HCQA
Health Care Quality Assessment

Patient Safety Reporting System

2019 Summary Report

Philip D. Murphy, *Governor*
Sheila Y. Oliver , *Lt. Governor*

NJ Health
New Jersey Department of Health

Judith M. Persichilli, RN, BSN, MA
Commissioner

New Jersey Department of Health
Report Preparation Team

Mehnaz Mustafa, MPH, MSc, *Executive Director*
Healthcare Quality and Informatics

Jianping Juang, PhD, *Director*
Health Care Quality Assessment

Eva Besserman, DO, MBA, FCCM, *Clinical Director*
Patient Safety Reporting System

Adan Olmeda, *Administrative Support*
Patient Safety Reporting System

Emmanuel Noggoh, *Contractor*

Jan Applebaum, *Designer*
Printing & Graphic Design Studio

Date: August 2022

For further information contact:

Patient Safety Reporting System
Office of Population Health
Health Care Quality Assessment
New Jersey Department of Health
PO Box 360
Trenton, NJ 08625-0360
Phone: (800) 418-1397
Fax: (609) 984-7707
Website: **www.NJ.gov/health/ps**

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* Most frequently reported events include falls, pressure ulcers, retained foreign objects and care management "other" events. Falls and care management "other" events have been reviewed in the section "Specific Events with the Highest Number of Associated Deaths."

Patient Safety Reporting System

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Patient Safety Reporting System

Executive Summary

The New Jersey Patient Safety Act (P.L.2004, c.9) requires all New Jersey licensed health care facilities to report every serious preventable adverse event to the Department of Health (DOH) for the purpose of enhancing patient safety. Facilities must perform a Root Cause Analysis (RCA) to identify the systems issues which led to the event and to implement strategies to prevent future events. The Act defines a serious preventable adverse event as "an adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility."

The following types of facilities currently report to the New Jersey Department of Health's Patient Safety Reporting System:

- General acute care hospitals as of February 1, 2005;

- Comprehensive rehabilitation hospitals as of April 1, 2008;

- Psychiatric hospitals as of April 1, 2008;

- Special hospitals as of April 1, 2008;

- Licensed ambulatory surgery centers as of October 1, 2008; and

- End Stage Renal Dialysis facilities began reporting as of January 1, 2019.

Summary of reported adverse events for all facility types in 2019:

- 814 events were reported to the Patient Safety Reporting System by all facility types; this total includes six events that were deemed "unresolved;"

- 648 events met the statutory definition of (or satisfied the criteria for) a serious preventable adverse event ("reportable");

- 166 events did not meet the statutory definition and included less serious events, near misses and events that were not associated with the provision of health care ("not reportable");

- 90 deaths were associated with the adverse events.

General Acute Care Hospitals:

- Submitted 400 reportable adverse events in 2019 compared to 403 events in 2018;

- The average number of reportable events per reporting hospital was 6. (does not take into account hospital sizes and bed capacity);

- There were 56 deaths associated with the adverse events; specific events with the highest percent of associated deaths were care management "other" events (26), intraoperative or postoperative coma, death, or other serious preventable adverse events (11), and fall events (8);

- The most frequently reported events were falls, care management "other" events, pressure ulcers, retained foreign objects and suicide/attempted suicide;

- Adverse events were most often caused by care planning process, communication among staff and/or with the patient/family, physical assessment process, patient observation procedures, orientation and training of staff.

The most frequent consequences of the adverse events were: additional laboratory testing, increased length of stay, additional patient monitoring and major surgery.

Comprehensive Rehabilitation Hospitals:

- There were 28 reportable events and one deaths associated with care management "other;"

- The most frequently reported root causes were care planning process, physical assessment process and orientation of staff;

- About one-half of the events resulted in additional laboratory testing or diagnostic imaging as well as a visit to the emergency department.

Psychiatric Hospitals:

- There were 13 reportable events with no deaths;

- The most frequently reported root causes were patient observation process, care planning process and physical assessment process;

- Most of the events resulted in transfer to more intensive level of care, hospital admission and increased length of stay.

Special Hospitals:

- Seven events were submitted by five reporting facilities and four of the events resulted in deaths;

- The most frequently reported root causes were care planning process, patient observation procedures and orientation and training of staff;

- The most reported impact included death, additional patient monitoring and minor surgery.

Ambulatory Surgery Centers:

- Submitted 163 reportable events with eight deaths. All the deaths were associated with intra-operative or post-operative coma, death or other serious preventable events;

- The most frequent root causes were care planning process, physical assessment process and "other;"

- The most reported impact of these adverse events were hospital admission, additional laboratory testing or diagnostic imaging, increased length of stay and a visit to the emergency department.

End Stage Renal Dialysis Facilities:

- There were 37 reportable events submitted with 21 deaths. Almost all the deaths resulted from the care management "other" category.

- The most frequent root causes were: care planning process, physical assessment process and other.

- The impact of these events included death, hospital admission, additional laboratory testing or diagnostic imaging and a visit to the emergency department.

I. Introduction

This report presents the findings from serious preventable adverse events reported to the Department's Office of Health Care Quality Assessment (HCQA), Patient Safety Reporting System (PSRS). The findings of the report are based on data reviewed and analyzed from event and Root Cause Analysis (RCA) reports submitted in 2019.

Health care facilities are required to report serious preventable adverse events and perform a root cause analysis (RCA) for each reportable event. The Act defines a serious preventable adverse event as "an adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility." Serious preventable adverse events ("reportable events") are divided into 5 categories: Care Management, Environmental, Product or Device-related, Surgery-related and Patient Protection-related.

Patient Safety Regulations also require facilities to report in the appropriate category events that are not specifically listed that meet the definition of a serious preventable adverse event. These types of events (such as lost surgical specimens and failure to follow up with results of diagnostic studies) are submitted as "Other" events in the appropriate category. The classification and definitions of serious preventable events can be found in Appendix 1.

The Act requires facilities to provide a description of the event; an analysis of why the event happened; the corrective actions taken for the patient; the method for identifying other patients that may be affected by a similar event; the systemic changes needed to reduce the likelihood of similar events; and how the corrective actions will be monitored (See Appendix 2 for additional details).

Each RCA is reviewed by PSRS professional clinical staff to ensure that the facility performed a thorough and credible review of the adverse event. PSRS staff work with facilities to improve their analysis and the corrective actions designed to minimize the recurrence of events.

Prior to the implementation of the web-based reporting system, events were designated as reportable or not reportable. Since 2011, PSRS has the ability to capture less serious events and near misses pursuant to the Patient Safety Act. Less serious events, near misses and events that are not associated with the provision of health care ("not reportable events") do not require an RCA. However, healthcare facilities are encouraged to perform an RCA on less serious events and near misses which may be voluntarily submitted to the Patient Safety Reporting System.

In January 2019, End Stage Renal Dialysis facilities began reporting serious preventable adverse events to the Patient Safety Reporting System. The following facility types currently report to the Patient Safety program: Acute Care Hospitals, Comprehensive Rehabilitation Centers, Psychiatric Hospitals, Special Hospitals and Ambulatory Surgery Centers.

This report is one component of the Department's commitment to supporting quality through collecting and analyzing information on health care and making this information available for consumers and health care providers.

The report also includes the findings of reportable events from the Division of Behavioral Health Services (DBHS/Division) in section VII of this document.

II. Overall Reporting Patterns by Facility Type

This annual report summarizes the 2019 Patient Safety Reporting System (PSRS) reportable events and RCAs with a focus on events with a high percentage of associated deaths and the most frequently reported events. The report covers events and RCAs submitted by general acute care hospitals, specialty hospitals (comprehensive rehabilitation, psychiatric and special hospitals), ambulatory surgery centers and end stage renal dialysis facilities.

The number of reportable, not reportable and less serious events, and near misses submitted to the Patient Safety Reporting System for 2019 from all facilities totaled 814. This total includes six events that were classified as "unresolved."

Of this total, 648 were deemed reportable with 90 associated deaths. In 2018, the number of reportable events across all facility types was 631 with 88 associated deaths.

An in-depth analysis of the data shows that there were 17 more reportable events between 2018 and 2019. This increase in reportable events (17) may be attributed to reporting by End Stage Renal Disease centers.

The number of deaths in 2019 was 90 compared to 88 in 2018.

Table 1 shows the distribution of events reported to the New Jersey Department of Health Patient Safety Reporting System by facility types for the year 2019.

Table 1: Reporting Pattern by Facility Type (2019)

Facility Type	Number of Facilities	Number of Reporting Facilities	Number of Reportable Events	Number of Not Reportable Events	Number of Less Serious/Near Misses	Number of Deaths	Percent Reportable Deaths
General Acute Care Hospitals	71	67	400	1	28	56	14.0
Comprehensive Rehabilitation Hospitals	14	12	28	0	2	1	3.6
Psychiatric Hospitals	10	7	13	0	2	0	0.0
Special Hospitals	16	5	7	0	4	4	57.1
Ambulatory Surgery Centers	251	87	163	11	95	8	4.9
End Stage Renal Disease Centers	239	37	37	1	22	21	56.7
Total	601	215	648	13	153	90	13.9

A. Reporting Patterns (2005-2019)

Figure 1 and Table 2 demonstrate the reporting patterns for general acute care hospitals over the past 15 years.

In the early years of the reporting program, adverse events were designated as reportable if they met the statutory definition of a serious preventable adverse event or not reportable.

The percent of not reportable events by general acute care hospitals dropped from 9.2 percent in 2018 to 7 percent in 2019

Figure 1: General Acute Care Hospitals: Trends in Reportable Events 2005-2019
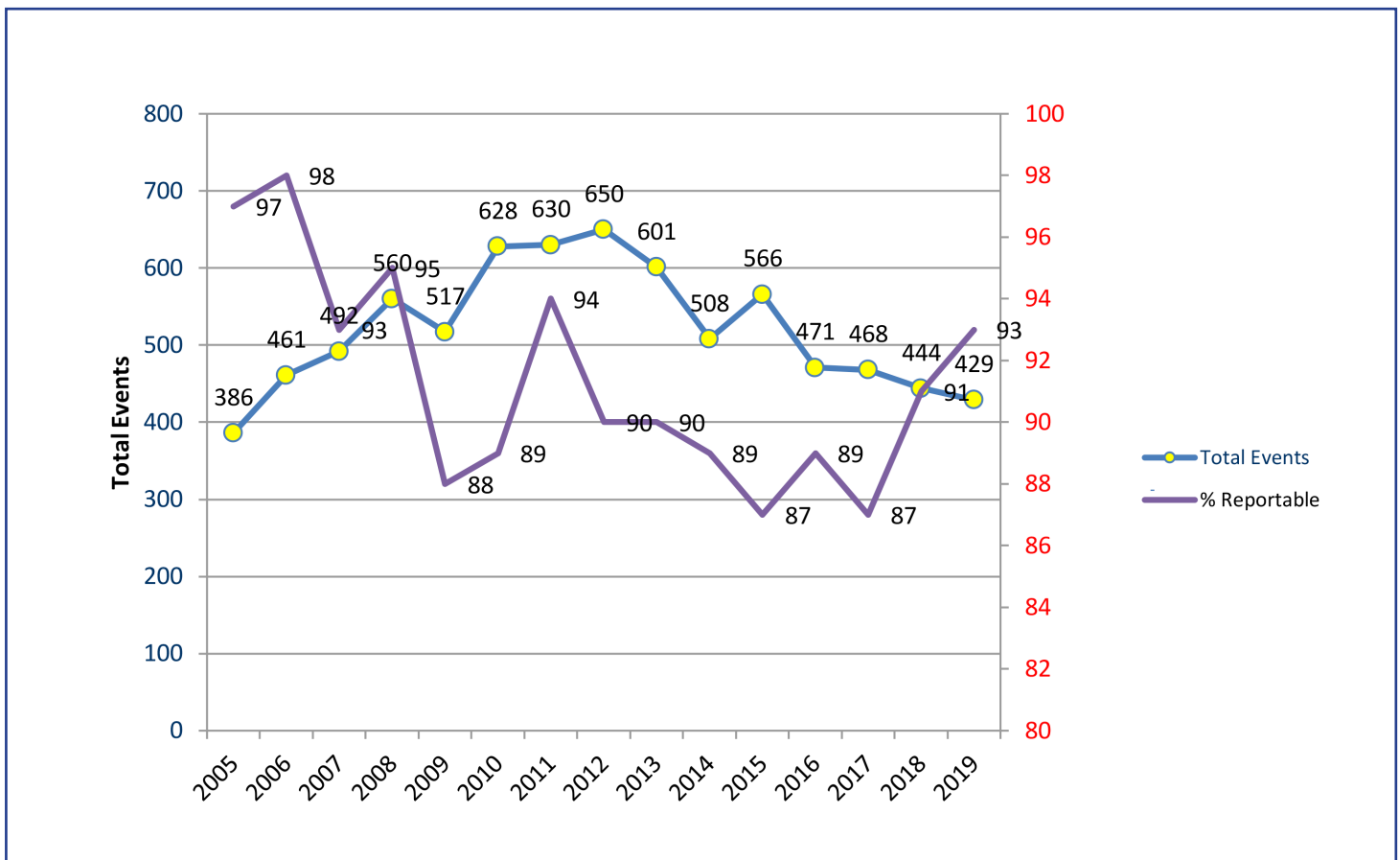
III. General Acute Care Hospitals

Table 2: General Acute Care Hospitals: Reportable, Less Serious Events/Near Misses and Not Reportable Events by Year[a]

Year	Reportable	Not Reportable	Less Serious/Near Misses	Total Events	Percent Not Reportable	Percent Reportable
2005[a]	376	10	NA	386	3	97
2006	450	11	NA	461	2	98
2007	456	36	NA	492	7	93
2008	533	27	NA	560	5	95
2009	455	62	NA	517	12	88
2010	562	66	NA	628	11	89
2011	601	10	31	642	6	94
2012	587	22	41	650	10	90
2013	542	5	54	601	10	90
2014	451	2	55	508	11	89
2015	491	8	67	566	13	87
2016	418	4	49	471	11	89
2017	405	4	59	468	13	87
2018	403	1	40	444	9	91
2019	400	1	28	429	7	93

a: Represents 11 months of data since the program started on February 1, 2005.

III. General Acute Care Hospitals

Since reporting began in February 2005, 7130 reportable adverse events have been submitted by New Jersey general acute care hospitals to the Patient Safety Reporting System (PSRS) through the end of year 2019.

In 2019, the fifteenth year of reporting, 400 reportable events from general acute care hospitals were submitted. The following table shows the serious preventable adverse events that occurred in general acute care hospitals.

In 2019, 67 general acute care hospitals in New Jersey submitted reportable events. The average number of reports per reporting hospital was 6.0. This average does not take into account hospital size and bed capacity.

Please note that starting in 2016 the data includes the actual number of events which occurred in that year (2019). In prior years, the data was collected based on the year the event was reported and could have inflated the number for those years.

Table 3: General Acute Care Hospitals: Reporting Patterns (2005-2019)

Reporting Year	Number of Reportable events	Hospitals			Average number of reports per hospital	Reportable Deaths	Percent of Deaths
		Number	Number Reporting	Percent Reporting			
2005[a]	376	82	68	82.9	5.5	57	15.2
2006	450	81	71	87.7	6.3	47	10.4
2007	456	80	75	93.8	6.1	72	15.8
2008	533	72	72	100.0	7.4	75	14.1
2009	455	72	68	94.4	6.7	74	16.3
2010	562	72	71	98.6	7.9	85	15.1
2011	601	72	69	95.8	8.7	89	14.8
2012	587	72	72	100.0	8.1	84	14.3
2013	542	72	72	100.0	7.5	84	15.5
2014	451	72	72	100.0	6.3	75	16.6
2015	491	72	72	100.0	6.8	96	19.6
2016	418	72	68	94.4	6.1	72	17.2
2017	405	72	72	100.0	5.6	75	18.5
2018	403	71	68	95.8	5.9	75	18.6
2019	400	71	67	94.4	6.0	56	14.0

a: Represents 11 months of data since the program started on February 1, 2005.

III. General Acute Care Hospitals

B. Reportable Events and Associated Deaths by Event Category

As indicated earlier in the report, there were 400 adverse events reported by New Jersey general acute care hospitals in 2019. There were 56 deaths associated with these adverse events. The events reported are classified into five event categories as follows:

- ◆ Care Management
- ◆ Environmental
- ◆ Product or Device-Related
- ◆ Surgery-Related
- ◆ Patient Protection

Tables 4A and 4B provide an overview of reportable events in the event categories with associated deaths. Please see Appendix 1 for the types of events associated with these categories.

Table 4A: General Acute Care Hospitals:
Reportable Events and Associated Deaths by Event Category-2019

Event Category	Total Reportable Events	Percent of Total Events	Total Deaths by Events	Percent Deaths by Event Category
A: Care Management	117	29.3	28	50.0
B: Environmental	145	36.2	9	16.1
C: Product or Device	0	0.0	0	0.0
D: Surgery-Related	80	20.0	16	28.6
E: Patient Protection	58	14.5	3	5.3
Total	400	100.0	56	100.0

Table 4B: General Acute Care Hospitals:
Reportable Events and Associated Deaths by Event Category-2019

Event Category	Total Reportable Events	Total Deaths per Event
A: Care Management	117	28
Care Management Other	53	26
Medication Error	9	2
B: Environmental	145	9
Fall	138	8
C: Product or Device	0	0
D: Surgery-Related	80	16
Intra/Post-Op Coma/Death/Other Events	18	11
Surgical Other	9	4
Retained Foreign Object	40	1
E: Patient Protection	58	3
Suicide/Attempted Suicide	55	3
Total	400	56

III. General Acute Care Hospitals

As Tables 4A and 4B demonstrate, the care management event category accounted for the highest number of deaths (28 out of 56) or one-half of all deaths reported. The second highest category for reported deaths was surgery-related (16), followed by environmental (9). Patient Protection accounted for three deaths and Product/ Device malfunction reported no events or death within that event category.

For surgery-related event types, retained foreign objects had the highest number of reported events (40); this was a decrease of 7 from 2018. There was one death associated with this event.

The second highest reported event was for intra-operative or post-operative events (18) with 11 (61.1 %) associated deaths.

Table 5 and Figure 2 show the results.

Table 5: Surgery-Related Event Types with Associated Deaths

Event Type	Reportable Events	Number of Deaths	Percent of Deaths by Event Type
Retained Foreign Object	40	1	2.5
Intra-Op/Post-Op Coma/Death/Other Event	18	11	61.1
Surgery "Other"	9	4	44.4
Wrong Site	6	0	0.0
Wrong Patient	4	0	0.0
Wrong Procedure	3	0	0.0
Total	80	16	20.0

Figure 2: General Acute Care Hospitals: Surgery-Related Events

Legend:
- Retained Foreign Object
- Intra-Op/Post-Op Coma/Death/Other Event
- Surgery-Other
- Surgery-Wrong Site
- Surgery-Wrong Patient
- Surgery-Wrong Procedure

Values shown: 40, 18, 9, 6, 4, 3
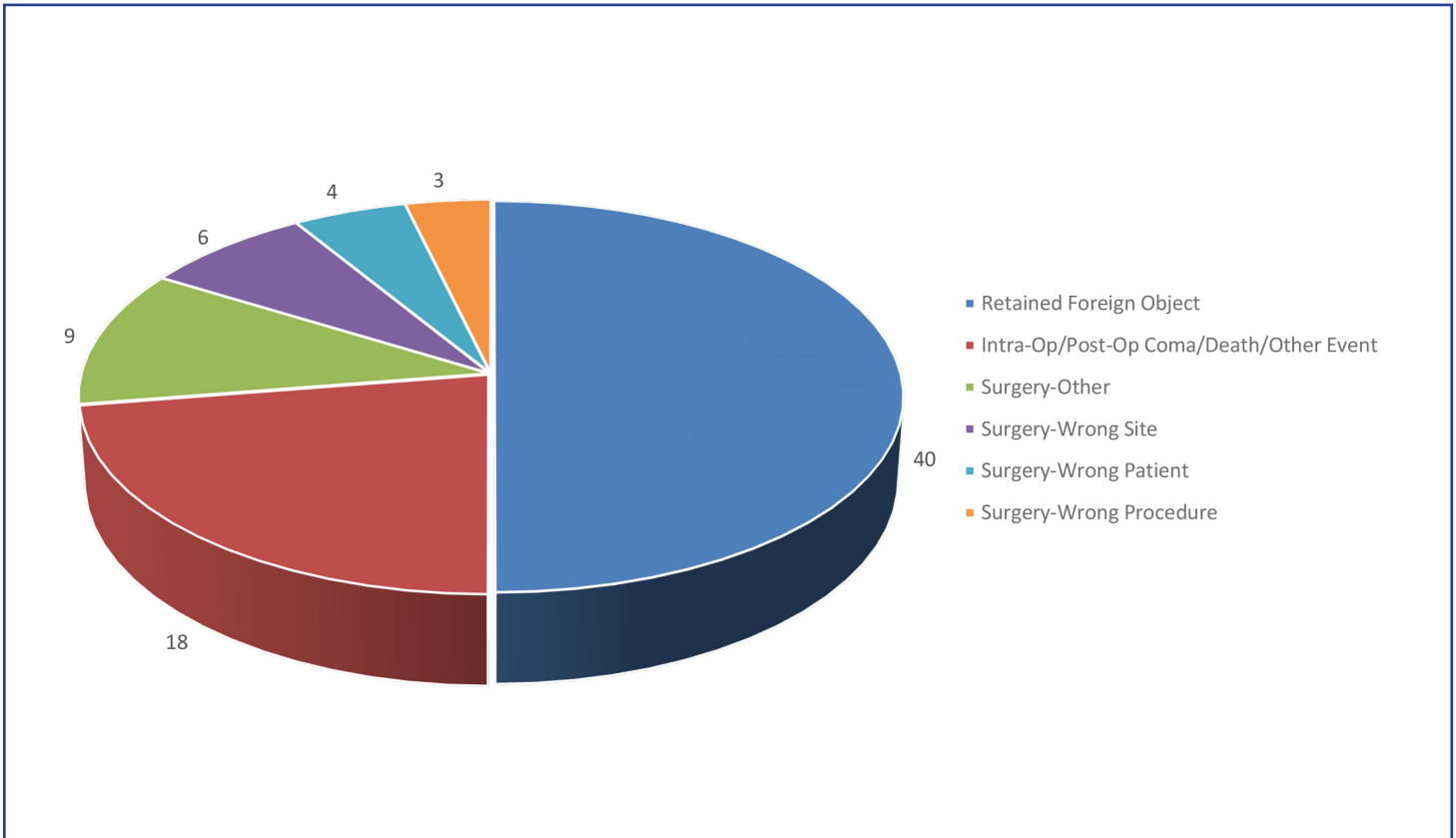
C. Events Types Associated with Highest Percent Deaths

Table 6 shows the event types with the highest percentage of deaths. In aggregate, the four event types identified below had a total of 218 reportable events which represent 54.4 percent of all events reported. However, the total number of deaths associated with these four events was 49 and accounted for almost 88 percent (87.5%) of all deaths reported in 2019.

