to healthcare that is free from harm.

Gail Brondum, LPN, BS
Executive Director

THE VALUE OF NCPS

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

The Benefits of Working with NCPS: NCPS is certified as a Patient Safety Organization (PSO) with the Agency for Healthcare Research and Quality, a division of the Department of Health and Human Services. As such, healthcare providers who work with NCPS receive privilege and confidentiality protections, under federal law, to encourage reporting of patient safety information and collaboration in learning from events to reduce adverse outcomes.[1]

- **Protect:** Certain information, defined as patient safety work product, is privileged and confidential when a provider works with a PSO. These protections apply in all U.S. states and territories and reach across state lines.
- **Report:** Providers can report quality and patient safety information both within their organization and to NCPS confidentially and without fear of legal discovery. Development of a strong reporting culture is a key component of a culture of safety and a high reliability organization.[2]
- **Analyze:** NCPS data experts collect and analyze data from multiple providers so that trends and patterns can be identified that may not be visible by looking at smaller numbers of events from a single organization. Rare and serious events may also be detected sooner. NCPS workforce assists healthcare providers with investigating single events and analyzing aggregate data in a protected and confidential manner.
- **Share:** Through event review and analysis, NCPS gains insight into underlying causes of patient safety events. De-identified Events, Patient Safety Alerts, and Reporting Committee Summaries are shared with NCPS members as part of the feedback loop asking, "Could this happen at your organization?"
- **Learn:** Lessons learned from event reports and feedback can be used to prevent patient safety events. NCPS offers education and training on safety culture development and a variety of patient safety topics.
- **Improve:** NCPS assists providers with developing effective approaches to improving patient safety and quality, such as evaluating culture of safety, conducting root cause analyses, and developing strong action plans.

[1] *Agency for Healthcare Research and Quality (2020). Choosing a Patient Safety Organization. AHRQ Pub. No. 20-0030 March 2020. https://www.ahrq.gov/sites/default/files/wysiwyg/patient-safety/pso-brochure.pdf*
[2] *Reason, J. (1997). Managing the Risks of Organizational Accidents. Hampshire, England. Ashgate Publishing Limited.*

PROTECTION OF NCPS

In 2005, the U.S. federal government passed the **Patient Safety and Quality Improvement Act** (PSQIA). The **Patient Safety Rule** was finalized in 2008 and defines how the PSQIA is implemented.[3] The Patient Safety Rule establishes a framework by which health care providers may voluntarily report information to patient safety organizations on a privileged and confidential basis for the aggregation and analysis of patient safety events.

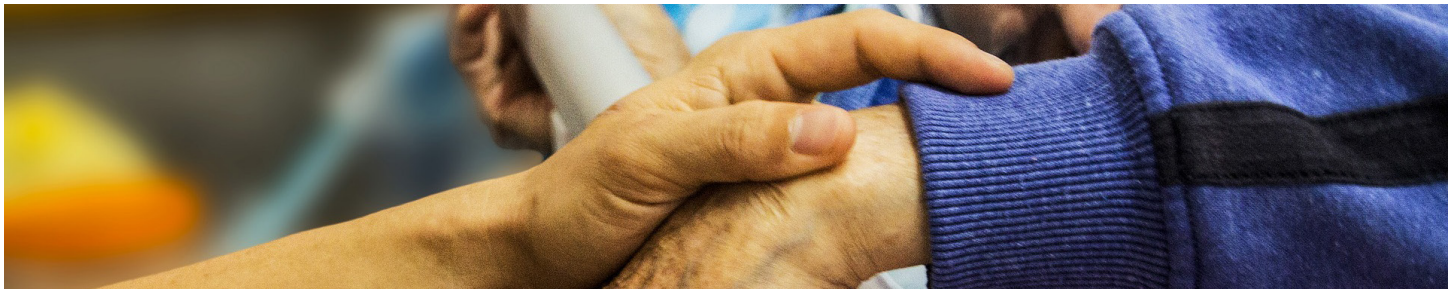
The **Patient Safety Rule** and the protections of the PSQIA have the force of federal law.[4] NCPS provides for a safe environment to report to, learn from, and share learnings about safety events. Additional information about the protections provided through NCPS membership include:

- **Confidentiality and privilege protections** can help overcome provider fear of liability exposure for sharing information about events and participating in quality and safety improvement activities.
- **Protections are broader** than most state protections, so all licensed or certified healthcare providers (facilities and individuals) can participate with a patient safety organization such as NCPS.
- **Protections are nationwide and uniform**, so healthcare systems can share protected information among affiliated providers in multiple states.

In 2009, NCPS became a federally listed patient safety organization with the Agency for Healthcare Research and Quality.

[3] *U.S. Department of Health and Human Services. Patient Safety and Quality Improvement Act of 2005 and Rule. https://www.hhs.gov/hipaa/for-professionals/patient-safety/statute-and-rule/index.html*

[4] *For online reference to the Patient Safety Rule, go to: https://www.ecfr.gov/cgi-bin/text-idx?SID=42192f8b6c83ddc-436beeab06ef0ab90&mc=true&node=pt42.1.3&rgn=div5#se42.1.3_110*



REPORTING EVENTS TO NCPS

NCPS creates a secure and protected environment for health care providers to report information about adverse events and hazards so learning can be shared with members and system improvements can be made to achieve safer, more reliable care. The NCPS Safety Event Report form is based on the Agency for Healthcare Research & Quality Common Formats[5] for reporting events in hospitals and nursing homes and the National Quality Forum Serious Reportable Events.[6]

Frequently Asked Questions about Reporting Events to NCPS:

Why is it important to report safety events to NCPS?

- ✓ Reporting safety events and near events allows NCPS to conduct meaningful data aggregation and analysis.
- ✓ Analysis of reported events within the robust database allows NCPS to identify trends and patterns in various types of events and levels of harm (where applicable).
- ✓ Members benefit from the insights gained by the NCPS aggregation and analysis of reports from multiple providers, especially regarding rare patient safety events.
- ✓ NCPS develops educational materials to share with members based on reported events to assist members with improving patient safety.
- ✓ Reporting events is a critical aspect of maintaining a reporting relationship with NCPS, through which members are provided confidentiality and privilege protections.

- There are no shared learnings if there are no reported events!
- If each member reported at least one event each month, NCPS would receive more than 700 reports each year.

What types of safety events should be reported to NCPS?

NCPS encourages members to report:

- ✓ Safety events that may or may not reach the patient.
- ✓ Safety events that reach the patient whether they result in harm or not.
- ✓ Unsafe conditions – those near events that pose risk to the environment.
- ✓ Findings from event investigations and root cause analyses.

How does our organization report to NCPS?

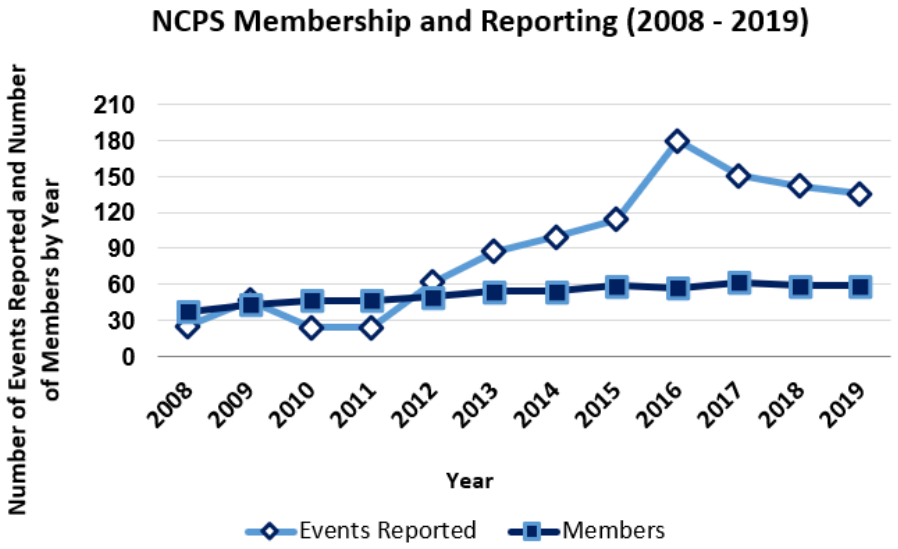
NCPS members can access the event reporting questionnaire and instructions on how to complete and submit the report through our members-only website portal, in the Tool Kit tab.

