

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

NCPS Update: August 2025

A Message from the Interim Executive Director

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

A goal NCPS has been working toward is the provision of recorded patient safety modules on our website which would be accessible to everyone, no NCPS website login needed. The first of these modules, Introduction to Just Culture, is now available!



It may be found on our website, under Educational Resources, [On-demand Recordings of Patient Safety Topics](#). Additional recordings to be added include: How PSOs Work, PSO 101, RCA Event Investigation, RCA Action Planning, and Orientation to NCPS. Please feel free to offer feedback on these modules or to suggest other topics that would be of benefit. You can email me at carlasnyder@unmc.edu.

NCPS is preparing to host our Virtual Annual Members Meeting on September 17th from 8:30am-12noon. We have three interesting, timely patient safety topics that will be presented; additionally, we will share the aggregated data and learning from the events you as members have submitted. See more about this meeting in the Learning Opportunities for NCPS Members section of this newsletter.

NCPS Shared Learning Resources

This month's Shared Learning Resource is an on-demand recording, [Introduction to Just Culture](#). This 45-minute learning module presents the concepts of Just Culture and provides an overview of the skills and tools needed to help organizations in their journey to establish a Just Culture.

It is the first of several learning modules that will be posted on the NCPS website and available to any person interested in the patient safety topic (NCPS membership is not required to view the overview training modules). Please know that NCPS offers full-day and half day trainings on Just Culture as well as RCA2 and TeamSTEPPS®. Email carlasnyder@unmc.edu for more information on these trainings.

Learning Opportunities for NCPS Members

September 17, 2025 8:30am - 12noon CDT

[Register here](#)

This year's meeting will offer 4 educational sessions on current patient safety topics:

8:30am - 9:30am Keynote Address:

Safety II- When Things Go Right (Success Cause Analysis)

Alan Bennett, BSIE, MBA, CPPS, LSSBB, PMP Associate Principal, Strategic Consulting

9:30am - 10:30am Session 1: Bridging Risk and Innovation: AI Strategies for Safer Patient Care

Sophie Feng, MD, PhD Assistant Professor, Nurse Anesthesia Program,
Clarkson College of Health Professions

10:30am - 11:30am Session 2: Communication as a Cure - Preventing Diagnostic Errors to Promote Patient Safety

Carla Snyder, MT(ASCP)SBB, MHA, CPHQ NCPS Interim Executive Director

Pam Dickey, MPAS, PA-C Assistant Professor, University of Nebraska Kearney
Physician Assistant Program

11:30am- 12noon Session 3: Review of NCPS Member Reported Event Data

Ashley Dawson, MS NCPS Patient Safety Statistician

Carla Snyder, MT(ASCP)SBB, MHA, CPHQ NCPS Interim Executive Director

10th Annual NPQIC Summit

September 12th 7:30am - 4:15 pm

CDT at the Scott Conference Center, Omaha, NE

This year's summit will address critical maternal and infant health issues, including obstetric hemorrhage, amniotic fluid embolism, birth trauma, perinatal mental health, substance use disorders, and syphilis. To learn more about the event and register for it, click [here](#).

Suicide Prevention National Safe Table

September 25th 10:30am CST

According to the American Foundation for Suicide Prevention, suicide is the 11th leading cause of death in the U.S. and that in 2023 49,316 Americans died by suicide. Join this safe table to learn best practices and strategies for suicide prevention. Agenda topics include: a review of data, assessment/screening, treatment, follow up and challenges. There will be dedicated time for group discussion. Register in advance for this webinar:

https://centerstone.zoom.us/webinar/register/WN_mXCpfu2ETLm2Dc8TffU3Ag#/registration

Patient Safety Resources

Mortality and Return Visit Frequency Among Emergency Department Patients Who Leave Without Being Seen at a Regional Health Care System

A review of NCPS member reported events (CY2023) found that leaving against medical advice or leaving without being seen accounted for ~13% of the events reported by our community hospital members and our speciality-behavioral health hospital members.

This paper is a retrospective study performed by researchers looking across a regional healthcare system which found that patients who left without being seen (LWBS) tended to be younger and were more likely to be from a socioeconomically disadvantaged group relative to the general ED population. LWBS patients were more likely to return to the ED, require admission, and die within 30 days than patients evaluated and discharged from the ED. Additionally, the authors point out that though patients from historically disadvantaged backgrounds are more likely to LWBS, leaving represents a potential danger to all patients. As such, one of their conclusions is that there is an immediate clinical and moral imperative to explore options to reduce rates of patients leaving the ED prior to their evaluation which can improve the quality and equity of care. The paper may be found [here](#).

The Vital Role of Health Workforce Tracking: Nebraska's Leading Model

Healthcare workforce tracking has emerged as a critical resource for states, researchers, policymakers, and healthcare organizations. Nebraska's Health Professions Tracking Service (HPTS), housed within the University of Nebraska Medical Center's College of Public Health, is an exemplar in this vital field. Healthcare workforce tracking provides crucial intelligence for healthcare organizations in multiple ways:

- Strategic planning for service expansion
- Recruitment planning based on regional provider availability
- Succession planning for an aging workforce
- Comparative analysis against state and regional benchmarks
- Documentation of economic contribution to communities

You may learn more about this service [here](#).

A Systems-Based Framework for Integrating Health Equity and Patient Safety

Recognizing that historically health equity research has focused on disparities in health outcomes, access to care, and quality of care prompted these researchers to examine patient safety's integration into health equity. To address the gaps found in existing frameworks, they developed a maturity framework for equity in patient safety. It is designed to provide a systematic, comprehensive approach that examines organizational processes and practices, structures, and culture that influence patient safety. The research paper may be found [here](#).

Overcoming Professional Silos and Threats to Psychological Safety: A Conceptual Framework for Successful Team-Based Morbidity and Mortality Conferences (M&M)

Adverse events in health care are frequently discussed in morbidity and mortality conferences. However, while healthcare has evolved to be delivered by interprofessional teams, M&Ms have been slow to include all team members. One identified barrier is a lack of psychological safety among team members. These researchers explored the link between professional silos and psychological safety among the health care team. From this work they developed a framework which allowed them to generate specific recommendations to promote psychological safety in team-based morbidity and mortality conferences. Their work may be found [here](#).

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