NCPS

Nebraska Coalition for Patient Safety

ANNUAL REPORT

April 2021

EXECUTIVE DIRECTOR MESSAGE

Dear Patient Safety Advocates:

As the Nebraska Coalition for Patient Safety (NCPS) enters its 16th year of operation, it is my privilege to provide you with this update of the patient safety activities we have conducted throughout the past year. And what a year it has been. We are humbled by the heroic response of the healthcare workforce to the COVID-19 pandemic. The innovation, collaboration, and resilience among healthcare providers in the face of unprecedented challenges has been truly inspiring. We are honored to serve you.

Since its inception in 2006, NCPS has remained steadfast in its mission to improve the quality and safety of healthcare across the region. Providing pertinent education, resources, and support to our members continues to be among our primary goals. NCPS identifies patient safety issues through analysis of reported events and ongoing communications with our members. Evidence-based best practices are shared through education programs, patient safety alerts and briefs, Reporting Committee summaries, our monthly NCPS Update newsletter, and the NCPS website. We invite you to page through this report to learn more about the core services we provide to members.

This year has also been one of remarkable change and growth for NCPS. We have increased the number of free education webinars provided to members and, in addition to providing nursing CEUs, NCPS now offers CMEs for select education programs. We launched virtual safe tables, which are designed for members to engage in meaningful dialogue about patient safety in a protected space. We welcomed two new organization members in 2020 and are preparing to welcome all Nebraska physicians and physician assistants as individual members of NCPS in the upcoming months. Our website has been completely transformed to give you improved access to resources. Check it out at www.nepatientsafety.org

As we reflect on the past, we are reminded how far we have come. We are excited for the opportunities ahead, especially when we consider how we have adapted and supported each other during this difficult time. We are committed to the continued development of valuable patient safety programs and services in collaboration with providers and professional organizations as we work together toward safer healthcare.

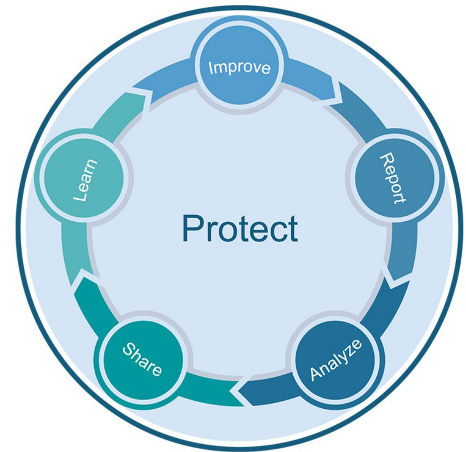
Thank you for your partnership and your unrelenting commitment to healthcare that is free from harm.

Gail Brondum, LPN, BS
Executive Director

THE VALUE OF NCPS MEMBERSHIP

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

We are all committed to making healthcare safer and better for our patients. One of the challenges to achieving this goal in healthcare delivery is the concern that patient safety information that a provider collects as part of quality improvement efforts could also be used in legal proceedings. Working with a federally listed Patient Safety Organization (PSO) can help providers overcome those concerns. NCPS has maintained its federal listing since 2009, and, as such, provides a safe and protected environment for health care providers to conduct patient safety activities.



PROTECT: The Patient Safety and Quality Improvement Act of 2005 authorized the creation of PSOs to promote shared learning and improve quality and safety nationally by conferring privilege and confidentiality protections on providers who work with federally listed PSOs. These protections apply in all U.S. states and territories and reach across state lines.

REPORT: Providers report patient safety information to NCPS confidentially and without fear of legal discovery.

ANALYZE: NCPS data experts collect and analyze data from multiple providers to identify trends and patterns. NCPS assists healthcare providers in investigating single events and analyzing aggregate data in a protected and confidential manner.

SHARE: Through event analysis, NCPS shares insight into underlying causes of patient safety events and provides members with education and resources as part of the feedback loop in the reporting relationships.

LEARN: Lessons learned from event reports can be used to prevent future patient safety events.

IMPROVE: NCPS assists providers with developing effective approaches to improve patient safety and quality through evidence based resources, education and training programs, and safety culture services.

"NCPS provides support and resources that meet organizations where they are at in their patient safety journeys. Whether quick, valuable responses to specific questions that arise; expert referrals and guidance around PSO protections; or access to literature review and expertise, our patient safety program would not be what it is without the supportive relationship with NCPS!"

