NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: May 2022

A Message from the Patient Safety Program Director

Carla Snyder, MHA, MT(ASCP), SBB

I was fortunate in attending the Nebraska Academy of Physician Assistants Annual Conference April 7-9th in Kearney. I so appreciated the many NCPS members that stopped by our exhibit booth to talk about NCPS' mission, to learn of their experiences as practicing PAs, and to thank them for their support of NCPS through the Patient Safety Cash Fund fees included in their Nebraska physician assistant licensing fee. Included in the group were Pam Dickey (NCPS Reporting Committee member) and Shaun Horak (NCPS Board of Directors) whom I'd not previously met in person. It was a delight to get to talk with them and to thank them for volunteering their time to serve these functions with NCPS. PA students from the College of St. Mary, Creighton University, Union College, and the University of Nebraska Medical Center were also at the meeting. Most were unfamiliar with the function and value of patient safety organizations so this was a great opportunity to inform them of the work a patient safety organization accomplishes and to encourage them to ask their future employers about the organization's membership status in a patient safety organization.

The medical world, especially those of us whose job roles are within the patient safety and quality improvement space, have been shocked at the criminal conviction of a former registered nurse for her role in a fatal medication error. I want to bring to your attention the resources offered by several national organizations to address this occurrence.

First, the Institute for Medication Safety Practice (ISMP) has assembled a comprehensive set of resources. These resources are posted on the ISMP website on the page titled Resources Related to Neuromuscular Blocker and ADC Errors. There are links to many resources including information on Just Culture, second victims of medication errors, and why the five rights of medication use, which were mentioned during this trial, do not work. A recording of the May 6th webinar, Lessons Learned about Human Fallibility, System Design, and Justice in the Aftermath of a Fatal Medication Error is also on found there or at https://www.ismp.org/resources-related-neuromuscular-blocker-and-adc-errors.

Finally, should you personally want to support RaDonda Vaught, the nurse found guilty of negligent homicide in this patient's death, there is a list of possible actions you might choose to take in advocating for her.

An additional resource you may find useful is a recording of an IHI Community Roundtable – Responding to Medical Errors With Care, Not Criminalization, which was held April 8th. An expert panel of industry leaders gathered to offer guidance on how best to respond to a serious clinical adverse event; provide key next steps for leaders, providers, and patients; and offer recommendations rooted in the concept of just culture. You may access a recording of the roundtable by completing a short form on IHI's website found here.

NCPS Shared Learning Resources

The NCPS learning resource this month is a tool, Cause Mapping. The use of this tool will help ensure the root cause(s) of a patient event have been identified and that proposed action steps will break the chain of events which led to the event's occurrence. You will find a Cause Map of the event that was shared in last month's newsletter (a positive COVID lab test result which was not on the patient's chart at the time of their admission for surgery and a misinterpretation of the lab result when it was charted) as well as a description of how to construct a Cause Map. In future Affinity Group Safety Huddles we will demonstrate the use of this tool when we performing case reviews. It may be found here as well as on the NCPS website within our members only portal.

Learning Opportunities for NCPS Members

Webinar: The Power of Patient Stories for Improving the Patient Experience

Thursday, May 12th 12 noon – 1:30 pm

This AHRQ webcast will provide an overview of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Narrative Item sets, and the insights that rigorously elicited and analyzed narratives can provide about patients' experiences with care that cannot be captured via closed-ended survey questions alone. Speakers will explain how patient narratives can help healthcare organizations address challenges and achieve successful quality improvement initiatives. Please use this link to register for the webinar.

Virtual Patient Safety Evaluation Summit

May 24-25 10:00 am – 2:00pm, CST each day

The Alliance for Quality Improvement (AQIPS) and the Collaborative Hospital PSO (CHPSO - California) are hosting a virtual summit centered around Patient Safety Evaluation Systems, what we know what we learned, and what needs to happen next. "The Summit" includes safe table discussions (including one led by NCPS Board President, Katherine Jones, PT, PhD and UNMC's CAPTURE Falls program team of Dawn Venema, PT, PhD, Anne Skinner, and Victoria Kennel, PhD regarding the falls prevention work they are involved in), as well as topic-focused breakout sessions, and amazing keynote presenters.

The Virtual PSES Summit will be held May 24-25 from **10:00 a.m.– 2:00 p.m., CST** each day. Please use this link to register for the webinar.

Medication Safety: Best Practices & Pitfalls Recorded Webinar

As a reminder, if you were unable to attend our April virtual education program, the recording is now available on our website on the member's only page. During this program, Dr. Gary Cochran from UNMC's Department of Pharmacy Practice outlined several sources for best practices in medication safety of and Continuing Education credits are not available for viewing the recorded webinar.

Collaborative Opportunity for NCPS Members

Nebraska Perinatal Quality Improvement Collaborative (NPQIC)

The reduction of premature birth rates in Nebraska by promoting tobacco cessation in all women of childbearing age is the focus of an initiative being launched by NPQIC.

