Sixth Annual Report
December 2015

NCPS Founding Members

NEBRASKA ACADEMY OF PHYSICIAN ASSISTANTS

NHA Nebraska Hospital Association
The influential voice of Nebraska's hospitals

Nebraska Medical Association
Advocating for Physicians and the Health of all Nebraskans

INNA NEBRASKA NURSES ASSOCIATION

NPA Nebraska Pharmacists Association

NCPS Sponsors

Platinum

COPIC
MMIC

Gold

Nebraska Hospital Association
Nebraska Medical Association

Silver

Nebraska Pharmacists Association

Bronze

Nebraska Academy of Physician Assistants

A Message from the Executive Director

As Nebraska Coalition for Patient Safety (NCPS) enters its 10th year of operation, we continue to grow in size and scope. Additional acute care hospitals have joined NCPS and in 2015 we welcomed our first ambulatory surgery center, for a total of 59 members in Nebraska and Iowa. Event reporting has reached a record high with 100 events reported in 2014. We continue to use those events to disseminate evidence-based patient safety practices and tools to members via member calls/meetings and the members-only section on the NCPS website www.nepatientsafety.org.

Providing education that is pertinent to our members remains one of our primary goals. In 2015, education offered was influenced by patterns in reported events (see page 6 for examples). In addition, we continued our collaboration with CIMRO of Nebraska and offered four patient safety specific break-out sessions at the May 2015 Nebraska Healthcare Quality Forum conference in La Vista. And finally, NCPS provided monthly de-identified events or patient safety alerts to members in order to provide a system-wide view of causal factors, root causes, and action steps, to accelerate learning across member organizations.

NCPS continues to collaborate with the Nebraska Association for Healthcare Quality, Risk and Safety (NAHQRS), the National Alliance of Patient Safety Organizations (NAPSO), and the Alliance for Quality Improvement and Patient Safety (AQIPS) to learn from events in Nebraska, Iowa, and other states, enhance knowledge and learning, and develop mutually beneficial programs and services related to patient safety.

One of the most exciting events this past year was the kick-off of the NCPS Just Culture Collaborative! The June 2015 collaborative trained 34 healthcare professionals from 11 member hospitals (see page 9 for a list of collaborative members). Ninety-seven percent of attendees are now certified Just Culture champions. We continue working with them as they integrate Just Culture principles into their organization.

As 2015 comes to an end, we are grateful to our members, board and committee members, founders, and sponsors, without whom our efforts and achievements could not be realized.

Ann McGowan, RN, MSN

Executive Director

What does NCPS do?

- ***Learn*** from reported events
  - Via data aggregation, which informs the education we provide to our membership
- ***Share*** reported events with membership
  - Using monthly *de-identified* events (based on individual events) and patient safety alerts (based on multiple events of similar type)
- ***Offer resources*** for follow up and feedback related to events
  - NCPS' reporting committee of health care professionals reviews and gives feedback on events and root cause analyses
- ***Provide education and training*** specific to patient safety
  - NCPS offers quarterly education (typically via webinar) as well as continuing education
- ***Provide protection*** from discovery
  - Event investigations are made privileged and confidential when reported to a PSO

NCPS Member Education

Member Education 2014

- Improving Alarm Management in the Healthcare Setting
- Hospital Acquired Delirium and Weakness
- Optimize Your Patient Safety Evaluation System
- Health Information Technology Webinars

Sample Topics of NCPS 2014 De-Identified Events

- Wrong Site Surgeries
- Surgical Awareness
- Look-alike/sound-alike medications
- Anticoagulant management

Did you know? NCPS members have access to all of our previous de-identified events through our members-only website portal.

2015 Quality Forum

NCPS Break-out Sessions

"Using the Multi-Team System to Improve Patient Safety"

Carol Kampschnieder, RN, MSN
Katherine J. Jones, PT, PhD

The presenters explored the use of inter-professional Multi-Team Systems (MTS) to implement and evaluate patient safety and quality objectives, with a focus on fall risk reduction. In addition, a hospital that successfully implemented a coordinating team to be accountable for fall risk reduction structures and processes shared the key changes implemented and how the use of the MTS had informed their thinking about management of safety and quality initiatives.

