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

NCPS
Nebraska Coalition for Patient Safety

NCPS Update
September 2021

A Message from the Patient Safety Program Director

Since 2008, patient falls have remained among the top 4 categories of safety events reported to NCPS. According to the Centers for Disease Control and Prevention, every second of every day in the U.S., an older adult (age 65+) falls, making falls the leading cause of injury and injury death in this age group. Strikingly, at least 300,000 older people are hospitalized for hip fractures each year, 95% of which are the result of falling. Fall prevention remains a National Patient Safety Goal for both hospitals and long-term care facilities. Every September on the first day of Fall, the Falls Free® Initiative promotes National Falls Prevention Awareness Week**.** This year, ***National Falls Prevention Week is September 20-24, 2021.*** Click here and scroll down to find the link to a toolkit that offers resources in digital and printable formats to encourage family members and friends to become involved in falls prevention efforts for their loved ones.

The National Council on Aging also encourages use of their digital tool, the Falls Free CheckUp, that provides a personalized overview of falls risk factors and ways that individuals can address them. This tool is available in English and in Spanish. And, visit the Collaborative And Proactive Teamwork Used to Reduce (CAPTURE) Falls website to access multiple evidence-based resources and tools that you and your teams can use to promote effective fall prevention in the hospital setting.

Join us for a FREE webinar on September 23 that will focus on fall prevention and provide you and your team with evidence-based fall risk reduction strategies. **See more information and how to register below!**

~ Regina Nailon PhD, RN

NCPS Shared Learning Resource: Patient Safety Alert

This month's learning resource is a Patient Safety Alert that focuses on risks associated with administering potassium and/or managing serum levels. This resource provides important information and evidence-based strategies to help mitigate risk. This resource is available to members by visiting the Educational Resources tab in the members only portal on the NCPS website: https://www.nepatientsafety.org/members/member-login.html

The Importance of Reporting Safety Events to NCPS

Is your organization submitting patient safety events to NCPS on a regular basis? We rely on our members to submit reports of safety events that occur with and without harm, as well as near events. Reporting events enables us to aggregate and analyze the information to identify

patterns and themes, and to develop educational resources for our members to help you with improvement efforts.
Please consider submitting event reports on at least a monthly basis! This will ensure that you are taking full advantage of the privilege and confidentiality protections that come with maintaining a reporting relationship with NCPS!

Learning Opportunities for NCPS Members

NCPS Webinar: Interventions for Hospital Fall Risk Reduction

Date: Thursday, September 23
Time: 12:00 – 1:00 PM Central Time
During this webinar, Dawn Venema, PT, PhD, Associate Professor, Division of Physical Therapy Education in the College of Allied Health Professions at UNMC will discuss linking evidence-based interventions to fall risk factors. Her presentation will include findings from UNMC's CAPTURE Falls program, a program that supports fall risk reduction in Nebraska critical access hospitals.
Register here.
Continuing Education Contact Hours pending from Iowa Western Community College, Iowa Board of Nursing Provider #6.

NCPS Webinar: Patient Safety Organizations: What Every Ambulatory Care Provider Needs to Know

Date: Wednesday, October 13
Time: 12:00 – 1:00 PM Central Time
During this webinar, Michael Callahan, Senior Counsel on the Katten Law Healthcare Team will discuss patient safety activities in the ambulatory care setting, and their implications for privilege and confidentiality protections within the context of working with a federally listed patient safety organization such as NCPS.
Register here.
Continuing Education Credit for nurses, physicians and physician assistants is pending.

Patient Safety Resources

Nebraska Medical Association Annual Conference

NMA
2021 ANNUAL
MEMBERSHIP MEETING

Registration is Open!

Join us for the 2021 NMA Annual meeting
Friday, September 17, 2021!
Embassy Suites Omaha-La Vista Conference Center

10:45 a.m. REGISTRATION BEGINS
11:15 a.m. WELCOME LUNCHEON & KEYNOTE SPEAKER
12:45 p.m. DEBUT OF NMA INSPIRE MEDICINE SPEAKER SERIES

3:00 p.m. NMA BUSINESS MEETING
4:00 p.m. HOUSE OF DELEGATES
5:30 p.m. COCKTAIL RECEPTION
6:30 p.m. INAUGURAL BANQUET

Register now!

Promoting the psychological well-being of healthcare providers facing the burden of adverse events: A systematic review of second victim support resources.

