NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: January 2025

A Message from the Executive Director

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

As we welcome 2025, I want to take a moment to express my gratitude to each of our member organizations and their dedicated team members. NCPS experienced significant membership growth in 2024, enabling us to collaborate on vital patient safety initiatives that benefit both Nebraska patients and the healthcare workforce. Membership renewal invoices will be sent by the end of this month, along with a brief survey to update your organization's contact information. Thank you for prioritizing patient safety within your organization!

I'd also like to highlight a few upcoming events and updates on data publication. The NCPS data team has decided to collect and analyze patient safety data from 2023-2024 for a single annual report, which will be published later this year. The increase in data volume has allowed us to better categorize event types and contributing factors. This will provide more detailed insights to support the understanding of trends, emerging threats, and best practices for interventions, helping guide our efforts in developing relevant programming and learning resources. We kindly request that all patient safety events from 2024 be reported to NCPS by March 31st.

Finally, please mark your calendars for upcoming NCPS education and training opportunities. We have scheduled a two-day TeamSTEPPS® Master Trainer workshop for June 5th-6th. This workshop is designed for individuals who have already been introduced to the TeamSTEPPS® curriculum and plan to serve as champions within their organizations. Additional details will be shared in the coming months. We also look forward to hosting our second annual virtual membership meeting on September 17th in observance of World Patient Safety Day.

If you have any questions or would like additional training or assistance with conducting the Surveys on Patient Safety Culture within your organization, please feel free to contact me at embarr@unmc.edu.

NCPS Shared Learning Resource

This month's learning resource is based on two events reviewed by the NCPS Reporting Committee in their December 2024 meeting. A known pressure injury which rapidly worsened after hospital admittance due to delay in completion of recommended treatment; and delay in the placement of a wound vac to aid in the healing of a surgical wound.

Both harm events shared the lack of clear communication between various care team members. This included the lack of a timely, coordinated team approach to develop a plan of care. In addition to resources for the care/treatment of presure injuries and the use of wound vacs, this month's shared learning document highlights the importance of having systems in place to ensure interdisciplinary care of patients. Effective communication tools being one of the most important ones. This resource may be found here within our Members only portal.

Legal Update

NCPS has included initial comments from the Alliance for Quality Improvement and Patient Safety (AQIPS) to the CMS Patient Safety Structural Measures. The comments outline issues related to case law in many states that may affect the implementation of the PSSM and potential resulting liability. Several case law examples are introduced in the comments, with specific Domain concerns from the PSSM, that contradict the language and intention from the Patient Safety Act. NCPS will continue to update members with important PSSM information as it unfolds. Please contact Emily Barr with any questions or comments regarding the PSSM at embarr@unmc.edu.

Learning Opportunities for NCPS Members

Categorizing Your Patient Safety Events - Rethinking Severity and Impact

January 29, 2025 12 noon CST

The Human Capital Institute is sponsoring this webinar which challenges attendees to expand their analysis of events of harm beyond the direct “harm” impact on the patient and instead to look at the harm's total impact. They explain that by doing so organizations will achieve the maximum benefit of their patient safety program. The learning objectives for this webinar are as follows:

Where did the severity scales come from?
Which one should we use?
The importance of the severity matrix.
Why we need to be thinking about more than severity.

Use this link to register for the hour long webinar.

AMA's Pre-visit Planning Toolkit

This toolkit, which was one of the American Medical Association's top three toolkits of 2024, is designed to save time, improve care, and strengthen care team satisfaction. A calculator which has you input the value of both time and money saved through pre-visit planning is included in the toolkit. The objectives for this educational opportunity include:

1. Identify the benefits of implementing pre-visit planning
2. Describe pre-visit team-based workflows
3. Employ pre-visit planning tools and templates

0.5 CME is available for those completing the module.

AMA's Measuring Accurately: In-Office BP Best Practices

Accurate blood pressure (BP) measurement is a crucial aspect of patient care, as it informs diagnosis, treatment, and management of hypertension and other cardiovascular conditions. However, the skill itself can be prone to errors, which can lead to misdiagnosis and inappropriate treatment. To reduce errors in BP measurement, guidelines recommend health care professionals undergo retraining every six to 12 months. This module is designed to refresh and retain the knowledge and skills required to ensure consistent and accurate BP measurement in in-office settings. It is appropriate training for all ambulatory direct patient care givers.

Patient Safety Resources

Family Room: Enhancing Patient Safety by Engaging Family Caregivers

Family Room was born from a simple yet powerful vision: to support and heal family caregivers during a patient's critical illness. The founders believe that family caregivers are essential members of the care team, not just visitors. Research consistently shows that engaged family members contribute to improved patient safety outcomes, reduced medical errors, and better care transitions. By supporting both families and healthcare professionals with the right tools and resources, an environment that promotes healing while reducing strain on our healthcare system can be created.

Their approach combines scientific rigor with human-centered design, ensuring that every solution developed is both evidence-based and practical. Working alongside healthcare providers and families, they have created tools that not only integrate seamlessly into existing systems but also support key patient safety initiatives and quality metrics.

As Family Room develops these solutions, your expertise as NCPS members is invaluable. You are invited you to join them in two important ways:
1. Participate in pilot programs to test and refine the tools in your healthcare setting
2. Share your insights through brief consultations during the development process

Together, a healthcare system that enhances patient safety through meaningful family engagement can be built. Contact them at hello@familyroom.health to learn how you can contribute to this important mission.

Biased Language in Simulated Handoffs and Clinician Recall and Attitudes

Using simulated verbal handoffs, reseachers examined the impact of biased language on recipient clinical information recall and attitude toward patients. They found participants had less accurate clinical information recall and less positive attitudes toward patients after hearing biased simulated verbal handoffs than after hearing neutral handoffs. These results further support standardization of handoffs which is critical to reducing biased language that can negatively impact clinicians perceptions of patients and reduce retention of key clinical information needed for patient care. The paper may be found here.

Psychological Safety What it is, Why Teams Need It, and How to Make It Flourish

Psychological safety has emerged as a critical feature of high performing teams. This review provides an overview of psychological safety in medicine, describing its impact on learning, patient safety, and quality improvement. The review also explores interventions and essential leadership behaviors that foster psychological safety in teams

Medication Errors: Key Areas and Strategies to Reduce Them

Medication errors are one of the top patient safety events reported to NCPS. Errors occur at all stages of the process; whether it is when a provider selects and orders the med, or the med is delivered and administered, or the monitoring and management after it has been prescribed. COPIC has compiled a checklist for physicians because they see many malpractice claims associated with medication errors. The checklist includes key areas where medication errors often take place, and recommended strategies for reducing those types of errors. This resource 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