Laura Peet Erkes, MSW, CPHRM, HEC-C |Director, Risk Management Operations – CHI Health/Midwest Division | Policy Management Leader

NCPS FOUNDERS

NCPS SPONSORS

PLATINUM:

GOLD:

SILVER:

PROTECTION OF NCPS

In 2005, Congress developed and enacted the Patient Safety and Quality Improvement Act in response to the Institute of Medicine publication *To Err Is Human*, which drew national attention to the number of preventable deaths related to medical errors that were occurring in the U.S. healthcare system each year. The Patient Safety and Quality Improvement Act confers federal confidentiality and privilege protections for certain information when it is used to improve patient safety and quality. These protections apply in all states and U.S. territories and can only be obtained by working with a federally listed PSO. NCPS has been designated by the Agency for Healthcare Research and Quality as a federally listed PSO since 2009.

In 2005, the state legislature passed the Nebraska Patient Safety Improvement Act. The Act called for the formation of a patient safety organization in Nebraska to encourage a culture of safety and quality by providing for:

- Legal protection of information reported.
- Aggregation of de-identified information about safety events.
- Sharing of de-identified information for improvement.

NCPS was formed in 2006 as a result of this state legislation.

Both state and federal protections for patient safety and quality improvement information may be obtained by working with NCPS as the state designated and a federally listed PSO.

In 2009, NCPS became a federally listed patient safety organization with the Agency for Healthcare Research and Quality.

"The Nebraska Coalition for Patient Safety has been helpful to us in offering guidance for standardizing Serious Reportable Events. I recently asked for direction to update our Patient Safety Evaluation System policy and procedure and they sent what I needed in a few days. We appreciate knowing that the events reported to the NCPS remain privileged and confidentially protected."

Shirley Knudsen, RN | Safety Coordinator; Cherry County Hospital, Valentine, NE

"NCPS is my "go to" source for resources; it may be assistance creating a causal statement for a root cause analysis, contacting a colleague for confidential advice on a challenging situation, or researching a new product or service. NCPS works collaboratively with its members to achieve patient safety and privilege protection."

Betty Froehlich | Regulatory Coordinator; Faith Regional Health Services, Norfolk, NE

REPORT

Reporting safety events enables the NCPS team to aggregate and analyze the information to identify patterns and trends, to share the learning from the events, and to identify topics for education. Regular reporting is encouraged to maintain a strong reporting relationship with NCPS. We encourage our members to consider reporting at least one event each month.

Why reporting events is important:

- ✓ Certain information reported to NCPS can become protected and privileged as patient safety work product.
- ✓ Reporting safety events and near events allows NCPS to conduct meaningful data aggregation and analysis.
- ✓ Analysis of reported events allows NCPS to identify trends and patterns in various types of events and levels of harm (where applicable).
- ✓ NCPS develops educational materials to share with our members, based on reported events, to assist members with improving patient safety.

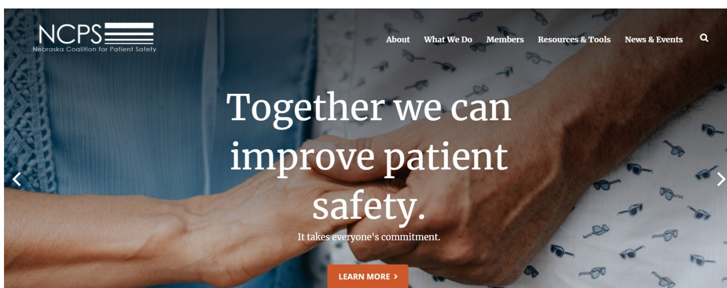
WHAT TO REPORT

NCPS encourages members to report:

- **Safety events that reach the patient (with and without causing harm).**
- **Safety events that do not reach the patient (near events and unsafe conditions).**
- **Findings from event investigations and root cause analyses.**
- **Any event or condition in which there are lessons learned that can be shared for improvement.**

The event report form, and information about how to submit reports can be found on our website. In 2021, NCPS will be researching a web-based reporting platform that will enable our members to enter event reports directly into the database or send data files to us electronically for importing into the database.

There is no shared learning if there are no reported patient safety events!



Visit our website for news and updates!