Table 6: General Acute Care Hospitals: Event Types Associated with Highest Percent of Deaths

Event Type	Number of Events	Number of Deaths	Percent Deaths to Events
Care Management "Other"	53	26	49.1
Intra-Op/Post-Op Coma, Death or Other Event	18	11	61.1
Surgery-Related "Other"	9	4	44.4
Fall	138	8	5.8
All Other Event Types	182	7	3.8
Total	400	56	14.0

1. Care Management "Other" Events

Of the 54 patients who received care in this event category in 2019, 26 (48.1 %) died. In 2018, 35 patients died out of a total of 49. Table 6 shows the results.

Care management "other" events include care management related events which do not meet the definition of the specific care management event types, such as medication errors and pressure ulcers. Events must meet the statutory definition of a serious preventable adverse event.
Care management "other" events have consistently been associated with one of the highest percentage of deaths and the number of deaths per year has remained relatively constant.

Examples of events reported for this event type include delays in responding to non- reassuring fetal heart rate tracings, delays in reporting or processing critical lab or EKG results, missing pathology specimen, incorrect placement of feeding tubes, IV extravasations/infiltrations, unexplained fractures, and failure to adequately monitor patients on cardiac monitors.

Figure 3 shows the number of facilities reporting this event type.

Figure 3: Care Management "Other" Events

Figure 3: Care Management "Other" Events

(Bar chart — Y-axis: Number of Events; X-axis: Number of Facilities Reporting)

Number of Facilities Reporting	4	11	3	1	1
Number of Events	4	22	9	5	14
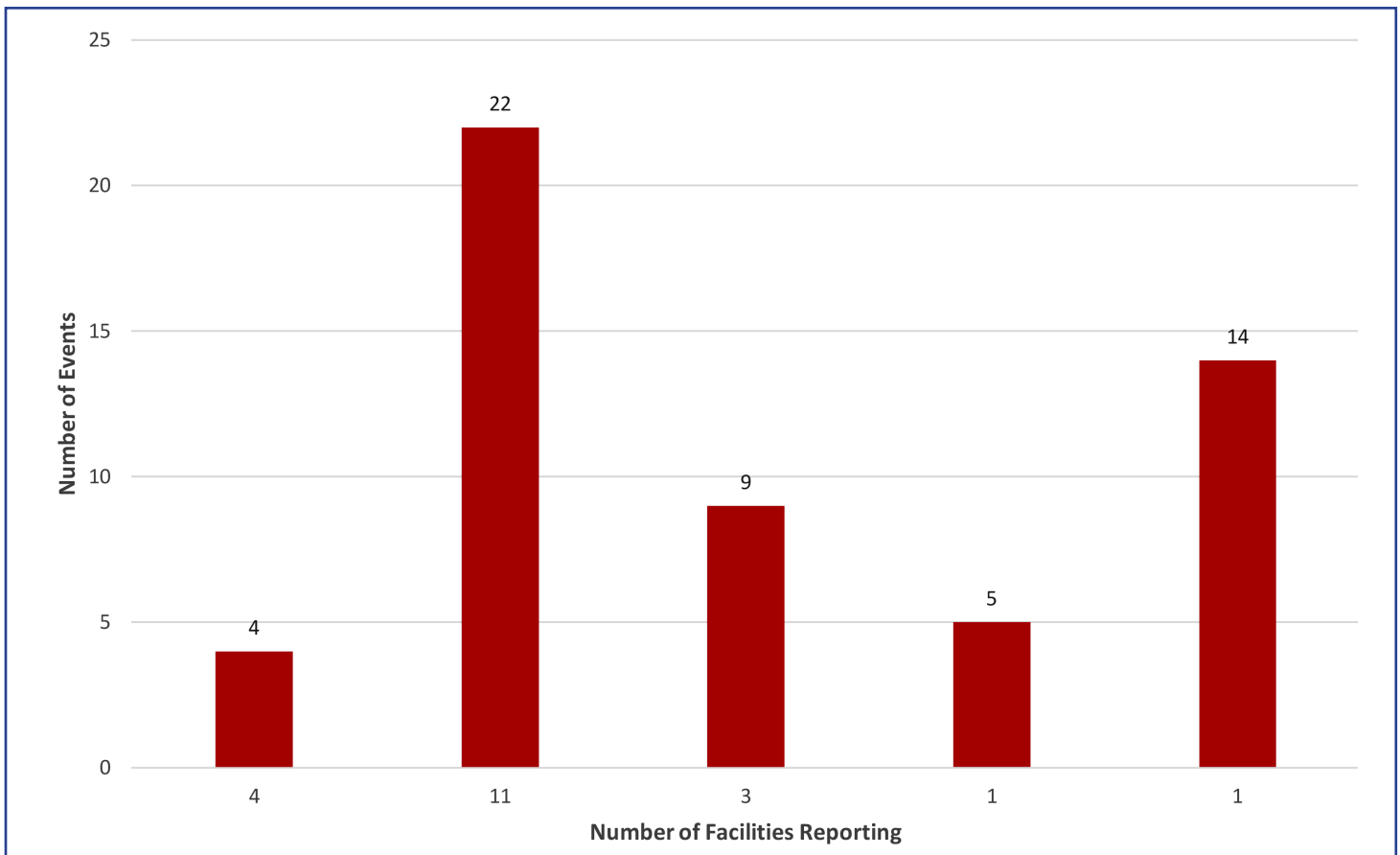
III. General Acute Care Hospitals

2. Intra-Operative or Post-Operative Coma, Death or Other Serious Event Preventable Adverse Event

There were 18 reports of intra-operative or post-operative (that is, within 24 hours) coma, death or other serious preventable adverse event in 2019 compared to 31 in 2018. The number of deaths decreased from 18 in 2018 to 11 in 2019.

Based on the American Society of Anesthesiology (ASA) classification, the patients fell into the following classifications: ASA Class l: 1, ASA Class ll: 7, ASA Class lll: 8, and ASA Class lV: 1 with one unknown ASA. See chart below.

Figure 4: ASA Classification

Intra/Post-Op ASA Classifications

■ ASA I ■ ASA II ■ ASA III ■ ASA IV ■ Unknown
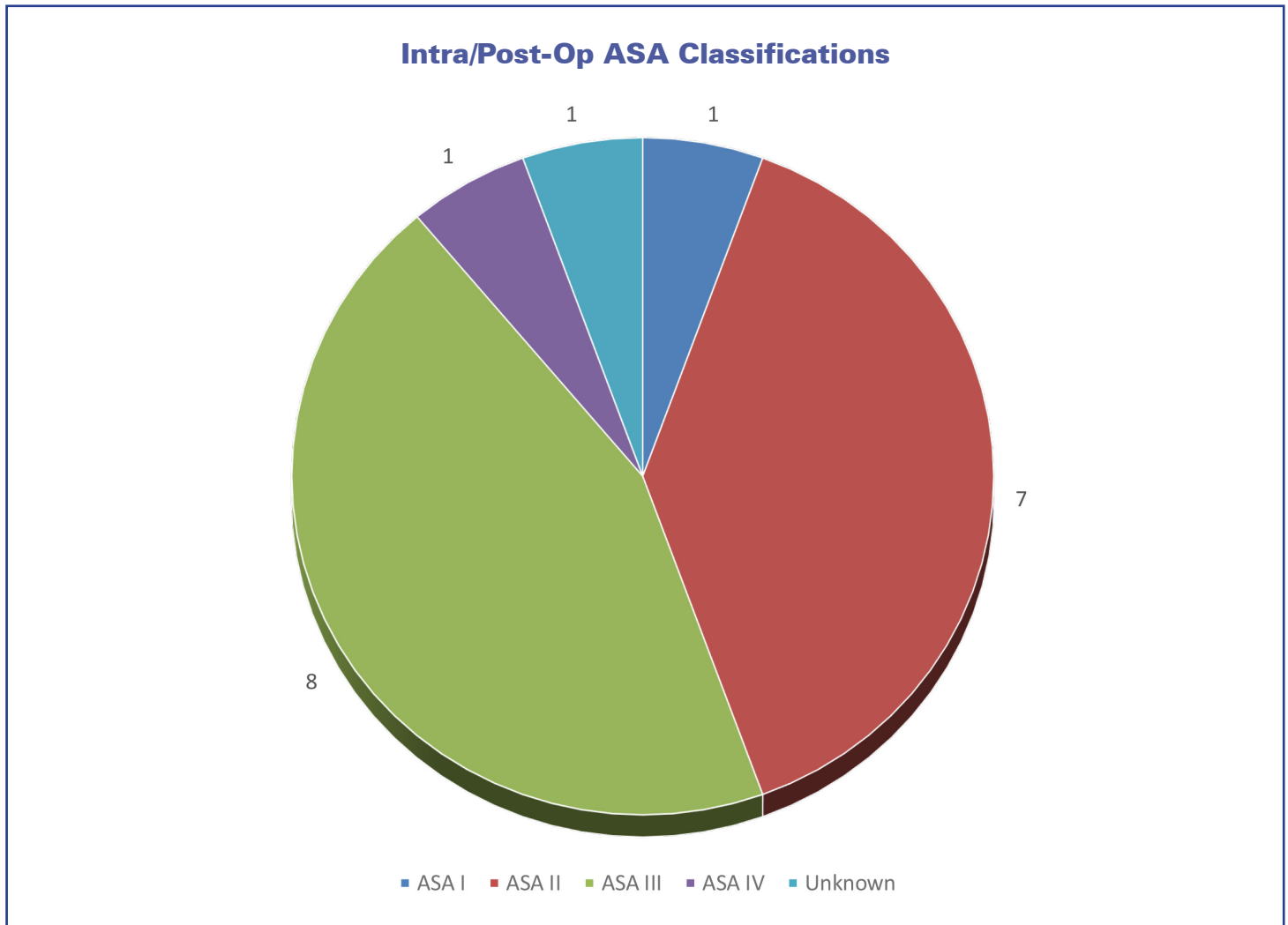
The 18 events were reported by facilities as follows:

Figure 5: Number of Facilities Reporting Intra-Op/Post-Op Events

Number of Facilities Reporting
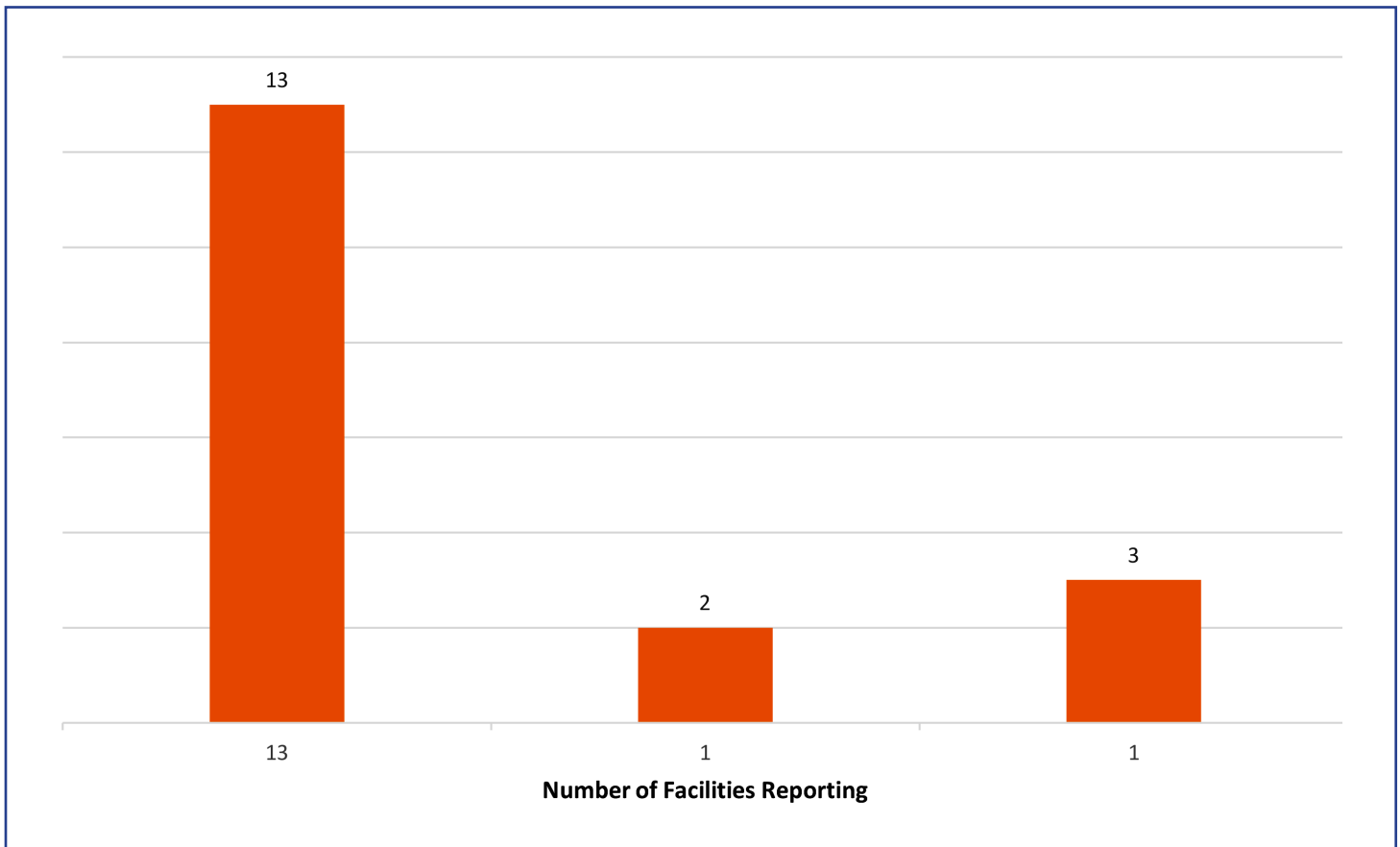
III. General Acute Care Hospitals

Events reported for this event type in the past years included death, cardiorespiratory arrest, ischemic leg following cardiac catheterization, infarct of brainstem and cerebellum following cervical fusion, hypotension (low blood pressure), blood vessel lacerations, perforations during or immediately (within 24 hours) following surgery.

The events occurred to the following types of patients as shown in the chart below:

Figure 6: Patient Admission Type

Legend: Inpatient, Outpatient, Same Day Surgery

Values: 1, 7, 10
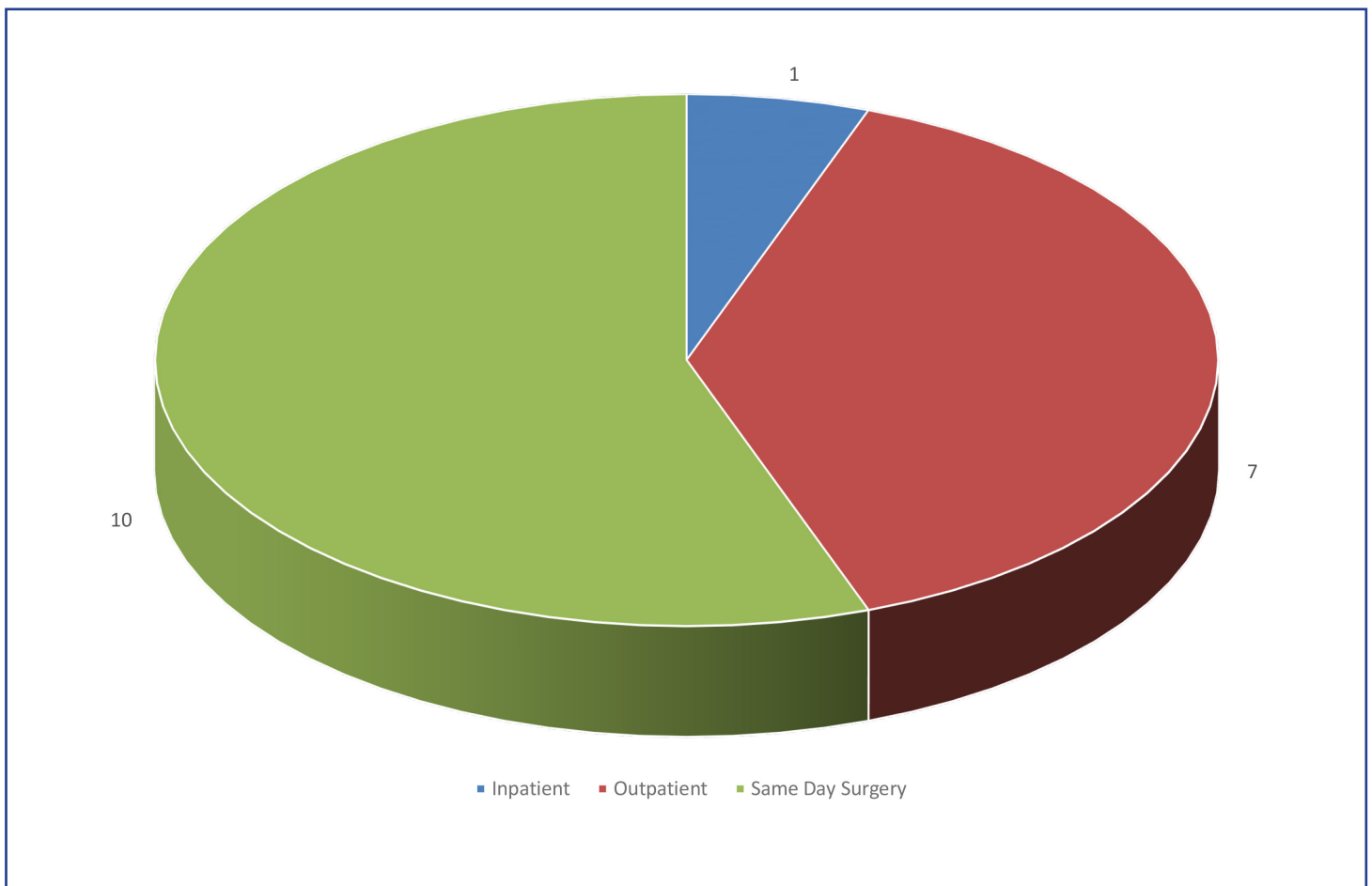
3. Surgery "Other" Events

Surgery "other" events include surgery-related events which do not meet the definition of the specific surgery event types, such as retained foreign objects, intraoperative or postoperative events and wrong site surgery events.

The number of reported events for this event type was 9 in 2019 compared to 19 in 2018.

Seven facilities reported the 9 events as follows: Six facilities reported one event each and one hospital reported three events.

Figure 7: Surgery "Other" Facilities Reporting

Number of Events (y-axis) vs *Number of Facilities Reporting* (x-axis)

- 6 facilities: 6 events
- 1 facility: 3 events
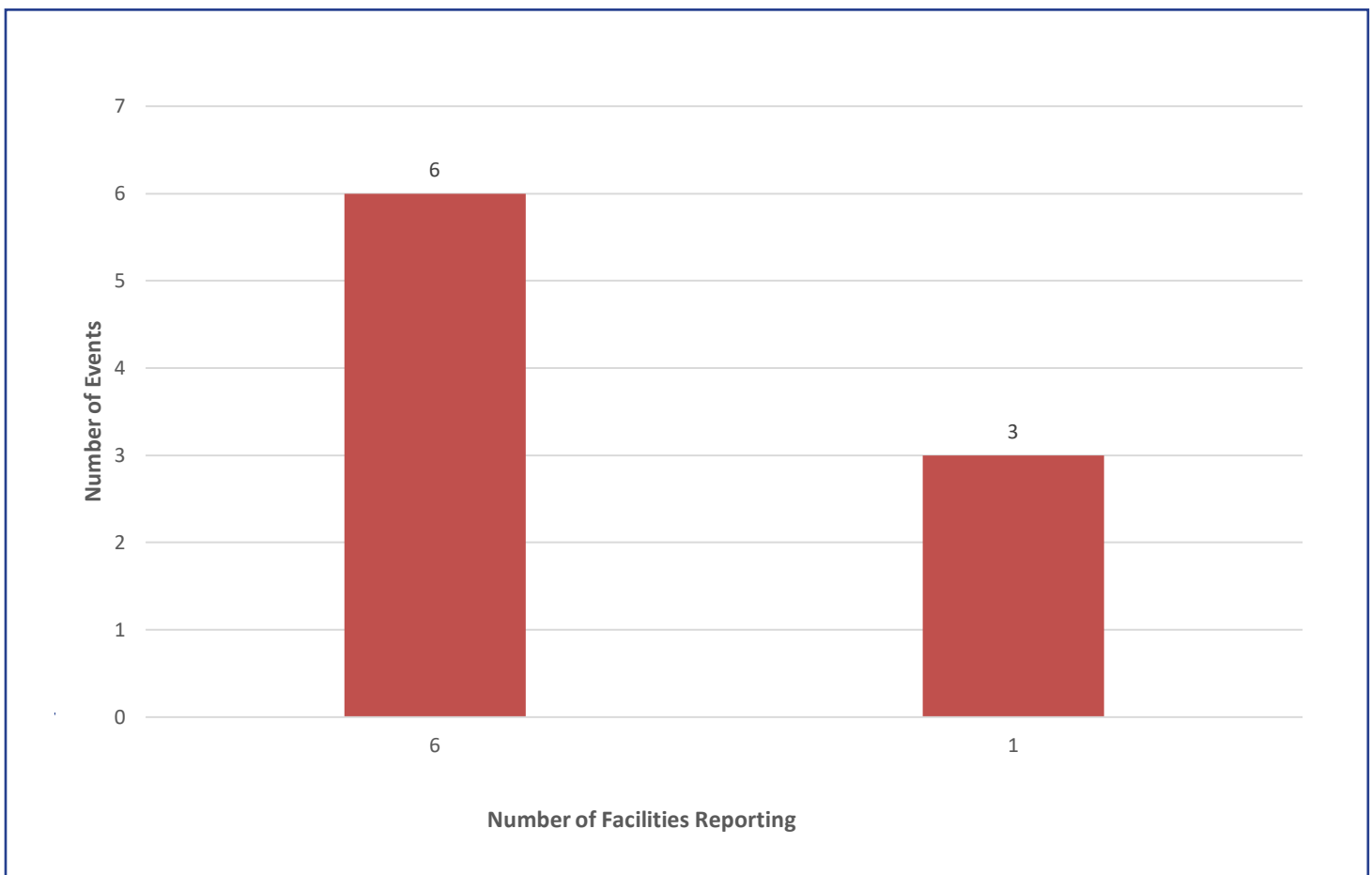
III. General Acute Care Hospitals

Of the 9 events submitted, five of the patients were designated as ASA Class lll (55.6%), three were designated as ASA Class II (33.3%) and one as ASA Class IV (11.1%).

