NCPS
Nebraska Coalition for Patient Safety

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

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# NCPS Update: October 2025

## A Message from the

## Interim Executive Director

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

National Patient Safety Day was September 17th. To celebrate it, and the important work NCPS and its members engage in, NCPS' Annual Members Meeting was held virtually that day. The handouts from the day's presentations (i.e., Communication as a Cure: Preventing Diagnostic Errors to Promote Patient Safety; Bridging Risk and Innovation: AI Strategies for Safer Patient Care; Safety II – When Things Go Right (Success Cause Analysis); and NCPS Member Reported Event Data) can be found in the members portal of our website.

Though some critics say the patient safety movement in the United States is flagging, there is evidence that the status of patient safety has seen significant improvements in recent years, particularly in the years leading up to the pandemic. A 2022 study published in JAMA found that in the decade prior to the COVID-19 pandemic, rates of in-hospital adverse events for healthcare related patient harm fell significantly in the United States.[1] Researchers tracked a total of 21 adverse events over the study period (e.g., adverse medication events associated with insulin or anticoagulants; infections such as central line-associated blood stream infections and catheter-associated urinary tract infections; and post-procedure events for joint replacement surgeries or post-surgery cardiac events) and found declines in each's respective occurrence rate. A September 2024 report published by the American Hospital Association showed key patient safety measures surpassed pre-pandemic levels [2]. A noted point of significance, these better patient outcomes were attained while hospitals were providing care to a larger and more complex patient population.

We remain vigilant in our ongoing work of making patient care safe in any healthcare setting; and appreciate our members who are involved in the front-line work needed to attain this goal. A significant part of this work includes reporting patient harm events that have occurred in their health care setting to allow learnings from these events for all NCPS members. Recent member suggestions for education and training have NCPS looking to provide webinars on the following topics in the coming months: Complete and Accurate EHR Documentation, Support for Staff Involved in a Patient Harm Event, Dealing with Difficult/Aggressive Patients and Their Family Members, and PSES Considerations for Contracted Services. Please do not hesitate to reach out should you identify needed trainings or support for you or your team in your patient safety journey. I can be reached at carlasnyder@unmc.edu.

[1] Journal of American Medical Association; Trends in Adverse Event Rates in Hospital Patients, 2010-2019. 2022;328;(2);173-183. Available at: https://jamanetwork.com/journals/jama/fullarticle/2794055

[2] American Hospital Association; New Analysis Shows Hospitals Improving Performance on Key Patient Safety Measures Surpassing Pre-Pandemic Levels; September 2024. Available at:

https://www.aha.org/guidesreports/2024-09-12-new-analysis-shows-hospitals-performance-key-patient-safety-measures-surpassing-pre-pandemic-levels

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## NCPS Shared Learning Resources

This month's Shared Learning Resource is an on-demand recording, RCA2 Part 1: Event Review. In this learning module, RCA2 is defined and its purpose described; the importance of culture and leadership's support of RCA2 and risk mitigation is reviewed; and the steps, strategies, and tools used in conducting an effective root cause analysis are described.(NCPS membership is not required to view the overview training modules).