Adverse patient events can have a negative impact on the well-being of healthcare providers. This study aimed to describe the types of support resources available in healthcare organizations, their benefits for second victims, peer supporters' experiences, and implementation challenges. Implementation challenges included persistent blame culture, limited awareness of program availability, and lack of financial resources. Findings indicate a need for implementing new second victim support programs, promoting current programs, and monitoring peer supporters' well-being. Access the full text article here.

AHRQ leadership to improve diagnosis: A call to action.

The Agency for Healthcare Research & Quality has released an Issue Brief focused on Diagnostic Safety. Evidence demonstrates that diagnostic failures occur in the general patient population across all setting types, and nearly half of them have potential for patient harm. Diagnostic timeliness and accuracy are not solely the responsibility of clinicians, but also are dependent upon system-level factors. Leaders occupying roles ranging from individual shift or practice managers to members of the executive team play a critical role in addressing the challenge of improving diagnostic safety.

Incidence, origins and avoidable harm of missed opportunities in diagnosis: Longitudinal patient review in 21 English general practices.

Diagnostic error continues to be a source of preventable patient harm. These authors undertook a retrospective review of primary care consultations to identify incidence, origin and avoidable harm of missed diagnostic opportunities (MDO). Nearly three-quarters of MDO involved multiple process breakdowns (e.g., history taking, misinterpretation of diagnostic tests, or lack of follow up). Just over one third resulted in moderate to severe avoidable patient harm. The authors recommend multifaceted interventions to address the contributing factors. Read the full text.

Prevalence and characteristics of interruptions and distractions during surgical counts.

Unintentional retention of foreign objects following surgery is considered a never event. This study quantifies and describes interruptions and distractions during surgical counting in 36

observed surgical procedures. The authors provide several suggestions to minimize interruptions and distractions during surgical counts. Read the study.

Safety implications of different forms of understaffing among nurses during the COVID-19 pandemic.

Through interviews with 120 nurses, the authors of this study examined near misses relative to nurse-to-patient ratios and skill mix. Findings indicated that understaffing of personnel led to increased use of workarounds, and that understaffing of expertise led to increased cognitive failures. The authors emphasize the importance of hospital leaders recognizing both forms of understaffing, especially during a crisis, and how they can affect patient safety. Read the study.

Root cause analysis to identify contributing factors for development of hospital acquired pressure injuries.

Hospital-acquired pressure injuries (HAPI) can result in increased costs and length of stay. Read how one geriatric rehabilitation hospital used root cause analysis to identify system- and human-level factors that contributed to the development of HAPI in its facility. The authors provide recommendations for improvement targeted both system- and human-level factors, including audits to reinforce adherence to hospital guidelines, streamlining the documentation system, and investing in improvements in staff education and new equipment. Access the full text.

New toolkit on developing family presence policies during emergencies.

During the pandemic, many health care organizations limited or restricted visitors to reduce the spread of the virus. This resulted in family members and care partners not being able to play a role in the patient's care. The "Family Presence Policy Decision-Making Toolkit for Nurse Leaders," recently released by Planetree International, is a toolkit that offers a framework for leaders to support safe family physical presence during a crisis. The toolkit studies a wide range of factors, including local conditions, current evidence, and equitable impact.
Access the toolkit.

COVID-19 Resources

Guidance for health care leaders during the recovery stage of the COVID-19 pandemic: A consensus statement.

This consensus statement, based on input from an international panel of individuals with expertise in health leadership, health care, and public health, outlines 10 factors to guide health and public leaders during the post-emergency stage of the pandemic, including supporting staff well-being and psychological health, preparing for future emergencies, and managing the backlog of delayed care. Read more.

Meaningful changes leaders can make to promote the long-term well-being of the health care workforce.

A recent Institute for Healthcare Improvement virtual round table focused on the changes and actions necessary to confront the systemic and structural drivers of workforce well-being in the

upheaval caused by COVID-19. Read how leaders can make strategic, structural changes to improve staff access to mental health and other support systems.

The influence of COVID-19 visitation restrictions on patient experience and safety outcomes: A critical role for subjective advocates

In an effort to further reduce the spread of COVID-19, hospitals across the U.S. altered visitation policies, by either limiting visitations or restricting visitations altogether by closing access to family, friends and care partners. This study examined the degree to which visitation restrictions helped to explain changes in patient experience and patient safety outcomes. Findings indicate that hospitals with closed visitations saw the most pronounced deficits in their performance with regard to fall rates and sepsis rates. Recommendations are given for how hospitals may achieve improved quality and safety outcomes even during instances when visitation needs to be restricted. Download the article.