Events reported for this event type included death, amputation, ruptured artery, organ perforation, retained piece of organ, hysterectomy and surgical site infection.

Figure 8: Surgery "Other" ASA Classifications

11%

33%

56%

■ ASA II   ■ ASA III   ■ ASA IV   ■
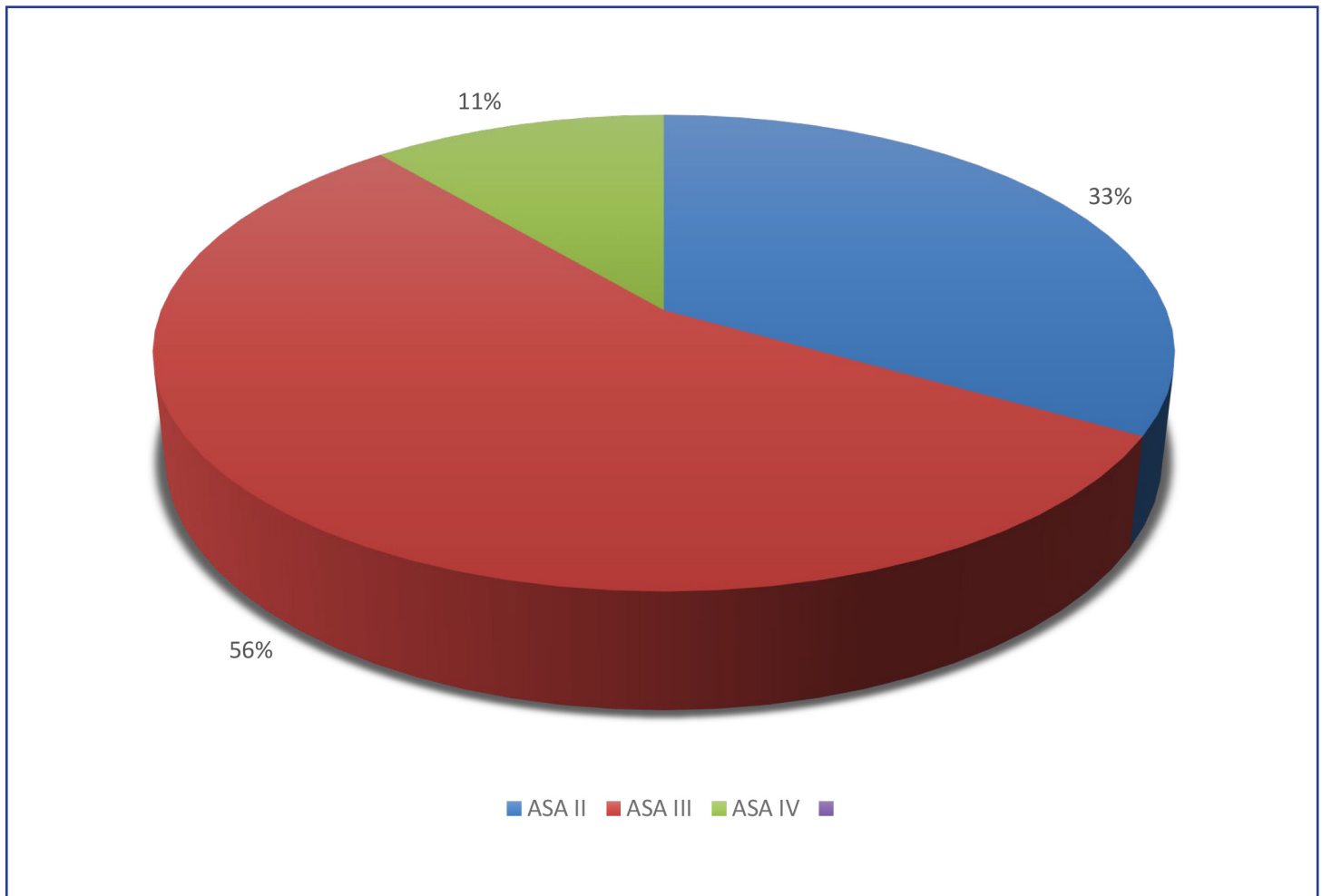
4. Fall Events

Falls continue to be the most frequently reported event submitted to the Patient Safety Reporting System. The number of reported falls in 2019 was 138 compared to 111 in 2018.

There were eight reported deaths from these events, compared to seven in 2018.

A total of 48 hospitals submitted these fall events as displayed below:

Figure 9: Number of Facilities Reporting Fall Events

Bar chart. Y-axis: Number of Events (0 to 30). X-axis: Number of Facilities Reporting.

Number of Facilities Reporting	Number of Events
16	16
13	26
5	15
6	24
2	10
3	18
1	7
1	9
1	13
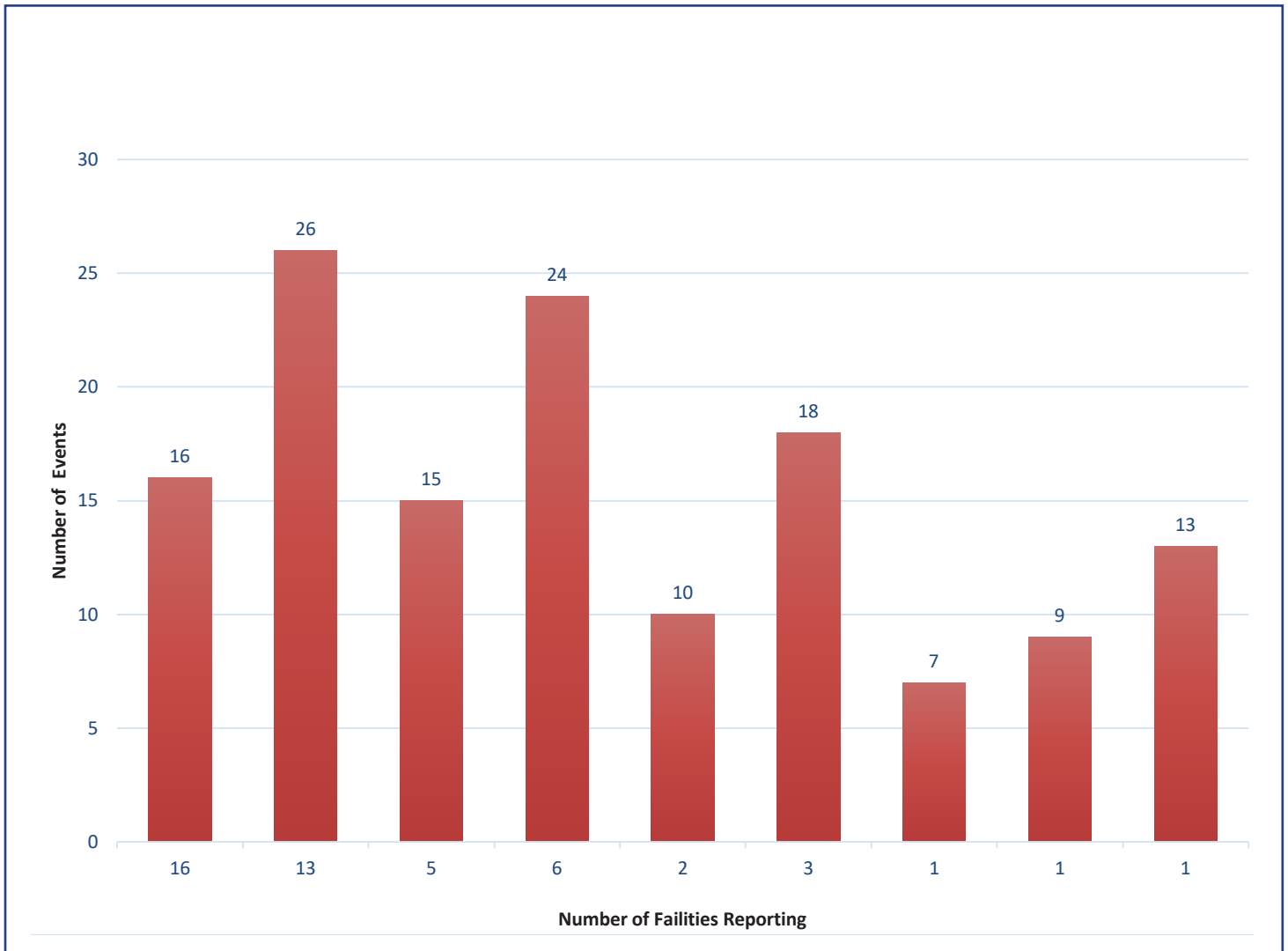
III. General Acute Care Hospitals

Prior to the fall, 71 patients (51.4 %) were known to be at high risk; 36 (26.1 %) were at medium risk; and 31 or (22.5 %) were considered to be at low risk for falls.

Figure 10: Fall Risk Categories
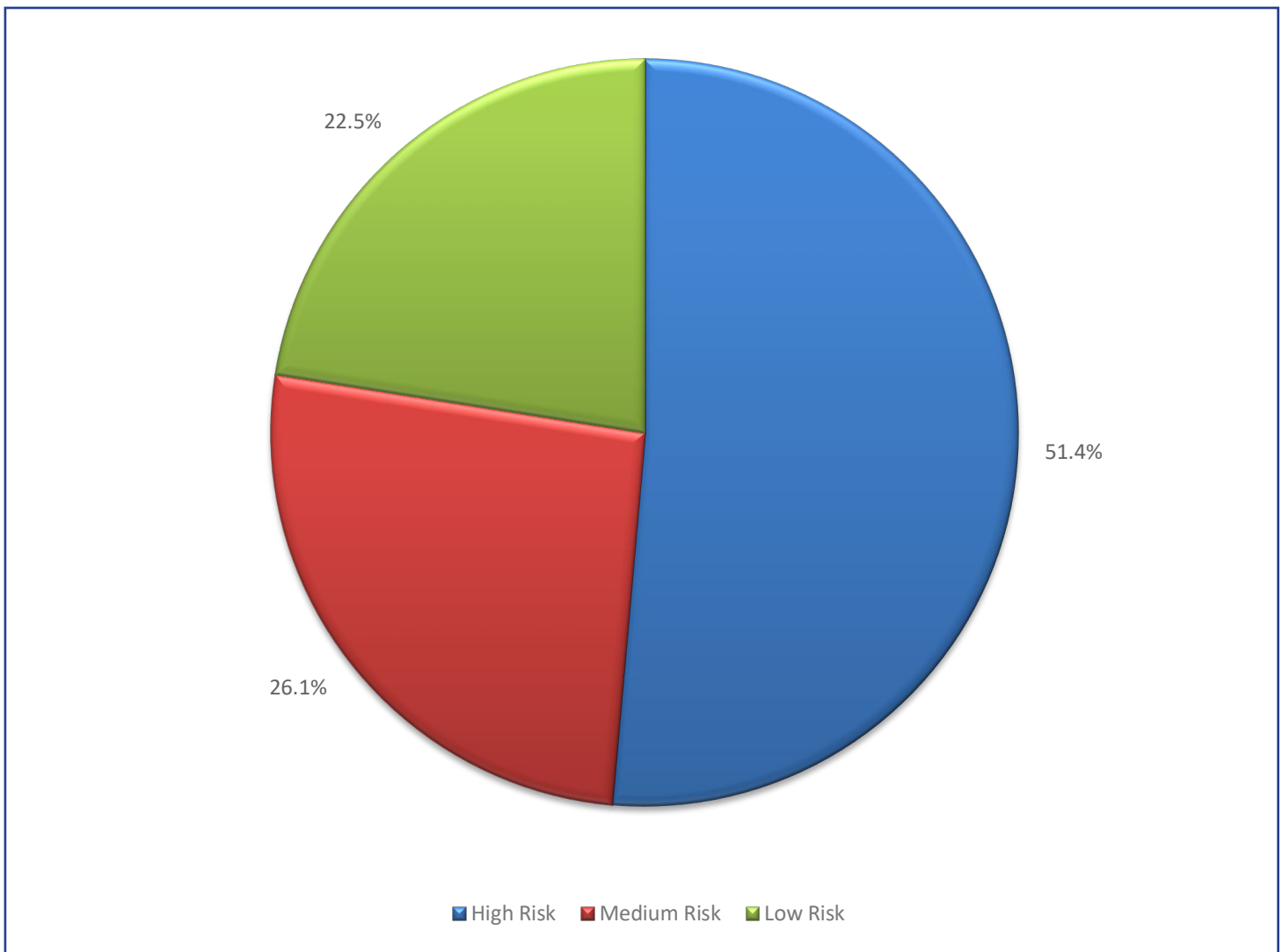
The chart below shows the various activities the patients were engaged in prior to the fall:

Figure 11: Activities Prior to Fall
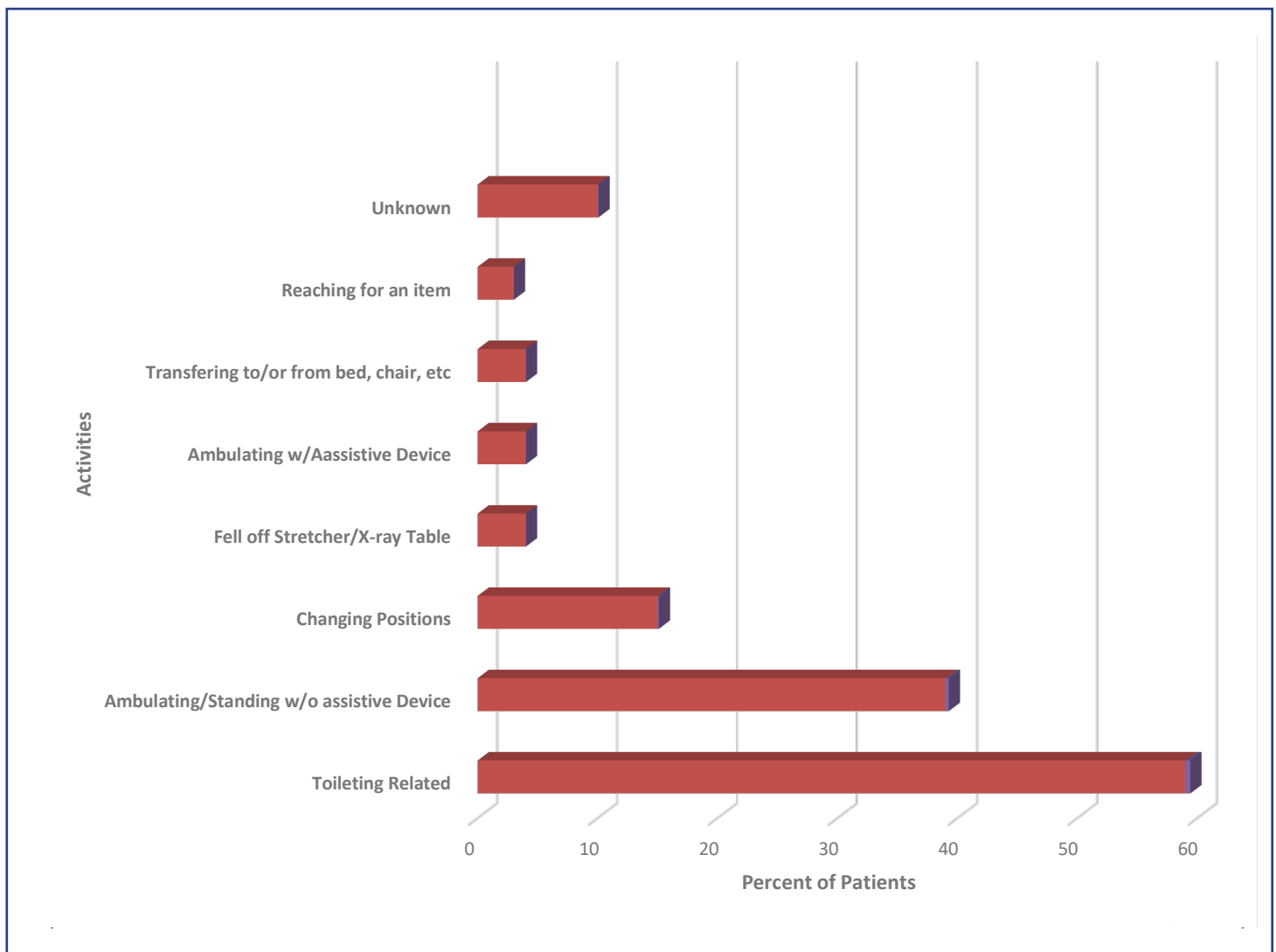
III. General Acute Care Hospitals

As in the past, a fall risk screening tool was used to assess the patient's risk prior to the fall. The most prevalent screening tool was the Morse Fall Risk Assessment (61, 44.2 %). The next mostly used tool was the Johns Hopkins Fall Risk Assessment Tool (48, 34.8 %), followed by the Hendrich II Fall Risk Assessment (16, 11.6 %). Nine patients were assessed by using the Edmonson risk assessment tools (9, 6.5 %) and four (2.9 %) other patients were assessed by using "Other" tools.

Eighty-eight of the patients (88, 63.8 %) were observed on patient rounds less than 30 minutes prior to the fall and another 31 (22.5 %) were seen less than 1 hour prior to the fall. For seven of the events (5.1 %), the last patient rounds occurred less than 2 hours prior. There were nine events for which the last time rounds was "unknown".

The chart below shows the locations where most of the falls occurred.

Figure 12: Percent of Patient Fall Locations

Legend:
- Near/from Patient's Bed
- Bathroom
- Between the bed and bathroom
- Near/from chair
- Beside Commode
- Not Applicable
- All Other
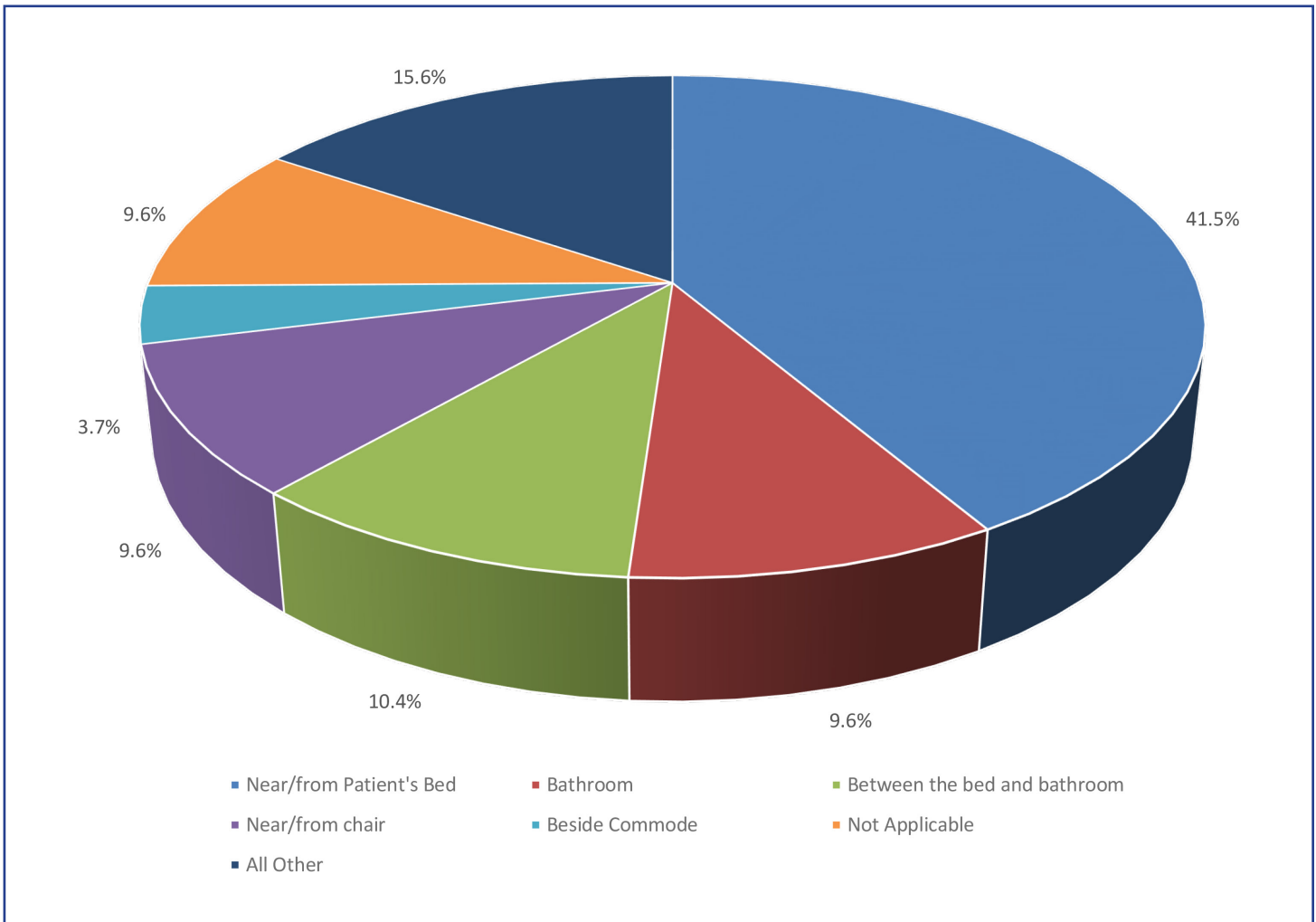
D. Most Frequently Reported Event Types

As shown in Table 7, the highest number of events submitted in 2019 were for the following specific events: fall, suicide/attempted suicide, care management other, pressure ulcer, retained foreign object and surgical intra/post-op coma/ death or other serious events.

Cumulatively, these events were the most frequently reported and accounted for almost 90 percent (89.2 %) of all events reported in 2019.

Figure 13 shows the reporting trends for these event types from 2016 to 2019.

