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**STATE OF NEBRASKA**

**STATUTES RELATING TO  
PATIENT SAFETY IMPROVEMENT ACT**



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## STATUTES PERTAINING TO THE PATIENT SAFETY IMPROVEMENT ACT

**71-8701. Act, how cited.** Sections 71-8701 to 71-8721 shall be known and may be cited as the Patient Safety Improvement Act.

Source: Laws 2005, LB 361, §1. Effective date April 28, 2005.

**71-8702. Legislative findings and intent.** (1) The Legislature finds that:

(a) In 1999, the Institute of Medicine released a report entitled "To Err is Human" that described medical errors as the eighth leading cause of death in the United States;

(b) To address these errors, the health care system must be able to create a learning environment in which health care providers and facilities will feel safe reporting adverse health events and near misses in order to improve patient safety;

(c) To facilitate the learning environment, health care providers and facilities must have legal protections that will allow them to review protected health information so that they may collaborate in the development and implementation of patient safety improvement strategies;

(d) To carry out a program to promote patient safety, a policy should be established which provides for and promotes patient safety organizations; and

(e) There are advantages to having private nonprofit corporations act as patient safety organizations rather than a state agency, including the enhanced ability to obtain grants and donations to carry out patient safety improvement programs.

(2) It is the intent of the Legislature to encourage the establishment of broad-based patient safety organizations.

Source: Laws 2005, LB 361, §2. Effective date April 28, 2005.

**71-8703. Purposes of act.** The purposes of the Patient Safety Improvement Act are to (1) encourage a culture of safety and quality by providing for legal protection of information reported for the purposes of quality improvement and patient safety, (2) provide for the reporting of aggregate information about occurrences, and (3) provide for the reporting and sharing of information designed to improve health care delivery systems and reduce the incidence of adverse health events and near misses. The ultimate goal of the act is to ensure the safety of all individuals who seek health care in Nebraska's health care facilities or from Nebraska's health care professionals.

Source: Laws 2005, LB 361, §3. Effective date April 28, 2005.

**71-8704. Definitions, where found.** For purposes of the Patient Safety Improvement Act, unless the context otherwise requires, the definitions found in sections 71-8705 to 71-8709 apply.

Source: Laws 2005, LB 361, §4. Effective date April 28, 2005.

**71-8705. Identifiable information, defined.** Identifiable information means information that is presented in a form and manner that allows the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information includes any individually identifiable health information as that term is defined in the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as such regulations existed on April 28, 2005.

Source: Laws 2005, LB 361, §5. Effective date April 28, 2005.

**71-8706. Nonidentifiable information, defined.** Nonidentifiable information means information presented in a form and manner that prevents the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information must be de-identified consistent with the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as such regulations existed on April 28, 2005.

Source: Laws 2005, LB 361, §6. Effective date April 28, 2005.

**71-8707. Patient safety organization, defined.** Patient safety organization means an organization described in section 71-8714 that contracts with one or more providers subject to the Patient Safety Improvement Act and that performs the following activities:

(1) The conduct, as the organization's primary activity, of efforts to improve patient safety and the quality of health care delivery;

(2) The collection and analysis of patient safety work product that is submitted by providers;

(3) The development and dissemination of evidence-based information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices;

(4) The utilization of patient safety work product to carry out activities limited to those described under this section and for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk;

- (5) The maintenance of confidentiality with respect to identifiable information;
- (6) The provision of appropriate security measures with respect to patient safety work product; and
- (7) The possible submission, if authorized by federal law, of nonidentifiable information to a national patient safety data base.

Source: Laws 2005, LB 361, §7. Effective date April 28, 2005.

**71-8708. Patient safety work product, defined.** (1) Patient safety work product means any data, reports, records, memoranda, analyses, deliberative work, statements, root cause analyses, or quality improvement processes that are:

- (a) Created or developed by a provider solely for the purposes of reporting to a patient safety organization;
- (b) Reported to a patient safety organization for patient safety or quality improvement processes;
- (c) Requested by a patient safety organization, including the contents of such request;
- (d) Reported to a provider by a patient safety organization;
- (e) Created by a provider to evaluate corrective actions following a report by or to a patient safety organization;
- (f) Created or developed by a patient safety organization; or
- (g) Reported among patient safety organizations after obtaining authorization.

(2) Patient safety work product does not include information, documents, or records otherwise available from original sources merely because they were collected for or submitted to a patient safety organization. Patient safety work product also does not include documents, investigations, records, or reports otherwise required by law.

