**Upcoming Events**

**Creating a Fair and Just Culture:**  
June 6, 2017  •  NC Hospital Center, Cary

**Flyer:** [https://www.ncqualitycenter.org/wp-content/uploads/2017/05/JCFlyer_2017-06.pdf](https://www.ncqualitycenter.org/wp-content/uploads/2017/05/JCFlyer_2017-06.pdf)

**Registration:** [https://events.ncha.org/event/1513/register](https://events.ncha.org/event/1513/register)

An organization includes a well-defined and consistent system of justice and accountability. It’s an organization, in which all employees feel comfortable reporting errors and near misses, errors and adverse events are utilized for learning opportunities, reliable systems are designed around human fallibility, and there is balanced accountability between employee choices and the systems designed by the organization.

This one-day workshop provides an introductory overview of the Just Culture principles and includes instruction in coaching and mentoring staff, as well as basic event investigation steps completed by Just Culture organizations, and hands-on practice through the use of de-identified cases.

**PSO Members Only - Safe Table**

**Topic: Retained Foreign Objects**  
June 27, 2017  •  NC Hospital Center, Cary

**Flyer:** [https://www.ncqualitycenter.org/wp-content/uploads/2017/05/SafeTableFlyer_RetainedObjects_June2017.pages.pdf](https://www.ncqualitycenter.org/wp-content/uploads/2017/05/SafeTableFlyer_RetainedObjects_June2017.pages.pdf)

**Registration:** [https://events.ncba.org/event/1534/register](https://events.ncba.org/event/1534/register)
Do You Have Topic Suggestions for a Future Safe Table? We would love to hear them!

Have you ever attended a NCQC PSO Safe Table? If your answer is YES then you already know how essential they are to best practice sharing and learning. Our goal is to hold safe tables that address some of your most challenging patient safety events. In addition to reviewing the events submitted to NextPlane Solutions, for hot-spot topics, we would love to hear your suggestions for upcoming Safe Tables. To offer suggestions or to host a safe table at your organization Click Here.

Coaching with Backbone and Heart

August 9, 2017 • Northwest AHEC, Winston-Salem

Registration: https://events.ncha.org/event/1513/register

Effective coaching is a key element of adult learning, and is a component of implementing TeamSTEPPS®, Just Culture and quality improvement activity. We’ve heard that “practice makes perfect,” but it’s not just practice, but “practice with feedback” that enhances performance and helps individuals improve. Giving useful feedback, encouraging others, mentoring and role modeling are all skills that can be learned and utilized by those in a coaching role. This workshop will prepare you to be an effective coach, through self-assessment, increased understanding, and skills development.

The Second Victim Experience: Train-the-Trainer Workshop

August 28, 2017 • NC Hospital Center, Cary

Registration: https://events.ncha.org/event/1516/register

When patients suffer an unexpected clinical event, healthcare clinicians involved in the care may also be impacted and are at risk of suffering as a “second victim”. Understanding this experience and recognizing the need for supportive interventions is critically important. This presentation will provide insights into the experience as well as interventions of support. This workshop will also provide instruction so that each hospital team will return to their organization with the knowledge, skills, and techniques necessary to support and train their peers.

This train the trainer workshop is lead by Susan Scott and Laura Hirschinger, organizers of the Missouri University Health Care’s peer-support ForYOU Team, which addresses the unique needs of second victims. Together they will share their seven years of experience with this initiative along with tools and insights. Sign up early as seats are limited.

