

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

## NCPS Update: January 2026

### A Message from the Executive Director

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

This year Patient Safety Awareness Week (PSAW) is March 8 – 14. The theme is “Team Up for Patient Safety.” The focus is on teamwork and the collaboration between the healthcare team and patients/families that leads to safer patient care. Here is a [link to the Center for Patient Safety's PSAW Toolkit](#). It includes ideas for recognizing and celebrating the patient safety work you accomplished this past year and to outline the goals you have for continued improvement.



One of the statements included in the toolkit explains why teamwork is so valuable in patient safety efforts, “Strong teamwork between patients, families, and care teams is necessary to create a safe care environment for everyone involved. When patients and families are actively engaged as partners, they share important information, ask questions, and speak up about concerns that might otherwise be overlooked. At the same time, care teams can explain plans clearly, confirm understanding, and invite feedback, which helps catch errors early and align expectations.”

In this newsletter's Patient Safety Resources section, you will find a comprehensive listing of the resources available from the Agency for Healthcare Research and Quality to help healthcare providers engage patients and families. I would also refer you to the [NCPS Reporting Committee Summary from Q1 2025](#) which provides strategies and tools to improve communication within the healthcare team.

Lastly, I want to mention the work NCPS' Board of Directors and I have been doing to secure continued funding of NCPS. The Patient Safety Cash Fund legislation which provided a substantial portion of NCPS' operating budget ended on January 1, 2026. Our appreciation to Physicians and Physician Assistants for their financial support over the past five years by paying an additional fee at the time of their state licensure is immeasurable. We offer a sincere “Thank You” to them!

In considering how to continue the funding needed, we decided our best option was to ask our state legislature to approve the transfer of dollars from the Nebraska Health Care Cash Fund to the Patient Safety Cash Fund. A bill to do so was introduced last week by State Senator Jason Prokop, LB1106. The bill has been referenced to the Appropriations Committee, but no hearing date has yet been assigned.

I am asking for your help in getting this legislation passed. Would you please reach out to your State Senator and encourage them to vote for LB1106? Help them understand how Patient Safety Organizations (PSO) provide vital patient safety resources for healthcare providers in our state which helps mitigate events of patient harm. That in collaboration with our members, NCPS'

goal is to reduce the number of Nebraska residents that experience temporary harm, permanent harm, or death from the 3,069 reported to NCPS in 2023 to the lowest number possible.

Additionally, NCPS has made a concerted effort to keep our membership rates low so that healthcare service providers in the state are able to afford membership. For many current NCPS members, obtaining membership in a larger, national patient safety organization is not feasible because of their cost. If NCPS was not available, these members would likely not be able to afford membership in another PSO.

Please let your State Senator know how you have personally benefited from the services NCPS provides. Whether it be the communication training provided via TeamSTEPPS® to improve communication in your healthcare team; instruction to help establish a Just Culture in your organization (which has been shown to result in safer patient care and increased staff satisfaction); instruction and/or facilitation of a Root Cause Analysis for your organization to help determine why a harm event occurred so you can take steps to keep it from happening again; provision of references for current best practices for various healthcare topics which has saved you time in not having to research them yourself; obtaining free continuing education credits needed for your state license by attending a NCPS provided webinar; or the safe care you or a loved one was provided in a Nebraska healthcare setting which in part is attributable to the patient safety work NCPS has led in the state for the past 20 years. Here is a [link](#) to the listing of Nebraska State Senators which contains their email addresses.

Please do not hesitate to reach out to me, [carlasnyder@unmc.edu](mailto:carlasnyder@unmc.edu), with questions, concerns, or to engage with NCPS in your patient safety work.

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## NCPS Shared Learning Resources

This month's Shared Learning Resource is the Q4 2025 Reporting Committee Summary, "Patient Given Medication to Which They Had Reported a Previous Severe Allergic Reaction". This summary demonstrates the importance of having several system processes in place:

1. Ensuring all people caring for a patient are aware of any allergies the patient may have and a method to update this information in the patient's medical record.
2. Staff trained and competent for calling and participating in a Rapid Response Team or Code Blue.
3. Regularly scheduled mock "Code Blue Drills" to ensure all patient care staff are aware of their part in a Code Blue situation and where supplies potentially needed for a Code Blue are kept.
4. A method to audit the effectiveness of pre-procedure time outs.

You may find the shared learning in our webpage's member only [Educational Resources](#).

## Learning Opportunities

### Reducing Medical Errors with Patient and Family Advisory Councils

**Wednesday, January 28, 2026 12pm CT**

In this webinar, Jane Powers, Director of Patient and Family Advisory Councils for the Betsy Lehman Center for Patient Safety, discusses how working with patients and families as advisors helps reduce medical errors and improve patient safety. Register [here](#).