"We Design our Buildings and Then They Kill Us"

Doug Elting, AIA, ACHA, EDAC

Doug presented the story of Evidence-Based Design and its impact on safety and patient outcomes. From Florence Nightingale to the Institute for Healthcare Improvement, the history of the built environment's impact on patient and staff safety was discussed.

"The Patient As Partner"

Carol Wahl, RN, MSN, MBA

Carol emphasized how the importance of patient engagement in achieving health outcomes is well documented in the literature. This presentation supported a partnership model through the identification and discussion of various strategies. Specific approaches included the implementation of a care partner program, formation of a patient/family partnership council, and early development of patient preference passports. Resources and tools were provided to support healthcare professionals with implementation.

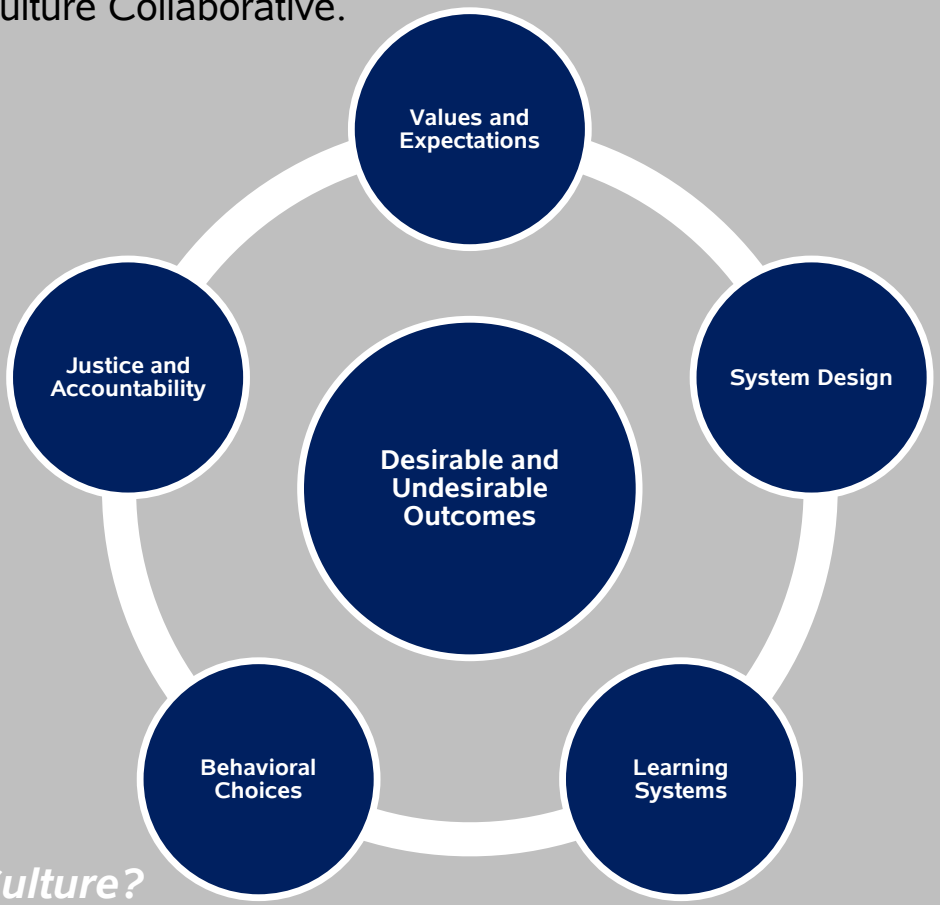
"Making Care Safer for Individuals by Leveraging Leadership"

Victoria Kennel, MA

Victoria discussed how implementing change to improve patient safety and quality is easier said than done and often requires support from organizational leaders. Tips and best practices were shared that organizational leaders could use to support the implementation of innovations that improve patient safety and quality of care.

NCPS Just Culture Collaborative

NCPS received a $146,000 grant from The Blue Cross Blue Shield of Nebraska Fund for Quality and Efficient Healthcare to support the development of Nebraska's first two-year Just Culture Collaborative.



What is Just Culture?

According to David Marx, an engineer, lawyer, and president of Outcome Engenuity, LLC, "a Just Culture is a culture of shared accountability, where healthcare institutions are accountable for the systems they have designed and for supporting the safe choices of the patients, visitors, and staff. Staff in turn is accountable for the quality of their choices, knowing that they may not be perfect but can strive to make the best possible choices available."

