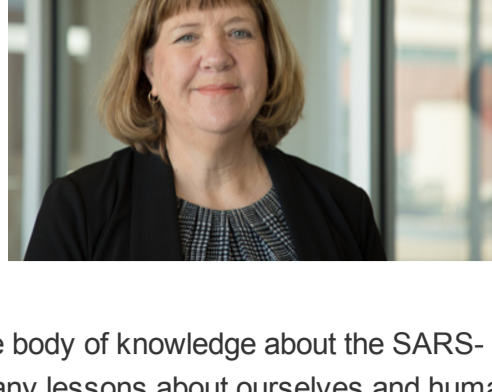


NCPS Mission: To continuously improve the safety and quality of healthcare delivery in the region.

NCPS Update: February 2022

A Message from the Patient Safety Program Director

Carla Snyder, MHA, MT(ASCP), SBB



As we find ourselves amid yet another surge of COVID-19 patient infections and related hospitalizations, it is sometimes difficult to imagine what our work worlds and personal lives will be like post COVID-19 pandemic. In addition to the immense body of knowledge about the SARS-CoV-2 virus and its epidemiology, we have learned many lessons about ourselves and human behavior over these past two years. For me, a short list of those lessons include:

- how to quickly pivot in your operational workflow
- the importance of open transparent communication, even if the person you are informing does not want to hear your message or believe the science guiding your actions
- healthcare workers are highly innovative in developing solutions when presented with challenges not previously encountered
- healthcare workers are tireless and selfless in their care for patients/patient families and there is a limit to this selflessness

The coming years will be full of publications explaining the many clinical and human behavior lessons learned during this pandemic. I am sharing a link to one of those articles [Adapting and Creating Healing Environments: Lessons Nurses Have Learned From the COVID-19 Pandemic](#) (nurseleader.com). Though this article was published in Nurse Leader, it is applicable for healthcare workers of other disciplines.

I am also including a link to an opinion piece, [The Healing Power of 'Thank You'](#) | MedPage Today. The physician who wrote the article reflects that, for him, being more sensitive to gratitude has helped him celebrate the many lives for which he's had the privilege to care. My hope is that his point of view is an encouragement to you, regardless of your job title, as you consider the many patients' lives you have positively impacted during this extremely difficult time of the COVID-19 pandemic.

Lastly, we at NCPS want to encourage you to reach out to us with any patient safety concerns or resource needs you may encounter. We recognize the significant strain on healthcare system resources the pandemic has caused and want to remind you to utilize us and the resources we can access and provide to you.

NCPS Shared Learning Resources

NCPS Patient Safety Alert - Failed/Delayed Response to Change in Patient's Condition

Failure/delayed response remains one of the top 4 categories of events reported to NCPS. Since these types of events often result in significant patient consequences, this patient safety alert was developed to review causes/contributing factors related to failure/delayed response to change in patient's condition and to provide resources to mitigate their possible occurrence. Click [here](#) to review it.

Debrief Collaborative Implementation Safe Table

NCPS hosted a virtual Safe Table on Thursday Thursday, January 27th to provide a forum for healthcare providers to learn about progress and challenges in developing structures and processes for conducting debriefs. Katherine Jones, PT, PhD facilitated discussion among 24 participants representing various healthcare organizations across the region. Safe Table attendees shared successes, barriers, stories and practices related to conducting debriefs in their organizations. A summary of the shared learnings from the Safe Table will be added soon to the [Debrief Collaborative Toolkit](#) on the NCPS website. The Debrief Toolkit includes a variety of helpful resources, such as Debrief educational webinar recordings, templates for team charters and policies, a Debrief Pocket Guide, and links to other evidence-based resources.

Learning Opportunities for NCPS Members

Webinar PSO Case Law Learnings on 4/12 at 1 pm CT

NCPS is a member of The Alliance for Quality Improvement and Patient Safety (AQIPS), the leading national nonprofit professional organization that assists PSOs and PSO members to build a safer health care system. AQIPS and Chart Institute PSO are offering a webinar which you as an NCPS member are invited to attend. NCPS members are encouraged to extend the invitation to their organization's legal counsel. PSO Case Law Learnings to Strengthen the PSES and Privilege Protection with Robin Locke Nagele, JD/Principal, Post & Schell, P.C. will provide practical tips derived from case law for strengthening the PSES framework that is the foundation for privilege protection under the federal Patient Safety Act.

Register [here](#) for the April 12th 1pm webinar.