National PSO Collaborative - Concentrated Insulin

The NCQC PSO is participating in a collaborative on concentrated insulin with 15 other PSOs! Our target is to collect at least 200-300 events among the PSOs. To maximize our potential to study these events please submit any events associated with the use of concentrated insulin to the NCQC PSO safety platform.
Safety Topics

Interruptions, More Than Just a Bother

When we think of interruptions, we usually associate them with negative thoughts: a disruption of our workload and thought processes and the possibility they could lead to a patient safety event. That’s why “Do Not Disturb Zones” such as the “sterile cockpit” were created for high risk medication preparation activities. But do they work and do co-workers respect them? What about the interrupters? What is the motivation for interrupting someone and when do they occur? Since staff can be interrupted throughout their work day, perhaps there is more to interruptions than what we see on the surface? Occasionally interruptions are necessary and the motivation can emanate from the “sharp or blunt end”. Interruptions can be a result of common purpose or immediate operational needs such as a physician interrupting a nurse who is intensely charting after a code to inform her that one of her patients can be discharged. Each are trying to complete their work processes, but the intersection of these work processes result in an interruption of one’s work flow and cognitive thinking. In another example, the nurse who is busy charting after a code and is interrupted by a manager about scheduling questions reflect the intersection of work processes that do not have a shared current purpose and could negatively affect the quality of the nurse’s recall of the code events. Could the interruption have waited until break time?

A broader analysis of interruptions could produce improved understanding and effective solutions to reduce or eliminate their occurrence. Units have levels of work processes (unit resource coordination, unit care coordination, patient care planning, patient care delivery, etc.) that run simultaneously alongside operational processes that make up a “system”. These levels involve different staff (internal and external to the unit), working at different times, with different information resources and varying priorities who need to coordinate with each other. Communications relating to admissions, discharges, test results, procedures, environmental issues, etc. occur constantly in units and within “systems” to provide care coordination. The function and burden of interruptions can affect how staff handle the demands for their time and attention and could alter their ability to carry out work processes effectively.

So the next time you encounter a patient safety event that may be triggered by an interruption, view it from a broader systems perspective to capture all of the multiple and sometimes contradictory perspectives of the interruption event. This will provide you with a comprehensive understanding of the coordination needs and motivations for the interruption within the functioning system. Then concentrate on the “problem” interruptions. The insights gained can lead to the development of appropriate and sustainable improvements in the work system that will benefit both the interruptee and the interrupter.
NCQC PSO Safety Platform

NextPlane Event Upload Reminder: 1st Quarter Events Due

First Quarter events (January – March) were due in NextPlane on April 28, 2017. If you have not done so please upload your events and supporting RCA documents. Our team is standing by waiting to review and offer feedback reports related to your work.

Feedback & Learning

How Do You Share the NCQC PSO Information?

How many people within your organization know about the NCQC PSO? Did you know that anyone within your organization is able to join the webinars and learning activities? With the high-level security measures that are stressed to protect the information secured by the PSO; it may feel like a members-only secret society club, but we want as many people within your organization to understand the value of the NCQC PSO and to learn from the sponsored educational activities.

Collaborative engagement is key to PSO membership, so don’t let your peers and others miss out, spread the word about the PSO. So, if you haven’t done so already:

- Start sharing the newsletter with your C-suite leaders, the legal department and provider champions
- Invite colleagues from various departments/units to join you to view the monthly webinars and attend the quarterly safe tables
- Use the webinar playback links, tools and resources found on our members only resource page to educate your peers on the great safety topics that are discussed within the local and national PSOs.

Highlights from the 9th Annual Meeting of Patient Safety Organizations

The ninth annual meeting of Patient Safety Organizations took place in April, convening 55 PSOs to share best practices, discover opportunities to collaborate, and learn about various approaches to continue to provide the highest value to members.

Topics included, but were not limited to, increasing reporting, partnering with members to assist with senior leadership training, building reporting relationships with the FDA, the benefits of using AHRQ patient safety indicators and healthcare cost and utilization project data to improve patient safety, and using RCA analysis feedback from the PSO to enhance healthcare organizations’ internal RCA processes.

There are currently 85 listed PSOs and approximately 19% are now submitting data to the Patient Safety Organization Privacy Protection Center. As of mid-March, the PSOPPC received 310,386 patient safety reports. Majority of the events fell into the categories of medication, falls, and surgery/anesthesia.


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