NCPS Just Culture Collaborative

NCPS' objectives for this collaborative are to assist participants to:

- Improve the safety of patients and staff by creating a culture that values reporting of adverse events,
- Apply principles of Just Culture to consistently manage responses to adverse events,
- Fairly evaluate staff interactions with organizational systems, and
- Renew focus on the reliability of systems and processes

NCPS Collaborative Members

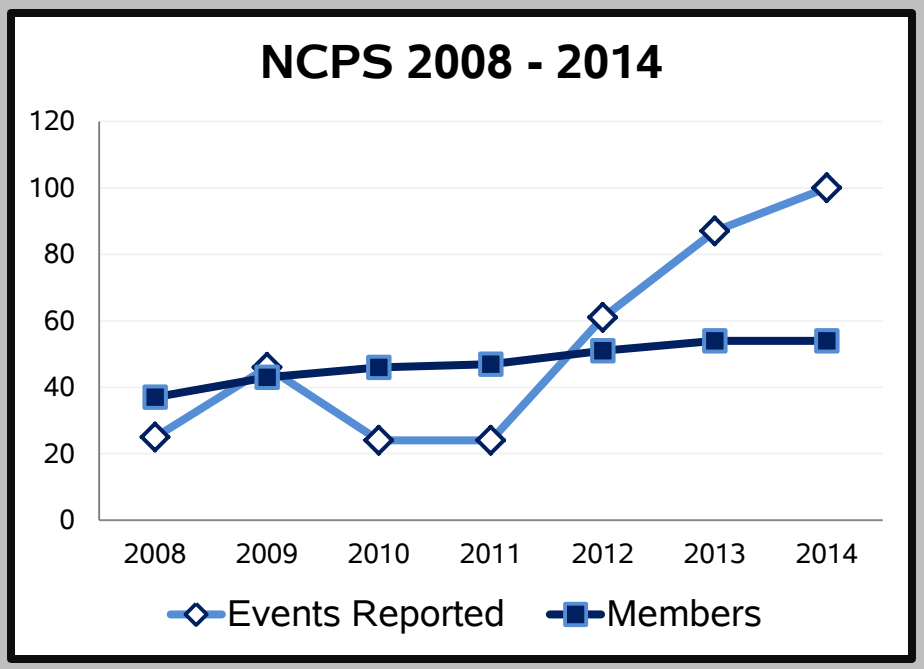
Box Butte General Hospital
Brodstone Memorial Hospital
Bryan Health
Columbus Community Hospital
Community Hospital*
Faith Regional Health Services*
Fillmore County Hospital
Fremont Health
Great Plains Health
Lexington Regional Health Center
Lincoln Surgical Hospital
Saunders Medical Center
St. Francis Memorial Hospital

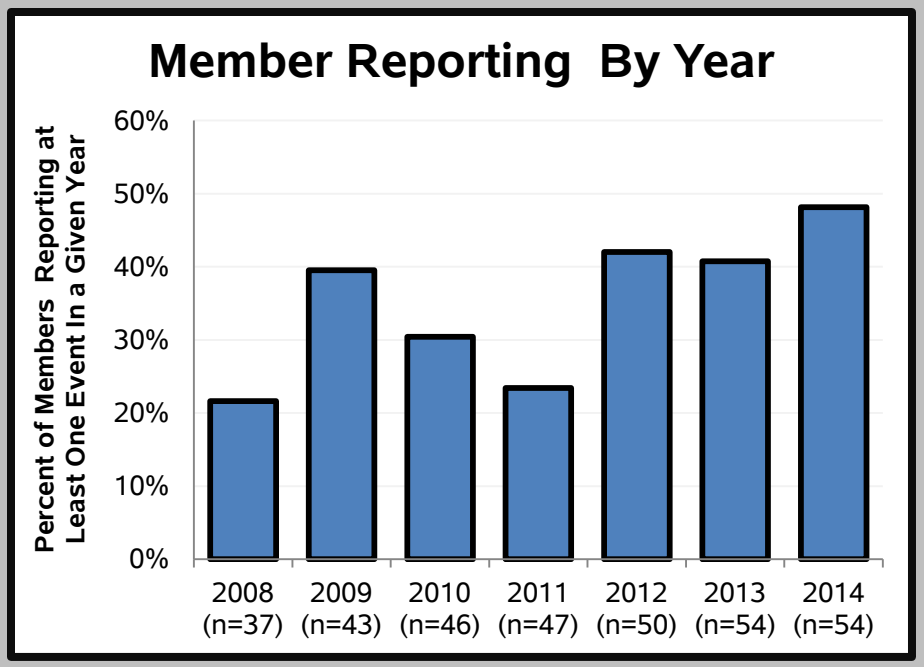
*participates in post-training collaborative activities