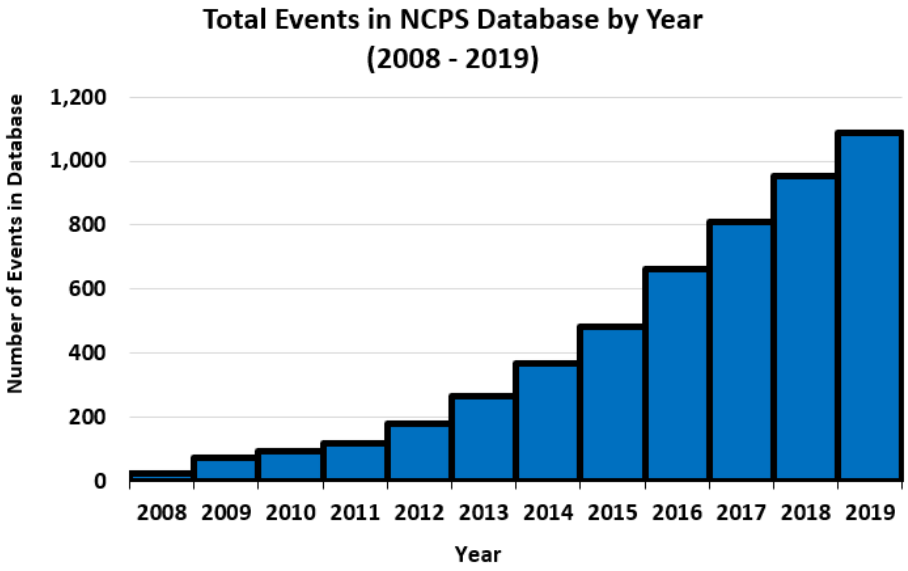
[5] *Agency for Healthcare Research & Quality. Common Formats – Scope and Reporting. https://www.pso.ahrq.gov/common/scope*

[6] *National Quality Forum. Serious Reportable Events. http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx*

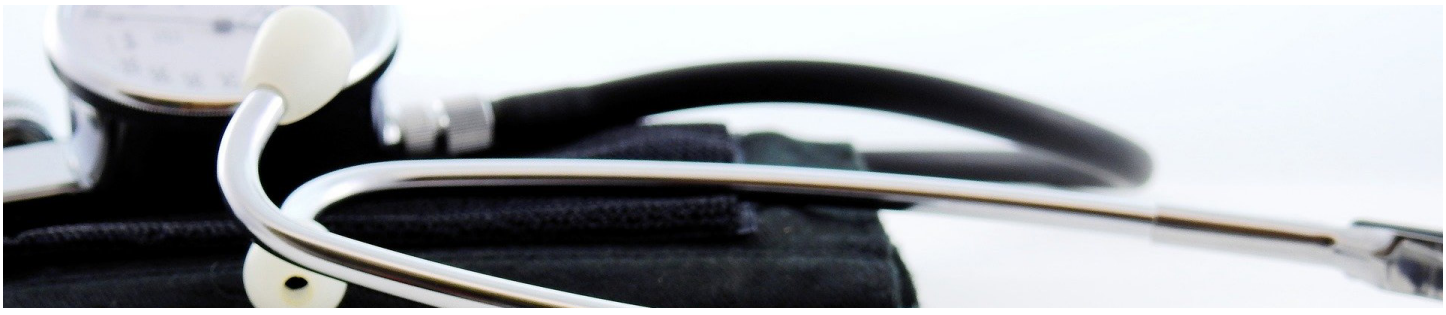
NCPS REPORTING ANALYSIS

- There were 59 hospital members in 2019
- Members submitted 136 event reports in 2019

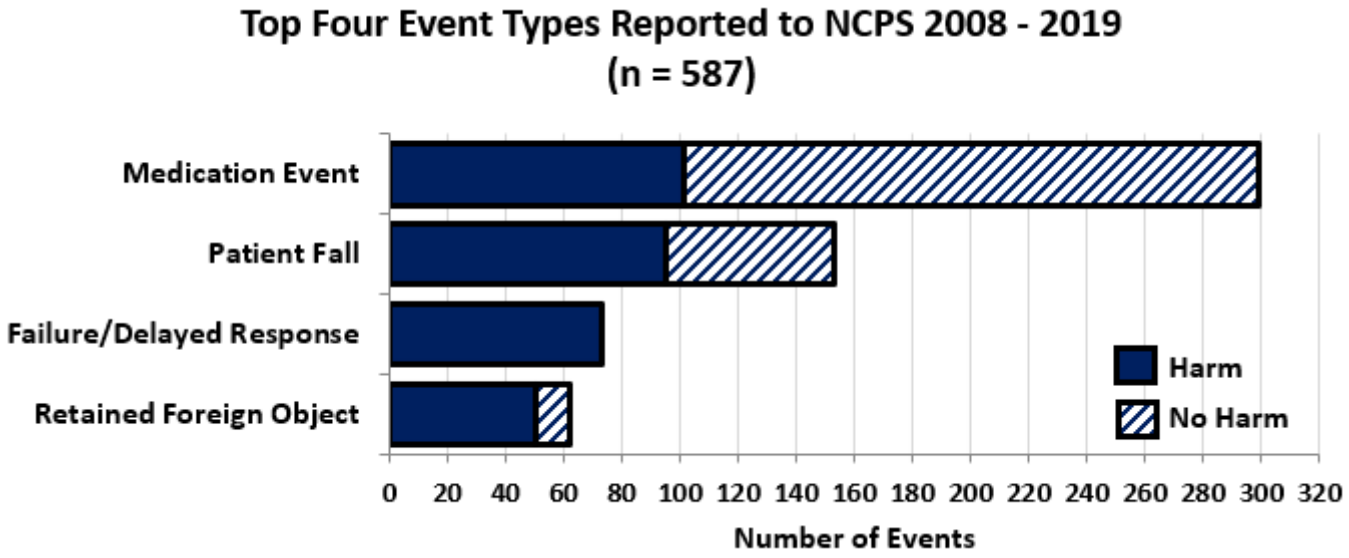




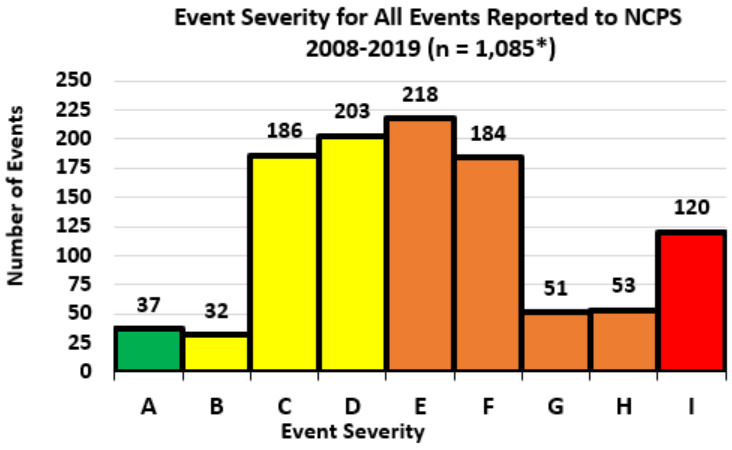
Since its beginning, there have been 1,090 events reported to NCPS. The graph on the left displays the cumulative number of events in the NCPS database by year.



NCPS REPORTING ANALYSIS



- Over one-half of all events reported to NCPS fall within the top four categories displayed. Overall, 54% of these reported events resulted in patient harm, while 46% did not.
  - ✓ Of the 299 medication-related events, 34% resulted in harm
  - ✓ Of the 153 patient fall events, 62% resulted in harm
  - ✓ Of the 73 failure to respond or delay in response events, 100% resulted in harm
  - ✓ Of the 62 retained foreign object events, 81% resulted in harm
- NCPS uses the National Coordinating Council for Medication Error Reporting and Prevention index of severity, which assigns a ranking based on the outcome of the event.