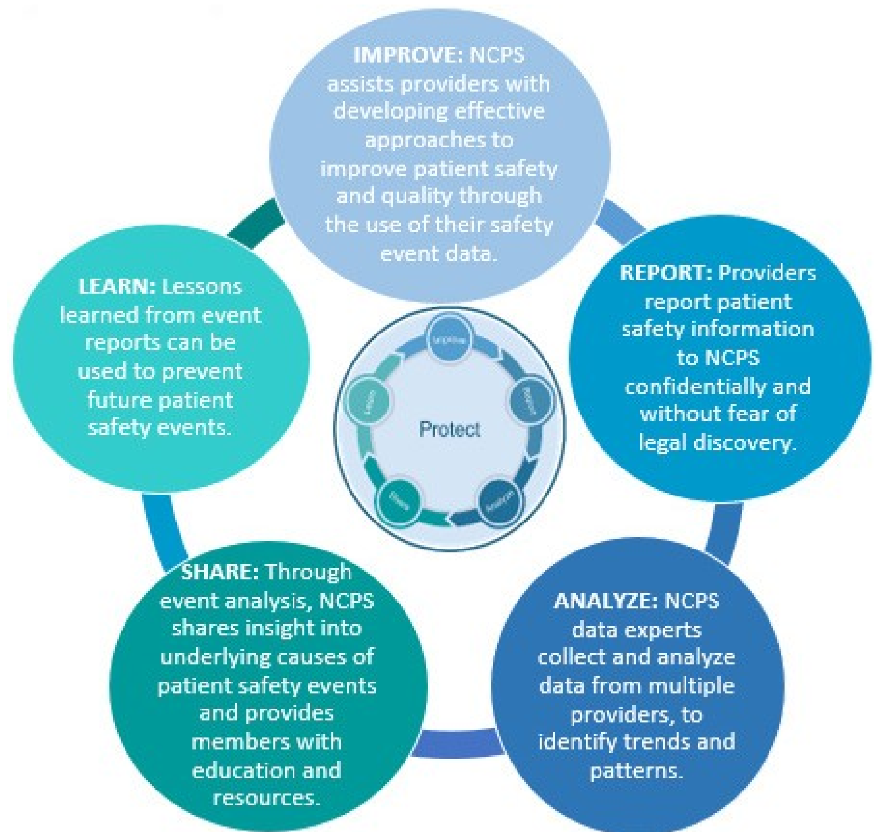
"We are so appreciative of the reporting process through which NCPS allows information to be shared within the PSO, allowing us to learn from situations that occur in member hospitals. This certainly provides safety information we would not have access to if we did not belong to NCPS."

Nicole Blaser, MSN, RN | Director of Quality & Compliance/HIPAA Privacy Officer; Columbus Community Hospital, Columbus, NE

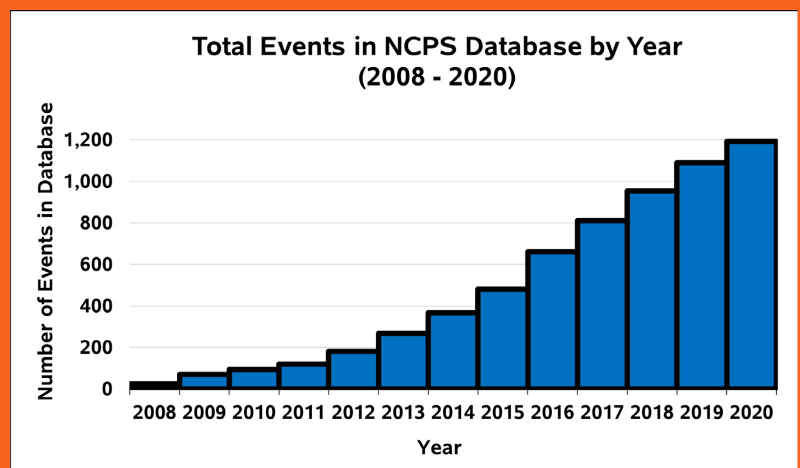
2020 PATIENT SAFETY EVENT ANALYSIS

NCPS assists members in safety culture development through aggregation and analysis of patient safety events and the sharing of education, tools, and other resources that members can learn from and use to improve the safety of patient care delivery.

NCPS members benefit from the insights gained by NCPS evaluative reports and aggregate data analyses from multiple providers, especially for high risk, low volume patient safety events.



Since its beginning, there have been 1,193 events reported to NCPS. The graph on the right displays the cumulative number of events in the NCPS database by year.