Table 7: General Acute Care Hospitals: Most Frequently Reported Event Types (2019)

Event Type	Number of Reportable Events	Percent of Events[a]
Fall	138	34.5
Suicide/Attempted Suicide	55	13.7
Care Management Other	54	13.5
Pressure Ulcer	52	13.0
Retained Foreign Object	40	10.0
Surgical Intra/Post-Op Coma, Death or Other Serious Adverse Events	18	4.5
All Other Events	43	10.8
Total	400	100.0

Note: Falls, care management "other" events, intra-op/post-op coma, death or other serious adverse events and surgery-related "other" events have been described in the prior section titled "Event Types Associated with the Highest Percent Deaths."

III. General Acute Care Hospitals

Figure 13: Most Frequently Reported Event Types 2016-2019

III. General Acute Care Hospitals
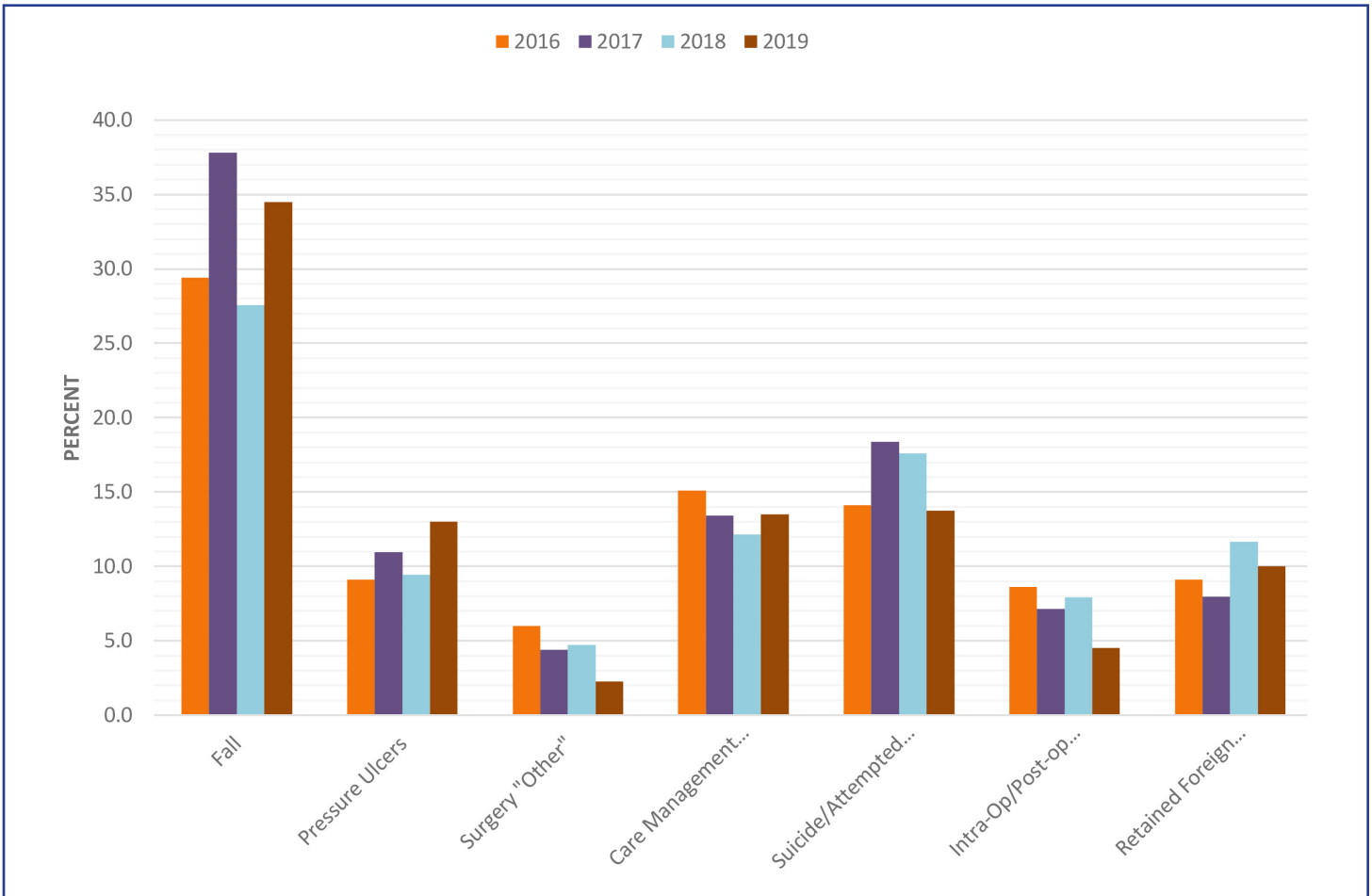
1. Suicide/Attempted Suicide Events

There were 55 reportable adverse events for this event type in 2019; a decrease of 16 from 2018 (71).

The 55 suicides and attempted suicides were submitted by 28 hospitals as shown in the chart below.

Figure 14: Suicide/Attempted Suicide Events
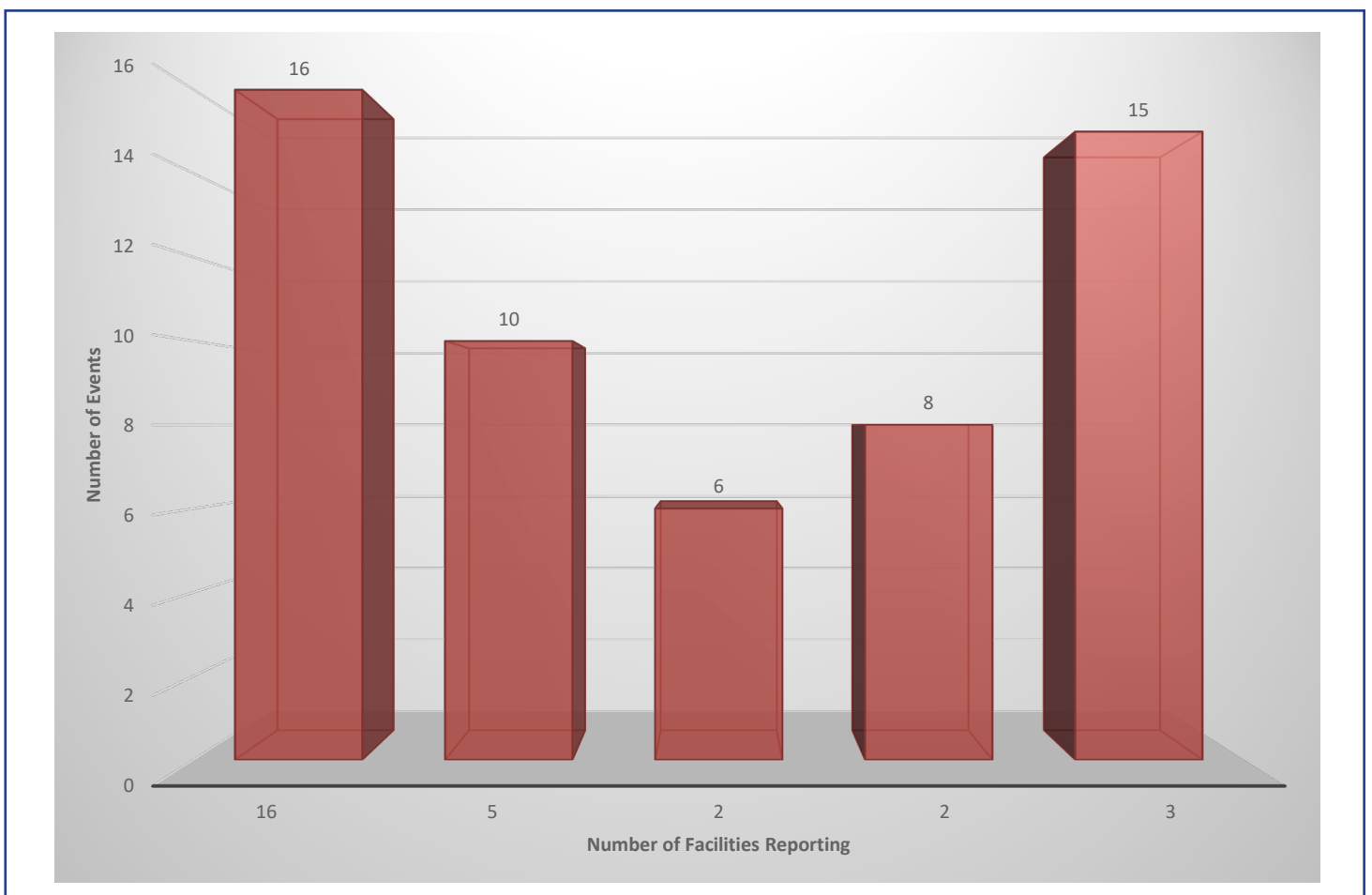
III. General Acute Care Hospitals

Of the 55 patients, 35 or 63.6 percent were considered at risk of suicide and were seen by a psychiatrist. Over one-half (56.4 %) of the patients had experienced a prior suicide attempt.

Figure 15, shows the locations where the suicide/attempted suicides mostly occurred. The Patient's room accounted for 38 out of 55 reported events. This was followed with 12 in the Patient's Bathroom and 4 in the Hallway/Common Area.

There were three reported deaths in 2019.

Figure 15: Suicide/Attempted Suicide Event Locations

- Patient Room   - Patient Bathroom   - Hallway/Common Area   - Procedure Room
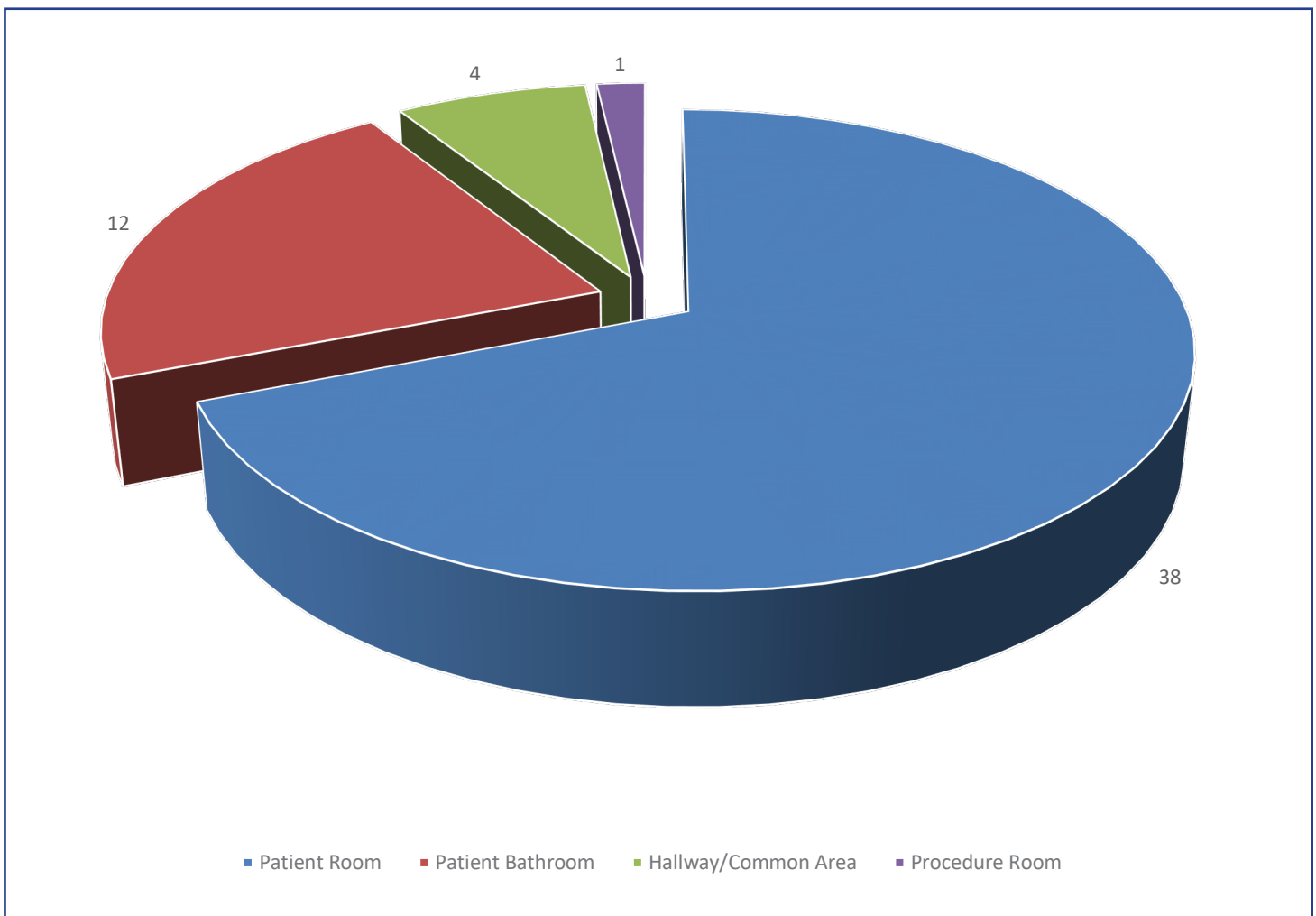
2. Pressure Ulcers

In 2019, there were 52 healthcare associated pressure ulcers compared to 38 in 2018, an increase of 14 events (36.8 %). There were no reported deaths associated with this event type.

The 52 pressure ulcer events were submitted by 22 hospitals. The table below shows the submission by facilities.

Thirty-one out of the 52 (59.6 %) of the pressure ulcers reported were located in the sacrum, six were on the buttocks, four in the sacrum/buttocks and the rest were classified as "other".

Figure 16: Number of Facilities Reporting Pressure Ulcer Events
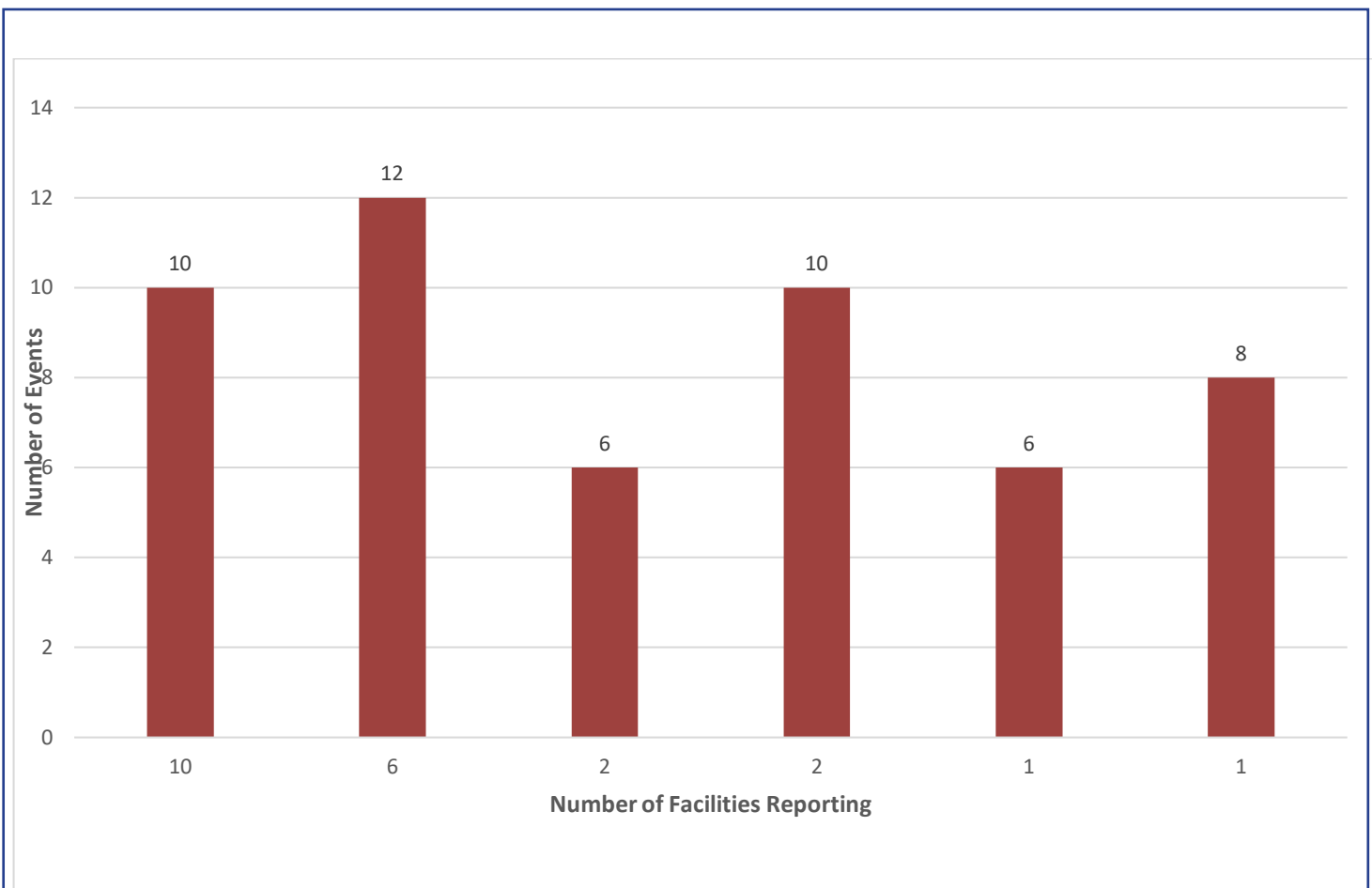
III. General Acute Care Hospitals

2a. Pressure Ulcer Patient Characteristics:

One-quarter of the patients (13 out of 52) who had pressure ulcer were diagnosed as being on dialysis and incontinent; eight were clinically deemed malnourished and 11 were classified as incontinent. Seven of the patients were categorized as being morbidly obese and with a body mass index (BMI) of 40 or greater. The remaining patients were classified as "Other". Of the 52 events, 34 (65.4 %) were categorized as Stage I and the rest Stage II.

Figure 17: Patient Characteristics Categories

Legend: Clinically Malnourished · Incontinent · On Dialysis · Morbid Obesity · Diabetic · All Others
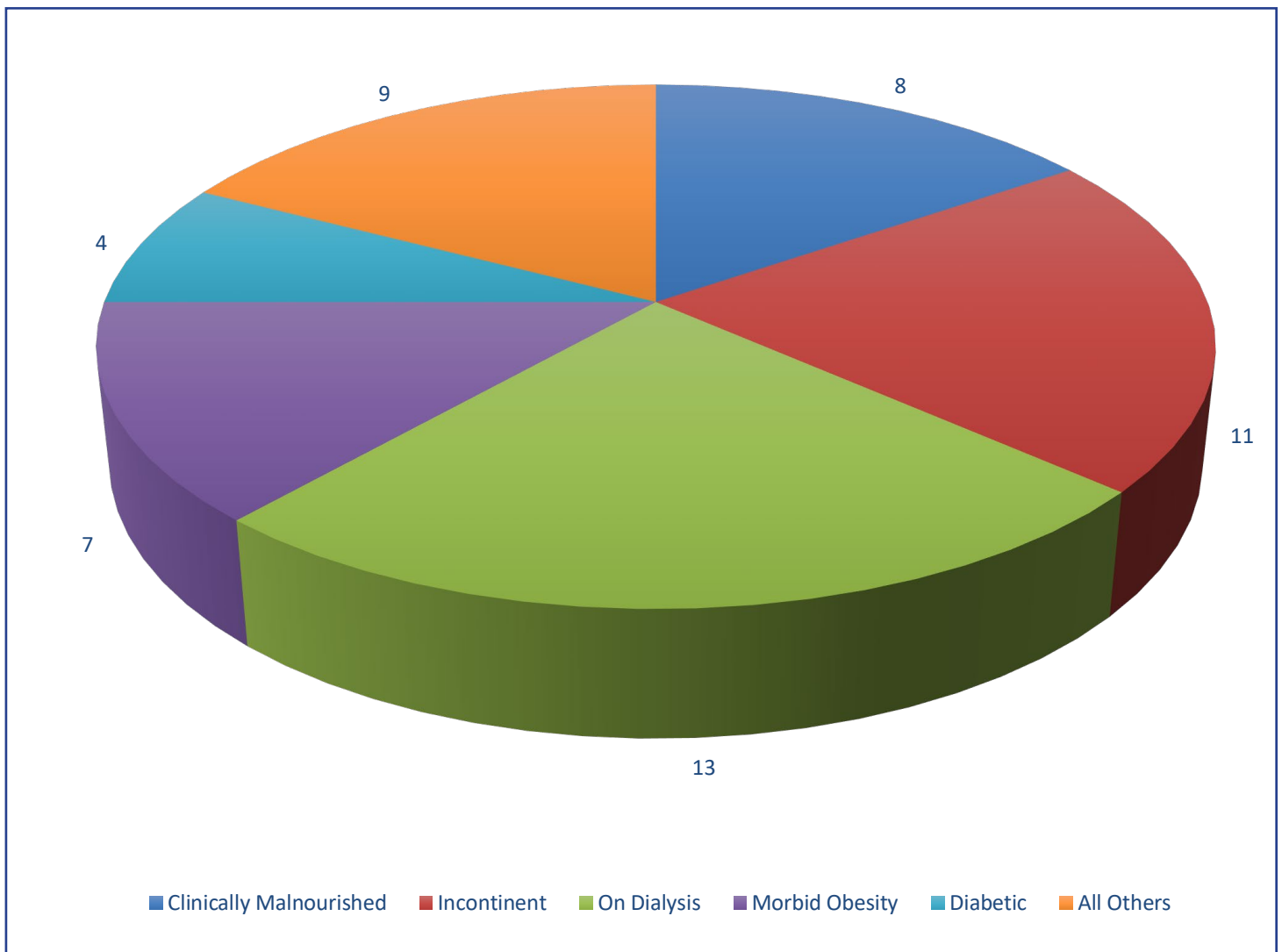
3. Retained Foreign Objects

There were 40 retained foreign object (RFO) events submitted in 2019 compared to 46 in 2018.

There was one death associated with these events.

Figure 18 shows the number of facilities reporting the events.

Of the 40 RFOs, 12 were sponges/gauze, three were needles, two lap pads, and the rest were classified as "other". Figure 19 shows the results.

Examples of other RFOs included a surgical towel, guidewire, PICC line, angioplasty balloon, ureteral stent, six-inch pliable ruler, hemovac drain, whisper wire and fractured drill bit.