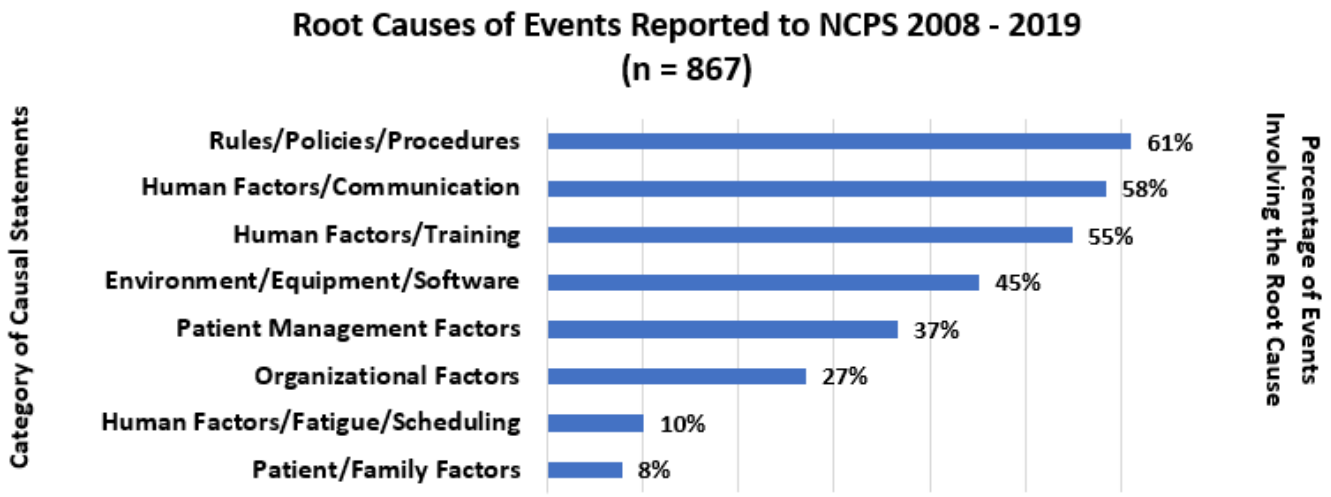


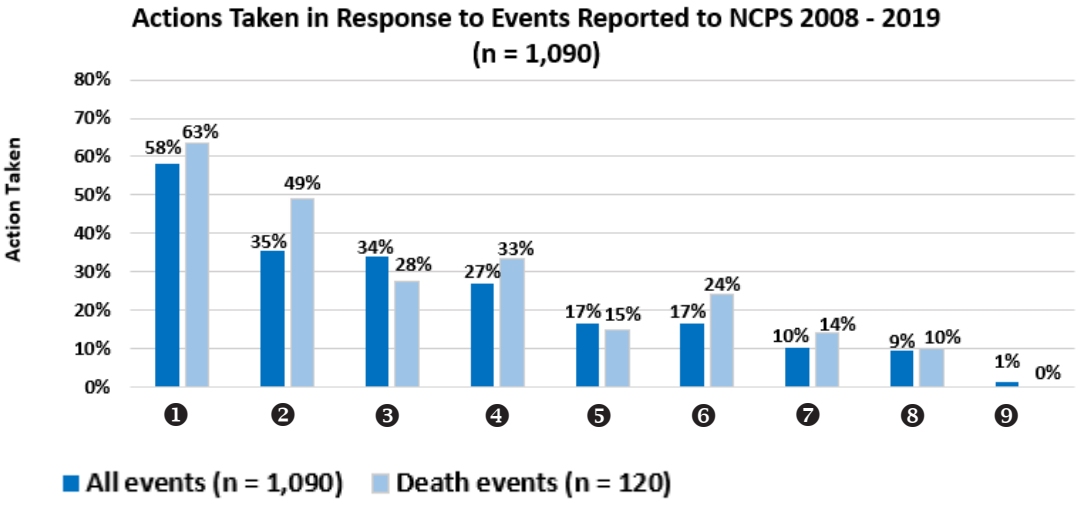
* One event with unknown severity not displayed; four events reported without severity indicated.

A	Circumstances or events occur that have the capacity to cause error
B	An error occurred, but the error did not reach the patient
C	An error occurred that reached the patient, but did not cause patient harm
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient, and/or required intervention to preclude harm; harm does not reach patient
E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required an initial or prolonged hospital stay
G	An error occurred that may have contributed to or resulted in permanent patient harm
H	An error occurred that required intervention necessary to sustain life
I	An error occurred that may have contributed to or resulted in patient death

NCPS REPORTING ANALYSIS

Of the 1,090 events reported since NCPS became a patient safety organization in 2008, member hospitals have identified root causes for 867 (80%) of these events. Across these 867 events, the most frequently identified root causes of reported events are Rules/Policies/Procedures (61%), Human Factors/Communication (58%), and Human Factors/Training (55%).





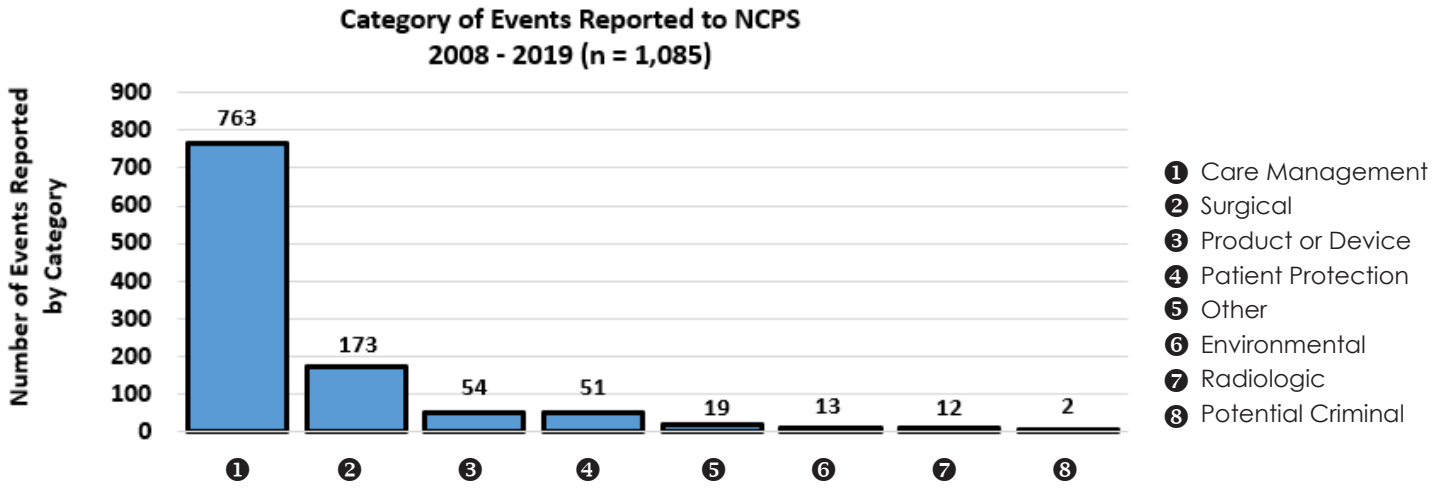
❶ Training/Education Provided
❷ Communication Process Improved
❸ Informed Patient/ Caregiver of Event
❹ Policy/Procedure Changed
❺ Equipment/Software Modified
❻ Policy/Procedure Instituted
❼ Environment Modified
❽ Staffing Practice/ Policy Modified
❾ Formulary changed

When examining the 1,090 events reported, actions most frequently taken included providing education and training (58%), improving communication processes (35%), and informing the patient and/or caregiver that the event occurred (34%). These actions are consistent with two root causes most frequently identified in the 867 events that reported root causes: human factors/communication and human factors/training. Although rules/policies/procedures were identified as a root cause in 61% of the 867 events that reported root causes, only 27% of actions taken of all events involved changing rules/policies/procedures.

The actions most frequently taken in response to the 120 events reported that resulted in patient death included providing education and training (63%), improving communication processes (49%), and changing policies/procedures (33%) and/or instituting new policies/procedures (24%).

NCPS REPORTING ANALYSIS

Of the 1,090 events reported to NCPS between 2008-2019, 1,085 indicated the type of event that had occurred. Of these, 763 (70%) fell into the Care Management category. This was followed by surgical events, which comprised 173 (16%) of the reported events.

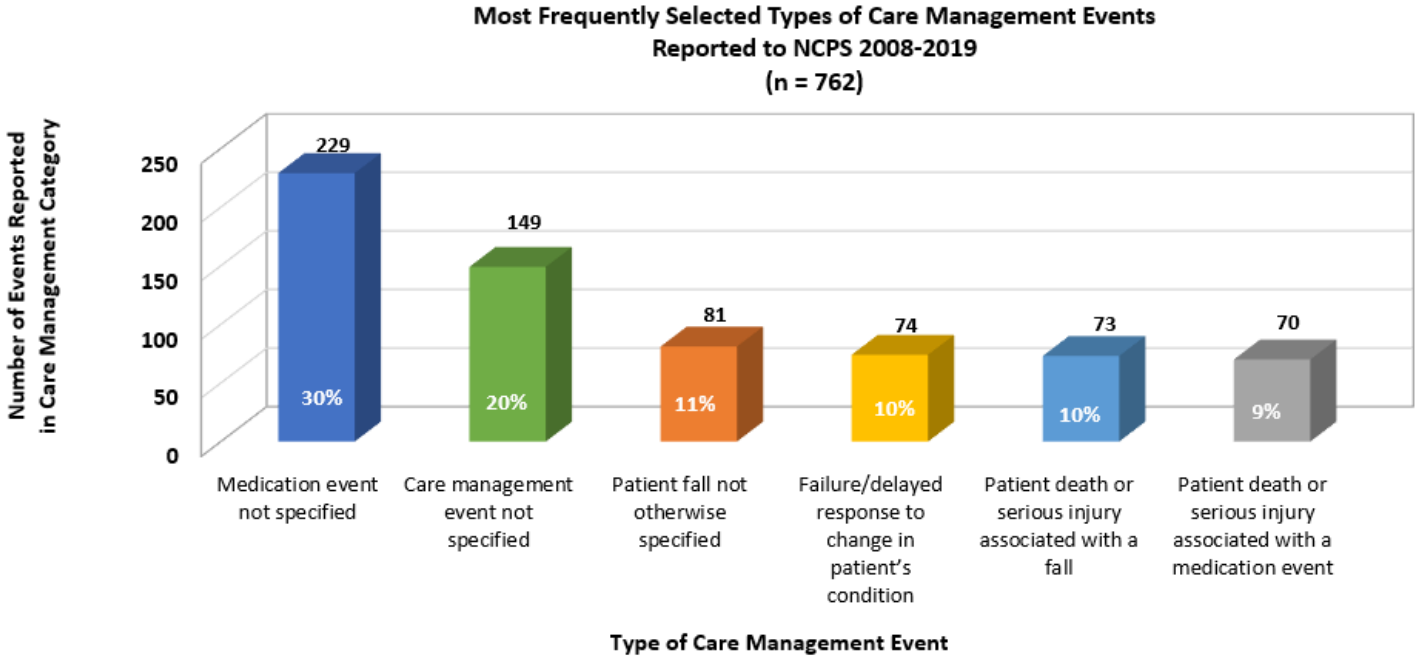


A detailed analysis of the Care Management and Surgical types of events is provided on the following pages. The table displays the types of events within each of the remaining categories displayed in the graph above.

