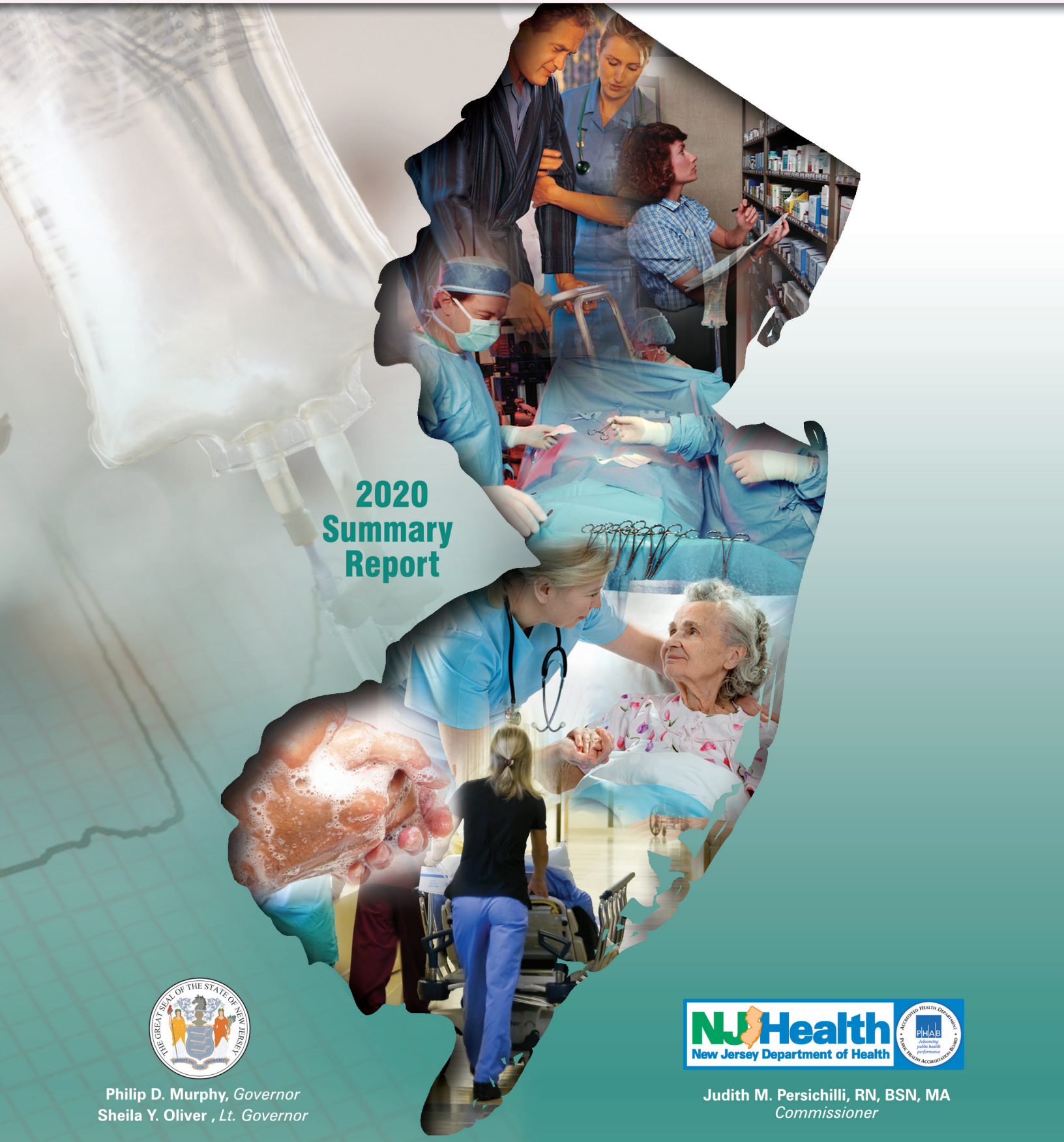
HCQA Health Care Quality Assessment

Patient Safety Reporting System



2020 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

Patient Safety Reporting System

New Jersey Department of Health Report Preparation Team

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

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

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

DaQing Song, PhD
Research Scientist
Patient Safety Reporting System

Adan Olmeda
Administrative Support
Patient Safety Reporting System

Emmanuel Noggoh
Contractor

Jan Applebaum
Designer
Printing & Graphic Design Studio

Date: February 2023

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
Website: https://www.nj.gov/health/healthcarequality/health-care-professionals/patient-safety-reporting-system/

