THE BENEFITS OF BELONGING TO A PATIENT SAFETY ORGANIZATION

Gail Brondum LPN, BS
Regina Nailon RN, PhD

NCPS
Nebraska Coalition for Patient Safety

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WELCOME!

- Continuing Education Credit:
  - Please complete both of the following forms, scan, and email to Ashley Dawson at ashley.dawson@unmc.edu:
    1. Registration half-sheet
    2. Program evaluation
  - Completed forms need to be received by Friday, March 6th in order to receive continuing education.
- Webinar Information:
  - This webinar will be recorded and available on the member-only page of the NCPS website.
  - CEUs will only be available for participants who attend the live webinar. CEUs are not available for viewing the webinar recording.
  - Participants are in listen-only mode. If you have questions, please type them in the question box. If we are unable to answer your question during the webinar, we **will do our best to provide answers via email after the webinar.**

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COURSE OBJECTIVES

- Describe the purpose of a patient safety organization (PSO).
- Examine the Patient Safety and Quality Improvement Act (PSQIA) of 2005 and its implications for providing federal confidentiality and privilege protections for providers reporting safety events and developing a patient safety evaluation system within their organization.
- Discuss the importance of reporting safety events and near events as it relates to meaningful data aggregation and analysis that allows for identification of trends and patterns to be used for driving quality improvement initiatives.
- Summarize the education and other resources provided to members by the Nebraska Coalition for Patient Safety that promote the culture of safety in healthcare delivery.

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INFORMATIONAL ONLY

- *This information is only meant to be general information for your consideration and is not intended to be construed as legal advice.*
- *Gail Brondum and Regina Nailon, the presenters, are **not** attorneys.*
- *Please seek the advice of your own legal counsel to review your policies and processes as they relate to the Federal and State laws and regulations discussed in this program.*

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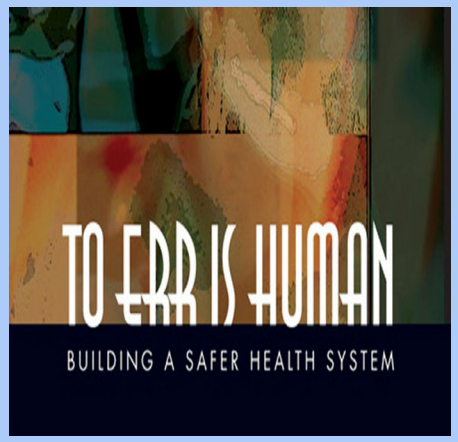
WHY THE NEED FOR PATIENT SAFETY ORGANIZATIONS?

- Institute of Medicine Report, 1999[1]
  1. Establish national focus and enhance knowledge base about safety.
  2. Encourage health care providers to participate in voluntary reporting systems.
  3. Raise expectations for improvements in safety.
  4. Improve culture and systems in health care organizations for safer healthcare delivery.



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HOW DID PATIENT SAFETY ORGANIZATIONS ORIGINATE?

- In 2005, the **Patient Safety Improvement Act** was passed by the Nebraska Legislature and signed by Governor Heinemann.[2]

- In 2005, the U.S. federal government passed the **Patient Safety and Quality Improvement Act** (PSQIA).[3]

- The goal of both the State and Federal legislation is to increase the likelihood that people who seek health care in Nebraska and across the U.S. are not harmed by the health care services that are intended to help them.

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THE PATIENT SAFETY RULE

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.

PSO listing and recertification are overseen by AHRQ and the Office for Civil Rights.

The **Patient Safety Rule** and the protections of the PSQIA have the force of Federal law.

For online reference to the Patient Safety Rule, go to: https://www.ecfr.gov/cgi-bin/text-idx?SID=42192f8b6c83ddc436beeab06ef0ab90&mc=true&node=pt42.1.3&rgn=div5

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WHAT IS THE PURPOSE OF A PATIENT SAFETY ORGANIZATION?

- The PSO Program was developed in response to the IOM report "To Err is Human" **to improve quality and safety by reducing the incidence of events that adversely affect patients**.
- The purpose of the program is to **promote shared learning to enhance quality and safety** by providing privilege and confidentiality protections for providers who work with PSOs.
- The primary activity of a PSO is to work with healthcare providers in a variety of settings where care is provided and **conduct patient safety activities.**
- A PSO does this by assisting providers with developing **patient safety evaluation systems**, through which their **patient safety work product** can be analyzed and shared within their organizations and with the PSO under the **confidentiality** and **privilege protections** of the PSQIA.