Members of the Just Culture collaborative participate in the following collaborative activities and events to support the integration of Just Culture into their local facilities:

- Participate in a 3-day Just Culture Certification Course, which helps build hospital expertise and certifies champions in Just Culture principles and tools
- Engage in monthly collaborative conference calls to share and learn from experiences of other collaborative members
- Utilize expert support for trained and certified staff to transfer the knowledge and skills essential to a Just Culture back to their hospitals through proven implementation strategies
- Evaluate hospital safety culture at the beginning and the end of the collaborative using the Agency for Healthcare Risk and Quality (AHRQ) Hospital Survey on Patient Safety Culture to build awareness of safety culture and to evaluate changes as a result of implementing Just Culture principles

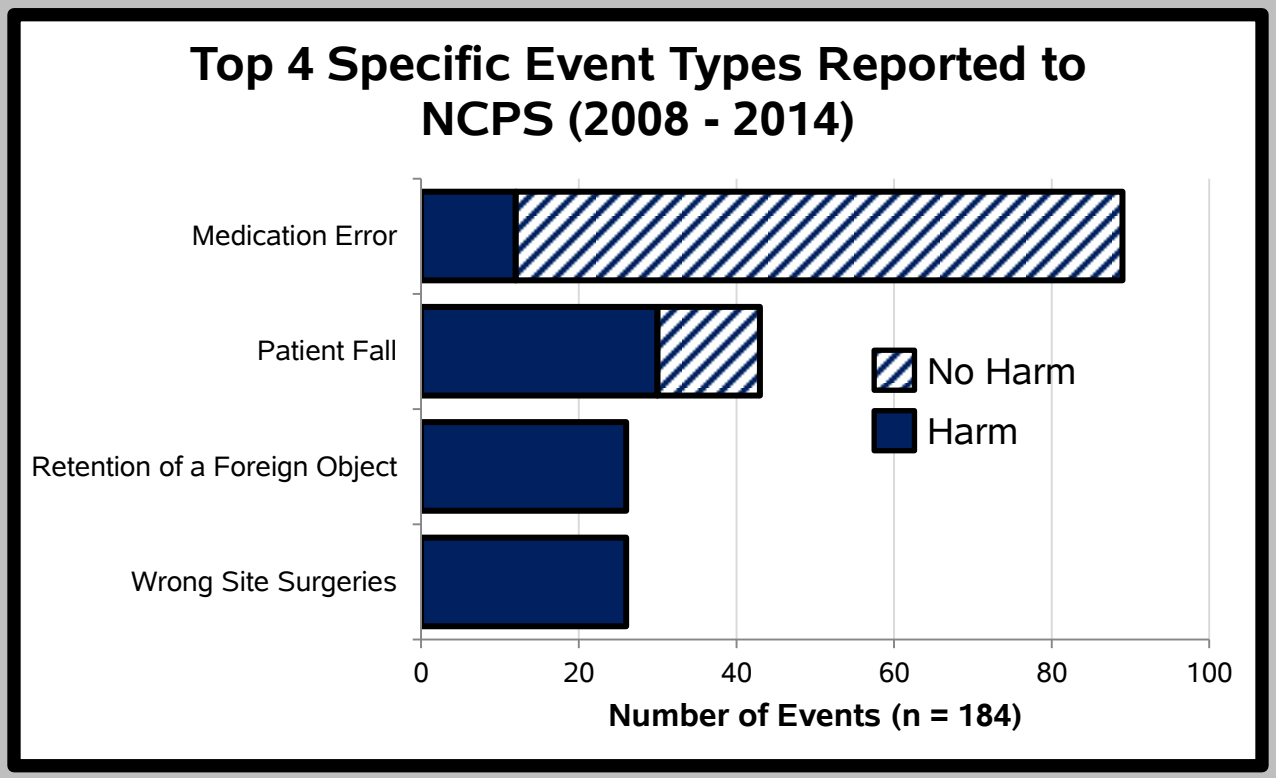
NCPS Reporting Statistics





- NCPS membership has grown from 37 members in 2008 to 54 members in 2014.
- In addition, member reporting has increased from 25 events in 2008 to 100 events in 2014.
- 2014 was the best year for NCPS member involvement. Almost half (48%) of our members reported at least one adverse event in 2014.

NCPS Reporting Statistics



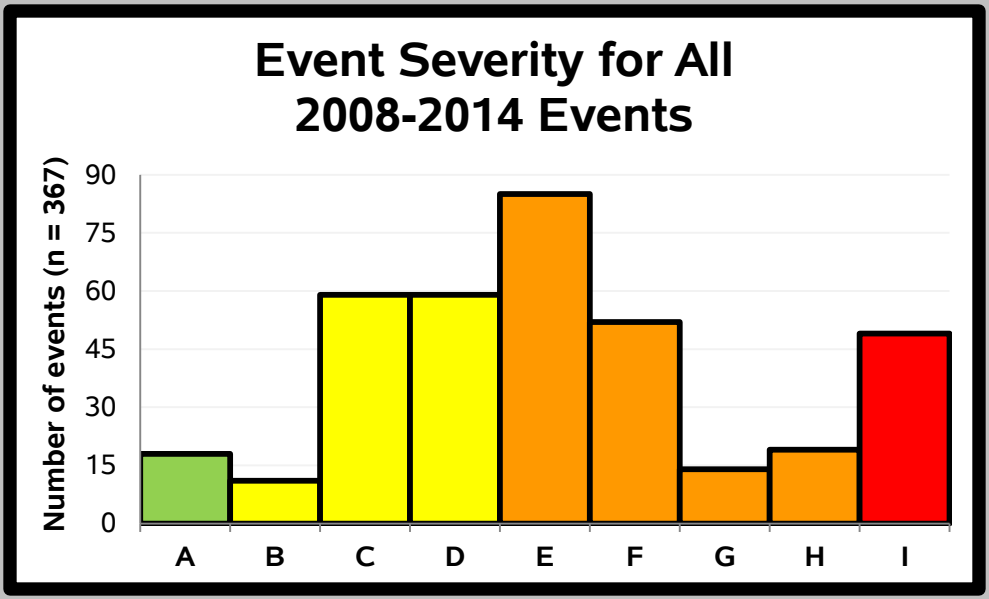
- Adverse events reported to NCPS are classified into specific event types which are based on the National Quality Forum's list of Serious Reportable Events. Roughly 50% of all events reported to NCPS fall within the above top four categories. Notice that out of these, roughly half did not cause patient harm, which allows us to learn about system weaknesses *before* a patient is adversely affected by them. NCPS actively encourages the reporting of near misses and unsafe conditions for precisely this reason.