Figure 18: Retained Foreign Objects Events

Number of Events (y-axis):
- 13 facilities reporting: 13 events
- 5 facilities reporting: 10 events
- 3 facilities reporting: 9 events
- 2 facilities reporting: 8 events

Number of Facilities Reporting (x-axis)
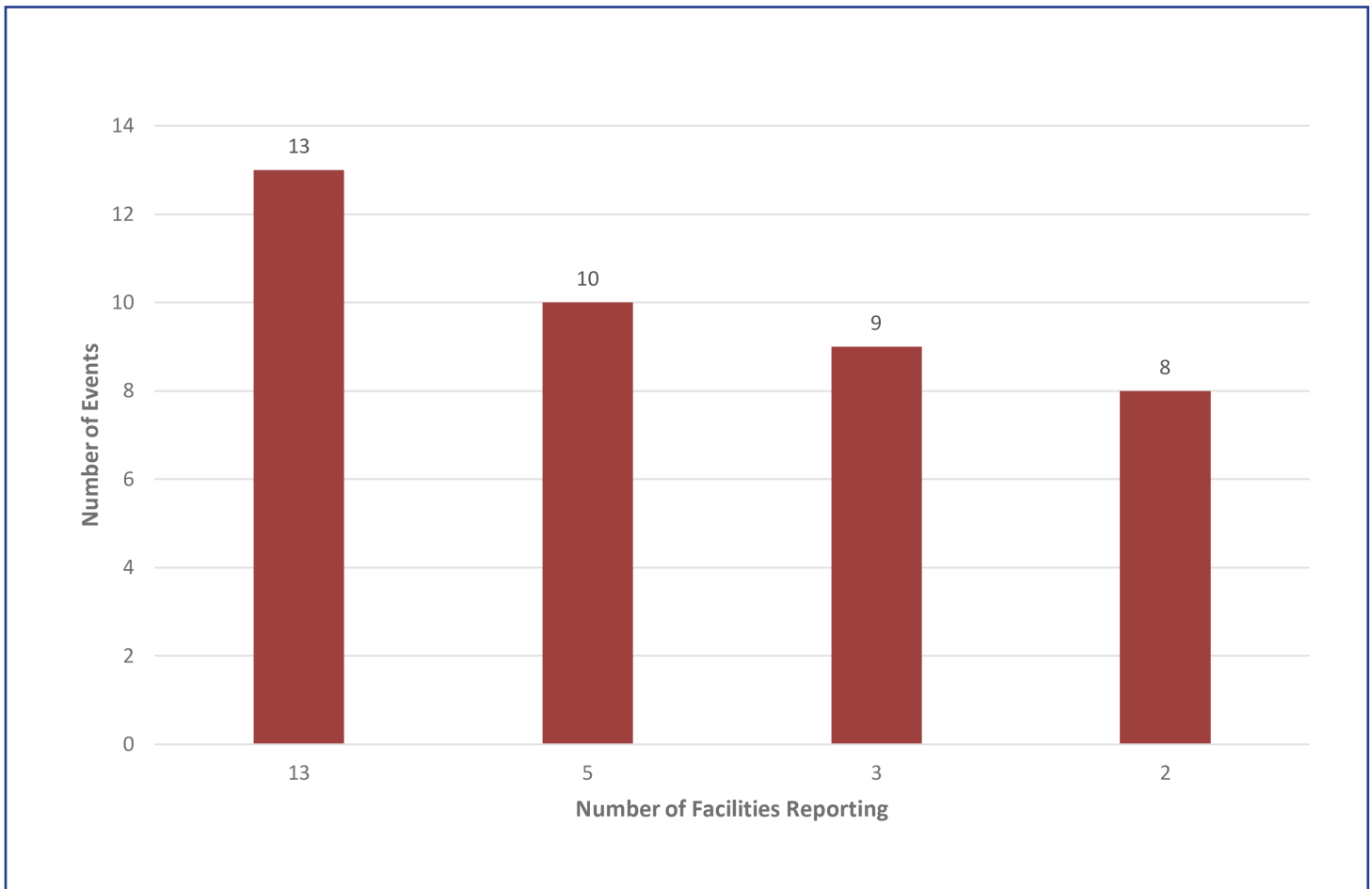
III. General Acute Care Hospitals

Of the 40 patients who suffered the unintended retention of foreign object, 28 (70.0 %) required a second surgery to remove the object.

Figure 19: Retained Foreign Object Items

Legend: Sponge/Gauze · Lap Pad · Needle · Other

Values shown: 12, 2, 3, 23
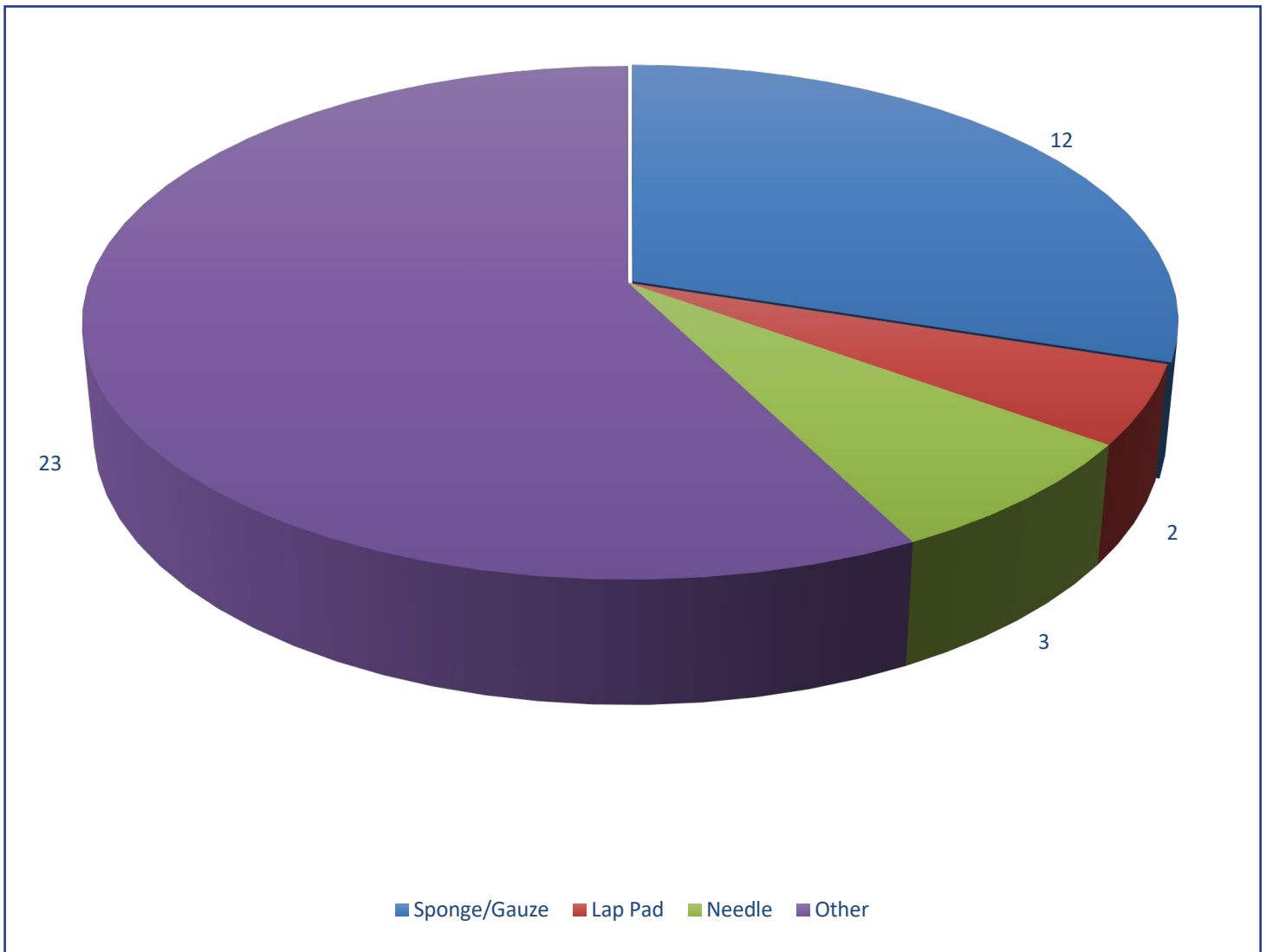
E. Major Root Causes for All Events

In 2019, the most frequent root causes of adverse events reported to PSRS were care planning process, communication among staff members, physical assessment process, patient observation procedures, and orientation and training of staff.

The root cause of "other" signifies that the hospital did not identify a system root cause for the event.

General acute care hospitals averaged almost two root causes per reportable event.

Table 8 shows the major types of root causes reported and the percent of all adverse events caused by each.

Table 8: General Acute Care Hospitals: Major Root Causes for All Events[a]

Root Cause	Number of Events	Percent of Events
Care Planning Process	212	53.0
Communication Among Staff Members	109	27.3
Physical Assessment Process	52	13.0
Patient Observation Procedures	51	12.8
"Other"	48	12.0
Orientation and Training of Staff	44	11.0

a: Data drawn from 400 RCAs submitted for 2019 events.

III. General Acute Care Hospitals

F. Contributing Factors to All Events

Table 9 shows the most frequently identified factors that contributed to the adverse events reported to the Patient Safety Reporting System.

Table 9: General Acute Care Hospitals: Contributing Factors to All Events[a]

Contributing Factors	Number of Events	Percent of Events
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	267	66.8
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	260	65.0
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	218	54.5
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	122	30.5
Staff Factors *(May include training, experience and inadequate staffing levels.)*	118	29.5
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	112	28.0
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	87	21.8
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs.)*	85	21.3

a: Data drawn from 400 RCAs submitted for 2019 events.

G. Impact of All Events on Patients

Table 10 shows the impact of the events reported by the acute care general hospitals. In addition to the other impacts identified below, there were 56 deaths which represent 14.0 percent of the 400 reportable events submitted

Table 10: General Acute Care Hospitals: Impact of All Events on Patients[a]

Impact/Outcome	Number of Events	Percent of Events
Additional Lab Testing or Diagnostic Imaging	212	53.0
Increased Length of Stay	189	47.3
Additional Patient Monitoring in Current Location	177	44.3
Major Surgery	118	29.5
Disability-Physical or Mental impairment	107	26.8
Transfer to more Intensive Level of Care	86	21.5
Death	56	14.0

a: Data drawn from 400 RCAs submitted for 2019 events.

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

Mandatory adverse event reporting for the comprehensive rehabilitation, psychiatric and special hospitals began on April 1, 2008.

There were 48 reportable events submitted from specialty hospitals in 2019 compared to 65 in 2018.

Twelve comprehensive rehabilitation hospitals submitted 28 reportable events. The average event reports per this facility type was 2.3. There was one death associated with this facility type.

Seven psychiatric hospitals submitted 13 reportable events in 2019; an average of 1.9 per facility. There were no deaths associated with this facility type.

Five special hospitals submitted seven reportable events averaging 1.4 reports per facility. There were four deaths attributed to this facility type.

Consistent with prior years, special hospitals have been the lowest reporters among the specialty hospitals. Variation in reporting may relate to the size and patient population of the facility type.

Table 11: Specialty Hospitals: Overall Reporting Pattern, 2019[a]

Facility Type	Number of Facilities	Number of Facilities Reporting	Number of Reportable Events	Average Number of Reports per Facility	Number of Deaths
Comprehensive Rehabilitation	14	12	28	2.3	1
Psychiatric	10	7	13	1.9	0
Special Hospitals	16	5	7	1.4	4
Total	40	24	48	2.0	5

a: Only psychiatric hospitals licensed by DOH are included in this section.

Patient Safety Reporting System

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

A. Comprehensive Rehabilitation Hospitals

Of the 14 comprehensive rehabilitation hospitals in the state, 12 reported at least one event in 2019. There were 28 reportable events and one death from these facilities.

The reported event types were as follows: falls (16), pressure ulcers (8), and four care management "other" events. These events are consistent with previous years' reporting.

1. Root Causes for All Events

Figure 20 shows the major causes for the events reported by this facility type.

Figure 20: Comprehensive Rehabilitation Hospitals: Root Causes for All Events[a]
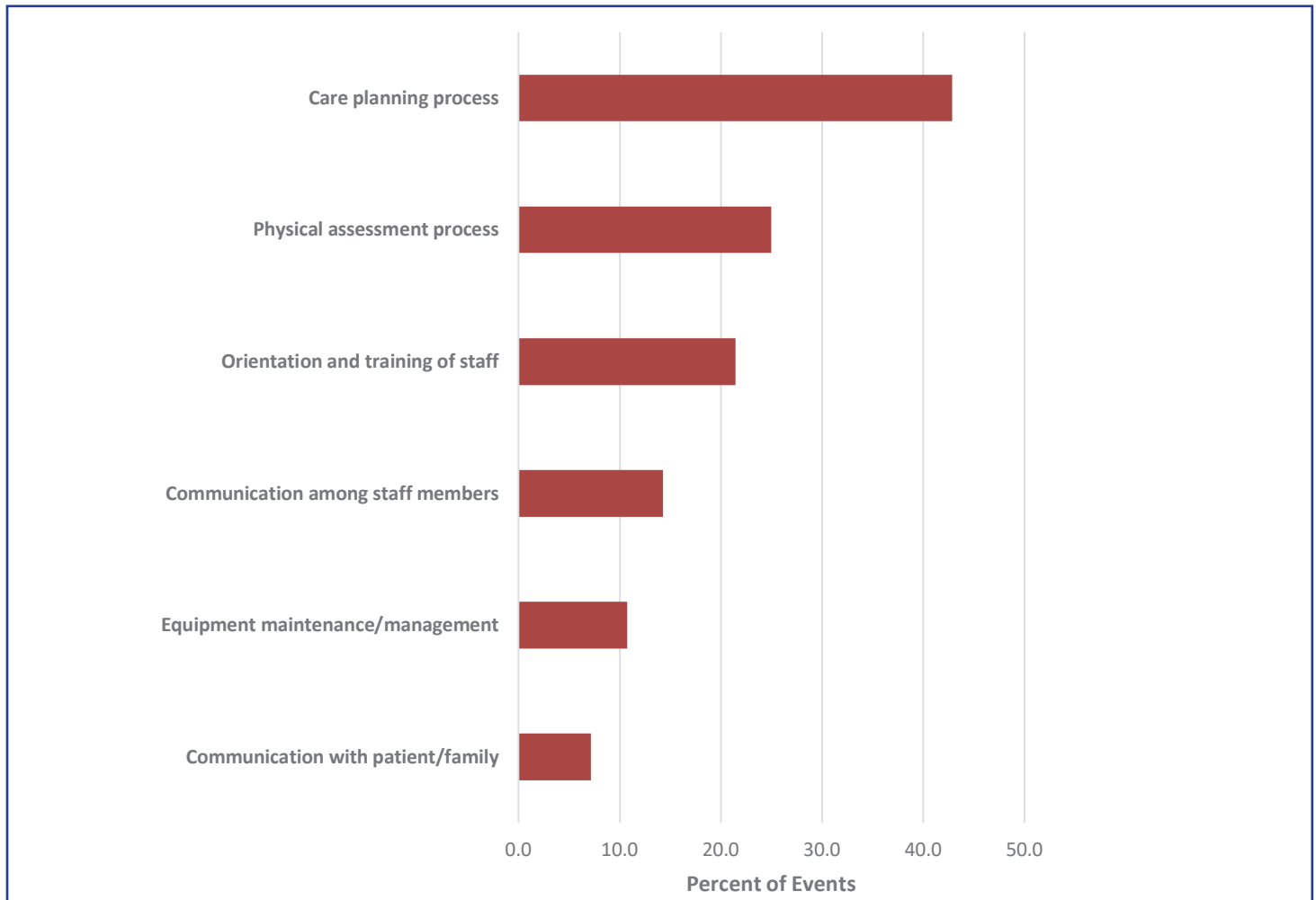
a: Data drawn from 26 RCAs submitted for 2018 events.

HCQA Health Care Quality Assessment

2019 Summary Report

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

2. Contributing Factors to All Events

In 2019, the most frequently reported contributing factors were patient characteristics, team factors, task factors, staff factors, equipment factors and patient record documentation.

Table 12 shows the results.

Table 12: Comprehensive Rehabilitation Hospitals: Contributing Factors to All Events[a]

Contributing Factors	Number of Events	Percent of Events
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	18	64.3
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	16	57.1
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	13	46.4
Staff Factors *(May include training, experience and inadequate staffing levels.)*	10	35.7
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs.)*	8	28.6
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	7	25.0

a: Data drawn from 28 RCAs submitted for 2019 events.

Patient Safety Reporting System

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

3. Impact of All Events

As a result of these adverse events, more than one-half (57.1%) of the patients experienced additional laboratory testing or diagnostic imaging as well as a visit to the emergency room. Other impacts included increased length of stay, hospital admission and major surgery.

There was one death reported from this facility type.

Figure 21 shows other impacts associated with adverse events from comprehensive rehabilitation hospitals.

Figure 21: Comprehensive Rehabilitation Hospitals: Impact of All Events[a]
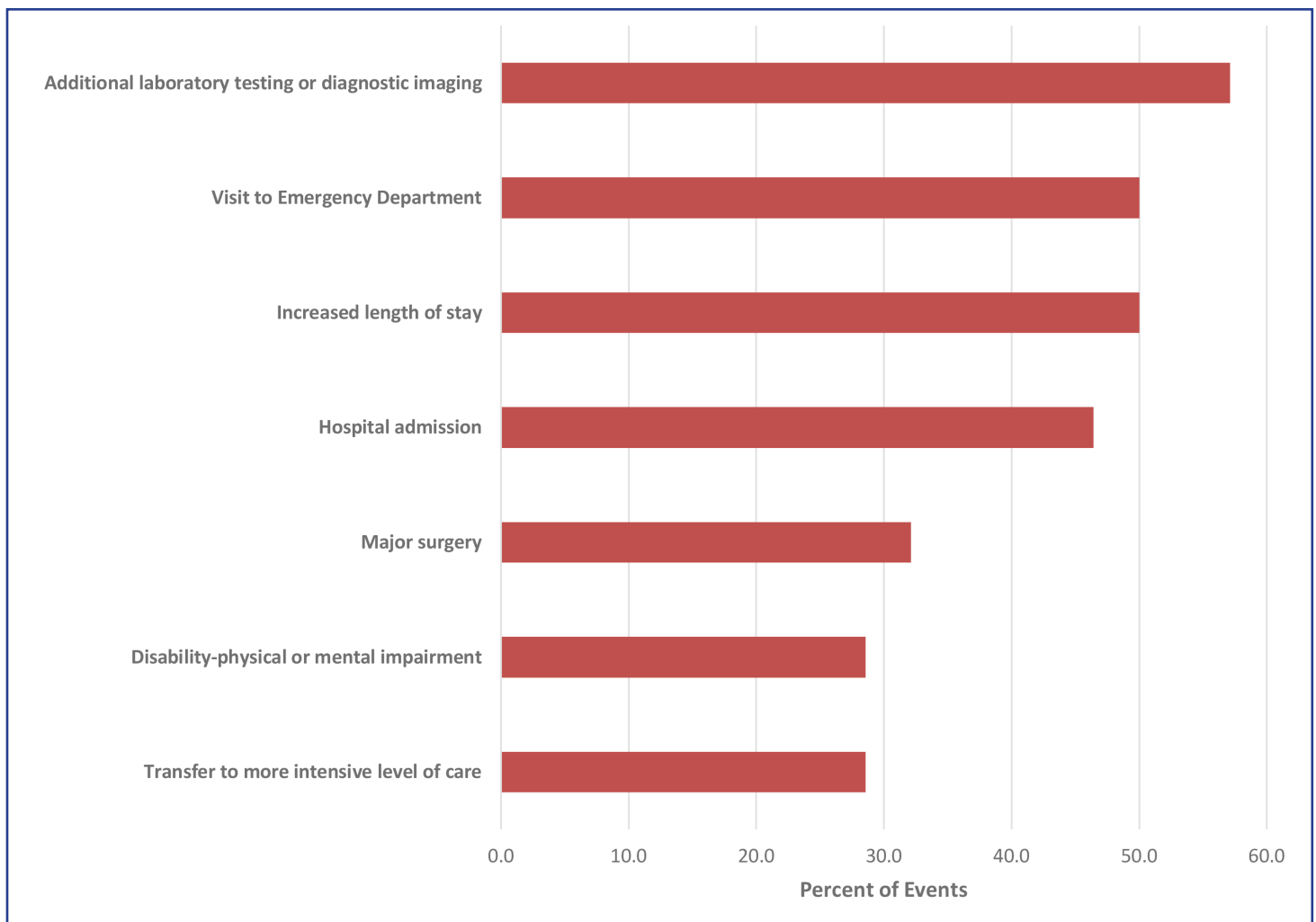
a: Data drawn from 28 RCAs submitted for 2019 events.

HCQA Health Care Quality Assessment

2019 Summary Report

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

B. Psychiatric Hospitals

Seven out of the 10 psychiatric hospitals reported at least one event during 2019. A total of 13 reportable events were submitted and were all related to falls. There were no deaths reported.

The average submission by this facility type was 1.9.

1. Root Causes for All Events

Figure 22 shows the most reported root causes for the events that occurred in Psychiatric hospitals.

Figure 22: Psychiatric Hospitals: Root Causes for All Events[a]

a: Data drawn from 13 RCAs submitted for 2019 events.

Patient Safety Reporting System

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

2. Contributing Factors to All Events

Table 13 shows the most frequently reported contributing factors for the events.

Table 13: Psychiatric Hospitals: Contributing Factors to All Events[a]

Contributing Factors	Number of Events	Percent of Events
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	13	100.0
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	9	69.2
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	8	61.5
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	6	46.2
Staff Factors *(May include training, experience and inadequate staffing levels)*	3	23.1
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	3	23.1
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	3	23.1

a: Data drawn from 13 RCAs submitted for 2019 events.

HCQA Health Care Quality Assessment

2019 Summary Report

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

3. Impact of All Events

Figure 23 shows the most frequently reported impact from the events. There were no deaths reported.