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WHY WORK WITH A PSO?

- **Confidentiality and privilege protections** can help overcome provider fear of liability exposure for sharing information about events and participating in QI activities.
- **Protections are broader** than most State protections, so all licensed or certified healthcare providers (facilities and individuals) can participate with a PSO.
- **Protections are nationwide and uniform**, so healthcare systems can share protected information among affiliated providers in multiple states.
- **Aggregate data** - providers benefit from the insights gained by the PSO evaluating reports and data from multiple providers, especially for rare patient safety events.
- Source: AHRQ PSO Program https://pso.ahrq.gov/with_PSO

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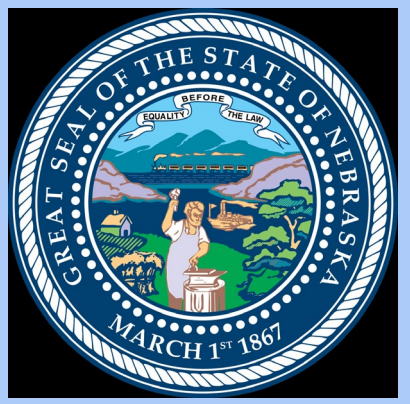
HOW WAS THE NEBRASKA COALITION FOR PATIENT SAFETY FORMED?

- The Act passed in Nebraska directed five professional associations to establish a private, nonprofit patient safety organization independent of State agencies to encourage a culture of safety and quality.
- Founding Associations:
  - Nebraska Hospital Association
  - Nebraska Medical Association
  - Nebraska Academy of Physician Assistants
  - Nebraska Pharmacists Association
  - Nebraska Nurses Association



- Non-profit 501c3 with governing board of representatives from five founding organizations.
- Nebraska Statutes 71-8701-8721 pertain to the Patient Safety Act.[4]

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NEBRASKA COALITION FOR PATIENT SAFETY

- In 2009, NCPS became a federally listed patient safety organization with the Agency for Healthcare Research and Quality.

- NCPS creates a secure and protected environment for health care providers (an individual or entity licensed to provide health care services) to report information about adverse events and hazards so learning can be shared and system improvements can be made to achieve safer, more reliable care.

- NCPS fosters safety culture development by providing education, tools, and other resources to its members.

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NCPS MISSION STATEMENT

Continuously improve the safety and quality of healthcare delivery in the region.

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WHAT IS A PATIENT SAFETY EVALUATION SYSTEM?

- A ***Patient Safety Evaluation System*** (PSES) is the collection, management, or analysis of safety-related information for reporting to or by a PSO.
- A PSES includes all the ways in which your organization reports, investigates, documents, analyzes and communicates information about safety events and efforts to improve.
- A PSES could include information in and from, for example:
  - Quality and safety committees, discussions, minutes, actions
  - Root cause analyses and event investigations
  - Peer review activities
  - Safety huddles
  - Hallway conversations, emails, meetings related to patient safety events and quality improvement
  - Quality report cards and score cards
  - Incident reports, reporting systems and reporting solutions
- A PSES for an organization can be outlined and defined by its policies and procedures. NCPS has templates that can be modified for your use.

WHAT IS PATIENT SAFETY WORK PRODUCT?

- ***Patient safety work product*** (PSWP) means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) that:
  - Could improve patient safety, health care quality, or health care outcomes.
  - Are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes:
    - Information that is documented as **within a patient safety evaluation system** for reporting to a PSO, and
    - Such documentation includes the date the information entered the patient safety evaluation system; or
  - Are developed by a PSO for the conduct of patient safety activities.
- *Under the law, deliberations and analyses conducted in the PSES become protected as PSWP immediately.* https://pso.ahrq.gov/with_PSO

WHAT IS PATIENT SAFETY WORK PRODUCT?

- Patient safety work product *does not include:*
  - a patient's medical record
  - billing and discharge information
  - any other original patient or provider information
- Nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system.
- Separate information (or copies of separate information) that is reported to a PSO are not considered PSWP simply because it has been reported to a PSO.
- What are you reporting outside the PSES (outside of your provider or PSO-related PSES)?

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WHAT ARE 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.

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WHAT ARE PATIENT SAFETY ACTIVITIES?