## Learning Opportunities for NCPS Members

### Workplace Well-being: Guide for Healthcare Professionals on Workplace Violence and De-escalation

**On Demand (provided by the University of North Texas Health Fort Worth)**

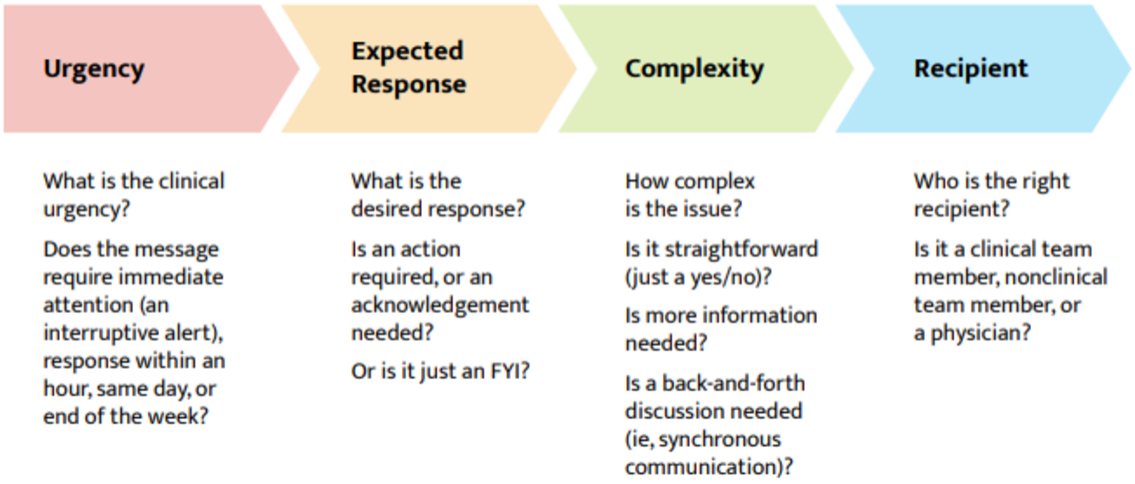
Workplace violence remains a pressing concern in healthcare, with recent data revealing a troubling rise in incidents that jeopardize the safety and well-being of both staff and patients. This module is designed to empower healthcare workers with the knowledge and skills necessary to recognize, prevent, and manage violence in clinical settings. You may register for this no cost course here. One CE is available for those completing this learning.

### How to Effectively Work with Medical Interpreters

Review of NCPS member submitted events found a significant number of Language Interpreter events. The Healthcare Center Association of Nebraska (HCAN) has developed a short 14-minute training video on the dos and don'ts of working with medical interpreters - including sample scenarios. This video will aid all direct patient care facing health care workers with the needed skills to ensure accurate and complete communication with their patients when using Medical Interpreters. https://www.youtube.com/watch?v=4c4mIsiJz_w

### The Saving Time Playbook

It can be a challenge for members of the clinical team to deliver messages to providers without causing unnecessary interruptions, particularly when the communication is time-sensitive but does not warrant an immediate response. One of the strategies in the Saving Time Playbook (developed by the AMA) includes thoughtful communication. It describes how to identify times for providers to respond to these messages and starts with the clinical team recognizing and understanding the key characteristics of communication as shown in this graphic.

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## Patient Safety Resources

### Improving Awareness and Communication of Do Not Resuscitate Orders During Transitions of Care

Do not resuscitate (DNR) orders are not always documented at transitions of care, which may lead to inappropriate resuscitation attempts. The researchers in this study sought to 1) investigate the challenges in ensuring that all staff are aware of a patients' DNR orders, 2) to examine documentation of DNR orders at transitions of care, and 3) to improve knowledge about DNR orders in institutions and at transitions of care. The paper may be found here.

### Non-Operating Room Anesthesia (NORA) Self-Assessment Tool

Non-operating room anesthesia represents a growing field of practice, with an increase in the number of cases performed over the previous decade; NCPS provided a Patient Safety Brief on this topic in February 2023. Recently, the Academic Medical Center PSO (AMC PSO) published a self-assessment tool on this same subject. Both tools will help you mitigate risks associated with non-operating room anesthesia.

### Predatory Conferences

Educational conferences promote knowledge and provide a platform to share findings, build networks, and gain valuable insights, which makes them essential. However, there is a rising number of predatory conferences. These conferences advertise as legitimate events but, in reality, deceive speakers and attendees. This article in a recent American Nurse publication highlights the warning signs of such events so that you will not waste time and reputation or suffer financial losses.

### System Strategies to Optimize the Critical Role of the Medical Interpreter

The most recent Joint Commission Journal on Quality and Patient Safety included a commentary highlighting the need for in-person interpreters to support the care team in the delivery of fair, comprehensive, and equitable care. The following significant points were discussed:

- Benefits of interpreter use for patient care delivery
- Barriers to effective interpreter use
- Facilitators of effective interpreter utilization

The paper may be found here.

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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

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