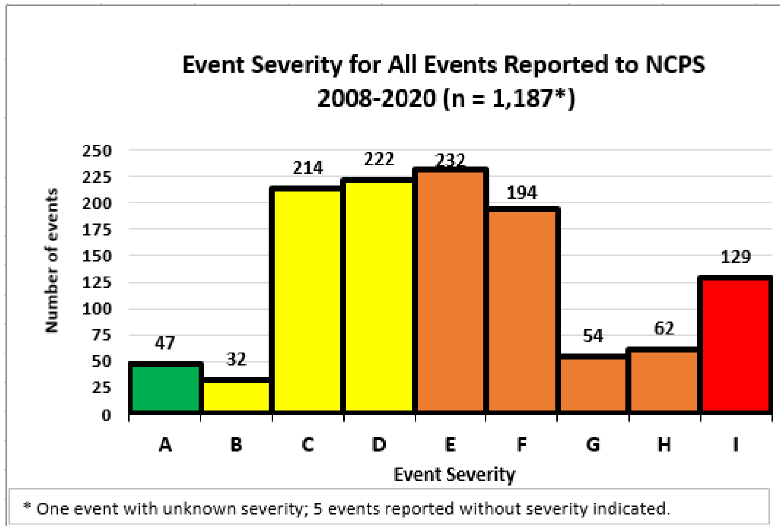


"Mary Lanning Healthcare chose the NCPS as its Patient Safety Organization because we prefer to work with a local PSO. Sharing the event investigations that are reported to the NCPS and the lessons learned from these events using evidence-based best practices help to improve patient safety at our facility. These are widely distributed so we do not 'have to reinvent the wheel'."

Sandy Klimek-Milton | Patient Safety and Risk; Mary Lanning Healthcare, Hastings, NE

2020 PATIENT SAFETY EVENT ANALYSIS

NCPS uses the National Coordinating Council for Medication Error Reporting and Prevention index of severity, which assigns a ranking based on the outcome of the event.



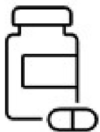
HARM

A	Circumstances or events occur that have the capacity to cause error
B	An error occurred, but the error did not reach the patient
C	An error occurred that reached the patient, but did not cause patient harm
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient, and/or required intervention to preclude harm; harm does not reach patient
E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required an initial or prolonged hospital stay
G	An error occurred that may have contributed to or resulted in permanent patient harm
H	An error occurred that required intervention necessary to sustain life
I	An error occurred that may have contributed to or resulted in patient death

- **There were 63 hospital members in 2020.**
- **Members submitted 103 event reports in 2020.**

Of the reported events…
46 resulted in some level of harm to the patient, with 9 resulting in death.

Just as in every year since 2008, the top four event types reported to NCPS in 2020 were related to medications, patient falls, surgical procedures, and failure/delayed response.



15% of events (n=15) were medication-related

13% of events (n=13) were related to patient falls

Surgical incidents such as wrong site, wrong patient or retained foreign object accounted for 12% of events (n=12)

Failure/delayed response to change in patient condition accounted for 7% of events (n=7)

SHARE

NCPS 2020 SHARED LEARNING

Educational materials developed by NCPS include Patient Safety Alerts and Briefs, De-identified Events and Reporting Committee Summaries. Topics are selected from the aggregation and analyses of reported events which reveal patterns and trends, as well as low volume-high risk events that could occur in any healthcare setting. These resources are shared with members to assist with driving patient safety and quality improvement initiatives. Emphasis is placed on mitigating future risk by developing these resources within the framework of an organizational self-assessment tool which asks, "Could this happen in your organization?" and providing members with evidence-based best practice recommendations.

"The education and resources provided through our membership with the Nebraska Coalition for Patient Safety over the years has been invaluable to improving the safety of the care we provide at Columbus Community Hospital. One of the resources we find most helpful is the Reporting Committee Summary. We utilize this tool with our Patient Safety Committee to mitigate previously undetected risks in our care environment and take action to prevent patient harm."

Nicole Blaser, MSN, RN | Director of Quality & Compliance/HIPAA Privacy Officer; Columbus Community Hospital, Columbus, NE

Patient Safety Alerts

- Medication-related events in infants 12 months of age and younger.
- Managing medical diagnoses during pregnancy
- Fall Prevention .
- Psychological Safety: If you see something, say something.

De-Identified Events

- Isolation Precautions and Alarm Fatigue.
- Telemetry / Cardiac Monitoring Patient Safety.

Reporting Committee Summaries

Each quarterly summary provides an organizational self-assessment of risk mitigation strategies around selected patient safety topics.