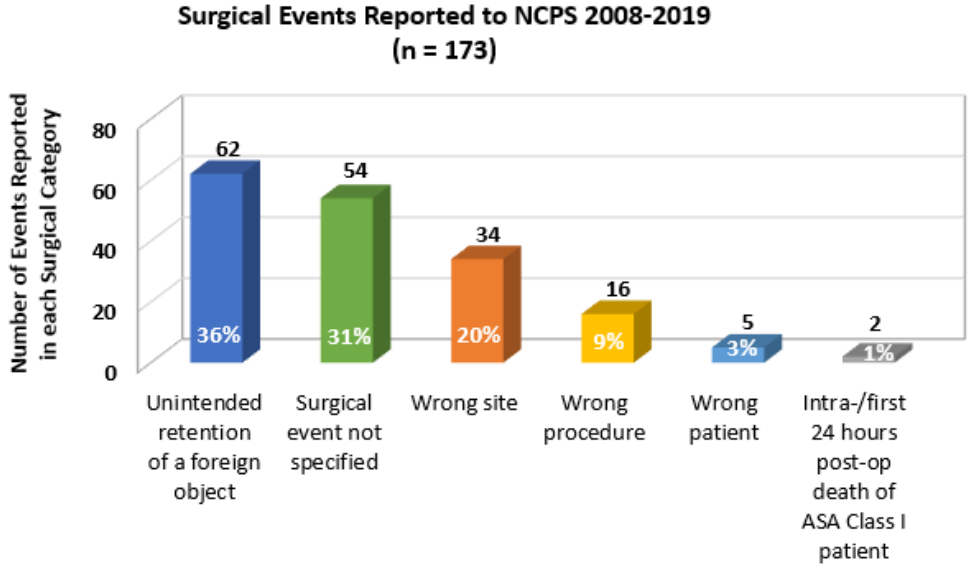
Event Category	Number Reported	Percentage Reported
Product or Device Events (n = 54)		
Patient death/serious injury with use of contaminated drugs, devices or biologics products.	9	17%
Patient death/serious injury with use or function of a device in patient care, when device is used or functions other than intended.	6	11%
Patient death/serious injury associated with intravascular air embolism.	5	9%
Product or device event not otherwise specified.	34	63%
Patient Protection Events (n = 51)		
Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting or suicide within 72 hours of discharge.	29	57%
Patient death/serious injury associated with patient elopement (disappearance).	2	4%
Patient protection event not otherwise specified.	20	39%
Environmental Events (n = 13)		
Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.	9	69%
Environmental event not otherwise specified.	4	31%
Radiologic Events (n = 11)		
Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field or any delivery of radiotherapy to the wrong region or greater than 25% above the planned dose.	5	45%
Radiologic event not otherwise specified.	6	55%
Potential Criminal Events (n = 2)		
Abduction of a patient/resident of any age.	1	50%
Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.	1	50%

NCPS REPORTING ANALYSIS

762 (70%) of reported events fell into the Care Management category. Of these, the majority (229, 30%) were medication errors; an additional 70 (9%) medication-related events resulted in patient death or serious injury. Patient falls accounted for 11% (n = 81) of all Care Management-related events, and an additional 73 (10%) Care Management-related events resulted in patient death or serious injury associated with a fall. The specific category was not identified in 149 (20%) of the Care Management-related events that were reported.



Of the 173 surgical events reported, 62 (36%) involved unintended retention of a foreign object, while 34 (20%) of the reported surgical or invasive procedures were performed on the wrong site. The wrong procedure was performed in 16 (9%) of the reported events. Surgical or invasive procedures being performed on the wrong patient accounted for 5 (3%) of the events reported. In 54 (31%) of the reported surgical events, the type of surgical event that had occurred was not specified.

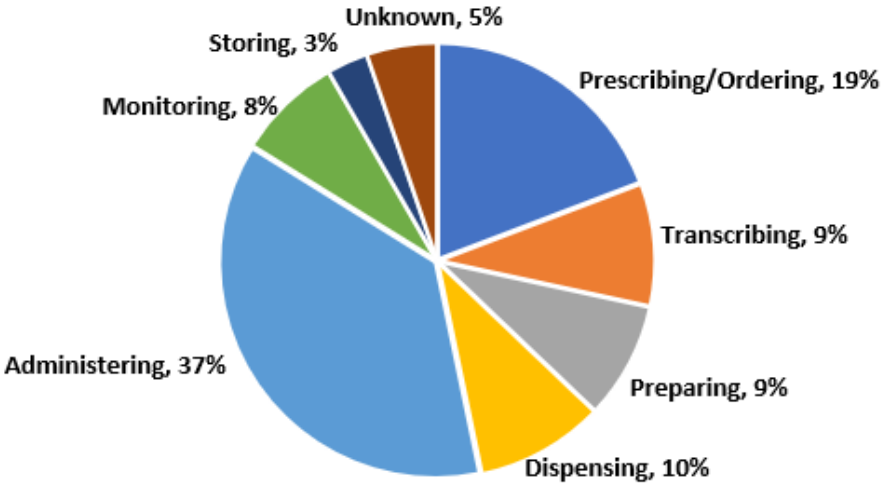


NCPS REPORTING ANALYSIS

Medication Events Reported to NCPS 2008-2019

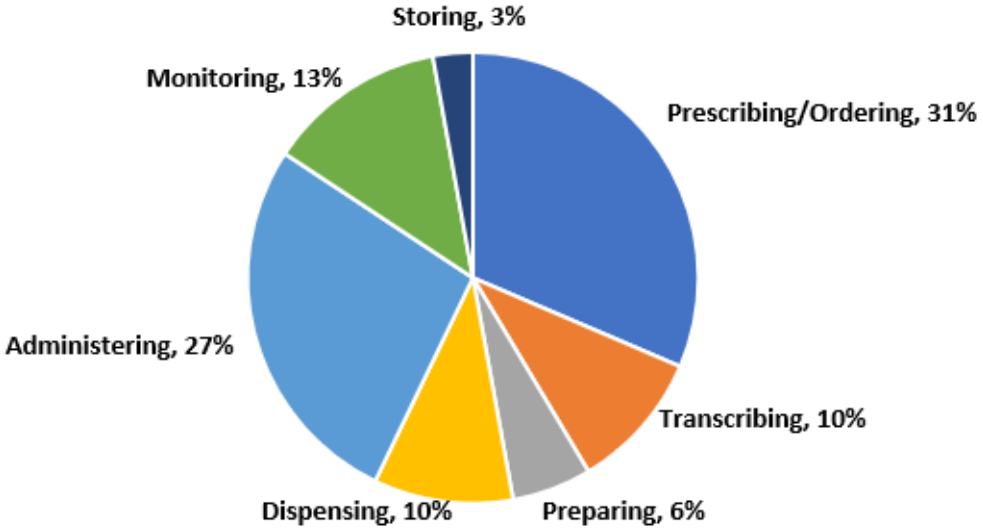
An analysis of the medication-related events reported to NCPS between 2008-2019 (n = 229) revealed that the majority (37%) occurred during administration of the medications. 44 events (19%) were related to prescribing/ ordering of the medications involved. Preparation and dispensing of medications accounted for 42 (19%) of the reported events.

Stage in Medication Process: Medication Events Reported to NCPS 2008-2019 (n = 229)



When examining the additional reported medication-related events that resulted in patient death or serious injury (n = 70), the data reveal that the majority (31%, n = 22) were related to prescribing/ordering of the medications involved. 19 (27%) of these medication-related events occurred during administration of the medications, while 9 (13%) revolved around monitoring of the patient who had received medications.