- ***Patient safety activities*** also include the following activities carried out by, or on behalf of, a **PSO or a provider**:
  - 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.

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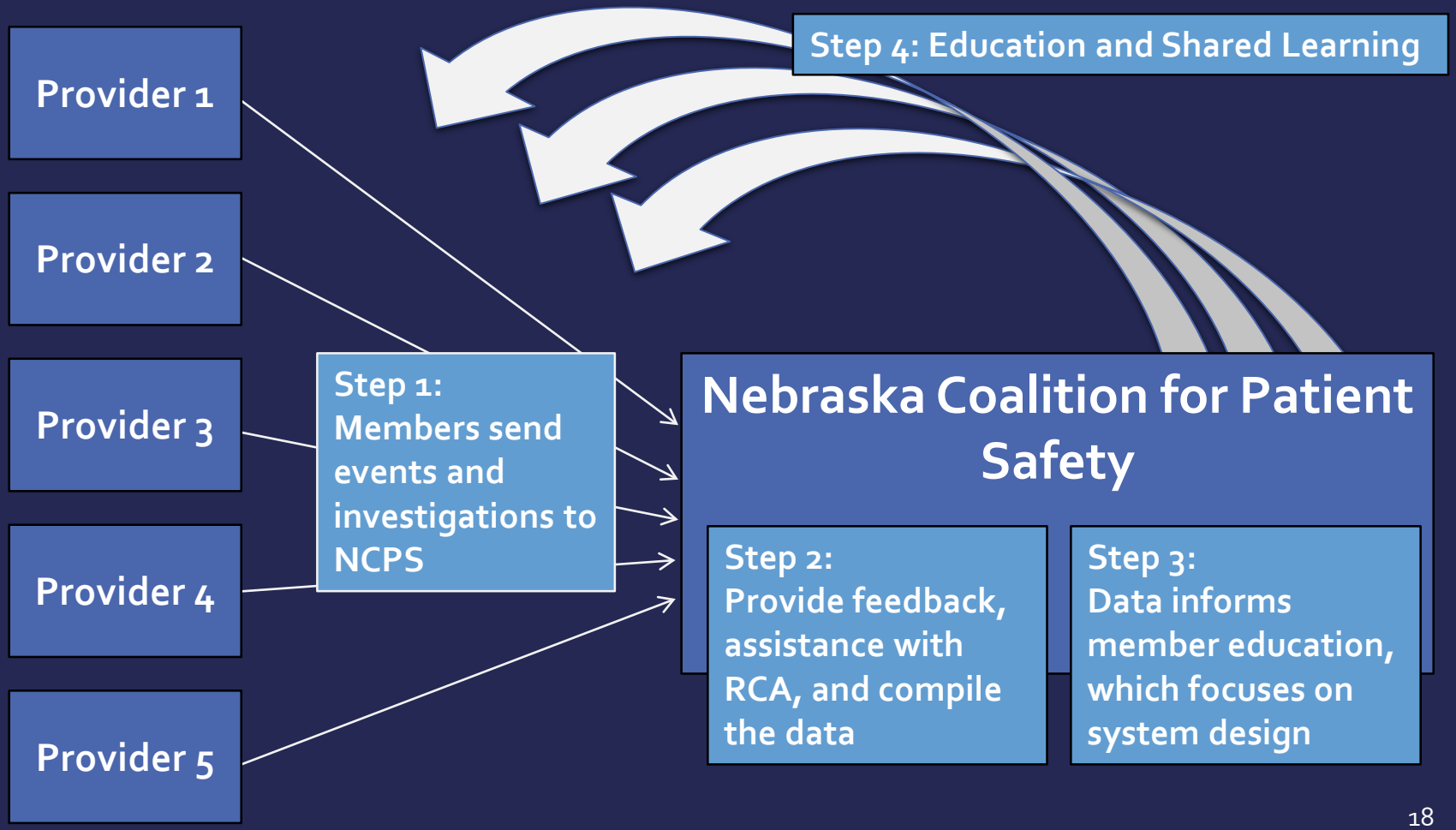
Function of a Patient Safety Organization



THE IMPORTANCE OF REPORTING SAFETY EVENTS

- ***Why is it important for PSO members to report safety events?***
  - Reporting safety events and near events allows the PSO to conduct meaningful data aggregation and analysis.
  - Analysis of reported events within the robust database allows the PSO to identify trends and patterns in various types of events and levels of harm (where applicable).
  - The PSO develops educational materials to share with members based on reported events to assist members with driving quality improvement initiatives.
- ***There are no shared learnings if there are no reported events!***

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THE IMPORTANCE OF REPORTING SAFETY EVENTS

- ***What types of events should be reported to a PSO?***
  - NCPS encourages members to report safety events that may or may not reach the patient.
  - NCPS encourages members to report safety events that reach the patient whether or not they result in harm.
  - NCPS encourages members to report unsafe conditions – those near events or near misses – that have the capacity to cause a safety event.

