

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

NCPS Update: December 2025

A Message from the Interim Executive Director

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

As 2025 ends, there is value in reflecting on our accomplishments of the past year as we prepare for a new year of challenges and opportunities. I will share our accomplishments with you here.



On-demand recordings of patient safety topics are now available on the NCPS website (e.g., Patient Safety 101; Introduction to Just Culture; RCA2 Part 1 - Event Review, etc.). These recordings are accessible to non-members as well as NCPS members and may be accessed [here](#).

We have had the opportunity to speak to healthcare students and explain not only the patient safety movement, but the patient safety resource available to them through NCPS. I welcome the opportunity to speak to any group of healthcare students. Please reach out to me if you would like NCPS to speak to your group of students, undergraduate college or graduate professional healthcare.

NCPS provided sponsorships and had informational tables at several state conferences. These are great opportunities to explain our mission to those unfamiliar with NCPS and to gain feedback and perspective from those who already know about NCPS. Included in that list of state conferences are:

- Nebraska Perinatal Quality Improvement Collaborative
- Nebraska Rural Health Conference
- Nebraska Medical Association Annual Meeting
- Nebraska Academy of Physician Assistants Spring CME Conference
- Nebraska Rural Engagement and Wellness Seminar

NCPS presented educational/training sessions at several national/regional/state meetings. Those meetings and the session topic are listed below:

- Copic 2025 Annual Meeting - Creating a Culture of Safety in Any Healthcare Setting
- Nebraska Academy of Physician Assistants 2025 Spring CME - Communication as A Cure: Preventing Diagnostic Errors to Promote Patient Safety in Nebraska
- Agency for Healthcare Research and Quality 17th Annual Meeting of PSOs - Lessons Learned: Using Electronic File Transfer of Risk Management Reporting for PSO Data Collection
- Nebraska Association for Healthcare Quality, Risk, and Safety December 2025 General Member Meeting - Overview of Success Cause Analysis

NCPS provided training and educational sessions for NCPS members as well as non-members. This included a 3-part webinar series on RCA2 for Louisiana Hospital PSO as well as providing

Just Culture Training for two NCPS member hospitals, providing TeamSTEPPS training for one member hospital, conducting RCA2 training for two member hospitals, and collaborating with one member hospital as they re-vamped and re-invigorated their TeamSTEPPS program. Our annual members meeting included sessions on AI in Healthcare, Diagnostic Safety, Success Cause Analysis – When Things Go Right, and a review of the data from NCPS member reported events. We have facilitated RCA2 event investigations for members and have researched specific patient safety best practices at member's requests.

NCPS authored articles on patient safety topics have been provided to the Nebraska Medical Association for inclusion in their quarterly publication as well to the Nebraska Academy of Physician Assistants for their newsletter. We hope to have a similar opportunity with our other founding member organizations (Nebraska Nurses Association, Nebraska Pharmacy Association, and Nebraska Hospital Association). Please reach out to me if you have a patient safety topic for which you would like NCPS to provide information.

Every month a shared learning resource, based on a de-identified event reported to NCPS or regional and national patient safety alerts, is provided to our members. Topics covered in 2025 include:

- Care Coordination/Management for Inter-Hospital Transfers
- Diagnostic Error Due to Communication Breakdown
- Pressure Injuries in Home and Skilled Nursing Settings
- Medication Errors When Using Epidural Pumps
- Risks Associated with AI-Enabled Health Technologies
- Inadequate Communication and Coordination During Discharge
- Care Team Ineffective Communication and Collaboration Resulting in a Delay in Diagnosis and Treatment
- Diagnostic Error: Failure to Follow Up on an Abnormal Test Result

The shared learning resource includes a section which guides members through a review of their own systems. This allows the identification of system gaps so steps to mitigate a similar event of harm in their workplace.

In 2025, we welcomed three new members to NCPS; and conducted Surveys on Patient Safety for four member organizations.

Lastly, I want to mention the ongoing opportunity we are presented, acting as a patient safety advisor to any member that phones or emails with a question, concern, or just wants to talk through an event that has occurred in their workplace. The support and patient safety expertise we offer to members is one of our most important services provided.