Stage in Medication Process: Medication Events Resulting in Patient Death or Serious Injury 2008-2019 (n = 70)



2019 NCPS SHARED LEARNING

Sharing the learning from events that are reported to NCPS is an integral component of the PSO - provider learning and feedback system. De-identified Events and Patient Safety Alerts are developed based on reports submitted to NCPS. These shared learning reports include lessons learned from event investigations, evidence-based best practices, and other resources for improvement. Webinars and in-person education offerings are developed based on needs identified from event reports and current patient safety topics.

De-Identified Events

- Retained Prep Sponge
- Delay in Home Medication Reconciliation
- Wrong Medication: Rocuronium Ordered - Vecuronium Given
- Wrong Patient: Emergency CVA Situation

Patient Safety Alerts

- Cautery Burns and Fires
- Antithrombotic and Thrombolytic Events

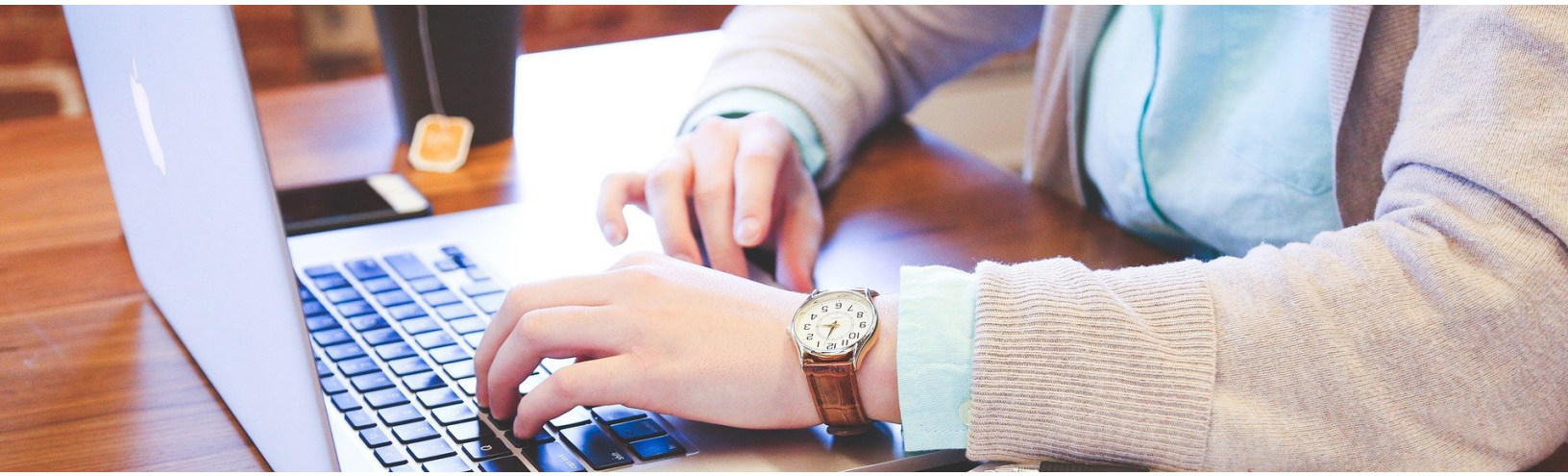
Member Webinar Topics

- Promoting Patient Engagement to Improve Safety
- Pain Management and Opioid Oversight
- Alliance for Quality Improvement and Patient Safety (AQIPS):
  - ✓ Patient Safety and Quality Improvement Act Case Law/Discovery Training for Counsel
  - ✓ Creating a Patient Safety Evaluation System (PSES), Step-by-Step
- Katten Law: Integrating Medical Staffs in a Multi-Hospital System: Challenges, Options and Proposed Solutions

Member Training Workshops

- Just Culture
- Root Cause Analysis
- TeamSTEPPS®

NCPS members have access to previous education and shared learning reports through our members-only website portal.



2019 NCPS MEMBER EDUCATION

2019 QUALITY FORUM: NCPS SESSIONS

Pre-Conference Workshop: Root Cause Analysis - An Essential Tool for Learning Organizations
Katherine Jones, PT, PhD

Keynote Introduction: Nebraska Coalition for Patient Safety
Katherine Jones, PT, PhD

Attendees at this session learned about the Nebraska Coalition for Patient Safety and the legal protections it affords its members as they maintain a reporting relationship that reflects a commitment to improving patient safety in care delivery.

NCPS Patient Safety Track Presentations:

Implementing Safety Culture: Do a Few Things Well
Katherine Jones, PT, PhD

Attendees at this session learned the importance of using an explicit definition of safety culture to facilitate planning, implementation, and measurement of safety culture and four types of interventions that support safety culture.

Looking Outside Your Silo: Systems Approach to Quality Problems
Victoria Kennel, PhD, Bethany Lowndes, PhD, MPH, Gary Cochran, PharmD, SM, and Anne Skinner, RHIA, MS

The presenters identified gaps in common solutions to complex quality and safety problems and explained the role that multiple members of the healthcare team can play in solving complex quality and safety problems. Attendees learned a process for analyzing complex safety and quality issues from a systems perspective.

Coalition Rx, Substance Use Disorders and Patient Safety
Edward M. DeSimone II, RPh, PhD, FAPhA

Attendees at this session learned the prevalence of substance use disorders and the mission of Coalition Rx to reduce the misuse of all substances of abuse by raising awareness and partnering with community organizations to provide public and professional education, prevention and treatment resources, and policy advocacy.

Pathway to a Safe and Just Culture
Julie Rezac, RN, BSN, M.Ed, Jessica Trutna, BSN, RN, and Joni Duerksen, BSN, RN

The presenters described the journey undertaken by Saunders Medical Center in developing and sustaining a safe and just culture. The pathway they developed included TeamSTEPPS® training and Just Culture training for all employees to ensure that safety is always a priority of everyone.

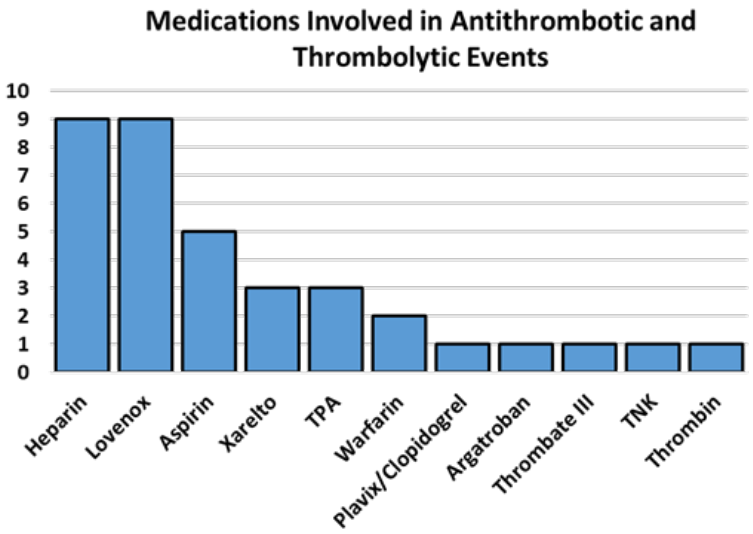
Events Involving Antithrombotic and Thrombolytic Agents

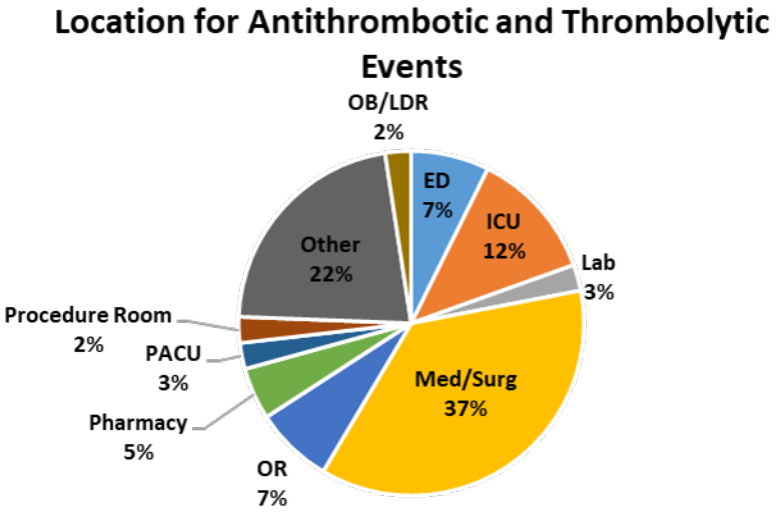
Antithrombotic agents are included in the Institute for Safe Medication Practices (ISMP) list of *high-alert medications that pose a high risk of causing significant patient harm when used in error*.[7] NCPS received a total of 38 event reports related to antithrombotic, thrombolytic, and similar agents between 2008 and October 2019. Thirteen of these events (34%) were reported in the most recent two years. This type of event accounts for 12% of all medication errors reported to NCPS. A Patient Safety Alert on this topic was issued by NCPS in October of 2019.