Figure 23: Psychiatric Hospitals: Impact of All Events[a]
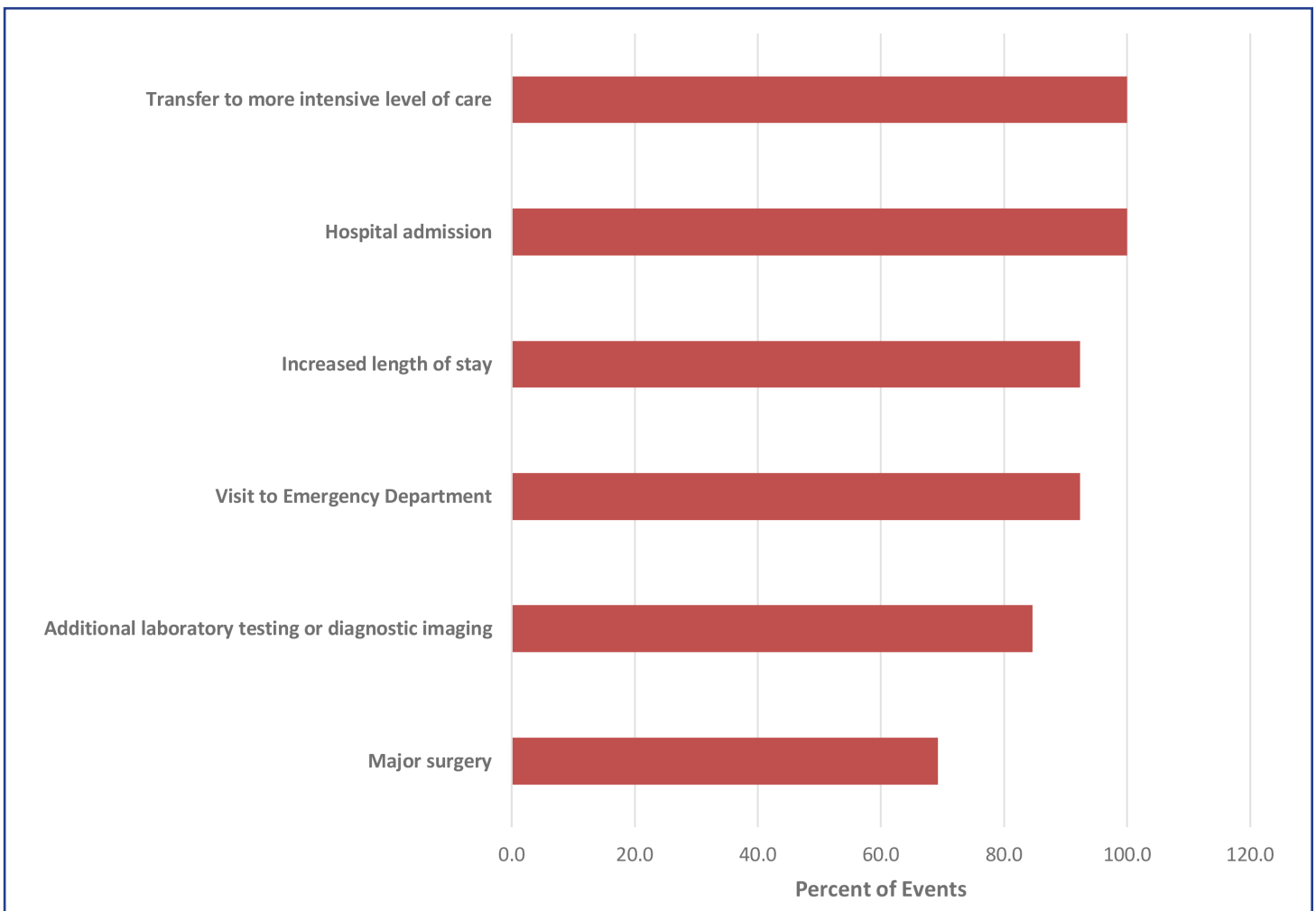
a: Data drawn from 13 RCAs submitted for 2019 events.

Patient Safety Reporting System

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals
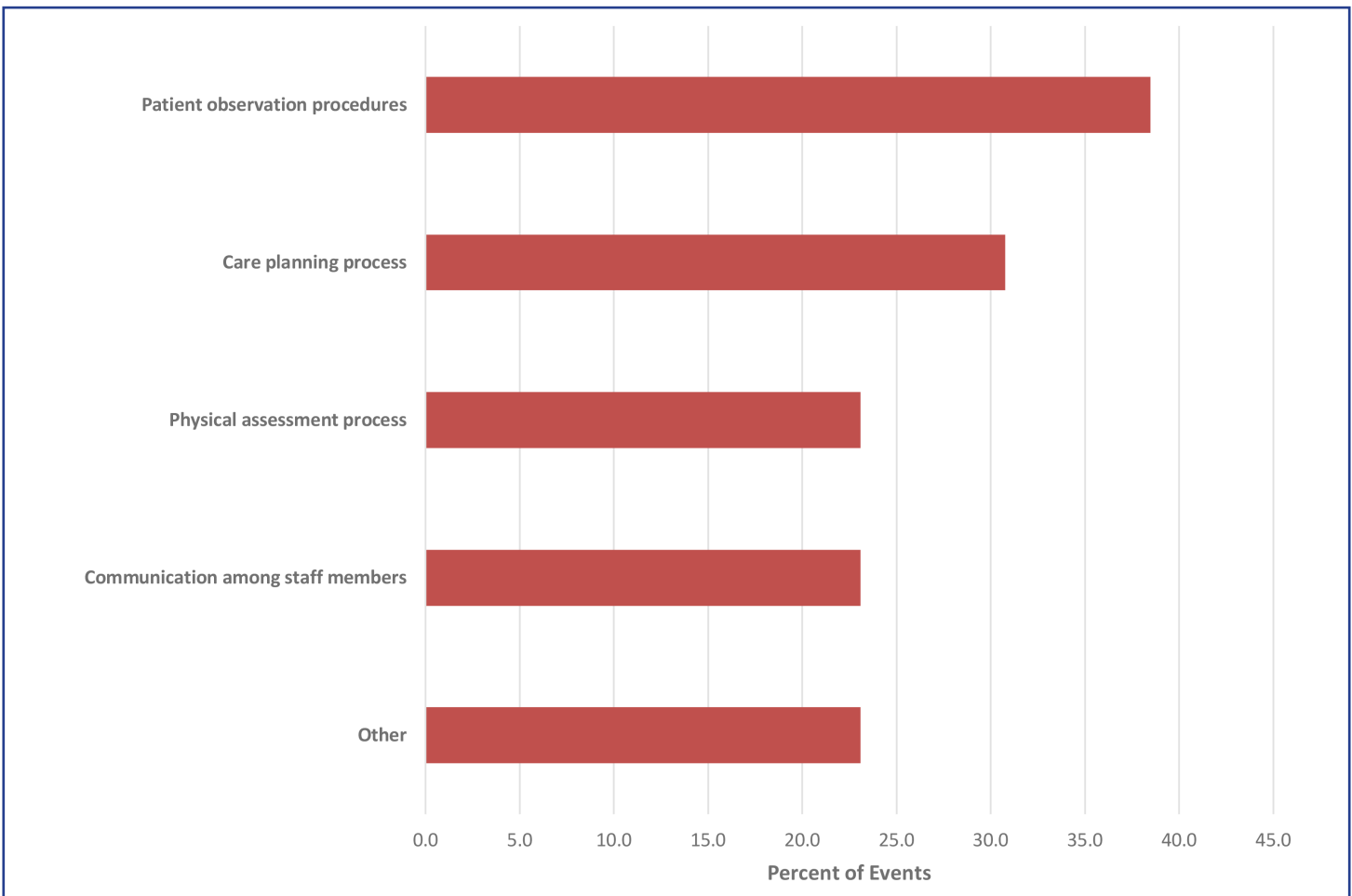
C. Special Hospitals

There were seven reportable events submitted by special hospitals in 2019. This low reporting is consistent with prior years. There were four deaths reported for this facility type

1. Root Causes for All Events

Figure 24 shows the most frequent root causes of events within this facility type.

Figure 24: Special Hospitals: Root Causes for All Events[a]
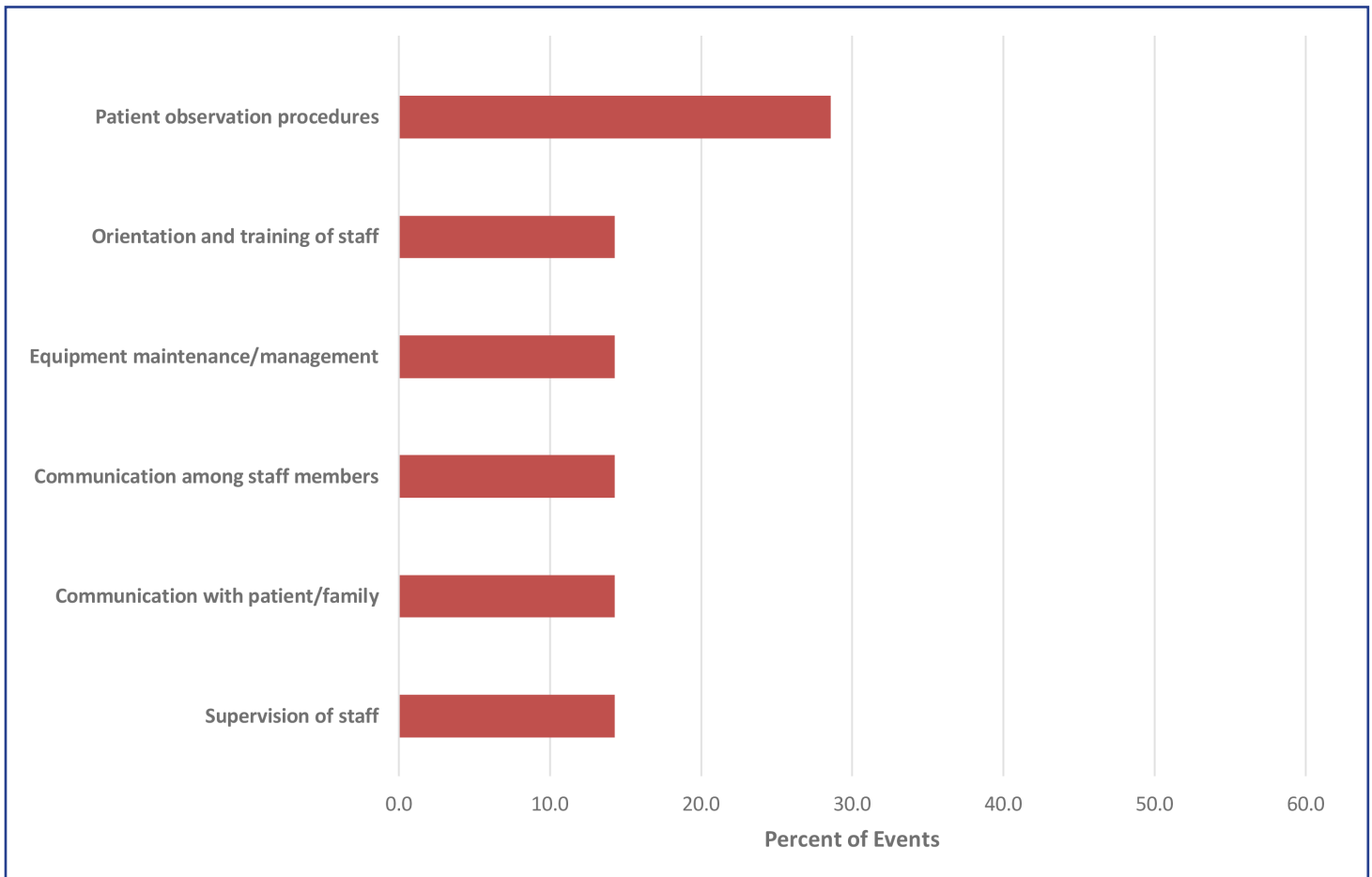
a: Data drawn from 7 RCAs submitted for 2019 events.

HCQA **Health Care Quality Assessment**

2019 Summary Report

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

2. Contributing Factors to All Events

Table 14 shows the most frequent contributing factors to the events reported by special hospitals in 2019. The most frequently reported contributing factors were task factors, patient characteristics, team factors, patient record documentation and staff factors.

Table 14: Special Hospitals: Contributing Factors to All Events[a]

Contributing Factors	Number of Events	Percent of Events[a]
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	6	85.7
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	5	71.4
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	3	42.9
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	2	28.6
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	2	28.6
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	2	28.6
Staff Factors *(May include training, experience and inadequate staffing levels.)*	2	28.6

a: Data drawn from 7 RCAs submitted for 2019 events.

Patient Safety Reporting System

IV. Overall Reporting Patterns for Specialty Hospitals: Comprehensive Rehabilitation, Psychiatric and Special Hospitals

3. Impact of All Events

Figure 25 exhibits the most frequently identified impact from the reportable adverse events submitted by special hospitals.

Figure 25: Special Hospitals: Impact of All Events[a]
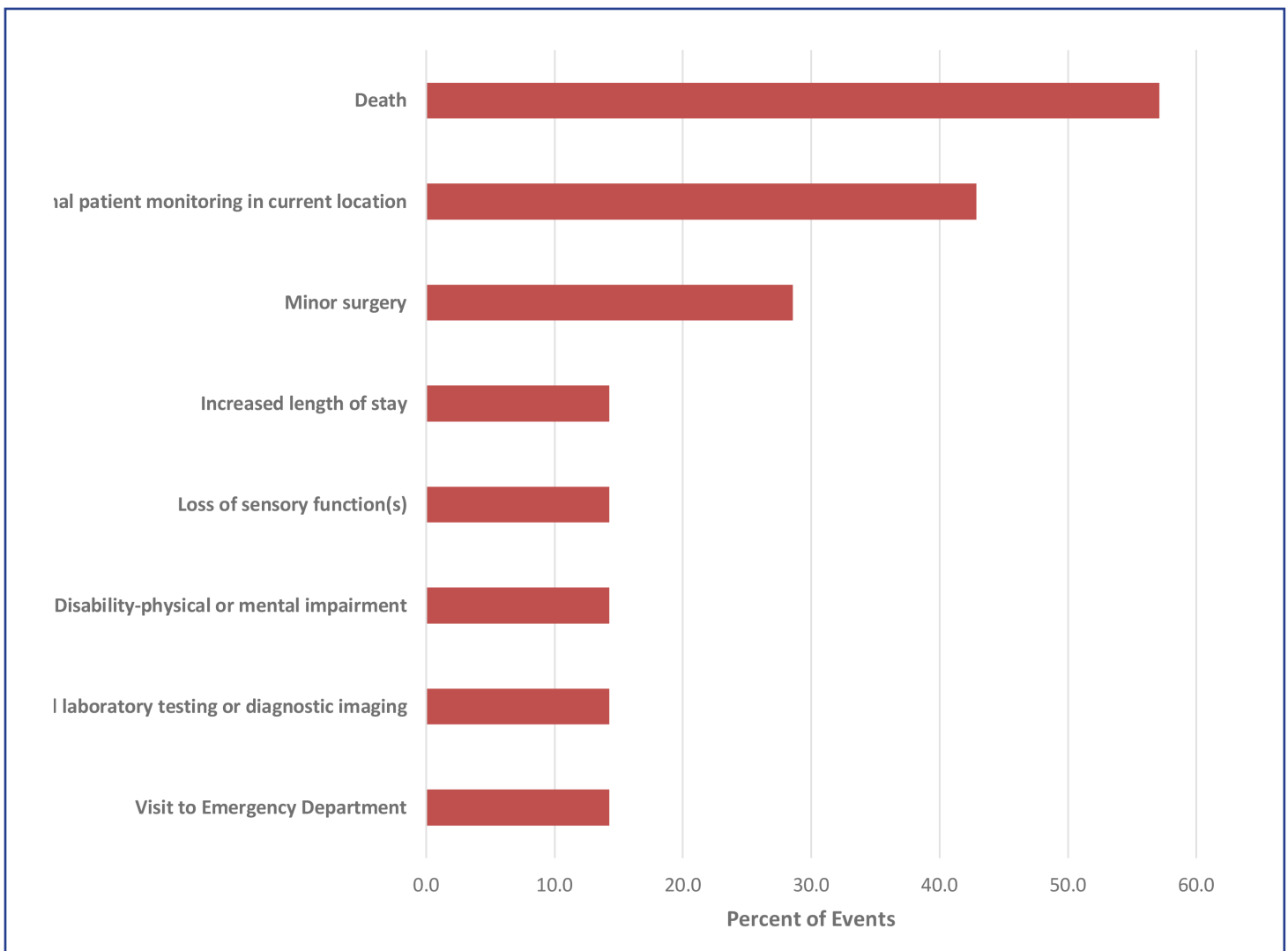
a: Data drawn from 7 RCAs submitted for 2019 events.

V. Ambulatory Surgery Centers

New Jersey licensed ambulatory surgery centers (ASCs) began reporting serious preventable adverse events to PSRS as of October 1, 2008. Of the 251 ambulatory surgery centers in New Jersey, 87 facilities submitted events in 2019. A total of 265 events were submitted of which 163 were deemed reportable (61.5%).

There were eight deaths and were all related to intra-op or post-op coma, death or other serious preventable adverse events.

Table 15 and Figure 26 show the reporting patterns for the period 2008 to 2019.

Table 15: Ambulatory Surgery Centers: Reporting Patterns (2008-2019)[a]

Year	Reportable	Not Reportable	Less Serious/Near Misses	Total Events	Percent Not Reportable	Percent Reportable
2008[a]	13	0	NA	13	0	100.0
2009	48	4	NA	52	7.7	92.3
2010	74	17	NA	91	18.7	81.3
2011	144	10	9	163	11.7	88.3
2012	199	31	88	318	37.4	62.6
2013	200	17	135	352	43.2	58.6
2014	201	6	154	361	44.3	55.7
2015	165	5	162	332	50.3	49.7
2016	154	14	141	309	50.2	49.8
2017	144	10	130	284	49.3	50.7
2018	163	10	114	287	43.2	56.8
2019	163	7	95	265	38.5	61.5

a: Represents 3 months of data since reporting started on October 1, 2008.

Figure 26: ASC Trends in Reportable and Not Reportable Events 2008-2019
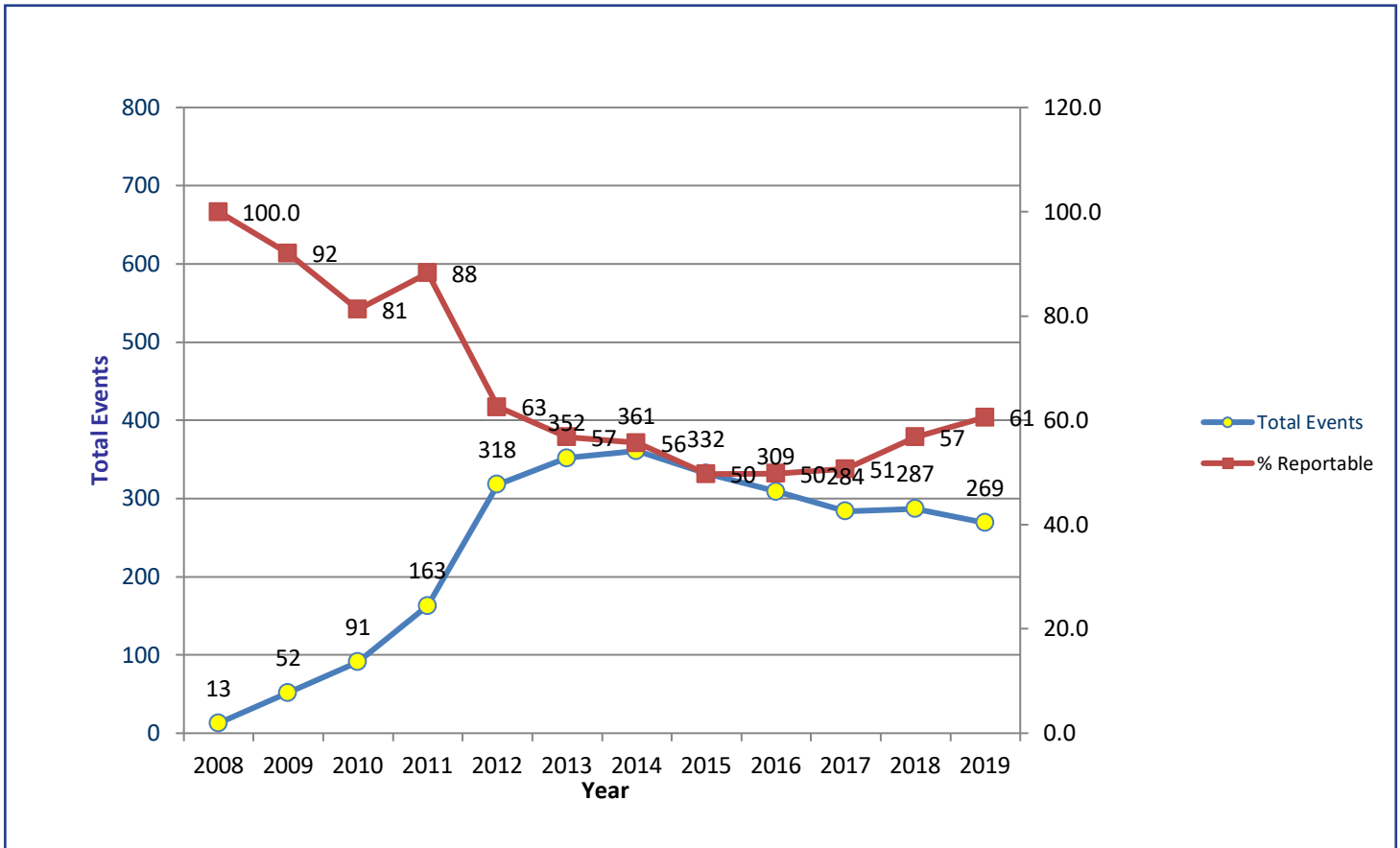
V. Ambulatory Surgery Centers

Table 16 shows the highest reportable cases were intra-operative or post-operative coma, death or other serious preventable adverse events. The second highest event type was surgery-related "other" events with 18 cases.

There was a total of eight deaths reported and were all associated with intra-operative or post-operative coma, death or "other" serious preventable adverse events type.

Table 16: Ambulatory Surgery Centers: Events Reported in 2019

Event Type	Number of Events	Percent of Total Events	Number of Deaths
Intra-Operative or Post-Operative Coma, Death or "Other" serious preventable adverse event	133	81.6	8
Surgery-Related "Other" Event	18	11.0	0
Wrong Site	8	4.9	0
Retained Foreign Object	4	2.5	0
Total	163	100.0	8

As stated earlier, there were 133 intra-operative/ post-operative events submitted by 62 ambulatory surgery facilities. The chart below shows the reporting pattern by ambulatory surgery facilities.