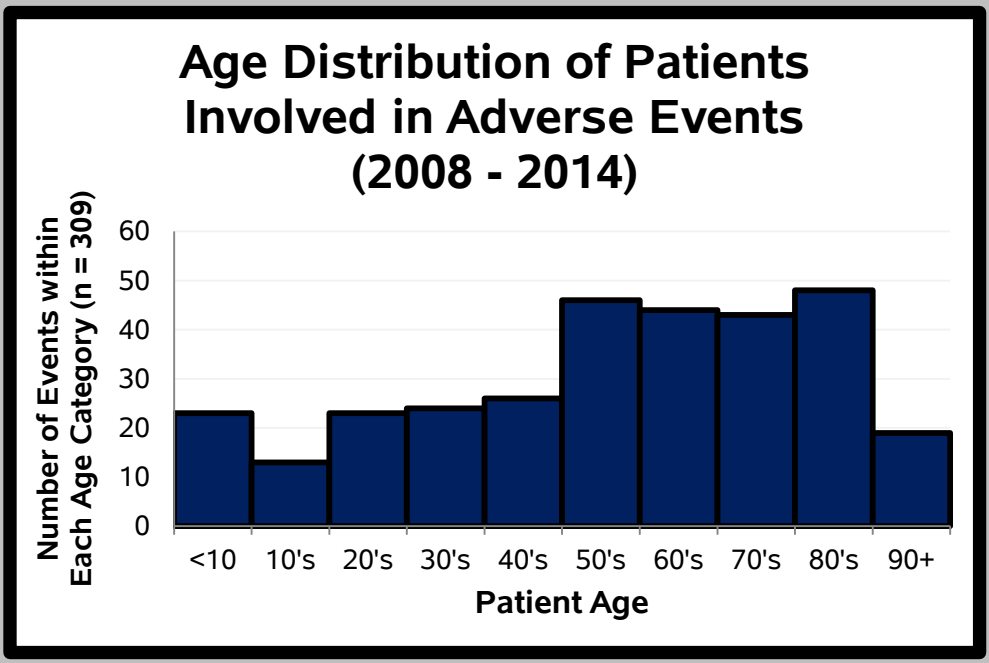
NCC MERP Index of Error Severity

A	Circumstances or events occur that have the capacity to cause error
B	An error occurred, but the error did not reach the patient
C	An error occurred that reached the patient, but did not cause patient harm
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient, and/or required intervention to preclude harm; harm does not reach patient
E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required an initial or prolonged hospital stay
G	An error occurred that may have contributed to or resulted in permanent patient harm
H	An error occurred that required intervention necessary to sustain life
I	An error occurred that may have contributed to or resulted in patient death

NCPS uses the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) index of error severity, which assigns an alphabetical ranking, A through I, based on the severity of the outcome to the patient.

NCPS Event Statistics





- NCPS receives events in all of the NCC MERP error severity categories. Green and yellow indicate no harm. Orange indicates harm and red indicates patient death.
- As can be seen in the age distribution graph, adverse events appear to be more common in older patients, however NCPS receives events involving patients of all ages.

Spotlight on Medication Errors

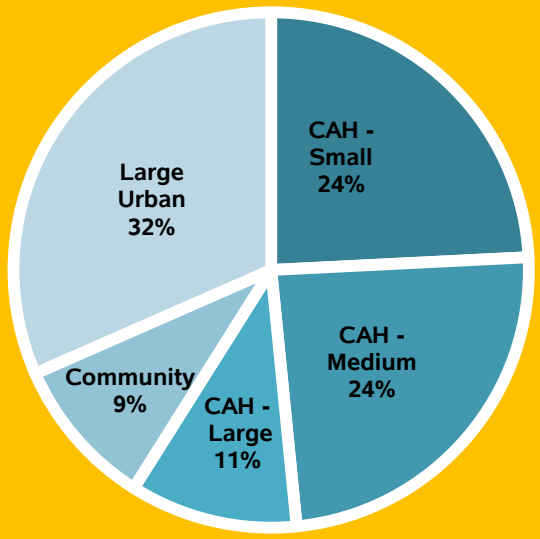
At Nebraska Coalition for Patient Safety (NCPS), medication errors make up **23% of all adverse events** that are reported to the coalition.

The most common medication errors that were reported involved:

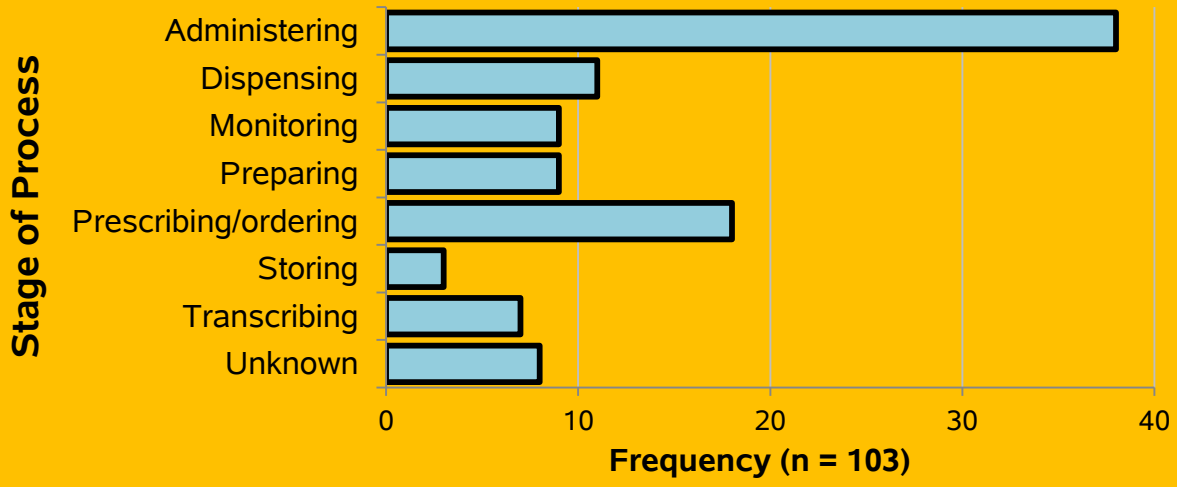
- **Wrong Dose (27%)**
- **Wrong Drug (25%)**
- **Wrong Route of Administration (8%)**
- **Delay in Administration (7%)**