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THE IMPORTANCE OF REPORTING SAFETY EVENTS

- ***What information should be included in events reported to a PSO?***
  - The NCPS Safety Event Report form is based on:
    - The Agency for Healthcare Research & Quality Common Formats for reporting events in hospitals and nursing homes.[5]
    - The National Quality Forum Serious Reportable Events.[6]
  - This standardized format enables NCPS to aggregate the data in a manner that yields an *apples to apples* comparison reports.
  - Complete the entire form and check all applicable fields, including:
    - contributing factors
    - proximal causes
  - **A formal RCA is not required to report on contributing factors and causes!**

- ***Shared learnings are most meaningful when <u>contributing factors, proximal causes</u>, and <u>causal statements</u> are reported in the events!***

NCPS Safety Event Report Form

NEBRASKA COALITION FOR PATIENT SAFETY Event Questionnaire

Hospital _____ ***Reporter*** _____

Date of Event: _____ **Date RCA Completed:** _____ **RCA Not Applicable (Harm less than E)**____

Date of this Report: _____ Patient Age (if younger than 90) _____ Patient Gender: ☐ M

Patient Age 90 or older check here:☐ ☐ F

Check the location of the event:

- ☐ Emergency Department
- ☐ Intensive care unit
- ☐ Laboratory
- ☐ Medical/surgical ward
- ☐ Operating Room/Surgical Suite
- ☐ Pharmacy
- ☐ Post Anesthesia Care Unit
- ☐ Procedure Room
- ☐ Radiology/Imaging Suite
- ☐ Rehabilitation Unit
- ☐ OB/LDR
- ☐ Other _____

Check the ONE category that describes the SEVERITY of the EVENT based on harm to the patient. The coalition requires that you report any events of harm level E or greater. You are encouraged to share any de-identified event that may have educational value for other Nebraska hospitals.

	NO ERROR	**NO HARM**
	Category A	Circumstances or events that have the capacity to cause error
	ERROR	**NO HARM**
	Category B	Error occurred but it did not reach patient
	Category C	Error occurred that reached the patient, but did not cause harm (includes errors of omission)
	Category D	Error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to prevent harm
	ERROR	**HARM**
	Category E	Error occurred that may have contributed to, or resulted in, temporary harm to the patient of unknown duration and required intervention
	Category F	Error occurred that may have contributed to, or resulted in, temporary harm to the patient and required initial or prolonged hospitalization
	Category G	Error occurred that may have contributed to, or resulted in, permanent harm to patient
	Category H	Error occurred that required intervention necessary to sustain life
	ERROR	**DEATH**
	Category I	Error occurred that may have contributed to, or resulted in, patient death

DESCRIBE THE EVENT, how it occurred, how it was discovered (a narrative may be attached):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Check factors that contributed to the event:

- ☐ A contributing factor not determined
- ☐ Barcode, missing
- ☐ Barcode, non-readable
- ☐ Barcode, system non-functional
- ☐ Code situation
- ☐ Computer system/network down
- ☐ Cross coverage
- ☐ Distractions
- ☐ Emergency situation
- ☐ Fatigue
- ☐ Imprint, identification failure
- ☐ Language, barrier
- ☐ No 24-hour pharmacy
- ☐ No access to patient info
- ☐ Patient names similar/same
- ☐ Patient transfer
- ☐ Poor lighting
- ☐ Range orders
- ☐ Shift change
- ☐ Staff, agency/ temporary
- ☐ Staff, floating
- ☐ Staff, inexperienced
- ☐ Staffing, alternative hours
- ☐ Staffing, insufficient
- ☐ Workload increase
- ☐ Other:_____
- ☐ Other:_____

Check known immediate or proximal cause(s) of the event:

