NCPS
Nebraska Coalition for Patient Safety

CONTINUOUSLY IMPROVING THE SAFETY AND QUALITY OF HEALTHCARE DELIVERY IN THE REGION

The Importance of Patient Safety Organizations

Promoting Patient Safety is a National Priority

The Patient Safety and Quality Improvement Act

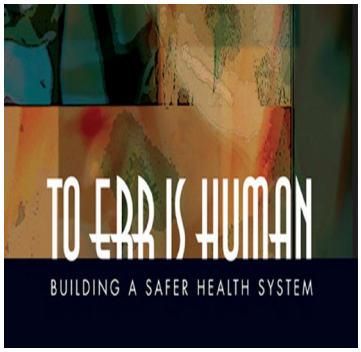
We are all committed to making healthcare safer and better for our patients. One of the challenges to achieving this goal in healthcare delivery is the concern that patient safety information that you or your organization collect as part of care improvement processes could also be used against you in legal proceedings. Working with a federally listed Patient Safety Organization, or PSO, can help you overcome those concerns.

The Nebraska Coalition for Patient Safety (NCPS) is designated by the Agency for Healthcare Research and Quality (AHRQ) as a federally listed Patient Safety Organization.

Patient Safety Listed PSO Organization

In 2005, Congress developed and enacted the Patient Safety and Quality Improvement Act (***Patient Safety Act***) in response to the Institute of Medicine report, T*o Err Is Human*, which drew national attention to the number of preventable medical errors that were occurring in the US healthcare system.

The Patient Safety Act authorized the creation of PSOs to promote shared learning and improve quality and safety nationally by conferring privilege and confidentiality protections on providers who work with federally listed PSOs.



The IOM report emphasized four strategies for improving patient safety in the US:

- Establish national focus and enhance knowledge base about safety.
- Encourage health care providers to participate in voluntary reporting systems.
- Raise expectations for improvements in safety.
- Improve culture and systems in health care organizations for safer healthcare delivery.

Nebraska Patient Safety Improvement Act

The act called for formation of a patient safety organization in Nebraska to encourage a culture of safety and quality by providing for:

- Legal protection of information reported.
- Aggregation of de-identified information about safety events.
- Sharing of de-identified information for improvement.

Visit our website:
www.nepatientsafety.org

Glossary of Terms Related to Patient Safety Organizations*

Culture of Safety	A culture of safety encompasses: a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment; a culture that encourages collaboration across ranks and disciplines to seek solutions to patient safety problems; and, an organizational commitment of resources to address safety concerns.
Listed PSO	A PSO that has submitted its certification submission and has had its submission accepted by AHRQ is deemed "listed" by AHRQ. The list of PSOs is available online at www.pso.ahrq.gov.
Patient Safety Act	The Patient Safety Act is an informal name of The Patient Safety and Quality Improvement Act of 2005 (P.L. 109-41), 42 USC 299b et seq.
Patient Safety Activities (PSAs)	The Patient Safety Rule defines 8 patient safety activities. ***Patient safety activities*** include the following activities carried out by, or on behalf of, a **PSO or a provider**: • Efforts to improve patient safety and the quality of health care delivery. • The collection and analysis of patient safety work product. • The development and dissemination of information with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices. • The use of patient safety work product for the purposes of encouraging a culture of safety and of providing feedback and assistance to minimize patient risk. • The maintenance of procedures to preserve confidentiality with respect to patient safety work product, • The provision of appropriate security measures with respect to patient safety work product, • The utilization of qualified staff, and • Activities related to the operation of a patient safety evaluation system and to the provision of feedback to participants in a patient safety evaluation system.
Patient safety evaluation system (PSES)	Incorporates the collection, management, or analysis of information for reporting to or by a PSO.
Patient Safety Rule	The set of regulations at 42 CFR Part 3 that implement provisions of the Patient Safety Act. The **Patient Safety Rule** was finalized in 2008 and defines how the PSQIA is implemented. The **Patient Safety Rule** establishes a framework by which hospitals, doctors, and other health care providers may voluntarily report information to patient safety organizations (PSOs) on a privileged and confidential basis, for the aggregation and analysis of patient safety events.
Patient Safety Work Product (PSWP)	In general, refers to information, including written or oral statements (or copies of any of this material) which could improve patient safety, health care quality, or health care outcomes, which exists within a patient safety evaluation system and which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO; or are developed by a PSO for the conduct of patient safety activities. PSWP includes the deliberations or analysis of information within a patient safety evaluation system. Specific provisions can be found at §3.20.
Privilege	Patient safety work product is privileged under federal law and is not subject to discovery, disclosure, or subpoena, or to be admitted as evidence in Federal, State, local, or Tribal civil, criminal, or administrative proceedings or admitted in a professional disciplinary proceeding under State law, except as provided for in the Patient Safety rule at §3.204.
Provider	A provider means: (1) an individual or entity licensed or otherwise authorized under State law to provide health care services; and (2) a parent organization of one or more entities licensed or otherwise authorized under State law to provide health care services. The definition of provider in section 3.20 of the Patient Rule includes additional language specific to Federal, State, local, or Tribal governments.
Workforce	For an individual to be considered a member of a PSO's or reporting provider's workforce, the Patient Safety Rule requires that the individual's work performance is under the direct control of the PSO or provider, whether or not the individual is paid.

* **Sources:**

Agency for Healthcare Research and Quality (March 2017). PSO Program: Common Terms and Acronyms. Accessed from: https://pso.ahrq.gov/sites/default/files/pso-program-acronyms.pdf

Electronic Code of Federal Regulations. Accessed from: https://www.ecfr.gov/cgi-bin/text-idx?SID=42192f8b6c83ddc436beeab06ef0ab90&mc=true&node=pt42.1.3&rgn=div5#se42.1.3_120

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