Breakdown of Hospital Type From Which Medication Errors Have Been Reported (n = 95)

CAH = Critical Access Hospital



Stage in the Process Where Error Occurred (2008 - September 2015)

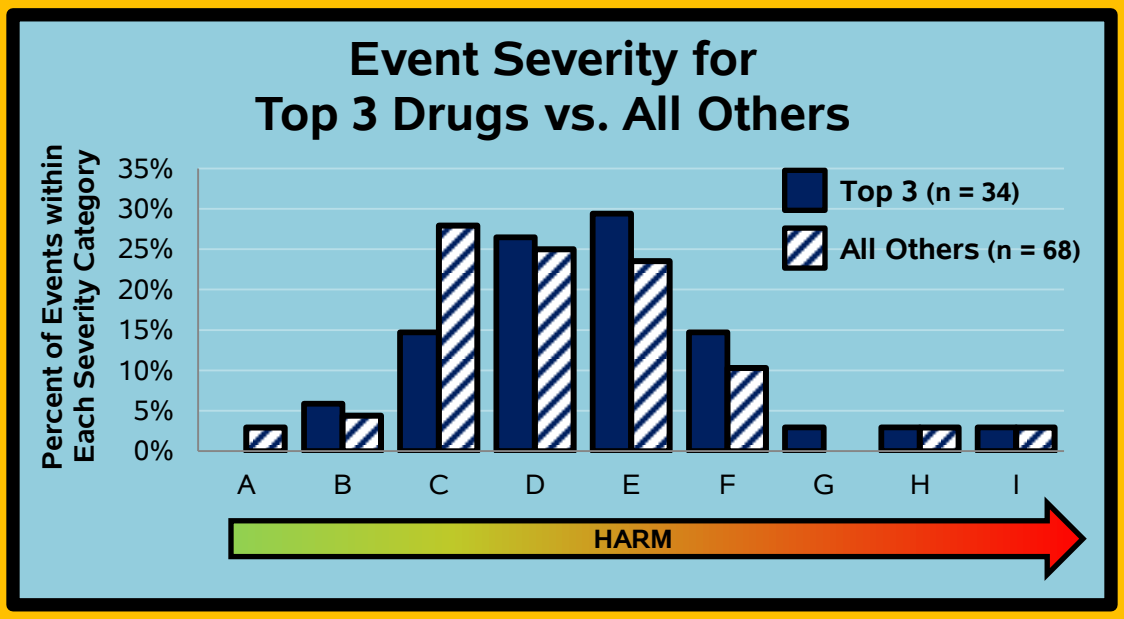


Spotlight on Medication Errors

The most common drug classifications that are involved in events reported to NCPS included:

- **Narcotics (15%)**
- **Anticoagulants (14%)**
- **Insulin (8%)**

These top three most common drug types are all considered high-alert medications by the Institute for Safe Medication Practices (ISMP, 2015). As can be seen in the graph below, the severity related to events containing one of these three drug types tends toward greater harm when compared to all other drug types.



Medication errors are often featured in our monthly de-identified events, which give a brief description of an event, the contributing factors and actions of the facility where the event occurred, as well as a literature review regarding best practices related to that event. Recently, based on causal factors identified in the de-identified events, our literature reviews have focused on best practices for independent double checks, tips to avoid mix-ups with look-alike/sound-alike medications, and promotion for the use of standardized protocols.

