NCPS
Nebraska Coalition for Patient Safety

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

NCPS Update: June 2025

A Message from the

Interim Executive Director

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The Agency for Healthcare Research and Quality, AHRQ, held their 17th Annual Meeting of Patient Safety Organizations May 15-16th. I was fortunate to attend in person and listen as NCPS Consultant, Katherine Jones, PT, PhD, and NCPS Statistician, Ashley Dawson, MS, presented "Lessons Learned: Using Electronic File Transfer of Risk Management Reporting for PSO Data Collection." (*The full NCPS report may be found here.*)

The implementation of electronic file transfer software is one of the important initiatives financially underwritten by the Patient Safety Cash Fund. This fund, which was established by the Nebraska Legislature in 2019, is supported by biannual license renewal fees paid by physicians and physician assistants. Use of the electronic file transfer software has increased the number of events reported to NCPS from 119 in CY2021 to 43,514 in CY2023. This increase in reporting provides us with additional data which informs NCPS how to best provide members with the feedback, tools, and education needed to improve patient safety in their healthcare setting.

Here are a few of the interesting findings from Katherine and Ashley's analysis:

- **7% (3,075/43,514) of reported events occurring in 2023 resulted in temporary harm, permanent harm, or death.**
- **The most frequent conditions resulting in permanent harm or death:**
  - › Care Mgt Failure/Delay (32%)
  - › Care Mgt/Not Specified (19%)
  - › Medication or other Substance (12%)
  - › Surgery/Invasive Procedures (11%)
  - › Perinatal (9%)
  - › Other (9%)
  - › Fall (2%)
- **Five factors contributed to greater than 10% of events.**
  - › Policies/Procedures (inadequate/absent/lack of adherence to (20.5%)
  - › Human Factors (17.5%)
  - › Staff Qualifications (17.2%)
  - › Patient/Family Factors (17.2%)
  - › Communication/Team Factors (10.7%)
- **The five most prevalent contributing factors reveal the need to improve implementation of existing evidence-based patient safety interventions.**
  - **› Just Culture** principles/strategies to address lack of adherence to policies/procedures and the need to design systems to account for human factors (these two factors contributed to

38% of reported events)

› Team strategies and tools (i.e., **TeamSTEPPS**) to improve communication, manage changing workloads, and serve as a safety net for human fallibility; Communication and Team Factors contributed to half of Care Management Failure/Delay events.

› Credible, thorough, and acceptable root cause analyses that consider staff qualifications and patient factors.

Since the reporting of patient safety events to NCPS is voluntary, it is difficult to quantify the number of harm events and near misses averted because of the work NCPS has done in helping members to improve their patient safety culture as well as the tools introduced to them through our educational offerings (e.g., RCA2, Briefs/Debriefs/Huddles, monthly Shared Learnings, etc.). An Agency for Healthcare Research and Quality sponsored research project to determine the benefit an organization realizes when working with a Patient Safety Organization (PSO) to improve their patient safety culture found these three themes.[i]

1. Patient safety culture improvement starts with assessment.

2. PSO privacy and confidentiality protections promote trust.

3. PSOs facilitate improved patient safety culture by offering collaborative initiatives, education, and training.

Thanks to our members that report events of harm and near misses. This is the basis for the programs of education and learning NCPS provides. Our goal is to help our members make system changes, through the provision of tools and education, when they do discover gaps in their care processes and systems.

Unsafe patient care is a systemwide problem and though historically the focus for patient safety initiatives has been within hospitals, half of the global disease burden arising from patient harm originates in primary and ambulatory care.[ii] So please know, membership in NCPS is available and encouraged for providers in every healthcare setting (e.g., ambulatory clinics, specialty hospitals, long term care, etc.).

Thank you for joining us in our mission "***To continuously improve the safety and quality of healthcare delivery in the region***". Our work would not be possible without the support of our founding member organizations and those that provide financial support for the work we do. We have accomplished much and have much to yet accomplish. Working together we will succeed in reducing the number of harm events that caused temporary harm, permanent harm, or death from the 3,075 events reported in 2023.

