NCPS January 2020 Newsletter

Happy new year everyone!

As you all know, I joined the NCPS team as the Patient Safety Program Director in December. Please let me tell you a little bit about myself. My name is Regina Nailon and I was born and raised in Omaha. I moved to the Pacific Northwest in my early 20's and earned my RN degree at Lower Columbia Community College in Longview, Washington. I love to learn and over the years, continued to pursue my nursing education. I completed my doctorate in nursing degree in 2004, at the Oregon Health & Sciences University. My husband, Jim, and I were thrilled to settle back in Omaha in 2006. For the past nearly 11 years I have enjoyed working with all types of healthcare providers and leaders across Nebraska Medicine as we developed, implemented and evaluated quality improvement programs and activities. I love to work with data, and I love to help people understand it in a way that allows them to turn it into information that they can use to change processes and to improve safety and outcomes. I am excited to bring my knowledge and expertise to my new role with NCPS. I look forward to meeting each of our NCPS members and helping you to improve patient safety in your organizations. Please feel free to contact me and introduce yourself. I would love to hear from you, and to find out how best I can serve you in my new role!

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NCPS Patient Safety Program Director
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Reporting Committee Summary and Facility Self-Assessment

The 4th Quarter 2019 NCPS Reporting Committee Meeting Summary is available in the members-only section of our website. This quarter, the summary's focus is on human factors and systems as they relate to patient fall events in a variety of care delivery areas within an acute care hospital.

☑ Register for AQIPS Webcast: UNC Confidential Care for the Caregiver Program

Wednesday, February 19th
1:00 p.m. CST

This webcast will provide information about a peer support program developed at University of North Carolina Medical Center to support second victims of serious adverse patient events. The peer support program is protected under the Patient Safety Evaluation System of the medical center. The UNC Medical Center policy is attached and a white paper from the Center for Patient Safety PSO can be viewed by following this link https://www.centerforpatientsafety.org/wp-content/themes/patient-safety/pdf/Second-Victims-White-Paper.pdf

Speaker: Celeste Mayer, RN

☑ Register for AHRQ Webcast: Understanding SOPS Surveys: A Primer for New Users

Wednesday, February 19th
1 - 1:50 p.m. CST

This AHRQ webcast will provide an overview of the Surveys on Patient Safety Culture™ (SOPS™). Speakers will describe the SOPS program, surveys, supplemental items, databases, and resources available to users. They will also highlight what is new in 2020.

Speakers:

- **Caren Ginsberg, Ph.D.,** Agency for Healthcare Research and Quality, Rockville, MD
- **Laura Gray, M.P.H.,** Westat, Rockville, MD
- **Theresa Famolaro, M.P.S., M.S., M.B.A.,** Westat, Rockville, MD
- **Naomi Yount, Ph.D. (Moderator),** Westat, Rockville, MD

IHI's Top 12 for 2019

The Institute for Healthcare Improvement (IHI) continues to be a change agent and foster new concepts for improving patient care. In order to help you filter through all the great ideas that come to healthcare providers, the IHI developed a list of their top 12 for last year.

At the top of their list is the ***Patient Safety Toolkit***: http://www.ihi.org/resources/Pages/Tools/Patient-Safety-Essentials-Toolkit.aspx which includes information about improving communication and teamwork, conducting event investigations, developing strong action plans, and other safety tools.

See the IHI's full top 12 here: http://www.ihi.org/communities/blogs/top-12-picks-from-2019?utm_campaign=New%20Years%202020&utm_source=hs_email&utm_medium=email&utm_content=81221108&_hsenc=p2ANqtz-9Mhalo3_DeE9cG32TulwCFvOmIjDvkP_4mWoqoBndx7lZWZqLHsg27rfe6HARE1Vl3sHgCvjjzsHe4TFz8E9WuyrhKCQ&_hsmi=81221108

Review of Alternatives to RCA for Incident Report Analysis

This narrative review searched available literature in PubMed and Embase to identify tools used to investigate incident reports that may use fewer resources than a full Root Cause Analysis. There were seven tools identified that take less time and provide a lower depth of analysis. Some of these tools have been incorporated by large health systems into frameworks that help guide teams to the appropriate tool, based on the type of event being investigated. See the full article here: https://bmjopenquality.bmj.com/content/8/3/e000646

Diagnostic Error and Patient Safety in Primary Care

- The National Academy of Medicine defines diagnostic error as the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or to (b) *communicate that explanation to the patient*.
- Missed or delayed diagnoses may account for up to 50% of office practice liability claims.
- Developing a reliable system for closed loop communication of test results is essential in reducing patient harm related to diagnostic error.

For more information, visit https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/ and https://psnet.ahrq.gov/issue/prioritizing-patient-safety-efforts-office-practice-settings

NCPS – Brief Year in Review

Our Annual Report will be coming soon, but here is a quick review of activities and events related to NCPS and how we have served our members throughout 2019:

- Nebraska Legislative Bill 25 passed, as a result of the leadership of the Nebraska Medical Association and the Nebraska Academy of Physician Assistants, allowing for future additional funding of NCPS through licensure fees for physicians and physician assistants.
- Regina Nailon, PhD, RN joined the NCPS team in December as our full-time Patient Safety Program Director.
- Ron Belyan, MPA, joined the NCPS team in October as our part-time Patient Safety Project Coordinator.
- Member organizations reported 135 events to NCPS.
- De-identified Events, Reporting Summaries, and Patient Safety Alerts were sent out on the following topics:
    - Human and Systems Factors in Reported Events
    - Anti-thrombotics and Thrombolytics
    - Cautery Burns and Fires
    - Retained Prep Sponge
    - Delay in Home Medication Reconciliation
    - Wrong Patient Emergency Situation
    - Wrong Medication – Vecuronium
- Webcasts and podcast topics included:
    - Pain Management and Opioid Oversight: Ensuring Quality, Safety, and Compliance
    - Promoting Patient Engagement to Improve Safety
    - Implementing Root Cause Analysis and Action (RCA^2)
    - Human Factors: Demonstrating Application of Human Factors Principles in the Real World
    - PSES 101 Boot Camp for Providers
    - Conducting Peer Review Under the PSQIA Protections
    - Integrating Medical Staffs in a Multi-hospital System: Challenges, Options, and Proposed Solutions
    - How to Make Patient Safety Easier to Explain and to Champion – shared from WIHI
- Educational Conference and Workshops were offered:
    - Nebraska Healthcare Quality Forum Patient Safety Track
    - Aggregate RCA Workshop
    - TeamSTEPPS Master Trainer Workshop
    - Just Culture for Healthcare Leaders Workshop

We plan to make 2020 a great year as well. Please let us know if there are patient safety topics that you would like to learn more about. We want to make sure we meet your needs!

Please contact Regina Nailon at: regina.nailon@unmc.edu or 402-559-8946 with any and all ideas you have!