### "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.

### **NPQIC Sponsored Webinar - Advanced Management of Obstetric Hemorrhage;**

#### **Beyond Atony**

**Thursday, February 26, 2026 from 12:00-1:00pm CST**

NPQIC Medical Director, Dr. Todd Lovgren, is the speaker for this webinar which offers free CME and Nursing CE to attendees. The objectives for this educational session include:

1. Synthesize advanced concepts that influence management and assessment of hemorrhage, pathophysiology of coagulopathy.
2. Assess pitfalls in the management of hemorrhage.
3. Demonstrate understanding of the purpose of integrating advanced aspects of hemorrhage management.
4. Evaluate how to implement advanced hemorrhage strategies into practice.

Register [here](#). The webinar will be recorded for those unable to listen live.

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## **Patient Safety Resources**

### **AHRQ Patient and Family Engagement Resources to Help Meet the CMS Patient Safety**

#### **Structural Measure Domain 5: Patient and Family Engagement**

- [Guide for Developing a Community-Based Patient Safety Advisory Council](#) - This guide provides information and guidance for hospitals to build a patient safety advisory council that involves patients, consumers, practitioners, and professionals from health care and community organizations. The guide presents 10 steps for creating the council, with descriptive examples to illustrate their implementation.
- [Guide to Patient and Family Engagement in Hospital Quality and Safety](#) - This guide helps hospitals identify and engage patients and families to improve quality and safety as advisors in a council or committee. It includes an implementation handbook and tools for patients, families, and clinicians.
- [Improving Healthcare Safety by Engaging Patients and Families](#) - This resource summarizes 54 AHRQ-funded projects to improve patient safety by supporting increased patient and family engagement.

### **AHRQ Resources by the CMS Patient Safety Structural Measure (PSSM) Domains**

This listing on AHRQ's website is a [concise outline of the five domains of the CMS PSSM](#). In addition to listing the domains, illustrative elements for each domain are presented.

### **AHRQ Resources By National Action Plan Foundation Area - Patient and Family Engagement**

- [Consumer Assessment of Healthcare Providers and Systems \(CAHPS\) Ambulatory Care Improvement Guide](#) - This comprehensive resource is for health plans, medical groups, and

other providers seeking to improve their performance in the domains of patient experience measured by CAHPS surveys of ambulatory care

- [CANDOR \(Communication and Optimal Resolution\) Toolkit](#) - This resource provides healthcare organizations with the tools to respond immediately when a patient is harmed and to promote candid, empathetic communication and timely resolution for patients, caregivers, and the healthcare organization.
- [Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families](#) - This resource offers four interventions (Be Prepared to Be Engaged; Create a Safe Medicine List Together; Teach-Back; and Warm Handoff Plus) and case studies designed to improve patient safety by meaningfully engaging patients and families in their care.
- [Guide to Patient and Family Engagement in Hospital Quality and Safety](#) - This guide helps hospitals work as partners with patients and families to improve quality and safety. It includes an implementation handbook and tools for patients, families, and clinicians.
- [Improving Healthcare Safety by Engaging Patients and Families](#) - This resource summarizes 53 AHRQ-funded projects to improve patient and family engagement.
- [TeamSTEPPS® 3.0 \(Team Strategies and Tools to Enhance Performance and Patient Safety\)](#) - TeamSTEPPS 3.0 is an evidence-based resource to optimize team performance across the healthcare delivery system focused on leadership, situation monitoring, mutual support, and communication. TeamSTEPPS is applicable to many clinical settings (e.g., hospitals, long-term care, office practices) and team participants (e.g., providers, patients, support staff, administrators).
- [Toolkit for Engaging Patients to Improve Diagnostic Safety](#) - This resource enhances communication and information sharing within the patient-provider encounter to improve diagnostic safety. Each strategy contains practical materials to support adoption within office-based practices.

## AHRQ Resources to Use to Make Patient Visits Most Meaningful and Efficient (And You Can Share With Your Patients)

- [For Hospital Staff](#)
- [For Patients and Families in the Hospital](#)
- [For Medical Office Staff](#)
- [For Patients and Families in the Medical Office](#)
- [For Long-Term Care Facility Staff](#)
- [For Ambulatory Surgery Center Staff](#)
- [For Patient and Families in Ambulatory Surgery Centers](#)

## Other AHRQ Resources

- [QuestionBuilder App](#) - helps patients and caregivers prepare for medical appointments and maximize visit time.
- [Patient Fact Sheet](#) - 20 Tips to Help Prevent Medical Errors

## Patient And Family Engagement Webinars

- [Empowering the Patient Voice in Safety Strategies](#) - In this webinar, speakers from Cincinnati Children's Hospital shared practical strategies for engaging patients, families, and the workforce to improve safety in healthcare systems.
- [Including Patients and Families in Improving Healthcare Safety](#) - In this webinar, speakers discussed the foundational elements for including patients and families in safety, new opportunities for engaging patients and families in making care safer, and how hospitals and healthcare systems can implement patient and family engagement.

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