[i] Agency for Healthcare Research and Quality, How PSOs Help Health Care Organizations Improve Patient Safety Culture. April 2016. Available at: https://pso.ahrq.gov/sites/default/files/wysiwyg/npsdpatient-safety-culture-brief.pdf

[ii] World Health Organization.Global patient safety report 2024. Available at: https://www.who.int/health-topics/patient-safety

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NCPS Shared Learning Resources

This month's Shared Learning Resource is a de-identified event involving a patient that was seen in a Critical Access Hospital's Emergency Department and then transferred to a hospital able to meet the higher level of cardiac care the patient required. The patient experienced care coordination/management issues. As noted above, the most frequent conditions resulting in permanent harm or death in our CY2023 data were Care Management Failure/Delay (32%) and Care Management/Not Specified (19%).

This de-identified event includes a Cause and Effect diagram that is effective in elucidating the process gaps that lead to the care management failure. This also serves as a reminder of the value that Cause and Effect diagrams bring in understanding if proposed corrective actions will be effective in keeping a similar event from occurring again.

The resource may be found on the NCPS website within the members only section of the Educational Resources tab.

Learning Opportunities for NCPS Members

Can Your Organization Spot a Conflict Before It's a Crisis?

June 24th 11:30am CDT

In today's complex healthcare environment, navigating third-party relationships has become even more challenging - whether it's vendor relationships, employee activities, or patient-facing interactions. Left unmanaged, these conflicts can compromise trust, regulatory compliance, and even organizational reputation.

Novo Nordisk VP, Corporate Compliance & Privacy Officer, Amy Phillips Pablos' presentation will provide you with 3 key takeaways:

- Learn how to design processes that flag and manage potential third-party risks before they escalate
- Discuss cross-functional tactics to assess risk, align on business impact, and create policies and controls based on organizational scope, size complexity and exposure
- Explore strategies that staff and leaders can use to empower teams react and respond with confidence and consistency

Register here.

From Structure to Safety: The Blueprint That Works

June 18th 11:05 AM - 12:05PM CDT

As part of June's Healthcare Risk Management week, Patient Safety & Quality Healthcare (PSQH) is sponsoring an online summit. This is one of their webinars which features discussions on safety measures in the environment in which we live and work. Strategies for success in risk management, structure and safety to prevent harm will also be discussed. Registration is free.

Patient Safety Resources

AHRQ's Rapid Review: Examining the Impact of Implementing High-Reliability Organization (HRO) Principles on Patient Safety Outcomes

Periodically AHRQ performs Rapid Reviews on new or emerging research topics, updates of previous reviews, critical topics, or to assess what is already known about a policy or practice. It is less rigorous than a complete systematic review but is typically completed within 5 weeks. Their purpose is to provide evidence synthesis that may provide more timely information for decision making compared with standard systematic reviews. One was recently completed on HRO Principles and their impact on patient safety outcomes. Their conclusion: While some data suggests that sustained implementation of HRO principles in organizations may improve patient safety outcomes, the published evidence is limited, making it challenging to draw conclusions about the effectiveness of specific interventions. The Rapid Review document may be found here.

CNOs, Here's How to Prepare for ICE Agents in Hospitals

On January 20th, the Trump Administration revoked a policy that protected sensitive locations, including hospitals, from Immigration and Customs Enforcement (ICE) and Customs and Border Patrol (CBP) enforcement actions. PSQH has published an article which provides general guidance for healthcare organizations should ICE agents present at their facility. Their strong recommendations include organizations 1) working with their legal departments to identify and distinguish private spaces from public areas, and leveraging signage and security guards to clarify private areas; 2) reviewing policies and including in them a list of designated private areas; 3) developing procedures for how to interact with ICE and CBP agents and handle law enforcement requests; 4) appointing a trained individual or legal advocate who can interact with ICE agents when they arrive. The article be found here.

Creating Opportunity From Challenge: Strategies to Address the Shortage of Respiratory Therapists

Despite a growing demand for respiratory therapists (RTs), there is a shortage. This is driven by retirements and a decrease in enrollment in RT programs. According to the American Association for Respiratory Care's (AARC) 2024 Human Resources Survey, more than 80,000 RTs are expected to retire by 2030.

As more patients are coming into the hospital with respiratory illnesses, there are strategies healthcare leaders can put in place to create an environment where RTs can thrive and grow as a critical component of a care team. Read those strategies in this AARC whitepaper.

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