Documentation

- ☐ Abbreviations (including leading zero missing and trailing zero present)
- ☐ Blanket orders
- ☐ Documentation inaccurate /omitted/ illegible/ confusing
- ☐ Non-metric units used
- ☐ Order confusing/incomplete
- ☐ Prefix/suffix misinterpreted
- ☐ Pre-printed order forms
- ☐ Other:

Electronic Medical Record

- ☐ Computer screen display unclear/confusing
- ☐ Computer prescriber order entry
- ☐ Computer entry
- ☐ Computer software
- ☐ Information mgmt. system
- ☐ Barcode-inaccurate, missing
- ☐ Other:

Environment

- ☐ Physical environment condition
- ☐ Workflow disruption
- ☐ Other:

Equipment:

- ☐ Equipment design confusing/inadequate
- ☐ Equipment failure/malfunction
- ☐ Equipment-improperly operated
- ☐ Equipment maintenance
- ☐ Fax/scanner involved
- ☐ Dispensing device involved
- ☐ Override warnings
- ☐ Other:

Human Performance

- ☐ Handoff Communication
- ☐ Did not communicate concern up the chain of command
- ☐ Knowledge deficit/training insufficient
- ☐ Language Barrier
- ☐ Patient disregarded instruction
- ☐ Patient identification failure
- ☐ Performance (human) deficit
- ☐ Shift Change
- ☐ Other:

Management System

- ☐ Measuring device inaccurate/inappropriate
- ☐ Monitoring inadequate/lacking
- ☐ Information mgt. system
- ☐ Reference material confusing/inaccurate
- ☐ Procedure/Protocol not followed
- ☐ Staffing issues
- ☐ System safeguards inadequate
- ☐ Other:

Supplies

- ☐ Barcode unavailable
- ☐ Label (manufacturer's) design
- ☐ Label (your facility's) design
- ☐ Labeling process
- ☐ Similar Packaging/container design
- ☐ Repackaging by your facility
- ☐ Repackaging by other facility
- ☐ Similar products
- ☐ Storage proximity
- ☐ Unlabeled syringe/container
- ☐ Other:

Medication

- ☐ Contraindicated, drug allergy
- ☐ Contraindicated, drug/ drug
- ☐ Contraindicated, drug/ food
- ☐ Contraindicated in disease
- ☐ Contraindicated in pregnancy/breastfeeding
- ☐ Decimal point
- ☐ Diluent wrong
- ☐ Dispensing device involved
- ☐ Dosage form confusion
- ☐ Drug distribution system
- ☐ Drug unavailable
- ☐ Incorrect medication activation
- ☐ Look alike/sound alike medications
- ☐ MAR variance
- ☐ Non-formulary drug
- ☐ Reconciliation-admission
- ☐ Reconciliation-discharge
- ☐ Reconciliation-transition
- ☐ Storage proximity
- ☐ Other:

Please attach a summary of the causal statements from your root cause analysis.

Recall that causal statements must follow five rules: **RCA Not Applicable (Harm less than E)**_____

1. Clearly show cause and effect relationships
2. Use specific and accurate descriptions
3. Identify the system cause of the error
4. Identify preceding cause of policy or procedure violation
5. Acknowledge that a failure to act is only causal when there is a preceding duty to act

Please check the categories of causal statements discovered in your root cause analysis:

- ☐ Environment/Equipment/Software
- ☐ Human Factors/Communication
- ☐ Human Factors/Fatigue/Scheduling
- ☐ Human Factors/Training
- ☐ Organizational Factors
- ☐ Patient Management Factors
- ☐ Patient/Family Factors
- ☐ Rules/Policies/Procedures

NCC MERP* Index of Error Severity

A	Circumstances or events occur that have the capacity to cause error.
B	An error occurred, but the error did not reach the patient.
C	An error occurred that reached the patient, but did not cause patient harm.
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient, and/or required intervention to preclude harm. Harm does not reach patient.
E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.
F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required an initial or prolonged hospital stay.
G	An error occurred that may have contributed to or resulted in permanent patient harm.
H	An error occurred that required intervention necessary to sustain life.
I	An error occurred that may have contributed to or resulted in patient death.