This call to action is a reminder to all providers about the importance of screening for and counseling all women of childbearing age about the risks of tobacco use before and during pregnancy since long-term tobacco use predisposes women to poor pregnancy outcomes and increases the risk of prematurity.

Healthcare providers are a trusted source of information and can play an important role in helping their patients quit tobacco by connecting them with the tools they need. Learn more about the Nebraska Tobacco Quitline at www.QuitNow.ne.gov/providers. Check out Quitline FAQs at https://ne.quitlogix.org/en-US/Just-Looking/Health-Professionals/Provider-FAQs. Information found there will help providers learn how to refer patients to this important free resource. In addition, free continuing education modules are also available for CME, CNE, and CPE at www.QuitNow.ne.gov/providers.

AHRQ's Challenge Competition to Update and Re-Create TeamSTEPPS Videos

AHRQ recognizes that many of their TeamSTEPPS training videos are a bit outdated and need a refresh. To address this need, they are inviting participants to develop innovative video content for the agency's TeamSTEPPS training program resources. Phase 1 of the competition calls for contestants to submit a written narrative on how to update a current TeamSTEPPS video in an equitable, culturally sensitive and health-literate manner. Ten contestants selected to advance to Phase 2 will develop replacements for existing TeamSTEPPS videos. Up to 10 $10,000 prizes will be awarded to Phase 2 contestants who produce successful videos. Winners will be announced by the end of 2022. Access more information [links.gd] about the TeamSTEPPS challenge and previous AHRQ competitions [links.gd].

Patient Safety Resources

AHRQ Toolkit for Preventing CLABSI and CAUTI in ICUs

Today's intensive care unit (ICU) teams understand the importance of providing high-quality care that relies on a culture of safety and evidence-based clinical practices to help prevent infections. Developed over a 5-year period, this toolkit was designed to reduce CLABSI and CAUTI in ICUs with persistently elevated infections rates. The toolkit may be found here or by going to https://www.ahrq.gov/hai/tools/clabsi-cauti-icu/index.html

ENFit - The Who, What, When, Where, and Why of ENFit

If your organization has not yet made the transition to the use of an ENFit system for enteral feedings please consider attending this webinar. ENFit systems are a patient safety tool which prevents misconnections of administrative sets and medication syringes with enteral feeding tubes. Register at **ENFit Live! The Who, What, When, Where, and Why of ENFit - Moog Medical** for this free webinar which offers 3 nursing CEUs.

What you don't know will hurt the patient: Cross-cultural clinical medicine and communication with ethnic minority patients

This case-based textbook, written by author Morten Sodemann, is largely based on patient cases and experiences accumulated by examining and treating patients from ethnic backgrounds within the Danish healthcare system. It is currently posted on IHI's website and is downloadable for free.

The book conveys the message that much becomes understandable when you understand the patient's life story. It also offers a clinical input that supports the teaching of narrative medicine aimed at medical and nursing students. Sodeman notes, "I hope this book will motivate doctors, medical students and anyone else working in health care with ethnic minority patients to spend time – with the patient – on approaching a common medical history that can form the basis for a sensible diagnosis and effective, appropriate treatment."

AHRQ How Leaders Can Engage Temporary and Permanent Nurses in Patient Safety

Recently reported data confirms the fears of many in the patient safety community about the impact of the COVID-19 pandemic: significant increases in healthcare-associated infections, declines in staff ratings of safety culture, and upsurges in some nurse-sensitive indicators (including patient falls and pressure injuries). The shortage of available staff, including nurses, has increased throughout the pandemic. Many organizations are dealing with the challenges that come with a growing proportion of their workforce being temporary staff. Given the association of nurse engagement with patient and workforce experience and outcomes, meaningful engagement of all nurses, both permanent and temporary, is a critical leadership priority. See How Leaders Can Engage Temporary and Permanent Nurses in Patient Safety (ihi.org)

COVID-19 Resources

American Heart Association's Oxygenation and Ventilation of COVID-19 Patients

The ongoing ventilation management of COVID-19 patients has resulted in healthcare providers being called on to assist in critical care roles that are beyond their routine daily activities. The materials in this toolkit are provided as quick resources and refreshers for providers in such situations. The AHA does note that it still advocates for advanced airways be inserted and managed by the most experience members of the clinical team. The toolkit may also be found at: https://cpr.heart.org/en/resources/coronavirus-covid19-resources-for-cpr-training/oxygenation-and-ventilation-of-covid-19-patients

James Lawler, MD, MPH's Weekly Corona Virus Updates

Listen to Dr. Lawler's April 12th twitter post where he reviews several studies that show the dramatic risks associated with "natural vaccination" for SARS-COVID-2. Many people still do not understand that the risks associated with having a COVID infection are not limited only to hospitalization nor how much greater the risks are for having a COVID infection as compared to having a COVID vaccination.

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