NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: December 2023

A Message from the Program Director

Carla Snyder, MHA, MT(ASCP)SBB, CPHQ

Each year at this time, I review the National Patient Safety Goals for the upcoming year and compare them to the current year's list. One notable change is the list for Critical Access Hospitals now contains the same goal for improving health care equity (**NPSG.16.01.01**) that was added to hospital and ambulatory health care on July 1 2023. We will all still be working to:

- identify patients correctly
- improve staff communication
- use medicines safely
- prevent infections
- prevent mistakes in surgery.

The importance of these goals is apparent when we review events of harm reported to us by our NCPS members.

NCPS has tools and resources available to help you meet these NPSG goals. In this past year we have provided shared learning resources for identifying patients correctly and preventing mistakes in surgery. The TeamSTEPPS training NCPS provides is specifically aligned with the goal to improve staff communication; and in June of this past year, we hosted a medication safety webinar with two medication safety experts that gave practical insight on this topic and shared tools. Our current webinar series, Improving Root Cause Analysis, highlight approaches to address vulnerabilities and create sustainable actions to prevent future harm. We believe the tools and education being provided will help your organization make the system level changes needed to prevent future events of harm.

We are also keeping aware of the patient safety issues that surround digital technology and transformation, artificial intelligence, and workforce talent challenges (retain and recruit the employees who have the skills needed to keep up with the changing health care landscape). We thank you for your collaboration and continued support. Please reach out at any time to let us know of any patient resources you need.

NCPS Shared Learning Resource

This month's learning resource is a glossary of Patient Safety Terms. We often use terms that may be unfamiliar to some, or that others may not be certain exactly what is trying to be conveyed. This listing is our starting point in an attempt to clarify many of those terms. We will be updating it as needed so please do not hesitate to suggest a word that would be helpful to

add to the list, or to suggest an edit that would make the explanation of the term more clear. This resource may be found on the NCPS website and is available to both non-members and members under the Resources & Tools tab.

Legal Update

All NCPS members are invited to attend the December 14th AQIPS quarterly Legal Counsel Meeting. It will begin at 12 noon and is for one hour. Topics to be discussed include:

- Patient Safety Act Case Law and what the cases mean to you
- Using the Patient Safety Act protections in Communication and Resolution Programs (CRP/CANDOR)
- CMS required certification of members in a PSO
- PCAST Report and its implications for PSOs

Use this **link** to join the scheduled meeting or join from the meeting link

https://aqips.my.webex.com/aqips.my/j.php?MTID=m2b79194badf4ef71131ce4b63d53cbc3

Call for Abstract Submission

NCPS invites individuals to submit abstracts for the NCPS Patient Safety Conference to be held in-person on April 26th, 2024, at the Scott Conference Center in Omaha, Nebraska. Each abstract submission must be entered separately. Depending on the number of abstracts accepted, there may be a poster session included as part of the agenda. All proposals will be considered for a general session (60 minutes).

The deadline for abstract submission is February 2, 2024. All submissions will be evaluated, and individuals will be notified of NCPS' decision no later than mid-February 2024.

Abstract Topics:

The following abstract topics are the general headings under which abstracts will be submitted and reviewed.

1. Clinical Practices (examples include: Enhancing diagnostic safety, fall prevention programs, medication safety programs, healthcare-associated infection prevention programs, adverse event analysis and learning)
2. System Quality Practices (examples include: Effective communication strategies, role of technology and/or artificial intelligence, patient safety culture practices within organizations, patient safety during transitions of care, workforce safety and well-being, patient and family engagement, health equity)

Please follow the link to submit your proposal: **https://www.surveymonkey.com/r/PLQVR2F**

Survey on Enteral Misconnections and Near Misses

Enteral feeding tube misconnections continue to be a patient safety issue (see *Misconnections and the Emergence of Enteral Nutrition Connectors for Patient Safety)*. The Global Enteral Device Supplier Association (GEDSA) continues to work at reducing such errors

and needs data from front line clinicians to help guide them. Would you please consider responding to their anonymous survey on enteral misconnections? The short survey may be found **here**.

Patient Safety Resources

Improving patient safety governance and systems through learning from successes and failures

Quality improvement and patient safety initiatives require incredible human and financial resources. As such, they must be selected carefully to achieve the greatest return on investment. This article describes important considerations for hospital leaders when selecting and implementing initiatives. Notable themes included safety culture, policies and procedures, supporting staff, and patient engagement. The included "patient safety governance model" provides a framework to develop patient safety policy. The article may be found here.

It depends who you ask: divergences in staff and external stakeholder narratives about the causes of a healthcare failure

Including both patient/relative and staff perspectives in investigations provides a deeper understanding of the event. This study applies natural language processing methodology to 40 staff and 53 patient/relative witness statements into a *C. difficile* outbreak in a UK trust. This novel method revealed that staff identified a lack of training and understaffing, whereas patients/relatives identified communication failures and the physical environment as contributing factors. You can find the article here.

Validation of a reduced set of high-performanc triggers for identifying patient safety incidents with harm in primary care.

Retrospective chart review, a resource intensive method, is the standard for estimating prevalence of adverse events via electronic health record in primary care. This study describes the construction and validation of an electronic trigger set, TriggerPrim, to rapidly identify charts with potential adverse events in primary care: ≥ 3 appointments in a week at the primary care center, hospital admission, hospital emergency room department visit, prescription of major opioids, and chronic benzodiazepine treatment in patients 75 years or older. Use of TriggerPrim reduced time required for EHR review by half. You can find the 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