- The Q1 summary focused on obtaining accurate allergy history and medication errors related to infusion rate and communication failures.
- The Q2 summary focused on specimen handling and test resulting.
- The Q3 summary focused on patient education; highlighting the importance of Teach Back and other strategies aimed at promoting health literacy.
- The Q4 summary focused on risk mitigation as it relates to working with students during their clinical rotations.

NCPS members have access to shared learning materials through the Members Resources portal on our website.

LEARN

Member Webinars

- **The Benefits of Belonging to a Patient Safety Organization**
  Presenters:
  Gail Brondum LPN, BS
  Regina Nailon PhD, RN
- **Creating Second Victim Resilience through Peer Support**
  Presenter:
  Carol Wahl, DNP, RN, MBA, NEA-BC, FACHE
- **Using Surveys on Patient Safety Culture to Evaluate and Improve Safety Culture**
  Presenter:
  Katherine Jones PhD, PT
- **Medical Human Factors: How to Improve Human-System Interactions for Safer Healthcare Delivery**
  Presenter:
  Bethany Lowndes, PhD, MPH, CPE
- **Stories of Silence, or Speaking Up? Psychological Safety in Healthcare Teams and Organizations**
  Presenter:
  Victoria Kennel, PhD

Two of the webinars were followed by virtual Safe Tables, the first ever offered by NCPS.

"Our hospital has been a member of NCPS for several years and continues to appreciate the benefits that NCPS offers. Most recently, they have offered Safe Tables which is a method to share patient safety learnings with other facilities in a protected environment. NCPS staff have consistently demonstrated knowledge and willingness to assist us when needed in our patient safety efforts."

Elaine Thiel RN, BA, CPHQ | Clinical Quality Improvement Specialist, Organizational Quality; Bryan Medical Center, Lincoln, NE

NCPS 2020 EDUCATION

NCPS offers its members educational webinars focusing on a wide variety of topics based on current patient safety priorities and needs identified from analysis of reported events. Live webinars award continuing nursing education credit and continuing medical education credit.

All webinars are recorded and archived for members' future use. The recordings and webinar handouts are available in the Members Resources portal of the NCPS website.

"NCPS is such a valuable patient safety resource for our organization. The educational resources offered and provided are current, evidence-based and practical, allowing quick incorporation into practice."

Barb Petersen, APRN, MSN, CPHQ | Chief Quality Officer and Wendy Ward, BSN, RN | Director of Patient Safety and Risk Management; Great Plains Health, North Platte, NE

A **Safe Table** is a meeting open to patient safety organization members only. During a Safe Table, a patient safety topic is discussed, and all are invited to share similar events that have occurred in their facilities, and what processes and practices were put in place to mitigate risk and improve safety. The conversations are held as part of each facility's patient safety evaluation system and are safeguarded from legal discovery through the privilege and confidentiality protections given to PSO members that work with federally listed PSOs such as NCPS.

NCPS IMPROVING PATIENT SAFETY CULTURE

NCPS offers a variety of training programs and other services to assist healthcare teams and their organizational leaders with developing and maintaining a care environment that promotes patient safety. These programs serve to enhance safety culture and systems by providing teams with the skills, knowledge, and resources they can apply immediately within their healthcare settings. NCPS members receive a discounted fee for these programs and services. Training opportunities include:

Just Culture Training:
A fair, transparent, and consistent system of workplace justice, or just culture, is a foundational component of a robust culture of safety. A just culture is a learning culture that takes a systems approach to holding individuals and the organization accountable for patient safety.

By developing a transparent, fair, and consistent system of workplace justice, organizations can move past a focus on outcomes (severity bias) and blame, to learning about the system and human factors that led to the outcome. NCPS offers customized Just Culture training for healthcare leaders in a variety of formats, using the Outcome Engenuity curriculum. Training sessions include a two-hour Introduction/Overview, a half-day workshop, and a full-day workshop.

Root Cause Analysis and Action Training:
A root cause analysis takes a systems-level view to enable organizations to learn from adverse patient safety events and improve care delivery. The goal of a root cause analysis is to improve systems, not to punish individuals. When staff members understand how patient safety event reports are used for improvement, trust and engagement improve, leading to increased reporting and more reliable safety systems. NCPS uses a Root Cause Analysis and Action (RCA2) curriculum when providing this training to healthcare teams. This approach emphasizes actions that will be taken upon completion of the in-depth event review, to mitigate the risk of event reoccurrence.