- The majority of antithrombotic and thrombolytic events reported occurred on medical/surgical units
- Heparin and Lovenox were the agents involved in the majority of events reported

NCPS data also showed that:

- Patients over the age of 50 were impacted in 76% of the events
- Of all antithrombotic and thrombolytic events reported, 42% (16/38) caused harm
  - ✓ 18% (7/38) percent caused serious harm
  - ✓ 8% (3/38) resulted in death





[7] *Institute for Safe Medication Practices. (2018). High-alert Medications in Acute Care Settings. Retrieved from www.ismp.org/recommendations/high-alert-medications-acute-list*

Events Involving Antithrombotic and Thrombolytic Agents

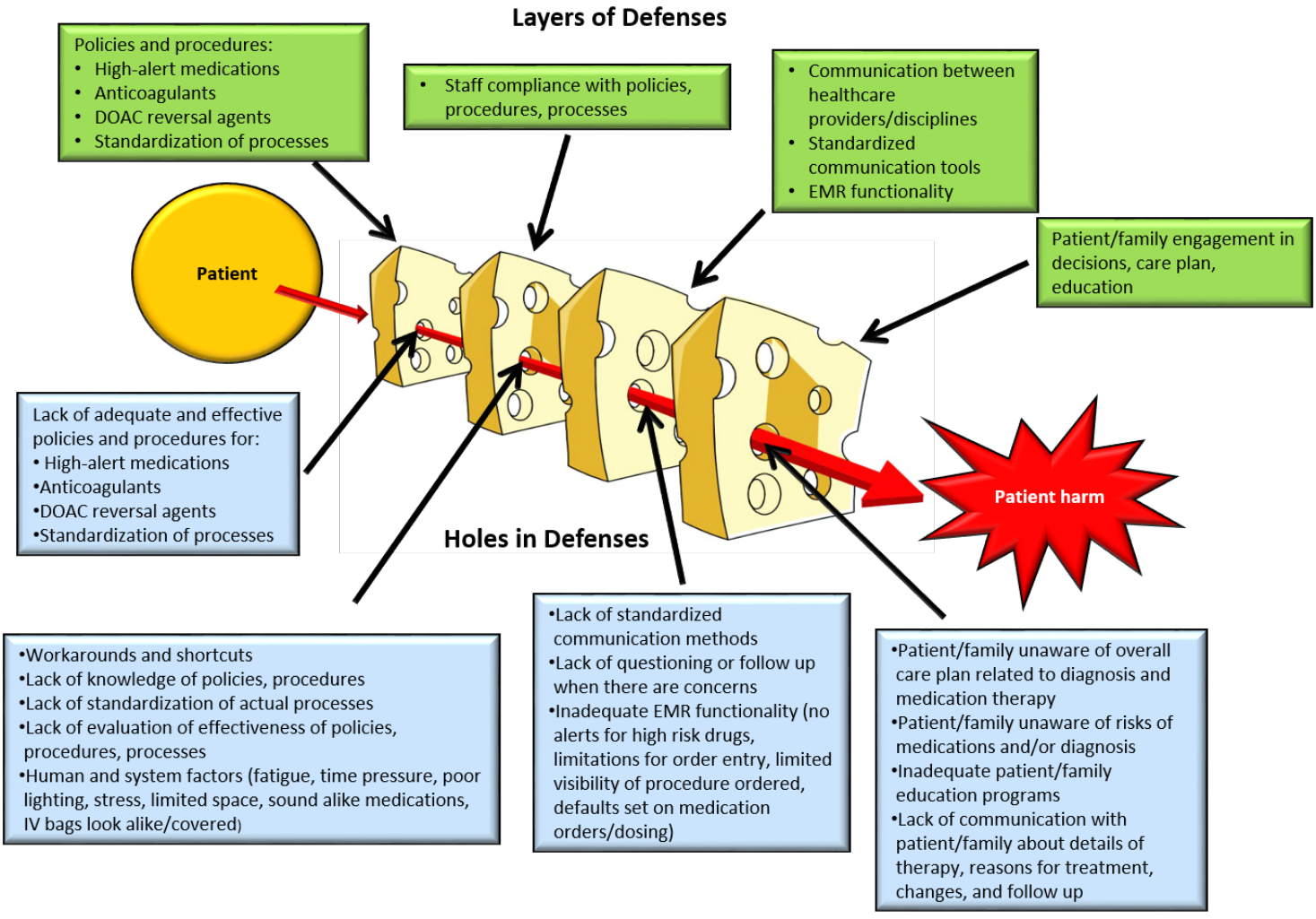
The most common causal factors reported with these events were:

- Communication breakdown, especially during handoffs
- Lack of compliance with a policy/ procedure or lack of a policy/procedure

Workarounds to established procedures were frequently an issue contributing to these events.

It was also noted that improved patient/ caregiver engagement and education might have prevented several of the events.

The Swiss Cheese Model[2] below demonstrates holes in the layers of defenses identified in antithrombotic- and thrombolytic agent-related events reported to NCPS. This model helps visualize how latent errors can contribute to adverse events and the potential for patient harm.



[2] *Reason, J. (1997). Managing the Risks of Organizational Accidents. Hampshire, England. Ashgate Publishing Limited.*

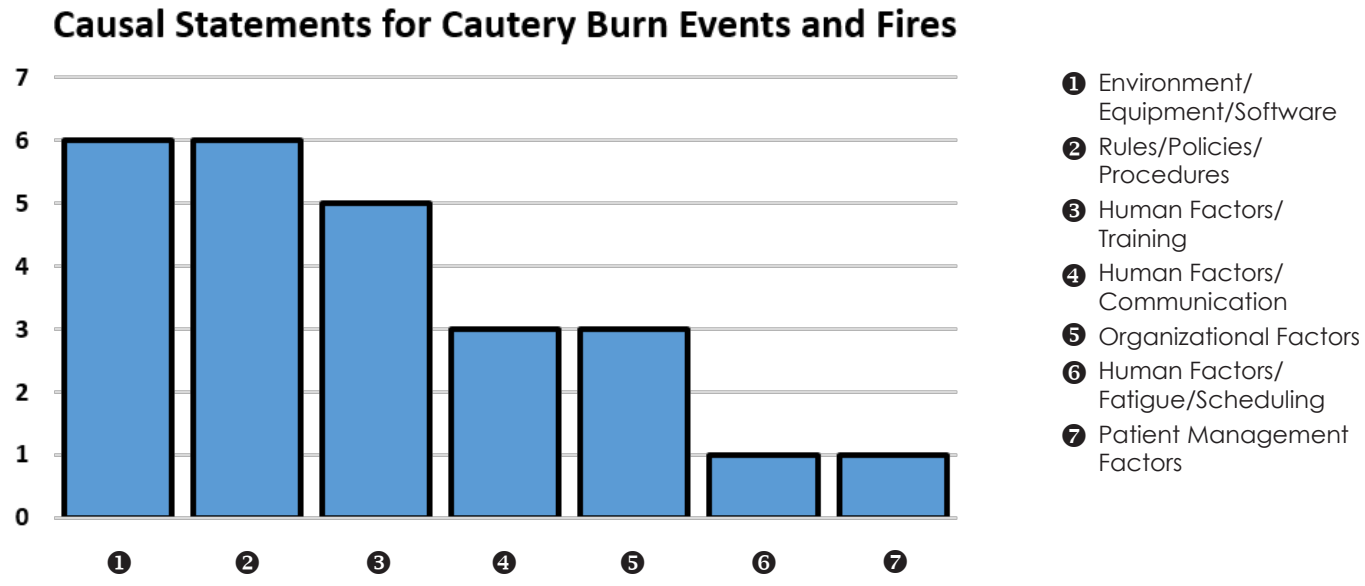
PATIENT SAFETY ALERT

Cautery Burns and Fires

While a small percentage (only about 1%) of all events reported to NCPS involve cautery, six of these events (67%) were reported in a 2-year period just prior to April 2019. All of the reported events resulted in either patient harm or an actual fire, which prompted a Patient Safety Alert to be issued on this topic.

The most common causal factors reported were related to:

- Environment/Equipment
  - ✓ Inspection/maintenance of cautery machine
  - ✓ Labeling of supply containers (flammability) and storage/access to adhesives
- Human Factors/Training
  - ✓ Awareness among staff about flammability of liquid adhesives and fire procedures
  - ✓ Surgical staff orientation/experience
- Rules/Policies/Procedures
  - ✓ Policies not updated/followed for skin preps, use of liquid adhesives, fire and safety
  - ✓ Policies not followed for cautery safety – placement of device/heat source when not in use, timing of use in relation to use of adhesives/ flammable liquids, use of insulated tips



Cautery Burns and Fires

Research and Best Practices:
NCPS searches for current, published literature about research, prevalence, causes, and best practices related to patient safety and shares those findings with members.

