NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: January 2024

A Message from the Executive Director

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

Embarking on a new year provides NCPS the opportunity to reflect on organizational accomplishments and plan upcoming priorities for patient safety work throughout the region. The NCPS team continues to focus around improving the online reporting process to create a seamless entry point for organizations to submit adverse patient safety events. Enhancing the reporting process will allow organizations to strengthen their patient safety activities within their Patient Safety Evaluation System (PSES) and promote advances in creating and sustaining a *learning* health system. We look forward to orientating users to the updated processes, including the incorporation of the RCA² materials from our recent training series.

NCPS is also happy to welcome back our Patient Safety Conference, which is scheduled for Friday, April 26th at the Scott Conference Center in Omaha. Please consider submitting a proposal for a general session presentation by February 2nd, to highlight the patient safety work within your organization. Further instructions and submission materials can be found at this link. Lastly, organizations will be receiving 2024 membership invoices and PSO member certifications by the end of January. If your organization's key contact individual has changed, or you have any questions about membership, please reach out to Emily Barr at embarr@unmc.edu. Please keep in mind that all employees of a member organization receive "members-only" access to the NCPS website. Team members just need to create an individual user account to gain access to the plethora of patient safety materials. Thank you for your continued support of NCPS and prioritizing patient safety, we look forward to another great year working together.

NCPS Shared Learning Resource

This month's learning resource is an update to a 2018 NCPS Patient Safety Alert, Newborn Falls and Drops. This rare, but potentially serious event, can result in physical injury to the newborn and cause emotional trauma to all involved including nurses, parents, and other hospital staff. A recent member's report of such an event prompted this review of current best practice guidelines for the prevention of newborn falls and drops. The resource may be found

on the NCPS website within the Educational Resources, Patient Safety Alert in our members only portal.

Legal Update

On December 1, 2023, CMS issued the list of Measures Under Consideration (MUC) that outline certain quality and efficiency measures that the Secretary of DHHS is considering for adoption through pre-rulemaking under Medicare. Forty-two Measures were approved for the list, including the *Patient Safety Structural Measure*. In summary, the measure *"is an attestation-based measure that assesses whether hospitals demonstrate having a structure and culture that prioritizes patient safety. This measure is designed to discern hospitals that practice a systems-based approach to safety, as demonstrated by leaders who prioritize and champion safety; a diverse group of patients and families meaningfully engaged as partners in safety; and practices indicating a culture of safety and continuous learning and improvement."*

In the recent public comment period, the Alliance for Quality Improvement and Patient Safety (AQIPS), the professional association for PSOs like NCPS, remarked how the provision is inconsistent with the Patient Safety Act, as the proposed requires PSOs to report to the AHRQ Network of Patient Safety Database for hospitals to meet this measure. Thus, reporting under this measure is not "voluntary" by hospitals or PSOs. NCPS will keep our member organizations informed as the rulemaking process moves forward. For more information on the Pre-Rulemaking MUC Lists please visit this link, and the full AQIPS comment can be found here.

Learning Opportunities for NCPS Members

ECRI and HCA Healthcare Safe Table: Strategies to Strengthen Workplace Violence Prevention (WPV) Programs in Acute Care Settings

January 24 12:00 noon - 1:30 pm

Topics to be included in this Safe Table are:

- Identifying a collaborative care team approach to prevent and provide early risk mitigation.
- Exploring how a Patient Safety Organization collaborative offerings sparked the development of initial strategies to address WPV in healthcare settings.
- Challenges and solutions found during initial implementation of those strategies.

Use this link to register for this important Safe Table.

AQIPS Q1 2024 Legal Counsel Meeting

February 8 12:00 noon - 1:00 pm

NCPS members are invited to the Q1 Legal Counsel Meeting hosted by the Alliance for Quality Improvement and Patient Safety (AQIPS). Case law around the Patient Safety Quality Improvement Act (PSQIA) and programs will be discussed. Use this link to register for this meeting.

Patient Safety Resources

Blackbox error management: how do practices deal with critical incidents in everyday practice? A qualitative interview study.

Critical incident reporting is common in inpatient settings but not always as robust in ambulatory or outpatient care. This study sought to understand how outpatient providers (i.e., primary care, dentists, dermatology, orthopedic surgery, psychiatry/psychology) define critical incidents and how they are handled in their offices. It was found that many practices did not have formal reporting or quality improvement systems in place. The authors emphasize the importance of including safety culture and critical incident reporting in medical training.

The full free text article may be found here.

The Role of Undergraduate Nursing Education in Patient Safety

This Perspective essay discusses how undergraduate professional nursing education integrates the topic of patient safety into classroom and clinical instruction, and how this affects patient safety as a whole. You can find the essay here.

Community Health Systems' ongoing journey to zero preventable harm

Through the deployment of specific high-reliability leadership methods, human error prevention behaviors, and a structured approach to cause analysis, CHS has achieved an 89% serious safety event rate reduction since implementing these processes in 2013. Nine key takeaways are cited as aiding in the program's success. You can find the case study 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