Our list of goals for 2026 is significant but reachable. We look forward to the continued collaboration with our founding organizations and our individual members. I want to thank all those dedicated healthcare professionals that volunteer their time and expertise to NCPS. This includes our Board members, members of the NCPS Reporting Committee, and the professionals from our founding member organizations that collaborate with us. Together we will meet our mission, “To continuously improve the safety and quality of healthcare delivery in the region.”

Please feel free to contact me, carlasnyder@unmc.edu, if you want to learn more about the work we do at NCPS or to discuss opportunities for strengthening our service delivery.

NCPS Shared Learning Resources

This month's Shared Learning Resource is an on-demand recording, How Patient Safety Organizations Work (PSO). In this learning module, the purpose and function of a PSO is

explained; the confidentiality and legal protections afforded an organization belonging to a PSO is discussed; and the benefits to a provider in improvement of their healthcare quality and patient safety is summarized. The recording is available to any person interested in learning more about patient safety organizations. (NCPS membership is not required to view this educational module). You may find the shared learning in our webpage's [Educational Resources](#).

Learning Opportunities for NCPS Members

"Clicktation" - Explaining Your EHR Note to a Jury

Thursday, February 5, 2026 12noon - 1pm CT

Join us as Copic General Counsel and Compliance Officer, Matt Groves, JD, explains ways to mitigate safety and liability pitfalls found in electronic documentation. This includes voice recognition, scanning, drop-down lists, checkboxes, templates, copy/past, auto-complete, and other technologies used in the creation of accurate medical records. The objectives for this session include:

- Identify factors that can cause documentation errors in EHRs.
- Understand the scope of liability risks associated with defective documentation.
- Evaluate approaches available to practitioners for reducing errors and improving the effectiveness of electronic documentation.
- Recognize liability concerns involved in the disclosure process.

No cost CPHQ and Nursing CEs are pending.

Register [here](#) for this webinar. NCPS membership is not required to attend this training.

Patient Safety Resources

Midwest Clinical Instruction Regional Network: Nursing Preceptor Training

This program has been designed to address training needs and create support for preceptors and clinical instructors. Participants will learn new skills, boost their credentials, and gain resources to help them in their work as they help onboard and educate others. The course utilizes a variety of interactive videos, discussions, and application exercises; participants gain access to a repository of just-in-time educational tools and materials. To learn more go about this valuable program go to <http://www.mcirn.com>

AHRQ Toolkit for Improving Skin Care and MDRO Prevention in Long-Term Care

This newly released toolkit outlines four evidence-based strategies to reduce infection risks and maintain skin integrity among long-term care residents. Unlike other healthcare settings, long-term care residents receive medical care in the same place they call home, making infection prevention a complex, critical task. Designed for practical use, the toolkit offers a structured bundle of interventions that address both clinical and cultural aspects of care. One notable feature is the

inclusion of Teachable Moments-real-world case scenarios that illustrate infection risks and best practices. The toolkit may be found [here](#).

Patient Safety Authority (PSA) Telemetry Monitoring Tips and Toolkit for Investigating Telemetry-Related Events

Telemetry monitoring enables healthcare workers to quickly detect and diagnose cardiac arrhythmia. However, it has been associated with negative patient outcomes due to overuse, alarm fatigue, and other telemetry-related complications. PSA has provided [telemetry monitoring tips](#) to mitigate these types of events and a [toolkit for investigating telemetry-related events](#).

Wrong-Route Errors Spur New TXA Alert From Safety Experts

Two leading patient-safety groups (Anesthesia Patient Safety Foundation and the Institute for Safe Medication Practices) are urging hospitals to overhaul how they store and dispense tranexamic acid (TXA) injection (Cyklokapron, Pfizer) after a series of catastrophic medication mix-ups in which the drug was mistakenly injected into the spine instead of a local anesthetic. In a [joint statement issued December 2nd](#), the central role pharmacists can plan in preventing these potentially fatal wrong drug-wrong route errors was explained and steps to be taken outlined.

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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