

The Nebraska Coalition for Patient Safety

Presented to NAHQRS

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Improving Patient Safety

‘Helping each other help patients’

- * PSOs are organizations that share the goal of improving the quality and safety of health care delivery
- * By providing both privilege and confidentiality, PSOs create a secure environment where clinicians and health care organizations can collect, aggregate, and analyze data

Objectives

- * Describe the Patient Safety Act of 2005
- * Define the role of Patient Safety Organizations
- * Explain relevance of reporting and a culture of safety
- * Name two key components of the Patient Safety & Quality Improvement Act of 2005
- * Discuss a provider's role in working with the Nebraska Coalition for Patient Safety

The Importance of Patient Safety

- * Medical errors are the 4th leading cause of death in the U.S.
- * Patients 72% lower chance of dying in a '5 star hospital' compared to a '1 star hospital'
- * Patients have a 50% lower chance of dying in a '5 star hospital' compared to an 'average hospital'

(Healthgrades)

Why Report?

- * Cornerstone of safe practice
- * Progress toward achieving a culture of safety
- * At a minimum, identifies hazards & risks
- * Target improvement efforts & system changes

(WHO Draft Guidelines for Adverse Event Reporting & Learning Systems)

Patient Safety and Quality Improvement Act (PSQIA) of 2005

- * To improve healthcare quality and patient safety
- * Share data within a protected environment
- * Identify and reduce potential risks associated with patient care
- * The Act is voluntary and provides no federal funding for Patient Safety Organizations

PSQIA: The Statute

- * The Patient Safety and Quality Improvement Act of 2005 (PSQIA) amends the Public Health Service Act by inserting sections 921 through 926
- * Key elements of the statute include key terms such as *Patient Safety Work Product (PSWP)*, *confidentiality and privilege protections*, disclosure of PSWP and violations of the protection, the network of patient safety databases and requirements for listing and delisting PSOs

What is Patient Safety Work Product? (PSWP)

- * Includes any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material), which could improve patient safety, health care quality, or health care outcomes
- * Assembled or developed by a provider for reporting to a PSO and are reported to a PSO
- * Information that is documented as within a patient safety evaluation system that will be sent to a PSO and information developed by a PSO for the conduct of patient safety activities

In Short...

- * The final rule provides that information documented as collected within a patient safety evaluation system by a provider shall be protected as patient safety work product

What is NOT PSWP?

- * Patient's medical record, billing and discharge information, or any other original patient or provider information
- * Information that is collected, maintained, or developed separately, or exists separately, from a PSES. *Such*
- * PSWP assembled or developed by a provider for reporting to a PSO but removed from a PSES and no longer considered PSWP if:
 - Information has not yet been reported to a PSO; and
 - Provider documents the act and date of removal of such information from the PSES

Confidentiality & Privilege

The Office of Civil Rights monitors the confidentiality provisions to make sure that information that is assembled and exchanged between providers and the PSO is kept confidential and protected

Privilege protections are enforced by the judicial system, which limit or forbid the use of protected information in criminal, civil, administrative or other proceedings

In short

Confidentiality:

- Protects against any form of disclosure of PSWP to a third party

Privilege:

- Protects against subpoena, discovery or admission into evidence in connection with a legal proceeding or professional disciplinary proceeding

Why Participate in a PSO?

- * Voluntary, provider-driven initiatives to enhance patient safety
- * PSO participation will enable learning from others
Learning from others

Why Participate in a PSO?

- * Consumer groups and advocates have called for more engagement of the patient and the public in improving healthcare systems
- * Better and safer care should be more efficient care which costs less in dollars as well as in patient suffering, clinician frustration and unhappiness
- * Healthcare providers want to provide the best possible care, but at times the fear of disciplinary action and/or liability prevents this

A Provider's Role in Working with NCPS

Establish and implement a patient safety evaluation system (PSES), that:

1. Collects data to improve patient safety, healthcare quality, and healthcare outcomes
2. Reviews data and takes action when needed to mitigate harm or improve care

A Provider's Role in Working with NCPS

3. Analyzes data and makes recommendations to improve patient safety, quality, and outcomes
4. Conducts RCAs, proactive risk assessments, in-depth reviews, and aggregate RCAs
5. Determines which data will/will not be reported to the PSO
6. Reports to PSO(s)

Event/Incident Reporting Policy

Modify existing policies as needed to reflect the purpose is for reporting is for ...

Patient safety, healthcare quality, and outcome improvement as well as reporting to a PSO

Include a process (through the PSES) for the removal of incidents from PSES or separate system for ...

Disciplinary action, Just Culture, Mandatory Reporting or Peer Review

Development of PSES Policy

Things to consider:

- * Who or what committee(s) collects data that will be reported to a PSO?
 - Single source or multiple sites?
 - Single department or organization wide event reporting?
- * Analyzes data that will be reported to a PSO?
- * Removes data from PSES prior to reporting to a PSO?
- * Submits the data from the PSES to the PSO(s)?
(Committee or individual authorized submission?)

PSES Questions to Answer

- * Where does data go for analysis within and outside of the organization?
- * Is the PSO listed by AHRQ?
- * Will we submit data to component PSO or multiple PSOs?

Mandatory Reporting to State Agencies

- * Providers have flexibility in defining and structuring their PSES, as well as determining what information is to become PSWP and, thus, protected from disclosure
- * Use information that is not PSWP to fulfill mandatory reporting obligations (e.g., medical records, surgery logs, etc.)
- * Report subjective incident report data to PSO for protections

Disclosure

Patient & Family

1. Objective Facts that are supported by documentation in the record
2. Actions taken to prevent harm to another patient

PSO

1. Event report that contains staff impressions related to why event may have occurred
2. Additional analysis
3. RCA recommendations

NCPS: 2011 and Beyond

Long Term Strategic Initiatives:

GROWTH

EDUCATION

PATIENT SAFETY BEST PRACTICES

RESEARCH & CONSULTING