(3) Patient safety work product does not include reports and information disclosed pursuant to sections 71-8719 and 71-8720.

Source: Laws 2005, LB 361, §8. Effective date April 28, 2005.

**71-8709. Provider, defined.** Provider means a person that is either:

- (1) A facility licensed under the Health Care Facility Licensure Act; or
- (2) A health care professional licensed under the Uniform Credentialing Act.

Source: Laws 2005, LB 361, § 9; Laws 2007, LB463, § 1307. Operative date December 1, 2008.

**71-8710. Patient safety work product; confidentiality; use; restrictions.** (1) Patient safety work product shall be privileged and confidential.

(2) Patient safety work product shall not be:

- (a) Subject to a civil, criminal, or administrative subpoena or order;
- (b) Subject to discovery in connection with a civil, criminal, or administrative proceeding;
- (c) Subject to disclosure pursuant to the Freedom of Information Act, 5 U.S.C. 552, as such act existed on April 28, 2005, or any other similar federal or state law, including sections 84-712 to 84-712.09;

(d) Offered in the presence of the jury or other factfinder or received into evidence in any civil, criminal, or administrative proceeding before any local, state, or federal tribunal; or

(e) If the patient safety work product is identifiable information and is received by a national accreditation organization in its capacity:

(i) Used by a national accreditation organization in an accreditation action against the provider that reported the information;

(ii) Shared by such organization with its survey team; or

(iii) Required as a condition of accreditation by a national accreditation organization.

Source: Laws 2005, LB 361, §10. Effective date April 28, 2005.

**71-8711. Patient safety organization; proceedings and records; restrictions on use; violation; penalty.** No person shall disclose the actions, decisions, proceedings, discussions, or deliberations occurring at a meeting of a patient safety organization except to the extent necessary to carry out one or more of the purposes of a patient safety organization. The proceedings and records of a patient safety organization shall not be subject to discovery or introduction into evidence in any civil action against a provider arising out of the matter or matters that are the subject of consideration by a patient safety organization. Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a patient safety organization. This section shall not be construed to prevent a person from testifying to or reporting information obtained independently of the activities of a patient safety organization or which is public information. A person who knowingly violates this section shall be guilty of a Class IV misdemeanor.

Source: Laws 2005, LB 361, §11. Effective date April 28, 2005.

**71-8712. Patient safety work product; unlawful use; effect.** Any reference to, or offer into evidence in the presence of the jury or other factfinder or admission into evidence of, patient safety work product during any proceeding contrary to the Patient Safety Improvement Act shall constitute grounds for a mistrial or a similar termination of the proceeding and

reversible error on appeal from any judgment or order entered in favor of any party who discloses or offers into evidence patient safety work product in violation of the act.

Source: Laws 2005, LB 361, §12. Effective date April 28, 2005.

**71-8713. Act; cumulative to other law.** The prohibition in the Patient Safety Improvement Act against discovery, disclosure, or admission into evidence of patient safety work product is in addition to any other protections provided by law.

Source: Laws 2005, LB 361, §13. Effective date April 28, 2005.

**71-8714. Patient safety organization; conditions.** A patient safety organization shall meet the following conditions:

(1) It shall be a Nebraska nonprofit corporation described in section 501(c)(3) of the Internal Revenue Code as defined in section 49-801.01, contributions to which are deductible under section 170 of the code;

(2) The purposes of the organization shall include carrying out the activities of a patient safety organization as described in the Patient Safety Improvement Act; and

(3) It shall have a representative board of directors as described in section 71-8715.

Source: Laws 2005, LB 361, §14. Effective date April 28, 2005.

**71-8715. Patient safety organization; board of directors; membership.** The board of directors of a patient safety organization shall include at least one representative each from a statewide association of Nebraska hospitals, Nebraska physicians and surgeons, Nebraska nurses, Nebraska pharmacists, and Nebraska physician assistants as recommended by such associations. At least one consumer shall be a member of the board. The board shall consist of at least twelve but no more than fifteen members as established at the discretion of the board.

Source: Laws 2005, LB 361, §15. Effective date April 28, 2005.

**71-8716. Election to be subject to act; contract; requirements.** (1) A patient safety organization shall contract with providers that elect to be subject to the Patient Safety Improvement Act. The patient safety organization shall establish a formula for determining fees and assessments uniformly within categories of providers.

