

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

NCPS Update: August 2026

A Message from the Executive Director

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

Chart Institute recently hosted the webinar, Patient Safety Part 1: Steps to Maximize Privilege Protections and Improve Patient Outcomes under the Patient Safety Act. The knowledge and experience of the

speaker, Michael R. Callahan, JD was evident. In his over 40 years of practice as a healthcare attorney his understanding of the Patient Safety Quality Improvement Act (PSQIA) as well as hospital/physician relations, medical staff bylaws and policies, peer review policies and investigations, privileging and credentialing issues is extensive.

He outlined the environmental issues which are motivating participation in PSOs (i.e., increased liability exposure, reimbursement based on quality, government and industry quality reports) and provided clarification on what is Patient Safety Work Product (PSWP), and what is not. Steps to take for establishing a Patient Safety Evaluation System (PSES) and an example of a health system PSES were provided.

The second portion of his presentation addressed the use of PSWP in peer review/disciplinary matters and human resources/risk management. This is an area not often discussed in educational presentations about PSES. His presentation included many practical considerations and guidance for when an organization has no other alternative but to consider the use of disciplinary action and PSWP is involved.

The pdf handout for this presentation may be found on our website in the [educational resources for members' section](#) within the legal updates. You will need a website sign-on to access this content. Please email me if you do not have a sign-on and we will set you up with a sign-on. My email address is carlasnyder@unmc.edu.



NCPS Shared Learning Resources

This month's Shared Learning Resource is a De-identified Event, [Patient Received Treatment Based Upon Inaccurate Lab Test Results](#). You can find this summary on the NCPS website within our [members' portal](#).

The member that submitted this event did a thorough job in identifying the root causes of the event and in creating an action plan that will mitigate similar events from occurring. We were able to provide the member with several additional tools they may find useful in future Root Cause Analysis reviews.

Learning Opportunities

The Power of Patient Safety Data

August 27, 2026 10am - 11am CST

The Patient Safety Authority is hosting this webinar to provide healthcare professionals with the tools needed to:

- transform patient safety data into actionable insights to improve patient safety outcomes
- identify key sources of patient safety data and describe how each contributes to understanding safety gaps
- recognize strategies for engaging interdisciplinary teams and leadership in data-informed patient safety improvement efforts

Register [here](#).

NPQIC Sponsored Webinar: Moving Toward Equitable Perinatal Toxicology Testing: An Evidence-Based Approach

September 3, 2026 12:00 noon - 1:00 pm CST

This webinar will explore evidence-based approaches to screening, treating, and supporting individuals with substance abuse disorder during pregnancy, with a focus on compassionate care, improved outcomes, and coordinated support. Dr. Laurie Halm, MD, Associate professor, Pediatrics-Pediatric Hospital Medicine is the speaker. Register [here](#).

Rapid Investigation Teams: A Novel Approach to Responding to Patient Safety events

September 16, 2026 11am - 12noon CST

The Patient Safety Authority is hosting this webinar with speaker, Cara Peck, MS, RN, the senior manager risk prevention and patient safety at main Line Health. She will describe the implementation of a centralized rapid investigation team within their multihospital health system. Additionally she will discuss strategies to improve consistency in root cause analysis facilitation and identify approaches to strengthen organizational learning from root cause analysis. Register [here](#).

Redefining Patient Safety Analyses: Lessons Learned From One Organization

September 22, 2026 12noon - 1pm CST

This webinar, hosted by the Patient Safety Authority, features speakers from Children's Hospital of Philadelphia and explores a systems-based approach to patient safety analyses. They will:

- Discuss the need for a systems approach to patient safety analyses
- Appreciate the role of, and collaboration with human factors engineers in analyzing patient safety events
- Examine an alternative framework and analysis tools beyond root cause analysis
- Describe one organization's process for developing and utilizing new cause analysis tools

Register [here](#).

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

Healthcare's Quality System Has a Problem. We're Measuring More and Learning Less

This June 2026 Healthcare Leaders cover story acknowledges how for two decades hospitals have been rewarded for reporting, documenting, and scoring well on quality measures and that now, many CMO's are asking the question: Are today's quality programs improving care or simply creating more work around it? Access the June 2026 cover story [here](#).

Complex Factors Associated with Disruptive Medical Professional Behavior

Disruptive behavior in medical settings, which includes bullying, intimidating, and other behaviors, is associated with medical errors, low patient and team satisfaction, high job turnover, and understaffing throughout the healthcare system. This study uncovered multiple underlying conditions in providers and the systems in which they work. These underlying conditions should be considered when developing personalized treatment plans that may address more than disruptive behavior. The article may be found [here](#).

Nurses' Perceived Causes of Medication Administration Errors: A Qualitative Systematic Review

This article, found in The Joint Commission Journal on Quality and Patient Safety, identified three main categories of factors that contribute to medication administration errors: knowledge-based factors, personal factors, and contextual factors (i.e., interruptions and distractions, poor communication/challenging relationships, lack of supervision/support/lone work, inexperience/lack of training, poor physical working conditions, and unsafe practice norms). Included in the text are steps to guide efforts aimed at identifying and modifying factors which contribute to medication administration errors. It may be found [here](#).

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