TeamSTEPPS® Training:
Team Strategies & Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) is an evidence-based team training curriculum developed by the Agency for Healthcare Research and Quality and the Department of Defense. It is used to improve collaboration and communication, and to optimize team performance. Patient safety experts agree that communication and other teamwork skills are essential to the delivery of quality health care and to preventing and mitigating medical errors and patient harm. NCPS offers initial and refresher courses for TeamSTEPPS® training, including a two-hour Essentials course, a one-half or a full-day Fundamentals course, and a two-day Master Trainer course.

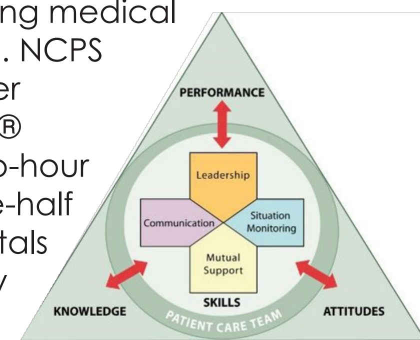


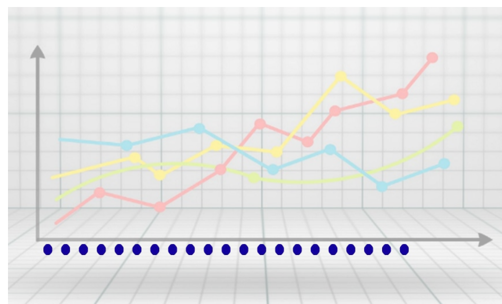
Image Source: About TeamSTEPPS. Content last reviewed June 2019. Agency for Healthcare Research and Quality, Rockville, MD.
www.ahrq.gov/teamstepps/about-teamstepps/index.html

NCPS IMPROVING PATIENT SAFETY CULTURE

Surveys on Patient Safety Culture™ (SOPS®): Safety culture refers to our shared beliefs and behaviors related to patient safety. These beliefs and behaviors reflect the relative importance we place on safety culture as compared to other organizational goals, such as efficiency. Ultimately, an organization's safety culture is a direct result of the actions that leaders take to ensure that all staff continuously learn from their experiences. NCPS offers leaders in a variety of healthcare settings an evidence-based and effective approach to safety culture assessment and improvement using the Agency for Healthcare Research and Quality Surveys on Patient Safety Culture™ (SOPS®). The surveys ask about the most important aspects of patient safety culture; reliably assess clinician and staff perceptions of patient safety culture; and provide national comparative databases that facilitate benchmarking.

Surveys are available to assess patient safety culture in the following types of healthcare settings:

- Hospital (1.0 version and new 2.0 version)
- Medical Office
- Nursing Home
- Ambulatory Surgery Center



NCPS has expertise in administering surveys, analyzing and interpreting results, and developing action plans that are individualized to each organization's survey results. We use sound survey research methods to maximize response rate while maintaining respondent confidentiality.

"Kearney Regional Medical Center (KRMC) partnered with NCPS to administer our Patient Safety Culture Survey and provide Just Culture training. Our survey results were aggregated and returned to us in useful graphical formats with explanations and valuable recommendations. The training provided was engaging as they weaved our results into the concepts of Just Culture."

Tina Whited MSN, RN CPHQ | Process Improvement Coordinator; Kearney Regional Medical Center, Kearney NE

NCPS ORGANIZATIONAL MEMBERS

We would like thank and acknowledge our 63 hospital and ambulatory surgery center members for their support in 2020.