Reference: Institute for Safe Medication Practices (2015). ISMP list of high-alert medications in Acute Care Settings. Retrieved from: https://www.ismp.org/tools/institutionalhighAlert.asp

NCPS Members

Antelope Memorial - Neligh
Avera Creighton Hospital - Creighton
Avera St. Anthony's - O'Neill
Beatrice Community Hospital - Beatrice
Boone County Health Center - Albion
Box Butte General Hospital - Alliance
Brodstone Memorial Hospital - Superior
Brown County Hospital - Ainsworth
Bryan Health - Lincoln
Butler County Health Care Center - David City
Cherry County Hospital - Valentine
CHI Health Bergan Mercy -Omaha
CHI Health Creighton University Medical Center - Omaha
CHI Health Good Samaritan - Kearney
CHI Health Immanuel - Omaha
CHI Health Lakeside - Omaha
CHI Health Mercy Corning – Corning, IA
CHI Health Mercy Council Bluffs - Council Bluffs, IA
CHI Health Midlands - Papillion
CHI Health Missouri Valley - Missouri Valley, IA
CHI Health Nebraska Heart Hospital - Lincoln
CHI Health Plainview - Plainview
CHI Health Schuyler - Schuyler
CHI Health St. Elizabeth - Lincoln
CHI Health St. Francis - Grand Island
CHI Health St. Mary's - Nebraska City
Columbus Community Hospital - Columbus
Community Hospital - McCook
Community Medical Center - Falls City
Cozad Community Hospital - Cozad
Faith Regional Health Services - Norfolk
Faith Regional Surgery Center - Norfolk
Fillmore County Hospital - Geneva
Fremont Health - Fremont
Great Plains Health- North Platte
Harlan County Health System - Alma
Howard County Medical Center - St. Paul
Jefferson Community Health Center - Fairbury
Lexington Regional Health Center - Lexington
Lincoln Surgical Hospital - Lincoln
Litzenberg Memorial County Hospital - Central City
Mary Lanning Healthcare-Hastings
Memorial Community Health - Aurora
Memorial Community Hospital & Health System- Blair
Memorial Health Care Systems - Seward
Nebraska Medicine - Omaha
Nebraska Methodist Health System - Omaha
Nebraska Orthopaedic Hospital - Omaha
Nemaha County Hospital - Auburn
Osmond General Hospital - Osmond
Pawnee County Memorial Hospital - Pawnee City
Pender Community Hospital - Pender
Phelps Memorial Health Care System - Holdrege
Providence Medical Center - Wayne
Saunders Medical Center - Wahoo
St. Francis Memorial Hospital - West Point
Thayer County Health Services - Hebron
Tri Valley Health System - Cambridge
West Holt Medical Services - Atkinson

Note that our membership is not restricted to Nebraska – we accept members from *all* states!

NCPS Board of Directors

Board Officers

President
Stephen B. Smith, M.D.

Vice President
Katherine J. Jones, PT, Ph.D.
University of Nebraska Medical Center, Omaha

Treasurer
Don Naiberk, CEO
Butler County Health Care Center, David City

Board Members

Ed DeSimone, II, RPh., Ph.D.
CHI Health Creighton University Medical Center, Omaha

Dan Rosenquist, M.D.
Columbus Family Practice Associates, Columbus

Doug Elting, AIA
Visions in Architecture, Lincoln

Cody Sasek, MPAS, PA-C
University of Nebraska Medical Center, Omaha

Laura Hoogestraat, RN, CIC
Faith Regional Health Services, Norfolk

Lindsey Stout, MPAS, PA-C
Hastings Internal Medicine, Hastings

Carol Kampschnieder, RN, MSN
St. Francis Memorial Hospital, West Point

Cary Ward, M.D., MBA, FACP
Chief Medical Officer, CHI Health

Paula Riesberg, RP
CHI Health St. Francis, Grand Island

Contact Info:
Ann McGowan, RN, MSN
Executive Director
Nebraska Coalition for Patient Safety
986055 Nebraska Medical Center
Omaha, NE 68198-6055
P: 402.559.8421
ann.mcgowan@unmc.edu
www.nepatientsafety.org