NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: March 2025

A Message from the Executive Director

Emily Barr, OTD, MBA, OTR/L, BCG

March 9-15 marks Patient Safety Awareness Week, a dedicated time to spotlight the importance of patient safety and drive action to enhance safety measures across healthcare systems. This week serves as a reminder that, while significant strides have been made in the 25 years since the publication of To Err is Human, the fight against medical harm continues. Adverse events during hospitalization remain a pressing issue, with approximately one in four Medicare patients experiencing them. Shockingly, nearly 40% of these events are caused by preventable errors.

In recognition of Patient Safety Awareness Week, NCPS encourages members and stakeholders to engage their teams through a variety of activities designed to foster a culture of safety. These initiatives include:

- Encouraging staff to “speak up for safety” by reporting adverse events.

- Initiating Surveys on Patient Safety Culture to assess and enhance organizational safety culture.

- Scheduling training sessions through NCPS to further educate and empower healthcare teams.

We invite everyone to actively participate in these efforts to improve patient safety and reduce preventable harm.

Looking ahead, the Agency for Healthcare Research and Quality (AHRQ) will host its 17th Annual Patient Safety Organization (PSO) Meeting in Washington, D.C., on May 15-16. We’re excited to announce that NCPS has been selected to present at this prestigious event. A special thank you to Ashley Dawson, Patient Safety Statistician I, and Dr. Katherine Jones, PT, PhD, NCPS Board Director, who will be presenting their session titled, “Lessons Learned: Using Electronic File Transfer of Risk Management Reporting for PSO Data Collection.” Their presentation will highlight key findings and innovative approaches to improving patient safety data collection and reporting, which will undoubtedly influence the future of NCPS programming. We look forward to sharing their insights and collaborating with other industry

leaders to continue advancing patient safety.

Finally, we're pleased to announce that NCPS will be hosting a TeamSTEPPS® 2-Day Master Training Workshop on June 5-6. This workshop, hosted at Gothenburg Health, will provide participants with valuable tools and strategies from the TeamSTEPPS® curriculum—proven to enhance teamwork and communication within healthcare settings. Attendees will also engage in strategy and implementation planning to tailor these tools to their own organizations. Registration for this event will open in early April, and more details will be available on the NCPS website. We're excited to offer this opportunity for healthcare professionals to deepen their skills in improving patient safety through effective teamwork.

NCPS Shared Learning Resource

Diagnostic error is defined by the Agency for Healthcare Research and Quality (AHRQ) as when one or both of the following occur (regardless if the patient experiences harm):

• **Delayed, Incorrect, or Missed Diagnosis**: missed opportunities to identify an accurate and timely diagnosis, based on available information at the time.
• **Failure to Communicate Diagnosis to the Patient**: an accurate diagnosis is available but is not communicated to the patient (including their family or representative).

Diagnostic errors are a significant public health crisis because of their implications for patient safety and outcomes. It is estimated that annually 1 in 20 outpatients experience a diagnostic error with greater than 50% of those errors having the potential to lead to severe harm or health[1]; in the hospital setting, diagnostic error is responsible for 6 to 17 percent of adverse events[2]; and an estimated 40,000 to 80,000 deaths annually can be attributed to diagnostic.error[3]. In 2023, diagnostic error accounted for 29% of the events reported to NCPS that resulted in permanent harm or death to a patient.

This month's learning resource **Diagnostic Errors - Failure to Follow Up on an Abnormal Test Result** is the first in a series discussing the various causes of diagnostic error and tools to mitigate their occurence. Highlighted in this month's resource are three events reported to NCPS where there was an issue with the needed follow-up for abnormal test results. This resource may be found here within our Members only portal.

[1] Singh, H., Meyer, A., Thomas, E. (2014). The frequency of diagnostic errors in outpatient care: estimates from three large observational studies involving US adult populations. BMJ Qual Saf; 23:727-731

[2] National Academies of Sciences, Engineering and Medicine.(2015). Improving diagnosis in health care. Washington, DC: The National Academies Press.

[3] Society to Improve Diagnosi in Medicine, 2020.

Learning Opportunities for NCPS Members

Accelerating Change Apparently - Using Apparent Cause Analysis as a Patient Safety Strategy

On demand 1 hour webinar

Health care professionals have many tools available to use in their efforts to improve processes and/or reduce the potential of patient harm events. In this webinar, offered by the American Society for Health Care Risk Management (ASHRM), one of those underutilized tools, Apparent Cause Analysis (ACA), is explained. ACA's value, methodology, and best practices for results dissemination are topics included in the webinar. Also included in the session is a comparison and contrasting of ACA with the more often used tools, Failure Mode and Effects Analysis (FMEA), and Root Cause Analysis (RCA). Knowing this information will allow the patient safety professional to understand what is the best tool to use for their particular event. There is no cost for this webinar and 1.0 continuing education is available at its completion.
Use this link to register for the hour long webinar.

Artifical Intelligence Tools to Improve Provider Effectiveness and Patient Outcomes

March 18 1:30 - 3:00pm CST

The expert panelists in this AHRQ Digital Healthcare Research Program sponsored webinar will discuss their own research on leveraging AI tools to improve provider effectiveness and patient outcomes in clinical settings. Continuing education/continuing medical education accreditation is pending for this event. Click on this link to register for this event.

Bringing Innovation to the Forefront of Patient Safety

Wednesday, April 16 12noon - 1:00 PM CST

In this PSQH sponsored webinar, Josh Clark, RN, MHA, Vice President, Quality and Safety Operating Systems at the Institute of Healthcare Improvement, discusses how the concept of care operating systems is transforming the experience of healthcare delivery. Use this link to register for the event.

Patient Safety Resources

Failure to rescue female patients undergoing high-risk surgery

Failure-to-rescue (FTR) refers to the idea that many complications of medical care are not preventable and that healthcare systems should be able to rapidly identify and treat complications when they occur. In a retrospective study of Medicare beneficiaries from 2015 to 2020, researchers found that female patients undergoing high-risk surgeries had rates of complications similar to male patients but higher 30-day mortality and failure-to-rescue rates. These findings highlight a gender disparity in perioperative care and the need for better recognition and management of clinical deterioration in female patients. The paper may be found here.

Diagnostic safety needs assessment and informed curriculum of an academic children's hospital

Diagnostic reasoning is a core component of safe care but is not always included in formal educational curricula. In this study, learners, attending physicians, and education leaders shared their experiences learning about or teaching diagnostic reasoning to inform development of a diagnostic reasoning curriculum. Learners and educators highlighted the importance of psychological safety to reporting missed diagnosis or diagnostic uncertainty, integrating the curriculum into existing educational programming, and faculty development on the topic. The paper may be found here.

Artifical intelligence related safety issues associated with FDA medical device reports

Patient safety reports submitted to the Food and Drug Administration's (FDA) Manufacturer and User Facility Device Experience (MAUDE) database provide a rich source for identifying how artificial intelligence/machine learning (AI/ML) may have contributed to the event. This study identified 429 safety reports associated with AI/ML-enabled medical devices; one-quarter were potentially related to AI/ML, underscoring the need for an AI patient safety program. The paper may be found here.

Implicit bias in the patient descriptor "homeless" and its association with emergency department opiod administration and disposition

Bias, including bias in clinical documentation, negatively impacts care of marginalized patients. In this study, emergency department (ED) physician notes were included if the patient had a history of unstable housing to establish if the use of the word "homeless" was associated with admission status and opioid prescription rates. Patients whose ED note contained the word "homeless" were more likely to be discharged rather than admitted and less likely to receive IV opioid medication. The paper is available 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