Antelope Memorial - Neligh	Franciscan Health Care – West Point
Avera Creighton Hospital - Creighton	Great Plains Health – North Platte
Avera St. Anthony's – O'Neill	Harlan County Health System - Alma
Beatrice Community Hospital - Beatrice	Howard County Medical Center – St. Paul
Boone County Health Center - Albion	Jefferson Community Health & Life - Fairbury
Box Butte General Hospital - Alliance	Kearney Regional Medical Center - Kearney
Brodstone Memorial Hospital - Superior	Kimball Health Services - Kimball
Bryan Medical Center – Lincoln	Lexington Regional Health Center - Lexington
Butler County Health Care Center – David City	Lincoln Surgical Hospital - Lincoln
Chadron Community Hospital & Health Services - Chadron	Mary Lanning Healthcare - Hastings
Cherry County Hospital – Valentine	Memorial Community Health - Aurora
CHI Health Ambulatory Surgery Center at Midlands - Papillion	Memorial Community Hospital & Health System - Blair
CHI Health Creighton University Medical Center Bergan Mercy - Omaha	Memorial Health Care Systems - Seward
CHI Health Good Samaritan - Kearney	Merrick Medical Center – Central City
CHI Health Immanuel- Omaha	Methodist Fremont Health - Fremont
CHI Health Lakeside – Omaha	Methodist Women's Hospital - Omaha
CHI Health Mercy Corning - Corning, IA	Midwest Surgical Hospital - Omaha
CHI Health Mercy Council Bluffs- Council Bluffs, IA	Nebraska Medicine Bellevue Medical Center - Bellevue
CHI Health Midlands – Papillion	Nebraska Medicine Nebraska Medical Center - Omaha
CHI Health Missouri Valley - Missouri Valley, IA	Nebraska Methodist Hospital - Omaha
CHI Health Nebraska Heart Hospital - Lincoln	Nebraska Spine Hospital - Omaha
CHI Health Plainview – Plainview	Nemaha County Hospital - Auburn
CHI Health Schuyler – Schuyler	OrthoNebraska - Omaha
CHI Health St. Elizabeth – Lincoln	Osmond General Hospital - Osmond
CHI Health St. Francis – Grand Island	Pawnee County Memorial Hospital - Pawnee City
CHI Health St. Mary's – Nebraska City	Pender Community Hospital - Pender
Columbus Community Hospital - Columbus	Saunders Medical Center - Wahoo
Community Hospital – McCook	Syracuse Area Health - Syracuse
Community Medical Center - Falls City	Thayer County Health Services - Hebron
Cozad Community Health System - Cozad	Tri Valley Health System - Cambridge
Faith Regional Health Services - Norfolk	West Holt Medical Services - Atkinson
Fillmore County Hospital - Geneva	

NCPS INDIVIDUAL MEMBERSHIP – NEW!

The Nebraska Medical Association and the Nebraska Academy of Physician Assistants initiated and advocated for legislation to enhance patient safety improvement activities conducted by NCPS. On March 13, 2019 Legislative Bill 25 (LB 25) was passed and became state law.

The passing of LB25 allowed for the creation of a Patient Safety Cash Fund that will be used to support NCPS activities. The Patient Safety Cash Fund will be established through the addition of fees attached to initial issuance or renewal of licensure to practice as a physician, an osteopathic physician, or a physician assistant in Nebraska.

Effective January 1, 2020, physicians pay a patient safety fee of $50, and physician assistants pay a patient safety fee of $20 at the time of state licensure. By virtue of this licensure fee, physicians and physician assistants are considered NCPS members.

This additional funding will enable NCPS to increase its capacity and resources to support healthcare providers in improving the safety and reliability of care delivery across the region.

“*The Nebraska Academy of Physician Assistants (NAPA) has long been the state's only professional organization for Physician Assistants (PAs) since 1975. The organization serves as a resource to Nebraska PAs, provides continuing medical education, strengthens public relations to the profession, advocates for quality patient care, and monitors legislation; taking action on legislative issues affecting health care and patient welfare. In 2006, NAPA envisioned an opportunity to collaborate with the NCPS to keep with the academy's mission to render loyal and faithful service to the medical profession and the public. As a founding member of the NCPS, NAPA has expanded its collaboration with Nebraska's other professional societies and improved patient safety for the region. With the recent passage of LB25, we can ensure that the envisioned partnership will have the available resources needed to continue with its mission. NAPA is a proud member of the NCPS and looks forward to the continued efforts of improving patient care and provider education.*

Shaun Horak, DMSc, PA-C
NAPA Patient Safety Liaison and NAPA representative
NCPS Board of Directors

Patient Safety is every physician's responsibility whether it is in the office, surgery center, urgent care facility or the hospital.

The recent modest increase in our Nebraska license goes directly into the Patient Safety Cash fund. This makes the Nebraska Coalition for Patient Safety more robust and effective as well as making us members.

