

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

NCPS Update: September 2026

A Message from the Executive Director

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An extremely troubling medication harm event has been reported by news outlets, including [Becker's Hospital Review](#). On August 14, 2026, a pharmacy error at Ascension Saint Thomas Midtown Hospital in Nashville resulted in four elective joint-replacement patients receiving potassium phosphate spinal injections instead of their intended spinal anesthetic, mepivacaine. All four patients experienced severe harm including cardiac arrest and paralysis. An investigation of the event found that there had been a mix-up of medications in the pharmacy the prior day when syringes were prepared for the next day's surgeries. Surveyors found [multiple failed safeguards](#) in the compounding area where the injections were prepared. The hospital has since put safety protocols in place to prevent such future error. This includes keeping high-alert drugs such as mepivacaine in separate, clearly marked locations to prevent mix-ups; adding a mandatory stop-and-verify step for any spinal medication scan alert; and requiring a second trained pharmacist to perform a final visual and physical check on spinal medication orders. The question in the minds of patients/patient family, healthcare workers, and patient safety advocates is, "Why were these best practice protocols and medication safeguards not in place prior to this harm event?"

Provided in the following links are resources to help you evaluate your current medication safety processes/protocols:

1. [ISPM Targeted Medication Safety Best Practices 2026-2027](#) - The Best Practices listed here are those that would have helped mitigate the risks leading to the Ascension Health patient harm event. See the document for complete rationale and strategies for the meeting these Best Practices.

Best Practice #11 – When Compounding Sterile Preparations, Utilize Workflow Management Systems

Best Practice #14 – Seek out and use information about medication safety risks and errors that have occurred in other organizations and take action to prevent similar errors.

Best Practice #9 – Layer numerous strategies throughout the medication-use process to improve safety with high-alert medications.

Best Practice #25: Improve the culture of safety.

tasks to help organizations establish or improve a medication safety program, with guidance on priority, impact, and resources needed. Organizations that do not have dedicated medication safety resources will find it particularly helpful to identify where to start and how to prioritize activities. It provides a structured approach to building a medication safety program, ensuring that essential foundation tasks are addressed.

3. Medication Safety Self-Assessment Tools – Links to two different tools are provided below. Both are fairly long and specific. ISMP's was published in 2011; however, you may find them of use and so I have included them here.

[ISMP Medication Safety Self-Assessment for Hospitals](#)

[HPSO Medication Safety: A Self-Assessment \(for the Outpatient Setting\)](#)

NCPS Shared Learning Resources

This month's Shared Learning Resource is a Reporting Committee Cumulative Summary which recounts a patient harm event that occurred in a rural health clinic. A surgical needle broke during the closure of a complex surgical incision and a small piece of the needle fell into the wound. The team performing the procedure performed a visual inspection of the wound when they observed the needle breaking but did not find the piece of broken needle. The results of this event: prolonged healing for the patient, additional follow up clinic visits, patient experienced ongoing pain, patient's loss of confidence in their healthcare team, and considerable time for the hospital's team to research what had happened and create an action plan to mitigate similar future harm.

In the review of the event, the hospital's quality/risk management team recognized a gap in their clinical practice because of the lack of policies/procedures and training/instruction for medical assistants that assist providers when surgical procedures are performed in the clinic. This is likely a common finding since historically patient safety efforts have been focused on hospital settings though our US healthcare system has evolved to where healthcare services are more often provided in outpatient/clinic settings than in inpatient settings. To help you consider the effectiveness of your organization's patient safety efforts in your ambulatory clinics, in the Patient Safety Resources section of this newsletter are links to several papers which discuss patient safety in ambulatory care settings.

This member did a thorough, complete investigation and created a strong action plan to mitigate future such events. I encourage you to review this comprehensive event review which contains useful resources and references. The summary, Retained Surgical Items in Clinic Surgical Procedure Highlighting Patient Safety Gaps in Ambulatory Clinic Settings, is on the NCPS website within our [members' portal](#). I would also call your attention to a previous de-identified event, Retained Surgical Items, which focuses on a hospital's RSI event where a surgical sponge was inadvertently left in a patient's abdomen. This document shares information on the frequency and cost of Retained Surgical Items.

It is also in the Educational Resources for members portion of our website.

Learning Opportunities

[Subscribe](#) to our email list.

NCPS to Present Pre-Conference Workshop "Leveraging Change Styles to Better Manage Organizational Change" at NHA Quality Conference in Kearney

November 11th 1 - 4pm

Have you ever wondered why some people seem reluctant to change while others are ready to challenge the status quo and take on risks in unexplored territory? Why do others seem able to balance all perspectives and see both sides of an issue, yet others can't? Understanding the differences in how people approach change is key to effective leadership and collaboration in navigating change. This training will help you learn how to understand your own change preferences and those of others, so you and your organization effectively manage change, whether it is planned or reactive.

The learning objectives for this training include:

1. Define the three change styles found along the change style continuum and how each reflects a preference for a certain approach to change.
2. Discover the attributes, strengths, and challenges of the various change styles.
3. Discuss leadership traits, preferred work environments, and potential pitfalls of different approaches to change.
4. Recognize how to leverage change preferences to effectively manage organizational change and support individuals and teams through transitions

You may find it of value to understand your own change style preferences prior to attending this workshop. The Change Style Indicator Assessment is available through MHS, a global leader in scientifically validated assessments which helps individuals and organizations identify, develop, and support human potential across diverse fields. The link to their website is <https://storefront.mhs.com/collections/csi-2>. There is a cost of \$35 for the assessment.

The assessment is not required to attend this workshop and both NCPS members and non-members are welcome to attend. This workshop is sponsored by NAHQRS (the Nebraska Association for Healthcare Quality, Risk, and Safety). NAHQRS is an organization you might consider joining if you are not already a member. NAHQRS offers great networking opportunities for quality, patient safety, and risk management healthcare professionals; and education on topics in those areas. Check out their [website](#) and plan to attend their morning session on the 11th. See the [NHA website](#) to register for this workshop and/or the entire 2-day conference.

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:

- 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

What Safety Events Are Reported For Ambulatory Care? Analysis of Incident Reports from a Patient Safety Organization

Researchers sought to describe the patterns and characteristics of incident reporting behaviors in ambulatory care. Among their findings, medication-related events were most common (45.3%). They found that outpatient reporting systems are limited for primary care and home/community settings, but ambulatory care systems report more harmful events related to diagnosis and patient and caregiver challenges. [The Joint Commission Journal on Quality and Patient Safety 2021;47:5-14](#)

Supporting Error Management and Safety Climate in Ambulatory Care Practices: The CIRSforte Study

This study suggests that the best way to support safety climate and error management in ambulatory care practices is to train practices teams, repeatedly providing them with practical tips and tools, and to facilitate the exchange of information between practices. [Journal of Patient Safety, Vol 20, Number 5, August 2024](#)

Implementing a Surgical Safety Checklist for In-Office Procedures

This article published in the American Association of Nurse Anesthesiology presents evidence to support the utilization of surgical safety checklists (SSC) in non-OR settings to mitigate potential patient harm. They also report on their work to implement SSC in an office setting that had recently adopted in-office surgical procedures requiring anesthesia. [AANA Journal, December 2024. Vol. 92, No. 6](#)

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

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