

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

NCPS Update: July 2026

A Message from the Executive Director

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

I want to let you know about an upcoming National Association for Healthcare Quality **(NAHQ) Learning Lab, Making Sense of Safety Events**. This is a 3-part series; and **I am the speaker for Part 2: From**

Reporting to Action. Part 2 will be presented on **July 29th at 12noon**. There is no cost for NAHQ members to attend; and a recording of the presentation will be available for on demand viewing after July 29th. One CPHQ credit will be awarded to attendees.



The learning objectives for the session include:

1. Evaluate patient safety event reports for clarity, consistency, and usefulness to support effective triage, escalation, and review decisions.
2. Conduct interviews and learning reviews that reduce hindsight bias and focus on understanding how work actually occurred at the time of the event.
3. Translate investigation findings into meaningful, risk-reducing actions rather than weak or one-time fixes.
4. Explain how the tools discussed (SAC Matrix, Interviewing Tips, Cause Mapping and Causal Statements, Strength of Interventions, etc.) can be used to improve your analysis and response to reported events.

I enjoyed having this opportunity to present on a patient safety topic for a national audience; and even more importantly, to be able to discuss some of the great patient safety work being done in Nebraska through the Nebraska Coalition for Patient Safety!

You can learn more about this 3-part Learning Lab and to register for it at this weblink: [Learning Lab Part 2: Making Sense of Safety Events - From Reporting to Action](#)

Contact me at carlasnyder@unmc.edu with questions, concerns, or to engage with NCPS in your patient safety work.

NCPS Shared Learning Resources

This month's Shared Learning Resource is a Reporting Committee Summary. [Communication](#)

[Subscribe](#) to our email list.

within our [member's portal](#).

As you are probably aware, the swing bed program was part of the 1980 Omnibus Budget Reconciliation Project and has been a tremendously positive program for rural hospitals and the residents of their service areas. In my review of these events, I was somewhat surprised that I did not find best practice guidance documents or any recent research on swing bed performance improvement initiatives. If you are aware of any such documents, please share them with me and I will include the information in an upcoming newsletter.

Learning Opportunities

11th Annual NPQIC Summit: Rooted in Quality

October 30, 2026 7:30am - 4:45pm

UNL Nebraska Innovation Conference Center, Lincoln, NE

The goal of this full day event is to equip participants to improve communication, increase patient satisfaction, and drive sustainable quality improvement in hospitals across the state. The summit will accomplish this by integrating patient perspectives, practical tools, and meaningful networking opportunities. Those that would benefit from attending the summit include physicians, nurses, midwives, doulas, public health professions, hospital leaders, quality improvement specialists, and community partners dedicated to improving outcomes for Nebraska birthing mothers, infants and families.

This year's summit will include sessions on:

- Fundamentals of Quality Improvement
- Maternal Substance Abuse
- Tools for connecting with parents of neonates
- Rural and urban breakout sessions
- Interactive delivery simulation demonstrating trauma informed care

Learn more about the summit and how to register for it [here](#).

Patient Safety Resources

Recording of Webinar: Mitigating Your Risk Exposure for Fall Events

The Center for Patient Safety PSO sponsored this webinar with nationally known patient falls expert, Amy Hester, PhD as the speaker. Because of NCPS' collaboration with them for this event, we are able to share the webinar recording with our members. Access the webinar recording [here](#). Download the session's handout [here](#).

Rates of Significant Preventable Adverse Events in Hospitalized Patients with Respiratory Disease

Patients admitted to the hospital with an acute illness secondary to respiratory disease are at increased risk of adverse events, many events may be preventable. In this study, preventable events were identified in over a quarter of admitted patients with respiratory disease who required an ICU transfer or died in-hospital. There is an interesting discussion addressing the need to understand the nature of potentially preventable adverse events and the surveillance options available for monitoring hospitalized patients with respiratory failure. This paper may be found in the Journal of Patient Safety,

Evaluation of Interruptions During IV Smart Pump Medication Administration in Intensive Care

Units

The objective of this project was to contribute to the understanding of how interruptions impact intravenous medication processes and identify areas for improvement. The type, frequency, and duration of interruptions, including IV smart pump (IVSP) alerts and alarms, were evaluated. Nearly 25% of nurses' activity time was consumed by IVSP alerts and alarms, interruptions caused by health care professionals and phone calls. The authors' conclusion: The need to address these challenges through streamlined alert systems and improved communication protocols is essential to enhance efficiency and patient safety in clinical settings. This paper may be found in the Journal of Patient Safety, Volume 22, Number 2, March 2026.

For more information about NCPS and the services we offer, please contact Carla Snyder MT(ASCP)SBB, MHA, CPHQ, NCPS Executive Director at: carlasnyder@unmc.edu

Share this email:



[Manage](#) your preferences | [Opt out](#) using TrueRemove®

Got this as a forward? [Sign up](#) to receive our future emails.

View this email [online](#).

986055 NE Medical Center
Omaha, NE | 68198 US

This email was sent to .

To continue receiving our emails, add us to your address book.