For example, 28 facilities reported one event each while 17 facilities reported a total of 34 events (i.e. 2 events per facility).

Figure 27: Ambulatory Surgery Centers: Intra-Op/Post-Op Death and Coma

Figure 27: Ambulatory Surgery Centers: Intra-Op/Post-Op Death and Coma
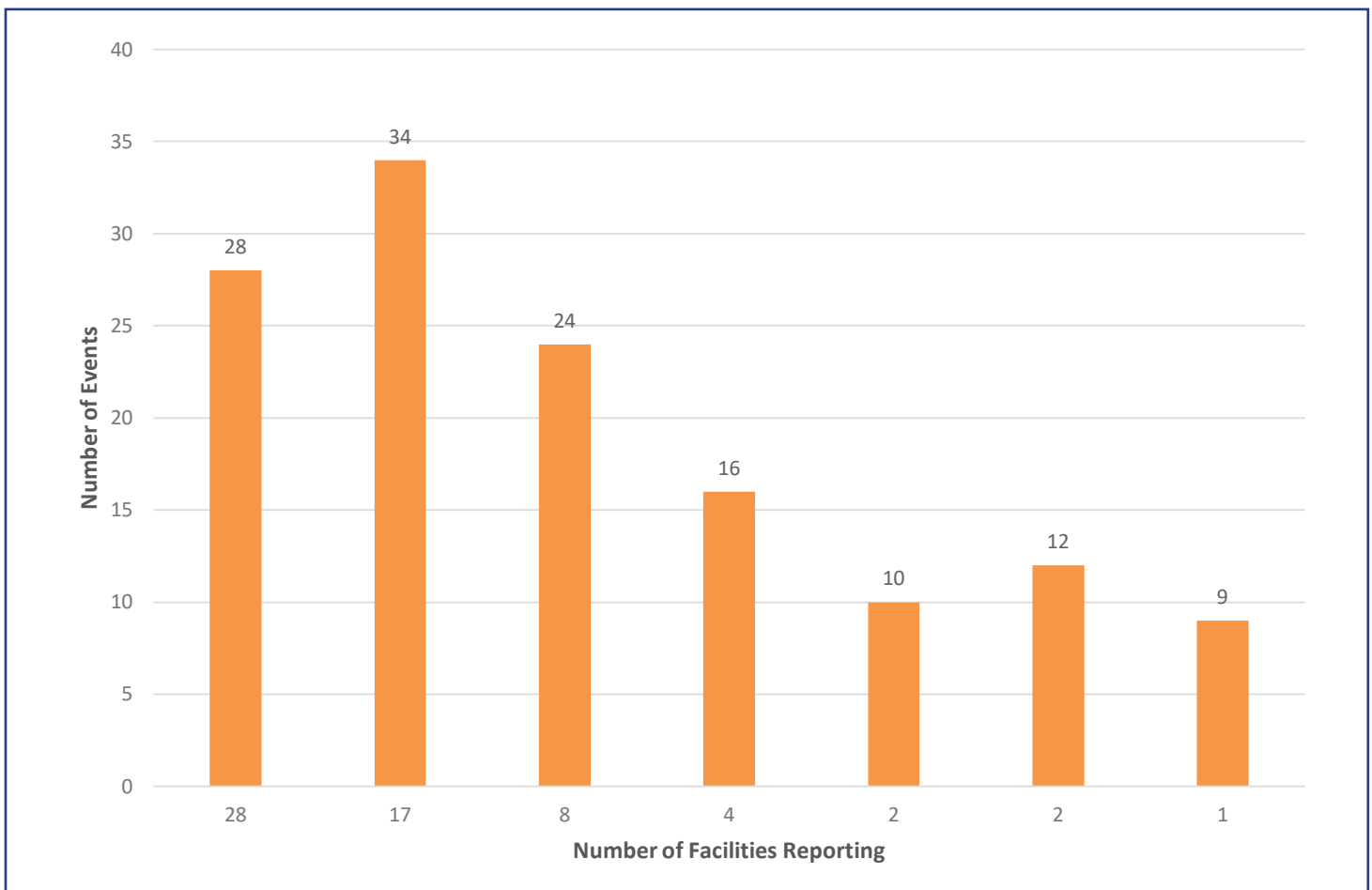
V. Ambulatory Surgery Centers

A. Root Causes for All Events

Figure 28 shows the most frequently identified root causes of the events reported by ambulatory surgery centers in 2019.

Figure 28: Ambulatory Surgery Centers: Root Causes for All Events[a]
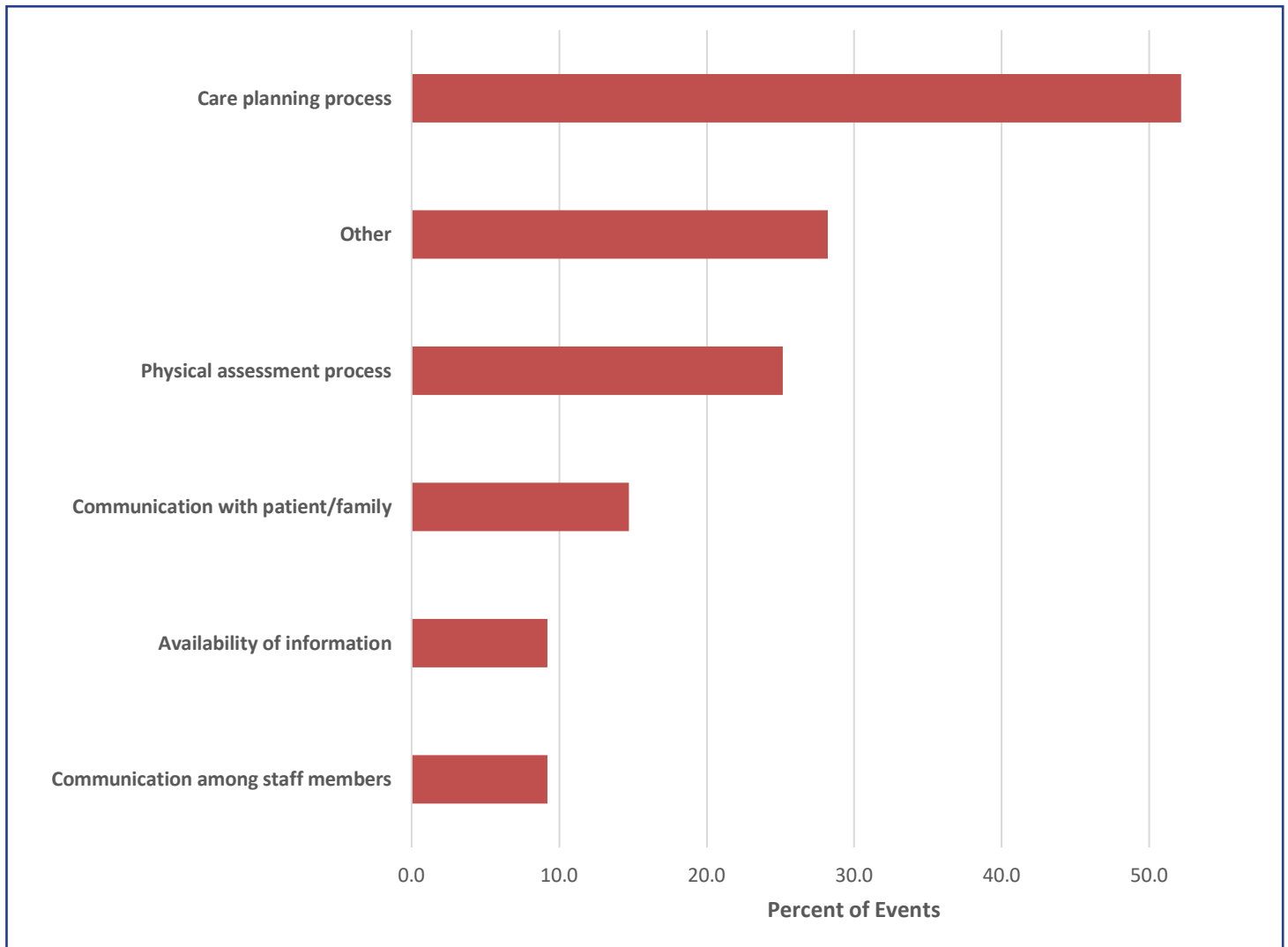
a: Data drawn from 163 RCAs submitted for 2019 events.

B. Contributing Factors to All Events

Table 17 shows the most frequently reported contributing factors at ambulatory surgery centers.

Table 17: Ambulatory Surgery Centers: Contributing Factors to All Events[a]

Contributing Factors	Number of Events	Percent of Events[a]
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	107	65.6
Patient Characteristics *(May include confusion, co-morbidities and the Patient's choice to refuse care.)*	99	60.7
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	94	57.7
Team Factors *(May include factors which interfere with the care teamworking together, such as inadequate communication.)*	39	23.9
Other Factors *(May Include factors not identified in the other categories.)*	33	20.2
Medications *(May include inappropriate administration, dose and prescribed medications not administered.)*	23	14.1

a: Data drawn from 163 RCAs submitted for 2019 events.

V. Ambulatory Surgery Centers

C. Impact of All Events

Figure 29 displays the most frequently reported impact of adverse events at ambulatory surgery centers.

Figure 29: Ambulatory Surgery Centers: Impact of All Events[a]
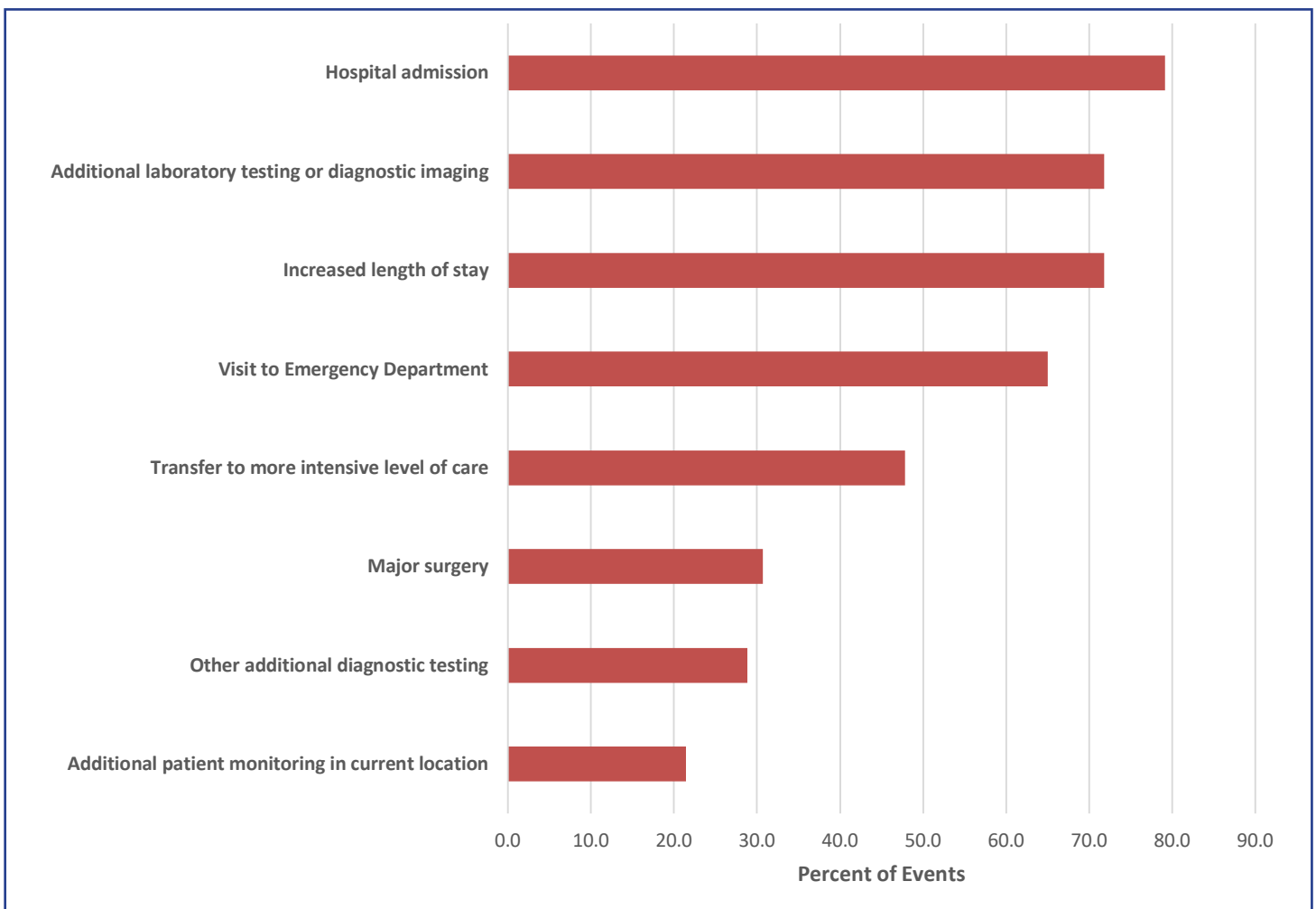
a: Data drawn from 163 RCAs submitted for 2019 events.

End Stage Renal Dialysis (ESRD) facilities began reporting preventable adverse events as of January 1, 2019. Of the 239 licensed facilities, a total of 60 events were submitted of which 37 were deemed reportable (61.7 %). Thirty of the events occurred in the Care Management "Other" category while the remaining seven events were related to falls. There were 21 deaths associated with these reported events. Twenty of the deaths were related to Care Management "Other".

Figure 30 shows the reporting patterns for ESRD facilities in 2019.

Figure 30: End Stage Renal Dialysis Facilities Reporting of Events
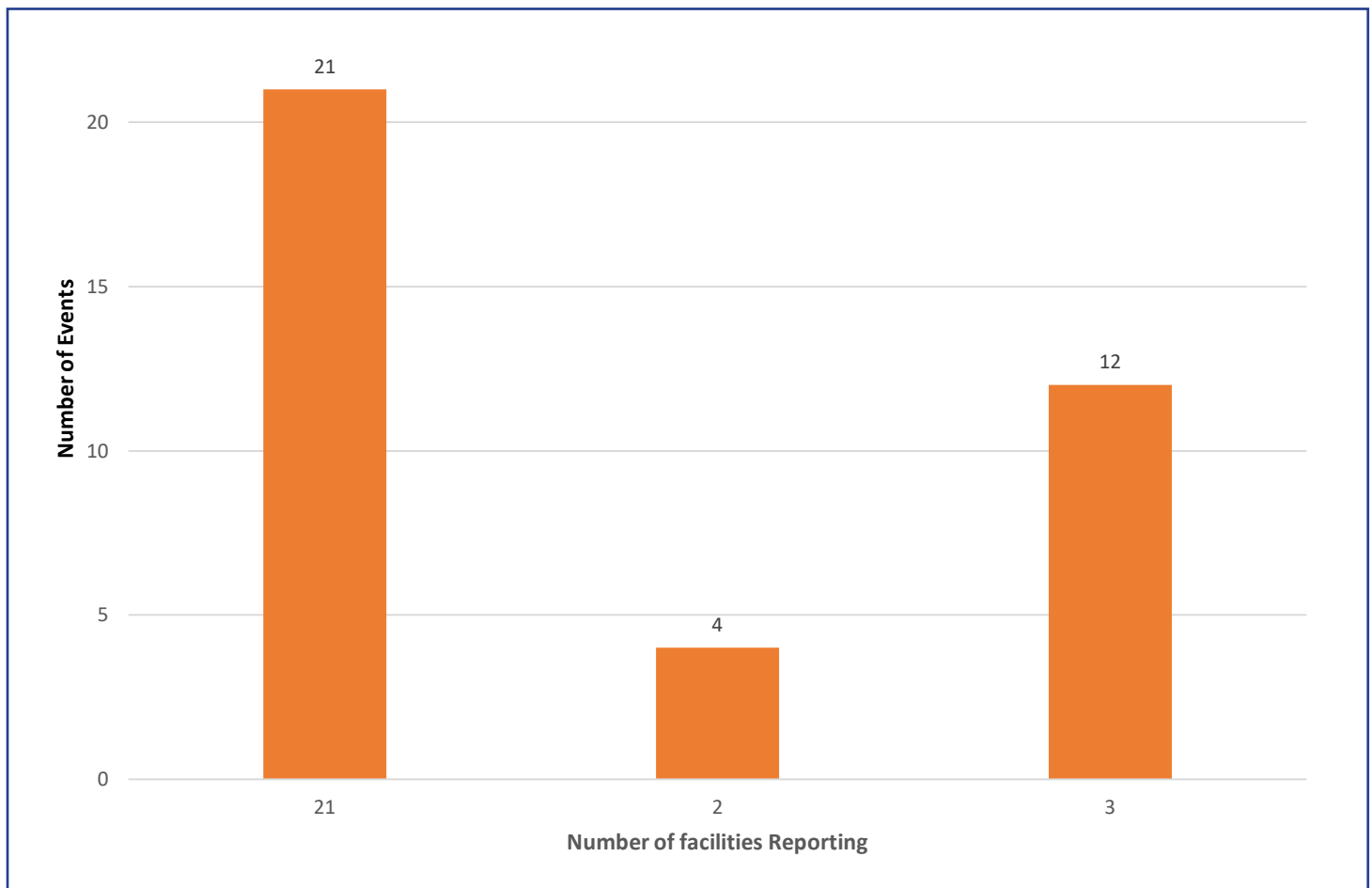
VI. End Stage Renal Dialysis Facilities

A. Root Causes for All Events

Figure 31 shows the major root causes of events for ESRD facilities.

Figure 31: End Stage Renal Dialysis Facilities: Root Causes for All Events[a]
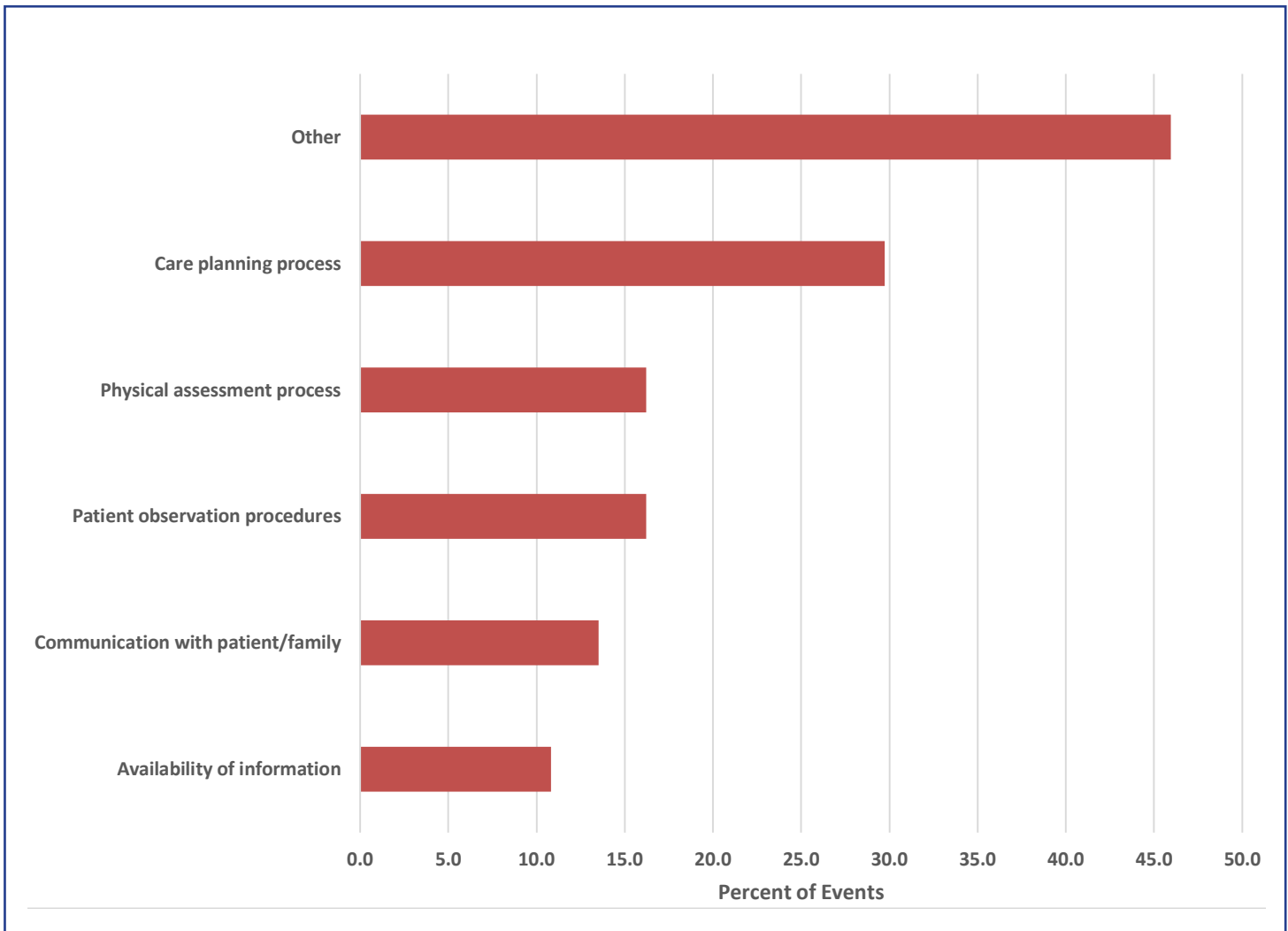
a: Data drawn from 37 RCAs submitted for 2019 events

B. Contributing Factors to All Events

Table 18 shows the most frequently reported contributing factors at End Stage Renal Dialysis Facilities.