Causes of Surgical Fires:
Hempel, Maggard-Gibbons & Nguyen et al. (2015) reviewed the root causes of adverse surgical events, including surgical fires, by examining nine databases.[8]

- In 90% of surgical fire cases, electrocautery was the ignition source
- Oxygen-rich environments, draping factors, and alcohol not being allowed to dry, were environmental factors
- Lack of staff awareness of and communication about risks and non-compliance with safe use of equipment were human factors

Safety Culture Best Practice:
Cabral, Eggenberger, Keller, Gallison & Newman (2016) reported on changes made in a hospital to improve safety culture in surgery.[9] The initiative included the following:

- Review of baseline data from their AHRQ Culture of Safety Survey
- Conducting two briefings (time-outs) and a de-briefing for each surgical case. This process has three parts:
  1. A briefing prior to induction of anesthesia with the patient, anesthesia care provider, nurse, and surgical technologist
  2. The second briefing occurs with all team members before the surgical incision is made and is a comprehensive, role based time-out

  During this briefing:
  - » The surgeon prompts team members to speak up with any concerns they may have about patient safety
  - » The team conducts a fire risk assessment as part of the surgical safety checklist
  3. A de-brief following the surgery, in which the surgical team members express gratitude for a job well done, and reinforce an environment of teamwork and caring

The authors reported a positive and significant impact on the surgical team's perceptions of communication as a result of this initiative.

Preventing Surgical Fires:
Preventing surgical fires is an integral part of patient safety when cautery is in use. The "triangle" in the operating room consists of the surgeon (controls ignition sources), perioperative staff (manages fuels), and the anesthesia provider (minimizes oxidizers).[10]

[8] *Hempel, S., Maggard-Gibbons, M., Nguyen, D. K., Dawes, A. J., Miake-Lye, I., Beroes, J. M., ... & Shekelle, P. G. (2015). Wrong-site Surgery, Retained Surgical Items, and Surgical Fires: A Systematic Review of Surgical Never Events. JAMA surgery, 150(8), 796-805. Retrieved from: https://jamanetwork.com/journals/jamasurgery/fullarticle/2301000*

[9] *Cabral, R. A., Eggenberger, T., Keller, K., Gallison, B. S., & Newman, D. (2016). Use of a surgical safety checklist to improve team communication. AORN journal, 104(3), 206-216. Retrieved from: https://aornjournal.onlinelibrary.wiley.com/doi/full/10.1016/j.aorn.2016.06.019*

[10] *Fitzpatrick, C. (2012). Practical advice for preventing surgical fires: Safety strategies from the front lines. Retrieved April 29, 2019 from https://www.fda.gov/media/83903/download*

PATIENT SAFETY CULTURE

Inadequate safety culture is a significant contributing factor to adverse events. Developing a strong culture of safety requires leaders to communicate the relative priority of patient safety in comparison to other organizational goals such as productivity.[11]

The four key components of a culture of safety include:[12]

- Just culture – a fair and transparent system of workplace justice where accountability for safety is shared between the organization (systems) and the employees (human choices).
- Reporting culture – people are on the lookout for and freely report adverse events, near misses, and potential safety hazards.
- Learning culture – the information from reports and other sources is used to understand causes of safety issues and develop solutions as part of the continuous improvement process.
- Flexible culture – the knowledge, skills, attitudes, language, and coordinating mechanisms inherent in teamwork[12] create the flexibility team members need to manage complexity[13] and learn from experience.[14-16]

NCPS has expanded its services to better support providers in their efforts to develop a culture of safety.

Surveys on Patient Safety Culture™ (SOPS®):

SOPS® are a family of patient safety culture assessment tools for hospitals, nursing homes, medical offices, community pharmacies, and ambulatory surgery centers developed by the Agency for Healthcare Research and Quality. Healthcare organizations use SOPS® to evaluate their current culture of patient safety, increase awareness of patient safety concepts, identify strengths and areas for improvement, conduct internal and external benchmarking, and assess change over time.[17] NCPS has expertise in administering surveys, analyzing and interpreting results, and developing action plans. We use sound survey research methods to maximize response rate while maintaining respondent confidentiality. Supplementary items are available to assess Hospital Health Information Technology Patient Safety, Hospital Value and Efficiency, Medical Office Diagnostic Safety, Staff Burnout, and implementation of TeamSTEPPS® or Just Culture.

Just Culture Training for Healthcare Leaders:

"People cannot improve systems if they cannot talk about what they are experiencing. Individuals must be able to report errors without fear of punishment or embarrassment." – Dr. Lucian Leape [18]

A just culture shifts the focus from errors and outcomes to system design and behavioral choices. By developing a transparent, fair, and consistent system of workplace justice, organizations can move past a focus on outcomes (severity bias) and blame to learning about the system and human factors that led to the outcome. NCPS offers in-person just culture training for healthcare leaders in a variety of formats using the Outcome Engenuity curriculum.[19]

Strengthening Reporting Systems:

High reliability organizations depend on reporting systems to provide feedback about system operations and to identify risks and hazards. The confidentiality and privilege protections of the Patient Safety Act which

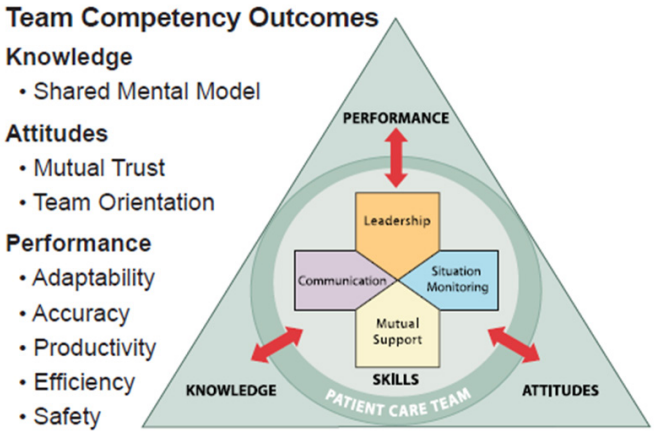
are available by belonging to a Patient Safety Organization may help healthcare professionals and organizations overcome fear of reporting. These federal protections extend to patient safety information, known as patient safety work product (PSWP) which is developed within a provider's patient safety evaluation system (PSES). NCPS helps providers understand how to protect PSWP by providing resources such as a webinar from the Alliance for Quality Improvement and Patient Safety, "Creating a Patient Safety Evaluation System, Step-by-Step" and related templates for developing PSES policies.

Root Cause Analysis Training:

The objective of a Root Cause Analysis is to understand what happened, why it happened, what should be done to prevent a reoccurrence, and then take action by implementing evidence-based solutions. When staff members understand how event reports are used for improvement, trust and engagement improve, leading to increased reporting and more reliable safety systems.[20] NCPS provides training in individual or aggregate root cause analysis at least annually for members.

TeamSTEPPS® Training:

Team Strategies & Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) is an evidence-based team training curriculum used to optimize team performance.[21] TeamSTEPPS® tools and strategies provide healthcare staff the ability to manage complexity and adapt to changing circumstances. NCPS offers options for TeamSTEPPS® training, including a two-day Master Trainer course, a one-day or half day Fundamentals course, and a 1-2 hour Essentials course.



Source: Reference 21 below

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[21] About TeamSTEPPS. Content last reviewed June 2019. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/teamstepps/about-teamstepps/index.html

LEGISLATIVE BILL 25

The Patient Safety Improvement Act was signed into law in Nebraska in 2005. This Act called for the establishment of the Nebraska Coalition for Patient Safety as a private, nonprofit 501(c)(3) patient safety organization, independent of state agencies. NCPS is governed by a Board of Directors with representatives from the founding associations, consumers, and other professional organizations.

NCPS provides legal protection from discovery for reported events and engages with providers (i.e., any individual or entity licensed or otherwise authorized under state law to provide healthcare services) to:

- improve patient safety and the quality of health care delivery
- collect and analyze patient safety work product submitted by providers
- develop and disseminate evidence-based practices
- encourage a culture of safety, and provide feedback and assistance to providers to minimize patient risk

The Patient Safety Improvement Act of 2005 did not provide funding to support this new patient safety organization. Instead, NCPS has been dependent upon voluntary member dues and other sponsors to maintain its operations since its inception.

NCPS has fostered a culture of safety since 2006. It has done this by providing a multitude of educational and training opportunities related to improving knowledge and skills, and mitigating risks associated with safety-related vulnerabilities identified in reported events. However, to date, these efforts have been limited primarily to member hospitals.

While much valuable information has been gathered through member reporting and engagement, NCPS has been limited in its understanding of the scope and nature of patient safety risks outside of hospitals, where the majority of healthcare services are provided. In order to accelerate safety improvement, NCPS must engage with the healthcare workforce across the continuum of care.

On March 13, 2019, Nebraska Governor Pete Ricketts signed Legislative Bill 25 (LB 25), which became State Law effective January 1, 2020.[22] The Nebraska Medical Association and the Nebraska Academy of Physician Assistants initiated and advocated for this legislation. The passing of LB25 will allow for the creation of a Patient Safety Cash Fund that will be used to support NCPS activities.