(2) A provider may elect to be subject to the Patient Safety Improvement Act by contracting with a patient safety organization to make reports as described in the act.

Source: Laws 2005, LB 361, §16. Effective date April 28, 2005.

**71-8717. Reportable patient safety events; provider; duties.** (1) Every provider subject to the Patient Safety Improvement Act shall track and report pursuant to section 71-8718 the following occurrences of patient safety events:

(a) Surgery or procedures performed on the wrong patient or the wrong body part of a patient;

(b) Foreign object accidentally left in a patient during a procedure or surgery;

(c) Hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;

(d) Sexual assault of a patient during treatment or while the patient was on the premises of a facility;

(e) Abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant;

(f) Suicide of a patient in a setting in which the patient received care twenty-four hours a day;

(g) Medication error resulting in a patient's unanticipated death or permanent or temporary loss of bodily function, including (i) treatment intervention, temporary harm, (ii) initial-prolonged hospitalization, temporary harm, (iii) permanent patient harm, and (iv) near death event in circumstances unrelated to the natural course of the illness or underlying condition of the patient, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, but excluding reasonable differences in clinical judgment on drug selection and dose;

(h) Patient death or serious disability associated with the use of adulterated drugs, devices, or biologics provided by the provider;

(i) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended; and

(j) Unanticipated death or major permanent loss of function associated with health care associated nosocomial infection.

(2) A patient safety organization, based on a review of new indicators of patient safety events identified by the Joint Commission on Accreditation of Healthcare Organizations, shall recommend changes, additions, or deletions to the list of reportable patient safety events, which changes, additions, or deletions shall be binding on the providers. Providers may voluntarily report any other patient safety events not otherwise identified.

Source: Laws 2005, LB 361, §17. Effective date April 28, 2005.

**71-8718. Reporting requirements.** (1) Every provider subject to the Patient Safety Improvement Act shall report aggregate numbers of occurrences for each patient safety event category listed in section 71-8717 to a patient safety organization. Reporting shall be done on an annual basis by March 31 for the prior calendar year.

(2) For each occurrence listed in section 71-8717, a root cause analysis shall be completed and an action plan developed within forty-five days after such occurrence. The action plan shall (a) identify changes that can be implemented to reduce risk of the patient safety event occurring again or formulate a rationale for not implementing change and (b) if an improvement action is planned, identify who is responsible for implementation, when the action will be implemented, and how the effectiveness of the action will be evaluated. The provider shall, within thirty days after the development of an action plan, provide a summary report to a patient safety organization which includes a brief description of the patient safety event, a brief description of the root cause analysis, and a description of the action plan steps.

(3) The facility where a reportable event occurred shall be responsible for coordinating the reporting of information required under the Patient Safety Improvement Act and ensuring that the required reporting is completed, and such coordination satisfies the obligation of reporting imposed on each individual provider under the act.

Source: Laws 2005, LB 361, §18. Effective date April 28, 2005.

**71-8719. Nonidentifiable information; disclosure.** A patient safety organization may disclose nonidentifiable information, including nonidentifiable aggregate trend data and educational material developed as a result of the patient safety work product reported to it.

Source: Laws 2005, LB 361, §19. Effective date April 28, 2005.

**71-8720. Public disclosure of data and information.** A patient safety organization shall release to the public nonidentifiable aggregate trend data identifying the number and types of patient safety events that occur. A patient safety organization shall publish educational and evidenced-based information from the summary reports, which shall be available to the public, that can be used by all providers to improve the care they provide.

Source: Laws 2005, LB 361, §20. Effective date April 28, 2005.

**71-8721. Immunity from liability.** Any person who receives or releases information in the form and manner prescribed by the Patient Safety Improvement Act and the procedures established by a patient safety organization shall not be civilly or criminally liable for such receipt or release unless the receipt or release is done with actual malice, fraudulent intent, or bad faith. A patient safety organization shall not be liable civilly for the release of nonidentifiable aggregate trend data identifying the number and types of patient safety events that occur. Because the candid and conscientious evaluation of patient safety events is essential to the improvement of medical care and to encourage improvements in patient safety, any provider furnishing services to a patient safety organization shall not be liable for civil damages as a result of such acts, omissions, decisions, or other such conduct in connection with the duties on behalf of a patient safety organization if done pursuant to the Patient Safety Improvement Act except for acts done with actual malice, fraudulent intent, or bad faith.

Source: Laws 2005, LB 361, §21. Effective date April 28, 2005.