Table 18: End Stage Renal Dialysis Facilities: Contributing Factors to All Events[a]

Contributing Factors	Number of Events	Percent of Events[a]
Task Factors (May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)	27	73.0
Patient Characteristics (May include confusion, co-morbidities and the Patient's choice to refuse care.)	24	64.9
Other Factors (May Include factors not identified in the other categories.)	11	29.7
Procedures (May include diagnostic or therapeutic interventions that contribute to the event.)	9	24.3
Team Factors (May include factors which interfere with the care teamworking together, such as inadequate	7	18.9
Staff Factors (May include training, experience and inadequate staffing levels.)	5	13.5

a: Data drawn from 37 RCAs submitted for 2019 events.
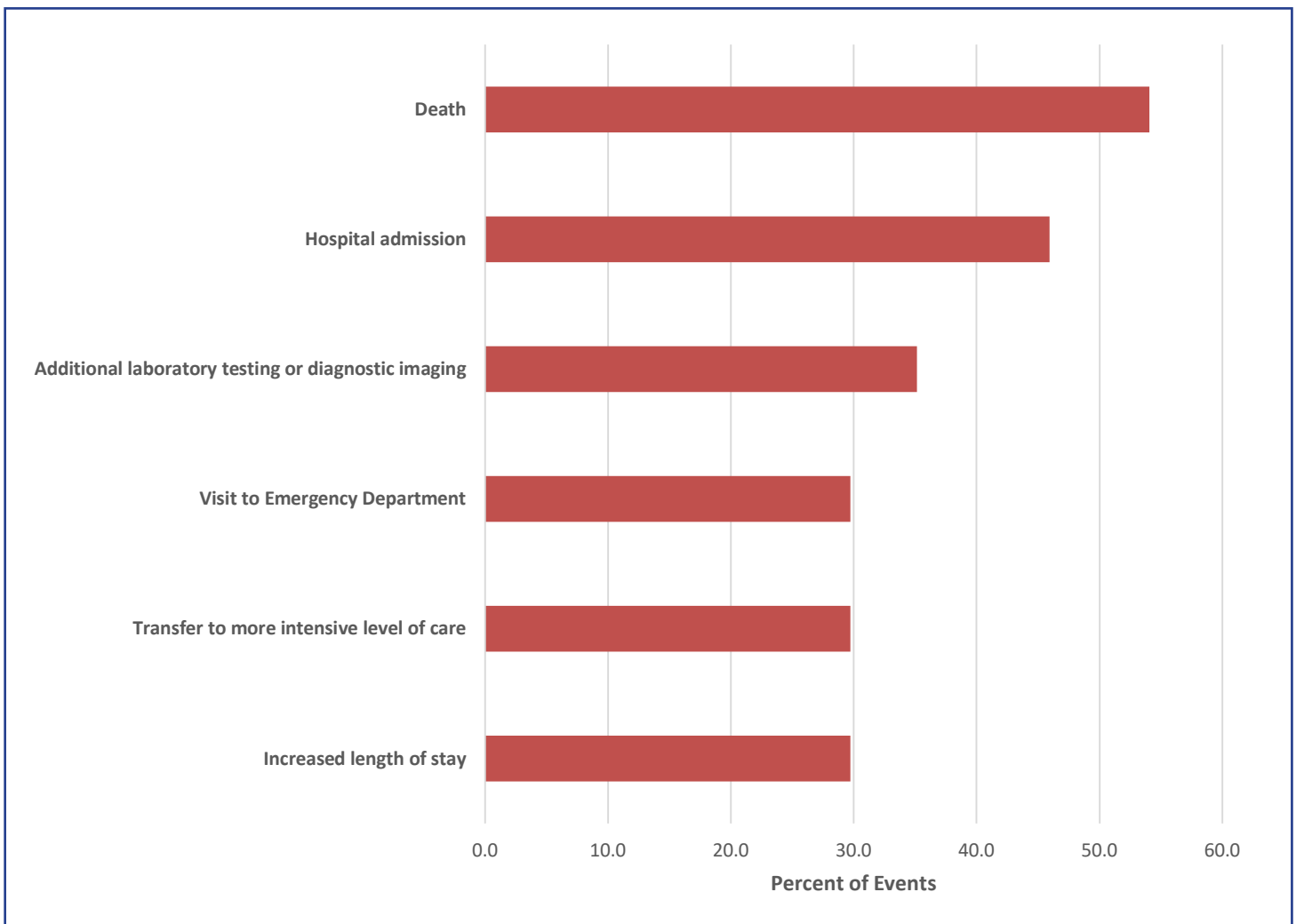
VI. End Stage Renal Dialysis Facilities

C. Impact of All Events

Figure 32 displays the most frequently reported impact of adverse events at end stage renal dialysis facilities.

Figure 32: End Stage Renal Dialysis Facilities: Impact of All Events[a]

a: Data drawn from 37 RCAs submitted for 2019 events.

**Department of Health
Division of Behavioral Health Services
Annual Patient Safety Act Report
January 1, 2019 through December 31, 2019**

Implementation

The Division of Behavioral Health Services (DBHS/Division) Patient Safety Act (PSA) advisory committee continues to receive and review the Root Cause Analyses (RCAs) submitted under the Patient Safety Act by the three (3) regional NJ state psychiatric hospitals and one (1) forensic psychiatric center. A log of PSA related events is maintained by the Division to monitor the timely submission and review of submitted RCA's.

The review committee, which consists of members of various disciplines including psychiatry, psychology, nursing, and rehabilitation services, assesses the Root Cause Analyses for timeliness, thoroughness, and credibility. Questions or concerns of the committee are shared with the RCA team/facilitator as well as the Director of Quality Assurance and Risk Manager of the facility where the event occurred. Facility staff review and provide responses to these questions/concerns and may be asked to reconvene the RCA committee as needed. If necessary, a revision to the RCA is requested.

During 2019, system initiatives/improvements that are expected to decrease the number of incidents reportable under the PSA in the hospitals included the following:

- The facilities utilize Performance Improvement approaches to identify and eliminate waste and improve patient care by initiating improvement activities and monitoring to control improvements to ensure sustainability.

- The facilities utilize implementation various programs across the system that promote violence prevention through using active treatment and behavioral management skills.

- The facilities utilize regularly assesses staffing plans and developed a standard for critical positions (i.e. Psychiatrists, Advanced Practice Nurses (APN), and Registered Nurses (RN)) as they relate to increased service levels and quality of care at each facility.

- The facilities implemented the electronic medical records, a Physician Ordering Electronic System that allows for the review, tracking, and adjustment of patient medication and will assist in the prevention of possible ordering/administration errors. Current features include but are not limited to admission/transfers/discharge tracking, medications ordering with alerts to support physician decision making, improved electronic medication reconciliation, automation of tracking of medication administration process, electronic monitoring of restraints/seclusions, and improved communication with each hospital's pharmacy. To date, the Division continues to update the piloted system with additional modules as its implementation is rolled out to two facilities in the system.

- Streamlined the process for reviews of high acuity patients (1:1, restraints, assaults), including recommendations are required to be added in the patients' treatment plan and a rational/justification the recommendations were not followed is reported to the Clinical Director at each facility.

VII. Division of Behavioral Health Services 2019 Report

- The facilities utilize a methodology that promotes the implementation of increased active treatment by psychologists, who are focusing on patients identified as at a high risk for suicide or self-injurious behavior; discharge resistant; in need for motivation towards treatment or in need of repeated use of restraints; and seclusion or 1:1 observation.

- The facilities utilize the Suicide Risk Assessment and the screening processes to include use of an evidence-based assessment tool that is used to assist in determining a patient's risk for suicide at various points in care. Policies and procedures regarding suicide risk assessments were revised and began implementation in June of 2019. To date, monthly meetings are held to monitor the implementation and to assess where the Division can continue to increase evidence-based practice.

- The facilities utilize Safety Plans for Suicide Prevention to assist patients in coping strategies and sources of support to be used by those who have been assessed to be at high risk for suicide. Exploring a nationally recognized suicide prevention safety plan for use across the system.

- The facilities identify and mitigates ligature risks. Each facility monitors possible risks and improve the environment of care for patients by systematically assessing ligature resistant in areas of; environmental improvements, hardware upgrades and complete room renovations.

- Completes an annual Hazard Vulnerability Analysis (HVA) to identify potential emergencies (i.e. ligature points), the likelihood of those events occurring, and the consequences of those events. As a result of that analysis, dedicated facility staff review and recommend projects and hardware upgrades based on most current best practices to continue to improve safety conditions on all units. Subsequently, each facility continues to mitigate ligature points as they arise."

- Conducting Executive Rounds regularly and consist of visits by facility executives to patient care areas to discuss patient safety issues and ask for suggestions to improve patient safety and verbalize their commitment to improving safety at each facility.

Overall Reporting Patterns

From January 1, 2019, through December 31, 2019, a total of eleven (11) events were reported and reviewed. Five (5) out of the eleven (11) events occurred at one (1) facility, four (4) events occurred at one (1) facility and one (1) event at each of the remaining two (2) facilities. The events consisted of; seven (7) suicide attempts (a 40% increase from 2018), one (1) accidental death, one (1) unexpected death, one (1) decubitus, and one (1) serious adverse reaction.

Focus on Specific Events

a. Attempted Suicides

There was a total of seven (7) suicide attempts in 2019. Five (5) involved female patients and two (2) male patients. Ages ranging between 20 and 35; with a mean age of 25.6, a median age of 25, there is no statistical mode.

Six (6) of the suicide attempts were dispersed evenly (3 each) between two (2) facilities, and the remaining one (1) occurred at a different facility. Six (6) events involved patients tying objects around their necks, an article of clothing, shower curtain or sheet. One (1) event involved using a piece of lightbulb to slash at throat. Five (2) events occurred in the bathroom, two (2) events occurred in a patient's bedroom.

Root causes:

- Team Factors: Failure in communication among staff members regarding identifying necessary suicide risk precaution interventions and objectives (long-term and short-term goals) for suicide or self-injurious behavior as evidenced by lack of documentation on the comprehensive individualized treatment in the medical record.

- Team Factors: Failure in communication among staff members of previous suicide attempt by the patient as evidenced by lack of documentation on the 24-hour report and medical record.

- Team Factors: Failure to request a Clinical Review (CRT) for a comprehensive review of the patient and alternative recommendation in the plan of care as evidenced by lack of documentation in the medical record.

- Task Factor: Gaps identified in procedures for conducting patient searches upon returning to the unit by Human Service Police Department (HSPD) as evidenced by contraband not found on patient..

- Other (Environmental) Factors: Failure to remove an easily breakable ceiling florescent light bulb that was identified as an environmental risk as evidenced by a patient using the object for self-harm and/or suicide attempt.

Prevention strategies:

- The new Administrative Bulletin (AB) 3:41 Screening, Assessment, Management and Treatment of Suicidal and Non-Suicidal Self-directed Violence will be implemented on 8/29/19 and will now require psychiatrists to complete Suicide Screeners on patients who are on 1:1 for suicide, before removing them from suicide precautions.

- Revise Assessment policy follow the requirements included in AB 3:41 requiring psychiatrists to complete Suicide Screeners on patients who are on 1:1 for suicide, before removing them from suicide precautions and prior to granting increased privileges for unsupervised periods on and off grounds of the facility

- Remediation by the Treatment Planning Administrator to the Program Coordinators and Treatment Team members regarding appropriate planning for suicidal patient.

- In-service Treatment Teams on the revised Clinical Review Process Policy emphasizing the requirement of requesting a Clinical Review for a patient who had been on precautions for more than 10 days.

- Revise Assessment Reassessment; policy 2.106 to ensure the patient was not thoroughly assessed for suicide risk before prior to discontinuing and/or modifying the 1:1 precaution including, medication education and counseling after a patient is placed on voluntary medication status after longstanding refusals

- Develop a mechanism for formal communication to assure direct hand-off between Human Services Police (NJSHSP) and licensed staff, including report of positive and negative events and observed patient behaviors while in custody. This mechanism would be beneficial in identifying the potential for a change in or a need to monitor a patient's behavior more closely upon return from arrest.

- Provide ongoing annual and after an event training and assess competency of staff implementation of observation of patient at an increased risk of suicide.

- Review with Rehabilitation and Nursing on the Unusual Incidents - Reporting, Investigation process

and Follow-up with monitoring.

- Revise "Environmental Checks" procedure/protocol to include specific frequency guidelines for sweeps/room searches of patients placed on observation for increased risk of suicide and deem staff competent on revised procedures.
- Conduct environmental validation audit for identified ligature points and identified areas of risk, including ceiling tiles.
- Nursing Supervisor to complete rounding on units with the completed assignment sheet to ensure sufficient coverage during staff lunches and breaks.

b. Serious Adverse Reaction

There was one (1) serious adverse reaction of Diabetic Ketoacidosis related to psychotropic medication involving a 33-year-old male patient.

Root causes

- Medication Factor: Failure to adhere to the "Treatment" policy; lab refusals and interventions implemented as evidenced by lack of documentation in the medical record.
- Task Factor: Failure to adhere to the "Vital Signs" policy; increase in weight and notification to the treating physician as evidenced by lack of documentation in the medical record.
- Task Factor: Failure of review of weight increase and lab results by the assigned Nutritionist as evidenced by lack of documentation in the medical record.

Prevention strategies

- Revise and review "Medication Administration" policy to include prescribed "Zyprexa" medication orders to include that correct contraindications and lab work are completed by the treating physician prior to dose increase.
- Review the "Consent to Treatment," "Vital Signs, and "Documentation" policies with the Treatment Team members, including nursing and Nutritionist regarding refusals of labs, documentation requirements and follow-up for patients refusing treatment including routine lab work.

c. Decubitus

A patient returning from a local medical facility with Dx of Stage IV pressure ulcer.

Root causes:

- Task Factor: Lack of clear guidelines for ongoing identification, appropriate monitoring, documentation in the medical record, and communication among staff members for high risk patients.
- Procedure Factor: Failure to identify new pressure injuries as evidenced by lack of documentation in the medical record.

Risk reduction strategies:

- Review of Exec. Policy on Skin Integrity Maintenance with all nurses regarding follow-up assessment and documentation of a patient's wound.

- Revision to Skin Integrity Policy to improve the identification of patients at risk for pressure injury includes the following:
  - Increasing the frequency of the completion of the Braden Scale (currently only upon admissions) upon return from Medical Surgical Transfer (MST), transfer between units and annually; including any change in patients' mobility, pattern of poor nutritional intake, and if he/she becomes incontinent.
  - Addition of the definition of Pressure Point
  - Addition of recurring self-injurious behaviors as an identifying risk factor for compromised skin integrity

- Improve the prevention process by including the following:
  - Increasing the frequency of the completion of the "Patient Inspection Record" to those patients who are transferred between units, during shower time on the units, any change in physical/mental status, and annually (in addition for all newly admitted patients and those returning from a community setting).
  - Daily completion of the "Patient Inspection Record", during the evening shift, for patients who are wheelchair and bedbound.

- Require the completion of a Patient Inspection Record every shift for a patient with a score of 12 or less on the Braden Scale, representing a high risk for the development of a pressure injury, with a reassessment using the Braden Scale completed weekly.

- Include team/psychiatrist evaluation and documentation for underlying psychiatric issues related to poor intake, immobility, etc.

- Include medical physicians' orders for "Pressure Injury Risk".

- Require Nurses to enter "Pressure Injury Risk" status into the Special Needs Section of the Patient Tracking Database with subsequent population onto the 24-Hour Ward Report for improved hand-off communication.

- Require daily completion of the "Patient Inspection Record", during the evening shift, for patients who are wheelchair and bedbound.

- Require the completion of the "Patient Inspection Record" every shift for a patient with a score of 12 or less on the Braden Scale with a reassessment using the Braden Scale completed weekly.

- Require the team/psychiatrist to evaluate patients for underlying psychiatric issues related to poor intake, immobility, etc. and medical physicians' orders for "Pressure Injury Risk".

- Improve communication among staff by requiring Nurses to enter "Pressure Injury Risk" status into the Special Needs Section of the Patient Tracking Database with subsequent population onto the 24-Hour Ward Report.

d. Unexpected Death

There was one (1) unexpected death which occurred during 2019; a 57-year old male for whom the cause was determined to be acute pulmonary embolism because of deep vein thrombosis.

Root causes:

- Team Factor: Patient history of pulmonary embolism and DVT was not listed on physical exam during admissions process.
- Task Factor: Failure to adhere to the "Code Blue" policy and respond to change in patient condition.

Prevention strategies

- Developed and implemented a Peer Review process to review that all diagnoses are entered on patient histories of every newly admitted patient. Quality management will conduct random reviews of peer review form to ensure compliance.
- Re-education of staff on policies/procedures and develop competencies involving code blue medical emergencies and responding to changes in patients' condition.
- Ongoing education for Medical physicians regarding required documentation of all medical diagnoses and ensure documented on proper forms and noncompliance will trigger a Focused Professional Practice Evaluation (FPPE).
- Implement the Physician Order Entry System (POES) in all four facilities to ensure that all past medical history information is reviewed by admitting physician. Currently POES has been fully implemented in one facility, with goal to implement in the remaining three facilities by the end of 2021.

DBHS Report Preparation Team

Glenda Torres, RN, BSN, MBA
Quality Assurance Coordinator
Acting Deputy Quality Improvement Director

Pursuant to the Patient Safety Regulations (N.J.A.C. 8:43E-10.6), the types of serious preventable adverse events include, but are not limited to, the categories listed below. A facility shall report in the appropriate category events that are not specifically listed that meet the definition of a serious preventable adverse event.

A. Patient or resident care management-related events include, but are not limited to:

1. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with a medication error (such as errors involving the wrong drug, wrong dose, wrong patient or resident, wrong time, wrong rate, wrong preparation, or wrong route of administration);

2. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated products;

3. Maternal death, loss of body part, disability or loss of bodily function lasting more than seven days or still present at discharge associated with labor or delivery in a low-risk pregnancy while in a health care facility;

4. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge associated with hypoglycemia, the onset of which occurs while the patient or resident is being cared for in the health care facility;

5. Death or kernicterusa associated with failure to identify and treat hyperbilirubinemia in a neonate while the neonate is a patient in a health care facility;

6. Stage III or IV pressure ulcers acquired after admission of the patient or resident to a health care facility. Progression from stage II to stage III is excluded, provided that stage II was recognized and documented upon admission; and

7. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with spinal manipulative therapy provided in a health care facility.

a: "Kernicterus" means the medical condition in which elevated levels of bilirubin cause brain damage.
b: "Hyperbilirubinemia" means elevated bilirubin levels. Bilirubin is a breakdown product of red blood cells.

B. Environmental events include, but are not limited to:

1. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with an electric shock while being cared for in a health care facility. Events involving planned treatments, such as electric countershock (heart stimulation) or elective cardioversion, are excluded;
2. Incidents in which a line designated for oxygen or other gas to be delivered to a patient or resident contains the wrong gas or is contaminated by toxic substances and results in patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge;
3. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with a burn incurred from any source while in a health care facility;
4. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with a fall while in a health care facility; and
5. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days, or in the case of a non-residential health care facility, still present at discharge, associated with the use of restraints or bedrails while in a health care facility.

C. Product or medical device-related events include, but are not limited to:

1. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with use of generally detectable contaminated drugs, medical devices, or biologics provided by the health care facility, regardless of the source of contamination or product. "Generally detectable" means capable of being observed with the naked eye or with the use of detection devices in general use;
2. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days, or in the case of a non-residential health care facility, still present at discharge, associated with the use or function of a medical device in patient or resident care in which the device is used or functions other than as intended, including, but not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators;
3. Intravascular air embolism that occurs while the patient or resident is in the facility. This does not include deaths or disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism; and
4. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with the use of a new or reprocessed single-use device in patient or resident care in which the device is used or functions other than as intended.

D. Surgery-related events include, but are not limited to:

1. Surgery initiated (whether or not completed) on a patient that is not consistent with the patient's documented informed consent, including, but not limited to, a surgical procedure intended for a patient "A" that is initiated on the wrong body part of patient "A," and a surgical procedure intended for another patient of the facility, but initiated on patient "A". Surgery- related events exclude emergent situations that occur in the course of surgery and as to which exigency precludes obtaining informed consent;
2. Retention of a foreign object in a patient after surgery, excluding objects intentionally implanted as part of a planned intervention, objects present prior to surgery that were intentionally retained, and retained broken microneedles; and
3. Intraoperative or post-operative (that is, within 24 hours) coma, death, or other serious preventable adverse event in any patient of an ambulatory surgery facility, in any hospital same-day surgery patient, or in any American Society of Anesthesiologists (ASA) Class I hospital inpatient. This includes all patient deaths, coma or other serious preventable adverse events in situations where anesthesia was administered, regardless of whether the planned surgical procedure was carried out.

E. Patient or resident protection-related events include, but are not limited to:

1. Discharge of an infant to the wrong person, excluding patient or resident abductions covered under N.J.A.C. 8:34E-10.11(b);
2. Patient or resident death, loss of body part, disability or loss of bodily function lasting more than seven days associated with patient or resident elopement; and
3. Patient or resident suicide or attempted suicide while in a health care facility. This does not include deaths or disability resulting from self-inflicted injuries that were the reason for admission to the health care facility.
   N.J.A.C. 8:43E-10.6(l)

The root cause analysis performed by a facility in response to a report of an occurrence of a serious preventable adverse event may vary in substance and complexity, depending on the nature of the facility and the event involved, but shall include the following general components:

1. A description of the event, including when, where and how the event occurred and the adverse outcome for the patient or resident;
2. An analysis of why the event happened that includes an analysis not only of the direct cause(s) of the event, but also potential underlying causes related to the design or operation of facility systems;
3. The corrective action(s) taken for those patients or residents affected by the event;
4. The method for identifying other patients or residents or settings having the potential to be affected by the same event and the corrective action(s) to be taken;
5. The measures to be put into place or systematic changes needed to reduce the likelihood of similar events in the future; and
6. How the corrective action(s) will be monitored to assess their impact.

New Jersey Department of Health Review of Root Cause Analyses

N.J.A.C. 8:43E-10.6(m)

The Department shall:

1. Review an RCA to determine whether it satisfies the criteria in (l) above; and
2. Return an RCA that does not meet the criteria in (l) above to the facility for revision and shall not consider the RCA complete until the Department determines that the RCA meets the criteria in (l) above.

Patient Safety Reporting System (PSRS) Contact Information

PSRS Telephone: 609-633-7759

PSRS Website: http://nj.gov/health/ps

PSRS Staff:

Eva Besserman, DO, MBA, FCCM, *Clinical Director*
Eva.Besserman@doh.nj.gov

Sara Day, RN, BSN, CPM - *Quality Assurance Coordinator*
Sara.Day@doh.nj.gov

Regina Smith, RN, BSN, MA - *Health Science Specialist*
Regina.Smith@doh.nj.gov

Alisa Simmons, RN, BSN - *Quality Assurance Specialist, Health Services*
Alisa.Simmons@doh.nj.gov

Kathleen Polhamus, RN, BSN - *Contractor*
Kathleen.Polhamus@doh.nj.gov

Adan Olmeda - *Administrative Support*
Adan.Olmeda@doh.nj.gov

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2019 Summary Report