National Center on Substance Abuse and Child Welfare Online Tutorial for Substance Abuse Disorder Treatment Professionals

Approximately 8.3 million children live with one or more adult who is dependent on alcohol or needs treatment for illicit drug abuse (USDHHS, 2009). Although most families with parental substance use do not come to the attention of child welfare, for those families that do, effective treatment can be critical. When parents have substance use disorders, the risk of child abuse and neglect increases, and 60–80% of substantiated abuse and neglect cases involve substance use by a custodial parent or guardian (Young, et al, 2007).

This [course](#), divided into five modules, will provide substance use disorder treatment professionals basic knowledge of the child welfare and dependency court systems. Included is information on the operations of child welfare and the dependency court; effective engagement strategies and treatment practices for families involved with child welfare systems; services needed by children whose parents have substance use disorders; and methods of improving collaboration among substance abuse treatment, child welfare and court systems. Continuing Education hours are available through the Association for Addiction Professionals for those completing the course and the Knowledge Assessment.

AMA's STEPS Forward Educational Modules Addressing Burnout and Wellbeing

Physician well-being is influenced by both organizational and individual factors. This collection of toolkits offers strategies on how to engage health system leadership, understanding physician burnout and how to address it, as well as developing a culture that supports physician well-being. There are 15 modules available and continuing medical education credits are available for each. Learn more [here](#).

Another valuable resource for physician well-being is The Nebraska Medical Association's [LifeBridge Physician Wellness Program](#). This no cost program is available to any Nebraska physician. It offers peer-to-peer coaching to assist in dealing with normal life difficulties and the challenges of a medical career, managing stress and reclaiming satisfaction in career and personal life.

AMA's 2021 Most-Downloaded Podcasts

As physicians and medical students are finding their personal time increasingly constrained because of the COVID pandemic, many are listening to podcasts to enhance their knowledge of trends in medicine. Here is a [link](#) to AMA's 10 most downloaded episodes for 2021. In these podcasts you can learn from doctors and other experts about a variety of topics while you are commuting, running errands, making dinner or doing housework. It is not surprising that many of this year's top 10 downloads were around COVID-19 topics.

Patient Safety Resources

Recommendation for Clinical Laboratories to Immediately Implement the CKD-EPI Creatinine Equation Refit Without the Race Variable

A joint task force of the National Kidney Foundation and the American Society of Nephrology has issued a recommendation to remove the race variable that has historically been included in GFR calculations. See the [SBAR](#) on the NCPS website.

Nebraska Perinatal Quality Improvement Collaborative (NPQIC) Plans of Safe Care/CARA- NPQIC Roundtable

On January 6th, NPQIC hosted a Roundtable where 3 hospitals shared how they have implemented the Comprehensive Addiction and Recovery Act (CARA) of 2016. This legislation focuses on infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder.

Two resources were shared with attendees: 1) A link to the Nebraska DHHS [website](#) which provides information about the legal requirements of the CARA legislation and resources available to hospitals and providers encountering patients with maternal substance use disorders (SUD). 2) A [brief](#) from The National Center on Substance Abuse and Child Welfare (SAMHSA) which outlines, by state, the actions taken to improve outcomes for the infants and families suffering from SUD.

If you have questions or would like more information about the information presented at the Roundtable, please contact Sydnie Carraher at scarraher@unmc.edu

Using Event Reporting Data to Identify Diagnostic Error

Diagnostic errors are receiving intense investigation in the safety community due to their high prevalence and harmful impact on patients. Diagnostic errors affect 12 million US adult patients per year in the outpatient setting and at least 0.7% of adult admissions involve a harmful diagnostic error. The COVID-19 pandemic has further strained the health care system, resulting in cognitive errors, burnout, challenges with hospital resources, and a rapid shift in operational workflows that may contribute to missed and delayed diagnoses.

The article, [Harnessing Event Report Data to Identify Diagnostic Error During the COVID-19 Pandemic](#), was originally published in the Joint Commission Journal of Quality and Patient Safety. It describes a new approach which leverages electronic safety reporting to identify and categorize diagnostic errors during the pandemic.

AHRQ Study Finds Deaf and Hard of Hearing at High Risk of Lower-Quality Care

Ineffective communication between providers and deaf and hard-of-hearing patients who use American Sign Language (ASL) could put the latter at high risk for lower-quality care, according to an AHRQ-supported study published in the *Journal of the American Medical Informatics Association*. The authors discuss barriers to improve health equity for deaf and hard-of-hearing people because ASL is misclassified by large-scale informatics networks such as the Patient-Centered Clinical Outcomes Research Network and the U.S. Census Bureau. Researchers highlight areas where clinical research networks, electronic health record (EHR) developers, healthcare institutions and users can improve to promote health equity research and patient-centered care for this population, including timely and appropriate identification and recording of patient language preferences in the EHR. You may access the abstract [here](#).