The Patient Safety Cash Fund will be established through the addition of fees that will be attached to each applicant for their initial issuance or renewal of licensure to practice as a physician, an osteopathic physician, or a physician assistant in Nebraska. Effective January 1, 2020, physicians will pay a patient safety fee of $50, and physician assistants will pay a patient safety fee of $20. These fees will be collected biennially with the initial or renewal fee for the credential.

We are excited for what lies ahead as NCPS expands membership and services to additional providers. We look forward to reporting the progress made this year in our 2020 Annual Report!

[22] Legislature of Nebraska, Legislative Bill 25. Available at: https://nebraskalegislature.gov/FloorDocs/106/PDF/Intro/LB25.pdf

NCPS MEMBERS

Antelope Memorial - Neligh	Great Plains Regional Medical Center – North Platte
Avera Creighton Hospital - Creighton	Harlan County Health System - Alma
Avera St. Anthony's – O'Neill	Howard County Medical Center – St. Paul
Beatrice Community Hospital - Beatrice	Jefferson Community Health & Life - Fairbury
Boone County Health Center - Albion	Kearney Regional Medical Center - Kearney
Box Butte General Hospital - Alliance	Kimball Health Services - Kimball
Brodstone Memorial Hospital - Superior	Lexington Regional Health Center - Lexington
Bryan Medical Center - Lincoln	Lincoln Surgical Hospital - Lincoln
Butler County Health Care Center – David City	Mary Lanning Healthcare - Hastings
Chadron Community Hospital & Health Services - Chadron	Memorial Community Health - Aurora
Cherry County Hospital - Valentine	Memorial Community Hospital & Health System - Blair
CHI Health Creighton University Medical Center Bergan Mercy - Omaha	Memorial Health Care Systems - Seward
CHI Health Good Samaritan - Kearney	Merrick Medical Center – Central City
CHI Health Immanuel- Omaha	Methodist Fremont Health - Fremont
CHI Health Lakeside - Omaha	Methodist Women's Hospital - Omaha
CHI Health Mercy Corning - Corning, IA	Midwest Surgical Hospital - Omaha
CHI Health Mercy Council Bluffs- Council Bluffs, IA	Nebraska Medicine - Omaha
CHI Health Midlands - Papillion	Nebraska Methodist Hospital - Omaha
CHI Health Missouri Valley - Missouri Valley, IA	Nebraska Spine Hospital - Omaha
CHI Health Nebraska Heart Hospital - Lincoln	Nemaha County Hospital - Auburn
CHI Health Plainview - Plainview	OrthoNebraska - Omaha
CHI Health Schuyler - Schuyler	Osmond General Hospital - Osmond
CHI Health St. Elizabeth - Lincoln	Pawnee County Memorial Hospital - Pawnee City
CHI Health St. Francis – Grand Island	Pender Community Hospital - Pender
CHI Health St. Mary's – Nebraska City	Saunders Medical Center - Wahoo
Columbus Community Hospital - Columbus	St. Francis Memorial Hospital - West Point
Community Hospital - McCook	Syracuse Area Health
Community Medical Center - Falls City	Thayer County Health Services - Hebron
Cozad Community Hospital - Cozad	Tri Valley Health System - Cambridge
Faith Regional Health Services - Norfolk	West Holt Medical Services - Atkinson
Fillmore County Hospital - Geneva	

NCPS BOARD OF DIRECTORS

Pursuant to the Nebraska Nonprofit Corporation Act, the NCPS Board of Directors includes at least one representative from the following organizations and one consumer of health care services:

A statewide association of:

a. Nebraska hospitals
b. Nebraska physicians and surgeons
c. Nebraska nurses
d. Nebraska pharmacists
e. Nebraska physician assistants

NHA: Nebraska Hospital Association
NAPA: Nebraska Academy of Physician Assistants
NMA: Nebraska Medical Association
NNA: Nebraska Nurses Association
NPA: Nebraska Pharmacists Association
NONL: Nebraska Organization of Nurse Leaders

Katherine J. Jones, PT, PhD (Community)
President
Adjunct Associate Professor
University of Nebraska Medical Center, Omaha

Daniel Rosenquist, MD (NMA)
Vice President
Physician
Columbus Family Practice Associates, Columbus

Don Naiberk, CEO (NHA)
Treasurer
CEO
Butler County Health Care Center, David City

Katie Peterson, RN, BSN (NONL)
Secretary
Chief Nursing Officer
Pender Community Hospital, Pender

Nicole Blaser, MSN, RN (NHA)
Director of Quality and Compliance
Columbus Community Hospital, Columbus

Ed DeSimone II, RPh, PhD (NPA)
Professor
Creighton University, Omaha

Pamela Dickey, MPAS, PA-C (NAPA)
Assistant Professor
Physician Assistant Education
University of Nebraska Medical Center
Kearney, NE

Douglas Elting, AIA, ACHA, EDAC (Community)
Owner
TRANSCEND Health Consultants, Lincoln

Cary Ward, MD, MBA, FACP (NMA)
Chief Medical Officer
CHI Health, Omaha

Michael German, PharmD, BCPS (NPA)
Pharmacy Clinical Services Coordinator
CHI Health St. Francis, Grand Island

Shaun Horak, MPAS, PA-C (NAPA)
Assistant Professor
University of Nebraska Medical Center, Omaha

Britt Thedinger, MD (NMA)
Physician
Ear Specialists of Omaha
Omaha, NE

Carol Wahl, DNP, RN, MBA, NEA-BC, FACHE (NNA)
Assistant Professor
University of Nebraska at Kearney, Kearney

NCPS REPORTING COMMITTEE

The NCPS Reporting Committee meets quarterly to discuss pertinent patient safety issues. Because patient safety improvements require collaboration among various healthcare provider types, the Reporting Committee members were selected to represent these diverse perspectives. The Committee members, listed below, represent medicine, nursing, pharmacy, and physical therapy. The Reporting Committee Summary contains a self-assessment on patient safety topics that are based on a review of de-identified events by the NCPS Reporting Committee and is distributed to NCPS members on a quarterly basis to promote shared learning.

Recent topics covered by the Reporting Committee include:

- Diagnostic errors
- Patient falls
- OB/Labor & delivery events
- Medication errors
- Wrong site surgery
- Specimen mishandling
- Medication reconciliation
- Suicide precautions
- Retained surgical objects

NCPS Reporting Committee Members
Daniel Rosenquist, MD
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Columbus Family Practice Associates, Columbus

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Fremont

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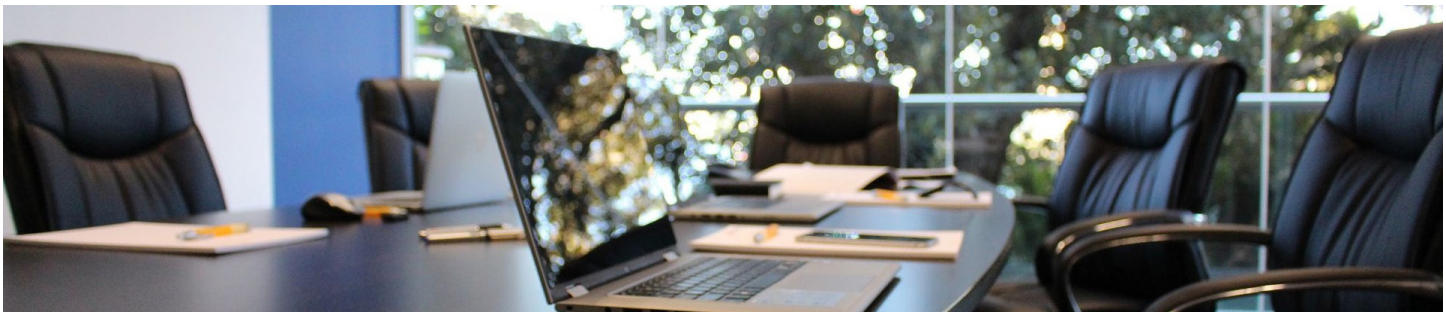

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NHA Nebraska Hospital Association
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Nebraska Pharmacists Association

NCPS FOUNDERS

NCPS PARTNERSHIPS

We are grateful for continued collaboration with regional and national organizations:

- ✓ Agency for Healthcare Research and Quality (AHRQ)
- ✓ Alliance for Quality Improvement and Patient Safety (AQIPS)
- ✓ National Alliance of Patient Safety Organizations (NAPSO)
- ✓ Nebraska Association for Healthcare Quality, Risk, and Safety (NAHQRS)
- ✓ University of Nebraska Medical Center, College of Public Health (UNMC-COPH)
- ✓ University of Nebraska Medical Center, College of Allied Health Professions (UNMC-CAHP)
- ✓ Nebraska Perinatal Quality Improvement Collaborative (NPQIC)
- ✓ CoalitionRx

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NCPS

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