

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

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## NCPS Update: October 2024

### A Message from the Patient Safety

#### Program Director

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

NCPS will be presenting a pre-conference workshop the afternoon of November 13th in Kearney, Nebraska as part of the Nebraska Hospital Association's Critical Access Hospital Quality

Conference. The workshop, "Engaging Your C-Suite to Advance Your Organization's Patient Safety Culture" is sponsored by the Nebraska Association for Healthcare Quality, Risk, and Safety ([NAHQRS](#)). Joining Emily and me in speaking on this subject is Marty Fattig, CEO at Nemaha County Hospital.



Culture, Leadership, and Governance is one of the four foundational prioritization areas identified as needful of work in order to attain total system safety in [Safer Together: A National Action Plan to Advance Patient Safety](#). During the workshop, we will share the recommendations and implementation tactics outlined in the action plan for this foundational area. Additionally, we will describe the leadership domains cited in the American College of Healthcare Executives' "Leading a Culture of Safety" which require CEO focus and dedication to develop and sustain a culture of safety. There will be time for participants to consider and evaluate strategies a quality leader can use to engage and influence their organization's leaders for support of quality and patient safety initiatives. The workshop will conclude with Mr. Fattig joining in conversation with workshop participants to help bring understanding of the concerns and informational needs a CEO experiences.

Registration for the workshop and the NHA CAH Quality Conference will soon be available on the NHA website. ***Nursing and CPHQ CEs for this workshop are pending.***

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### NCPS Shared Learning Resources

This month's Shared Learning Resource, "Incorrect Allergen Serum Administered", is based on the NCPS Reporting Committee's review of an event submitted by a member. The event occurred in an ambulatory setting and has several considerations that apply to vaccine administration. The resource may be found on the NCPS website within the members only section of the [Educational Resources](#) tab.

## Learning Opportunities for NCPS Members

### NAHQ's Healthcare Qualityweek™ Lunchtime Learnings

**October 20-26**

One week and five complimentary learning sessions! A different topic will be presented during the lunch hour each day of Healthcare Quality Week. The speaker for the Tuesday session, Taking Quality & Safety to Higher Ground, is the President and CEO at The Joint Commission, Jonathan Perlin, MD, PhD. To view all session descriptions and register for the webinars click [here](#) [t.e2ma.net].

### NPQIC Sponsored Emergency Department Identification and Management of Perinatal Hypertensive Disorders

**October 28 12 - 1pm CST**

The educational objectives of the webinar include participants being better able to:

- Explain the critical role of non-obstetric health care practitioners in identifying and managing obstetric emergencies in pregnant and postpartum patients who present outside the obstetric setting.
- Discuss how obstetrician-gynecologists and emergency medicine providers can work collaboratively to improve maternal health.
- Describe a QI project launched by the Texas Collaborative for Healthy Mothers and Babies on managing pre-eclampsia in the emergency department

Register for the event [here](#).

### Substance Use Disorders and Addiction Education to Meet New DEA Requirements

The American Medical Association has an on-line course available to satisfy the new, one-time eight-hour training requirement issue by the Drug Enforcement Administration (DEA) to meet the conditions of the MATE Act for all practitioners on treating and managing patient with opioid or other substance use disorders. If you have not met this specific eight-hour training requirement yet, the deadline to do so is the date of a practitioner's next scheduled DEA registration submission.

You may find additional information and register for the course [here](#).

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## Patient Safety Resources

### Reducing ambulatory central line-associated bloodstream infections: a family-centered approach

Eliminating central line-associated blood stream infections (CLABSI) remains a patient safety priority. This quality improvement project sought to reduce ambulatory CLABSI rates by improving caregiver management of central lines at home. The intervention included caregiver education, standardized ambulatory nurse central line care practices, and cleaning supplies. The evaluation identified a 52% decrease in ambulatory CLABSI rates, or 117 prevented infections. The paper may be found [here](#).

## **A Review of Modifiable Health Care Factors Contributing to Inpatient Suicide: An Analysis of Coroners' Reports Using the Human Factor Analysis and Classification System for Healthcare**

Inpatient suicides have devastating and long-lasting consequences for patients, families, and health care organizations. They pose a major challenge for hospitals. Many studies have identified patient risk factors; however, the modifiable health care factors are less understood. The authors of this study concluded that hospital suicide prevention initiatives need to be tailored to specific units and target individual and system vulnerabilities. The paper may be found [here](#).

## **IHI's Sustainability Planning Worksheet**

Ensure that your hard-won improvements stick. Use this worksheet to help plan for long-term success. The worksheet provides prompting questions for 5 key areas to consider when planning for the long-term sustainability of your improvement efforts. The worksheet may be found [here](#).

## **Components of pharmacist-led medication reviews and their relationship to outcomes: a systematic review and narrative synthesis**

The results of the review of 50 studies found the following common themes for improvement in patient outcomes:

- collaborative working may help reduce medicines-related problems and the number of medicines prescribed
- patient involvement in goal setting and action planning may improve patients' ability to take medicines as prescribed and help them achieve their treatment goals
- additional support and follow may lead to improved blood pressure, diabetes control, quality of life and a reduction of medicines-related problems

The paper may be found [here](#).

## **Impact of automated alerts on discharge opioid overprescribing after general surgery**

Overprescribing of opioids for acute pain (such as post-surgical pain) can increase the risk for long-term opioid dependence. This study evaluated whether implementation of an EHR alert reduced opioid overprescribing, [defined as opioid prescribing exceeding current recommendations](#). A significant decrease in opioid overprescribing was realized after the EHR implementation (48% pre-implementation to 3% post-implementation). A significant decrease in the average opioid supply at discharge was also observed. The paper may be found [here](#).

## **Leader safety storytelling: A qualitative analysis of the attributes of effective safety storytelling and its outcomes**

Storytelling is an effective way to engage workers in safety strategies. In this study, leaders and workers in safety-critical industries describe what effective storytelling looks and sounds like. Six story attributes (e.g., relatability, factuality) and three presentation styles (e.g., delivery style) were identified. Leaders may more effectively engage workers in maintaining and improving patient safety by addressing each attribute in their safety storytelling. The paper may be found [here](#).

## **The effectiveness of checklists and error reporting systems in enhancing patient safety and reducing medical errors in hospital settings: a narrative review**

Checklists and error reporting systems are designed to improve patient safety. This narrative review highlights the patient safety impacts of each, the similar challenges faced during implementation, and benefits of their use. You may read the paper [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](mailto:carlasnyder@unmc.edu)

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