National Action Plan to Advance Patient Safety

Though there have been considerable efforts over the past 20 years to reduce preventable harm in healthcare, this remains a major concern in the United States. Safer Together: A National Action Plan to Advance Patient Safety centers on four foundational and interdependent areas, prioritized as essential to create total systems safety.

The plan, found [here](#), gives clear direction that health care leaders, delivery organizations, and associations can use to make significant advances toward safer care and reduction of harm across the continuum of care.

COVID-19 Resources

Interactive Tool Provides New Data on Hospital Trends for COVID-19 and Other Conditions

AHRQ has developed an [interactive visualization tool](#) which displays state-specific monthly trends in inpatient stays related to COVID-19 and other conditions. It facilitates comparisons across patient/stay characteristics and states. Data is drawn from AHRQ's Healthcare Cost and Utilization Project (HCUP). Trends are reported beginning with January 2018 except for COVID-19, where trends are reported beginning with April 2020.

Coronavirus Disease 2019 (COVID-19) and Diagnostic Error

PSNet's Primer on Diagnostic Error has been revised to include the impact COVID-19 has had on the patient safety issue of diagnostic error. New information and evidence have been incorporated into the publication. Embedded links within the primer are intended to refer readers to relevant resources published on PSNet. Resources from other federal agencies and peer-reviewed literature are listed at the end. The primer may be found [here](#).

Patient Safety Events and the Role of Patient Safety Organizations During the COVID-19 Pandemic

There have been many drastic modifications in the way health services have been delivered across care settings during the COVID-19 pandemic. This has been especially true during surge periods when changes in patient workflows and reallocation of resources were needed. This [article](#) outlines the patient safety challenges experienced due to the COVID-19 pandemic and shares a link to the recently published analysis of data voluntarily submitted by federally listed Patient Safety Organizations to the Patient Safety Organization Privacy Protection Center (PSOPPC).

Health Inequities and COVID-19

The COVID-19 pandemic has accentuated the issue of health inequity based on various population characteristics such as race, gender, and economic status. This article focuses on elderly mental health-care vulnerabilities, and suggests a way forward for families and caregivers to be involved in the care of the elderly, with increased sensitivity to their mental health. Seven measures to undertake to ensure their psychological well-being are enumerated. ['Age and ageism in COVID-19: Elderly mental health-care vulnerabilities and needs' \(nih.gov\)](#)

Occupational Exposure to SARS-CoV-2 and Risk of Infection Among Healthcare Personnel

Health care providers (HCP) face SARS-CoV-2 exposure risks both in the community and in occupational settings. This [study](#), published in Infection Control & Hospital Epidemiology, found that the risk in community settings is greater than in occupational settings and that significant exposure to an infectious coworker was more common than exposure to a patient. HCP were three times more likely to test positive after an exposure to a coworker versus a patient. Several strategies were used to mitigate employee to employee transmission, including universal source control masking, opening overflow break rooms for social distancing during meals, and educating personnel and supervisors on best practices for shared workspaces and breakrooms.

Paxlovid for COVID-19 Treatment Useful However Cautions Surround Its Use

Though healthcare providers and the public are thankful to learn of an oral medication for the treatment of mild to moderate COVID-19 infections for patients at high risk of severe illness, there are cautions regarding its use. The Institute for Safe Medication Practices has issued a [safety warning](#) regarding prescribing it for patients with impaired renal function. Additionally, a non-invasive cardiologist discusses concerns regarding the drug-drug interactions between Paxlovid and many heart medications on [MEDPAGE Today](#).

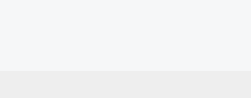
Results from a Recent WebMD Poll That Looked at COVID Fatigue

WebMD polled their readers to determine how often they experienced COVID fatigue; defined as "being angry, exhausted, frustrated or just plain fed up with disruptions to your life or those of your family and friends". Nearly three fourths of respondents said they are experiencing those feelings.

The poll found that most people experience COVID fatigue a few times a week, but men and women and older and younger people have reacted differently to it. Read the MedScape [article](#) to learn more.

For more information about NCPS and the services we offer, please contact Gail Brondum LPN, BS, Executive Director at gail.brondum@unmc.edu

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