* NCC MERP: National Coordinating Council for Medication Error Reporting and Prevention

GOALS OF NCPS

- ***Provide protection*** from discovery of events reported by members.
- ***Learn*** from reported events.
- ***Share*** with membership the trends and patterns identified in reported events.
- ***Offer resources*** for individualized follow up and feedback related to events.
- ***Provide education and training*** specific to patient safety.

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MEMBER EDUCATION

- Membership with the Nebraska Coalition for Patient Safety provides multiple types of resources that can be used to improve the safety of healthcare delivery.
- Educational offerings and other resources are made possible because of the event reports we receive from members.
- Aggregating and analyzing the event reports enables NCPS staff to identify patterns and trends so that the learnings from events can be shared!
- Foundational safety culture resources and training support providers in building a strong culture of safety.

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TYPES OF EDUCATION

- Monthly newsletters
- Webinars
- Patient Safety Alerts
- De-identified Safety Events
- Reporting Committee Summaries
- Workshops and Conference Presentations

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WEBINAR AND WORKSHOP TOPICS 2019

- Promoting Patient Engagement to Improve Safety
- Pain Management and Opioid Oversight
- Just Culture for Healthcare Leaders
- TeamSTEPPS Master Trainer Workshop
- Aggregate Root Cause Analysis

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PATIENT SAFETY ALERT AND DE-IDENTIFIED EVENT TOPICS 2019

- Cautery Burns and Fires
- Antithrombotic and Thrombolytic events
- Retained Prep Sponge
- Delay in Home Medication Reconciliation
- Wrong Medication: Rocuronium Ordered, Vecuronium Given
- Wrong Patient: Emergency Situation CVA

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TRAINING

- Root Cause Analysis
- TeamSTEPPS®
  - 2-hour
  - Half-day
  - Full-day
  - Master Trainer: 1-1/2 – 2 Days
- Just Culture
  - 2-hour
  - Half-day
  - Full-day

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MEMBERSHIP FEEDBACK ON EDUCATIONAL OFFERINGS

- "Content was educational and useful to our daily practice."
- "Appreciated the examples of medication errors."
- "Very good information. The importance of accurate med reconciliation and bedside reporting just reinforced the need for patient & family involvement."
- "Gail explaining the scenarios demonstrated how involving patients & families is critical to patient safety."
- "Loved the case studies & real discussion - can this happen in your facility?"
- "Outstanding presentation - appreciate your sharing lessons learned and best practices."

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MEMBERSHIP REQUESTS FOR EDUCATIONAL OFFERINGS

- "Could you make some policies on pain management available or have a template available that facilities could adapt?"
- "Excellent presentation. Future presentations ideas: suicide risk and environmental assessments, meeting Joint Commission ligature resistant standards, and risk mitigation for suicidal patients."
- "We would be interested in (pain management) education for (medical) providers if this is possible."
- "Would like introduction/overview to Just Culture."
- "It would be great to have another (compassion fatigue) session on more specific topics & tools."

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NCPS REQUEST FOR MEMBERSHIP EDUCATIONAL INTERESTS

- NCPS February 14 Newsletter – Member Survey
  - 5 questions.
  - ***We need to hear from you!***

5. From the list below, please select the 3 topics that you are most interested in learning more about through educational offerings provided by the Nebraska Coalition for Patient Safety in 2020. *

- [ ] How to set up a patient safety evaluation system
- [ ] Patient safety work product
- [ ] Safety event reporting process
- [ ] Safe tables/huddles
- [ ] Developing a safety culture
- [ ] How to use patient safety data to improve care processes and outcomes
- [ ] How to conduct a root cause analysis
- [ ] Other. Please specify:

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NCPS IS EXPANDING!

- 2020 (and beyond):
  - **New educational offerings – Safe Tables**
  - **Educational offerings with CME and CNE credit**
  - **Physician / Outpatient Clinics**
  - **Ambulatory Surgery Centers**
  - **Long Term Care Facilities**
- We continue to look for new ways to collaborate and we welcome your input!

Visit our website: https://www.nepatientsafety.org

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NCPS STAFF CONTACT INFORMATION

- Gail Brondum, BS, LPN
  - NCPS Executive Director
    - Gail.brondum@unmc.edu
- Regina Nailon, PhD, RN
  - NCPS Patient Safety Program Director
    - Regina.nailon@unmc.edu
- Ashley Dawson, MS
  - Health Data Analyst
    - Ashley.dawson@unmc.edu

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6. National Quality Forum. Serious Reportable Events. http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx