NCPS
Nebraska Coalition for Patient Safety

Patient Safety Brief

February 2021

Working with a PSO and Reporting Safety Events

Situation	• The purpose of the Patient Safety Organization (PSO) program is to promote shared learning to enhance quality and safety by providing privilege and confidentiality protections for providers who work with PSOs and submit patient safety events and unsafe conditions. • In 2019, **21** hospital members submitted reports of patient safety events and unsafe conditions to NCPS (**35.5%** of NCPS members). • In 2020, **13** hospital members submitted reports of patient safety events and unsafe conditions to NCPS (**20.6%** of NCPS members).
Background	• In 1999, the Institute of Medicine published *To Err is Human*, calling attention to the nearly 100,000 deaths that occur each year in the US as a result of medical error.[1] • In 2005, Congress passed the Patient Safety and Quality Improvement Act (PSQIA) which led to the creation of patient safety organizations (PSOs) and established a voluntary reporting system designed to enhance the data available to assess and resolve patient safety and health care quality issues.[2] • To encourage the reporting and analysis of medical errors and events, PSQIA provides Federal privilege and confidentiality protections for patient safety information, called patient safety work product, that is reported to NCPS by its members that have written agreements in place with NCPS.
Assessment	• NCPS relies on its members with written agreements in place to submit reports of patient safety events and unsafe conditions so that we can aggregate and analyze the data to identify trends and patterns. • It is through shared learning in the development and distribution of educational materials and other resources that NCPS is able to help its members with their efforts to mitigate risk of future events from occurring, and to improve patient safety and quality of care.
Recommendation	• Develop and maintain a Patient Safety Evaluation System (PSES) for collecting, maintaining, analyzing, and managing information about patient safety for improving quality and safety. • Maintain a reporting relationship with NCPS to ensure continuity of Federal privilege and confidentiality protections. • Report events, near-misses, unsafe situations and analysis of such events to NCPS on a regular basis and in a secure manner, as Patient Safety Work Product, within your organization's PSES.

Shared learning resources are made possible only through the committed efforts of NCPS members in reporting patient safety events. Please continue to report patient safety events to NCPS. *We improve safety when we learn together!*

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References

1. Institute of Medicine. To Err Is Human: Building a Safer Health System. Washington, DC: The National Academies Press, 2000.
2. U.S. Department of Health and Human Services. Patient Safety and Quality Improvement Act of 2005 and Rule. https://www.hhs.gov/hipaa/for-professionals/patient-safety/statute-and-rule/index.html

Additional Resources

From NCPS:

1. NCPS Website: ***What We Do***. https://www.nepatientsafety.org/what-we-do/
2. Webinar: ***The Benefits of Belonging to a Patient Safety Organization.*** Access and view in the Education section of the members only portal of the NCPS website - https://www.nepatientsafety.org/members

From the Agency for Healthcare Research and Quality

1. PSO Program. https://www.pso.ahrq.gov/
2. Work With a Patient Safety Organization. https://www.pso.ahrq.gov/work-with
3. Webinar: ***Working With Patient Safety Organizations (PSOs): The Value for Hospitals During COVID-19 and Beyond*** https://www.pso.ahrq.gov/resources/educational-tools

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