

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

NCPS Update: May 2026

A Message from the Executive Director

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



The report State of Healthcare Safety 2026, recently published by PressGaney, examines the latest national data and what it reveals about the state of safety in healthcare. One of the key insights noted in the report was the importance of an organization building social capital because it is a key driver of patient safety.[1]

What is social capital? It is the value derived from social networks, shared norms, and mutual trust established in the workplace which enables cooperation. This can lead to better communication and teamwork. When individuals trust and respect each other, they are more likely to effectively collaborate, openly share knowledge, and stay motivated. Knowledge sharing is crucial for patient safety. It leads to improved care coordination and reduced medical errors.[2] A study conducted in Sweden found that social capital – characterized by trust, reciprocity, and recognition- had a positive impact on healthcare workers' job satisfaction and work engagement. It also showed its role in fostering a motivated and proactive workforce.[3]

In their report, PressGaney discussed the “hidden infrastructure of safety.” They found that organizations that intentionally build social capital -which requires efforts to align behavioral norms and ensure cultures of trust and belonging – create the conditions where safety, engagement, and experience reinforce one another. Further they stated that two factors “play an outsized role in strengthening this relational infrastructure: leadership visibility and open communication.” They further noted that “psychological safety–the belief that it is safe to raise concerns without fear of blame-further amplifies this effect. When employees see reported concerns leading to action, reporting increases, learning accelerates, and trust deepens.”[1]

NCPS offers Just Culture and TeamSTEPPS training which are tools that will help your organization build social capital and increase psychological safety. Please contact me, carlasnyder@unmc.edu, if you would like to learn more about either of these trainings.

References:

1. PressGaney, The State of Healthcare Safety 2026. Available at <https://www.pressganey.com/resources/e-books/safety-2026/>
2. Strömberg, M, Ericksson, A., Bergman, DI, and Dellve, L. Social capital among healthcare

NCPS Shared Learning Resources

This month's Shared Learning Resource is a de-identified event involving a patient that had experienced a fall where they hit their head, presented to an ED, and then experienced a prolonged delay in their care due to CT results not being made available for several hours. Communication and system process breakdowns led to this "Near Miss" - fortunately the patient did not experience harm though their transfer to a higher level of care was significantly delayed.

This de-identified event be found on the NCPS website within the member's portal for educational resources, <https://www.nepatientsafety.org/members/education/de-identified-events>

Learning Opportunities

NCPS Hosted Webinar: Adverse Drug Events & Pharmacogenomics

Thursday, July 9, 2026 12 noon - 1pm

Adverse drug events (ADEs) -including medication errors, overdoses, allergic reactions, and side effects from drugs taken as prescribed-are a major but often underrecognized threat to public health. Several recent analyses suggest that ADEs may now be the 3rd leading cause of death in the United States. ADEs are often not recognized and are most likely underreported.

Christopher Schaffer, PharmD, PhD, MS, UNMC College of Pharmacy's Senior Associate Dean, will be our speaker for this webinar. In addition to information about adverse drug events, he will speak about his work with pharmacogenomics which is an area not widely known by healthcare practitioners. For the past seven years he has consulted with the Munroe-Myer Institute when a patient experiences an adverse drug event or a sub-therapeutic response to a prescribed medication. A similar program is being launched at Childrens Nebraska and Nebraska Medicine.

[Register for this webinar on the NCPS website.](#) You do not need to work at an NCPS member organization to attend. ***CEs for Pharmacists and Nursing are pending.***

Research Roundup: Insights and Safety Strategies From Pennsylvania Patient Safety Data May 20, 2026 10am - 11am CDT

Data from the Pennsylvania Patient Safety Reporting System (PA-PSRS) offers an unmatched view into patient safety events occurring across the commonwealth. PSA research scientists use this data to develop evidence-based analyses that can help healthcare facilities raise awareness, strengthen safety practices, and implement meaningful improvements. This session will highlight key findings from recent research and translate them into actionable strategies for healthcare teams. Topics covered will include: wrong drug events, insulin syringe errors, hospital falls surrounding discharge, language barriers, radiation therapy, wrong-site surgery

Click [here](#) to learn more and to register for the webinar.

Dealing with Unprofessional Behavior in Healthcare - An On Demand Webinar from Patient Safety & Quality Healthcare (PSQH)

In episode 157 PSQH: The Podcast, Dr. Gerald Hickson, Founding Director of the Center for Patient and

RLDatix, talk about the problem of unprofessional behavior in healthcare. The podcast's recording may be found [here](#).

Turning Knowledge into Action-Empowering Change in Complex Health Systems - An On Demand Webinar from ECRI

This webinar explores how asking the right questions - early and intentionally -can transform decision-making across complex systems. Participants will learn how to identify and reduce bias, clarify purpose, and connect decisions to what truly matters: patient outcomes, system priorities, and operational realities. This recording may be viewed [here](#).

Patient Safety Resources

The Safety Action Feedback and Engagement (SAFE) Loop: Initial Testing and Refinement of a Novel Intervention to Enhance Hospital Incident Reporting and Patient Safety

Researchers developed a tool, the Safety Action Feedback And Engagement Loop, to overcome the known barriers to voluntary incident reporting. The use of this tool improved the input received from nurses about patient safety problems and their prioritization; taught nurses to write more effective information reports and report priority incidents; standardized investigations; and provided feedback to nurses about mitigation plans. The paper published in the May 2026 Journal of Patient Safety may be found [here](#).

Root Cause Analysis, Action, and Audit (RCA3): A Novel Approach to Sustainably Reduce Medication Errors

Root Cause Analysis is a tool commonly used to investigate patient safety events. RCA2 was introduced in 2015 with the goal of strengthening traditional root cause analysis through the emphasis on action-oriented outcomes. To further enhance sustainability, a group of researchers implemented an iterative process which adds follow-up audits to evaluate long-term effectiveness of corrective actions. They named this process RCA3. The paper published in the May 2026 Journal of Patient Safety may be found [here](#).

Failure to Rescue Deteriorating Patients: A Systematic Review of Root Causes and Improvement Strategies

Failure to Rescue is an event reported fairly often to NCPS. For this research paper, researches reviewed eight hundred forty-two abstracts and did a full assessment of 52 articles. The results of their work, a proposed framework they call "The 3 Rs of Failure to Rescue" of recognize, relay, and react. The use of such a framework could serve as a valuable resource for understanding the phases where failure of patient salvage may occur; and would aid future efforts to mitigate the differences in outcomes from complication management between units. The paper may be found [here](#).

Combating Workplace Violence in Healthcare

CRICO, the medical professional liability coverage, claims management, and provider of patient safety resources primarily for Harvard medical School-affiliated hospitals, physicians, and healthcare organizations provided this article in their October 1, 2024 newsletter. It is a good review of safety strategies to address violence in health care settings and contains links to several Workplace Violence Reduction resources. It 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



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