NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: April 2025

A Message from the Patient Safety Program Director

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Each year ECRI (an independent, non-profit organization whose purpose is to improve the safety, quality, and cost effectiveness of care across all healthcare settings) publishes a listing of their Top 10 Patient Safety Concerns. The Top 10 is ECRI's view of what are the most pressing safety challenges facing both patients and staff. Each item on the lists represents an opportunity for healthcare providers and leaders to minimize preventable harm by taking action to mitigate the concern.

The 2025 list contains many first-time topics and emphasizes potential risks that could have the largest impact on patients. This year's number one topic is **risks of dismissing patient, family, and caregiver concerns**. It is understandable that with the challenges of managing complex patients, using multiple communication technologies, and working within time constraints, empathetic, patient-centered care can be hindered. However, it is also well documented that dismissing patient, family, and caregiver concerns can lead to misdiagnoses and delayed treatment of patients.

This number one risk is one that NCPS is addressing through our shared learnings, presentations, and training workshops. Tools to improve an organization's culture of patient safety, their teamwork, communication with patients and families, communication within healthcare teams, and strengthening interprofessional practice are subjects within the learnings we provide. (e.g., AHRQ's Be the Expert on You, TeamSTEPPS® for Improving Diagnosis, 60 Seconds to Improve Diagnostic Safety; TeamSTEPPS® 2.0); Leadership Behaviors to Improve Safety; De-identified Event – The Value of Reviewing Patient Complaints; De-identified Event – Failure to Follow Up on Abnormal Test Results; etc.).

Access to the full ECRI report may be found here. Included in the report are **Action Recommendations** for each safety concern included in the Top 10 list. Each Action Recommendation has specific tasks in the four quadrants of Total Systems Safety - Culture, Leadership, and Governance; Patient and Family Engagement; Workforce Safety and

Wellness; and Learning System. An extensive list of Resources and References is provided for each patient safety concern on the list.

The List for 2025

1. **Risks of Dismissing Patient, Family, and Caregiver Concerns**
2. **Insufficient Governance of Artificial Intelligence in Healthcare**
3. **The Wide Availability and Viral Spread of Medical Misinformation: Empowering Patients Through Health Literacy**
4. **Medical Error and Delay in Care Resulting from Cybersecurity Breaches**
5. **Unique Healthcare Challenges in Caring for Veterans**
6. **The Growing Threat of Substandard and Falsified Drugs**
7. **Diagnostic Error: The Big Three-Cancers, Major Vascular Events, and Infections**
8. **Persistence of Healthcare-Associated Infections in Long-Term Care Facilities**
9. **Inadequate Communication and Coordination during Discharge**
10. **Deterioriating Community Pharmacy Working Conditions Contribute to Medication Errors and Compromise Patient and Staff Safety**

NCPS Shared Learning Resources

This month's Shared Learning Resource is a de-identified event reviewed at the March NCPS Reporting Committee. Last month's resource was also on diagnostic error. It was specific for Abnormal Test Results Not Followed Up On. This month's resource highlights another source of diagnostic error, **Care Team Ineffective Communication and Collaboration Resulting in a Delay in Diagnosis and Treatment.** The resource may be found on the NCPS website within the members only section of the Educational Resources tab.

Legal Update

On March 27th, the U.S. Department of Health and Human Services (HHS) announced preliminary restructuring to address the Trump Administration's goals for workforce optimization. The restructuring included a significant downsizing of full-time employees and consolidation of existing HHS divisions. NCPS is currently a federally listed Patient Safety Organization under the Agency for Healthcare Research and Quality, a division within HHS. Per the March 27th announcement, "HHS will combine the Assistant Secretary for Planning and Evaluation (ASPE) and the Agency for Healthcare Research and Quality (AHRQ) into the Office of Strategy to conduct research that informs the Secretary's policies and evaluates the effectiveness of the Department's programs for a healthier America." The link to the DHHS press release and fact sheet can be found here: Fact Sheet: HHS' Transformation to Make America Healthy Again | HHS.gov

Public health and patient safety workers have expressed significant concern regarding the recent downsizing of AHRQ, with an informal estimation of 80-90% reduction within the agency. While details of staff and program reductions are unclear at this time, questions have been raised about how critical work towards patient safety priorities, such as diagnostic safety, will be maintained. As of the writing of this update, there have been no announcements regarding the PSO listing programs or the National Patient Safety Database program. If the PSO listing program through AHRQ is defunded, NCPS and other PSOs will continue to operate under current federal statute. NCPS will continue to update its members and stakeholders as events unfold. Please reach out to Emily Barr at embarr@unmc.edu with any questions.

Learning Opportunities for NCPS Members

The National Action Alliance Safety Culture Webinars

April 15, 11am –12 noon CT **Measuring and Responding (Session 3)**,
Register by clicking on the session title.

Mastering De-Escalation in Health Care: From Recognition to Resolution

Tuesday, April 22, 2025 12 noon CT

In health care, tensions can rise quickly, and knowing how to de-escalate potentially violent situations is essential for the safety of both patients and staff. Join this ASHRM webinar to gain practical skills to manage high-stress interactions effectively. Register here for this no cost webinar.

AMA's Steps Forward Innovation Academy: Debunking Regulatory Myths

Wednesday, May 7 12 noon CT

Over-interpreted regulations can result in unnecessary processes and impair efficiency. In this webinar, speakers Kevin Hopkins, MD, and Robyn Hoffmann, RN, MSN, CHC, discuss how the AMA's Debunking Regulatory Myths series can help reduce the guesswork in regulatory requirements so organizations can focus on streamlining clinical workflows and improving patient outcomes. Register here.

TeamSTEPPS Master Trainer Workshop

Thursday and Friday, June 5th and 6th in Gothenburg at Gothenburg Health
8:00am - 4:30pm each day

TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) is designed to help health care professionals improve patient safety and quality through effective communication and teamwork skills. TeamSTEPPS® is an evidence-based set of tools and a training curriculum to successfully integrate communication and teamwork principles into any health care system. Many studies have found that teamwork training can lead to a stronger culture of safety through:

□ Positive change in behaviors
□ Process efficiencies
□ Increased patient satisfaction
□ Cost savings
□ Improved outcomes

□ Enhanced staff satisfaction

You may learn more about this workshop and/or register for it on the NCPS website; or email Emily Barr, embarr@unmc.edu, or Carla Snyder, carlasnyder@unmc.edu,with any questions (CEUs for this training are pending).

Patient Safety Resources

IHI's Quality Improvement Project Measures Worksheet

Making a change in a complex system requires tracking measures to help the team understand the impact of the changes made. The typical method includes tracking one to two outcome measures, three to five process measures, and sometimes one to two balancing measures. This worksheet was designed to help quality professionals identify the process, outcome, and balancing measures for the quality improvement projects they undertake. The tool may be found here.

A Framework for the Analysis of Communication Errors in Health Care

In this study, the root causes of communication failures was studied and a systematic way to categorize the errors in processes created. The top 3 errors identified were 1) non-adherance to facility standard operating procedures, 2) written errors (e.g., unclear documentation or not using plain language), and 3) no communication. Included in the group's work was the development of a cognitive aid which may help with the analysis of communication errors and the preventative actions used to mitigate vulnerabilities and promote effective communication among health care workers. The paper may be found 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