Britt Thedinger, MD
NMA representative
NCPS Board of Directors

NCPS BOARD OF DIRECTORS

The Nebraska Coalition for Patient Safety is governed by a 12-15 member Board of Directors that includes representation from each of the founding organizations and at least one consumer member. Current board directors include:

NAPA: Nebraska Academy of Physician Assistants
NHA: Nebraska Hospital Association
NMA: Nebraska Medical Association
NNA: Nebraska Nurses Association
NONL: Nebraska Organization of Nurse Leaders
NPA: Nebraska Pharmacists Association

Katherine J. Jones, PT, PhD, President (Consumer)
Adjunct Associate Professor, Health Services Research and Administration
College of Public Health, University of Nebraska Medical Center
Omaha, NE

Daniel J. Rosenquist, MD, Vice President (NMA)
Columbus Family Practice Associates and COPIC Consultant
Columbus, NE

Douglas V. Elting, Treasurer (Consumer)
TRANSCEND Health Consultants
Lincoln, NE

Katie Peterson, RN, BSN, Secretary (NONL)
Chief Nursing Officer
Pender Community Hospital
Pender, NE

Nicole Blaser, MSN, RN (NHA)
Director of Quality and Compliance
Columbus Community Hospital
Columbus, NE

Edward M. DeSimone, II. RPh, PhD, FAPhA (NPA)
Professor of Pharmacy Sciences
School of Pharm. & Health Professions
Creighton University
Omaha, NE

Pamela Dickey, MPAS, PA-C (NAPA)
Assistant Professor
Physician Assistant Education
University of Nebraska Medical Center
Kearney, NE

Mike German, PharmD, BCPS (NPA)
Pharmacy Clinical Services Coordinator
CHI Health St Francis
Grand Island, NE

Shaun Horak, DMSc, PA-C (NAPA)
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Britt Thedinger, MD (NMA)
Physician
Ear Specialists of Omaha
Omaha, NE

Carol Wahl, DNP, RN, MBA, NEA-BC, FACHE (NNA)
Assistant Professor
University of Nebraska Medical Center College of Nursing
Kearney, NE

Ruth Stephens, MSN, RN (NHA)
President
Pawnee County Memorial Hospital
Pawnee City, NE

Michael Rapp, MD, FACS (NMA)
Vice President Medical Operations
CHI Health St. Elizabeth
Lincoln, NE

NCPS REPORTING COMMITTEE

The Nebraska Coalition for Patient Safety is largely supported by the work of individuals who volunteer their time and expertise. The Reporting Committee meets on a quarterly basis to review reported events from members, discuss the identified causal factors and the overall thoroughness of the information reported, and identify risk mitigation strategies to prevent the events from reoccurring. Information gathered in the meetings is used to develop a summary which includes evidence-based best practices and an organizational self-assessment that is shared with our members. The Reporting Committee members who served in 2020 are listed below.

- Linda Bontrager, RN, BSN
  Ithaca, NE

- Edward DeSimone, II, RPh., PhD, FAPhA
  Professor
  Creighton University, Omaha, NE

- Katherine Jones, PT, PhD
  Adjunct Associate Professor, Health Services Research and Administration
  College of Public Health, University of Nebraska Medical Center
  Omaha, NE

- Myrna Newland, MD
  Professor Emeritus, Department of Anesthesiology
  University of Nebraska Medical Center
  Omaha, NE

- Daniel J. Rosenquist, MD
  Columbus Family Practice Associates and COPIC Consultant
  Columbus, NE

- Elaine Thiel, RN, BA, CPHQ
  Clinical Quality Improvement Specialist
  Organizational Quality
  Bryan Health
  Lincoln, NE

NCPS PARTNERSHIPS

We are grateful for continued collaboration with regional and national organizations toward our mutual goal of improving the quality and safety of healthcare delivery:

- ✓ Agency for Healthcare Research and Quality (AHRQ)
  www.ahrq.gov
- ✓ Alliance for Quality Improvement and Patient Safety (AQIPS)
  www.aqips.org
- ✓ Association of Healthcare Emergency Preparedness Professionals (AHEPP)
  www.ahepp.org
- ✓ National Alliance of Patient Safety Organizations (NAPSO)
  www.chpso.org/nationwide-alliance-patient-safety-organizations
- ✓ Nebraska Association for Healthcare Quality, Risk, and Safety (NAHQRS)
  www.nahqrs.org
- ✓ Nebraska Perinatal Quality Improvement Collaborative (NPQIC)
  www.npqic.org
- ✓ University of Nebraska Medical Center, College of Allied Health Professions, Capture Falls (UNMC-CAHP)
  www.unmc.edu/patient-safety/capturefalls/index.html
- ✓ University of Nebraska Medical Center, College of Public Health (UNMC-COPH)
  www.unmc.edu/publichealth

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