Patient Safety Reporting System (PSRS) Contact Information

PSRS Telephone: 609-633-7759

PSRS Website:

https://www.nj.gov/health/healthcarequality/health-care-professionals/patient-safety-reporting-system/

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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** 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."*

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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 licensed in the State of NJ 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 2020:

- 678 events were reported to the Patient Safety Reporting System by all facility types;
- 580 events met the statutory definition of (or satisfied the criteria for) a serious preventable adverse event ("reportable");
- 98 events did not meet the statutory definition included less serious events, near misses and events that were not associated with the provision of health care ("not reportable");
- 108 deaths were associated with the adverse events.

General Acute Care Hospitals:

- Submitted 358 reportable adverse events in 2020 compared to 400 events in 2019;
- The average number of reportable events per reporting hospital was 5.6. (does not take into account hospital sizes and bed capacity);
- There were 67 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 (5), and fall events (15);
- 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.

a: Refer to the Introduction section on page 3 for a description of "other" event types.

Executive Summary

Comprehensive Rehabilitation Hospitals:

- There were 30 reportable events and one death associated with orientation and training of staff;
- The most frequently reported root causes were care planning process, communication among staff members, physical assessment and orientation and training of staff;
- One-half of the events resulted in additional laboratory testing or diagnostic imaging as well as increased length of stay.

Psychiatric Hospitals:

- There were 9 reportable events with two deaths;
- The most frequently reported root causes were care planning process and other;
- Most of the events resulted in transfer to more intensive level of care, hospital admission and increased length of stay.

Special Hospitals:

- Eleven reportable events were submitted by eight reporting facilities and four of the events resulted in deaths;
- The most frequently reported were root causes physical assessment, and 'other';
- The most reported impact include increased length of stay, disability-physical or mental impairment, additional patient monitoring in current location, death.

Ambulatory Surgery Centers:

- Submitted 132 reportable events with six 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 40 reportable events submitted with 28 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, transfer to more intense level of care, increased length of stay, additional laboratory testing or diagnostic imaging and additional patient monitoring in current location.

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 2020.

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 2020 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 2020 from all facilities totaled 678.

Of this total, 584 were deemed reportable with 108 associated deaths. In 2019, the number of reportable events across all facility types was 648 with 90 associated deaths.

An in-depth analysis of the data shows that there were 64 less reportable events between 2019 and 2020. This decrease in reportable events (64) may be attributed to the effect of the COVID19 pandemic on the reporting process within facilities.

The number of deaths in 2019 was 90 compared to 108 in 2020.

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 2020.

Table 1: Reporting Pattern by Facility Type (2020)

Facility Type	Number of Facilities	Number of facilities Reporting	Number of Reportable Events	Number of Not Reportable Events	Number of Less Serious/Near Misses	Number of Reportable Deaths	Percent of Reportable Deaths
General Acute Care Hospitals	70	64	358	2	20	67	18.7
Comprehensive Rehabilitation Hospitals	14	8	30	0	2	1	3.3
Psychiatric Hospitals	10	6	9	0	0	2	22.2
Special Hospitals	16	8	11	0	4	4	36.4
Ambulatory Surgery Centers	251	74	132	1	54	6	4.5
End Stage Renal Disease Centers	239	36	40	0	15	28	70.0
Total	**600**	**196**	**580**	**3**	**95**	**108**	**18.6**

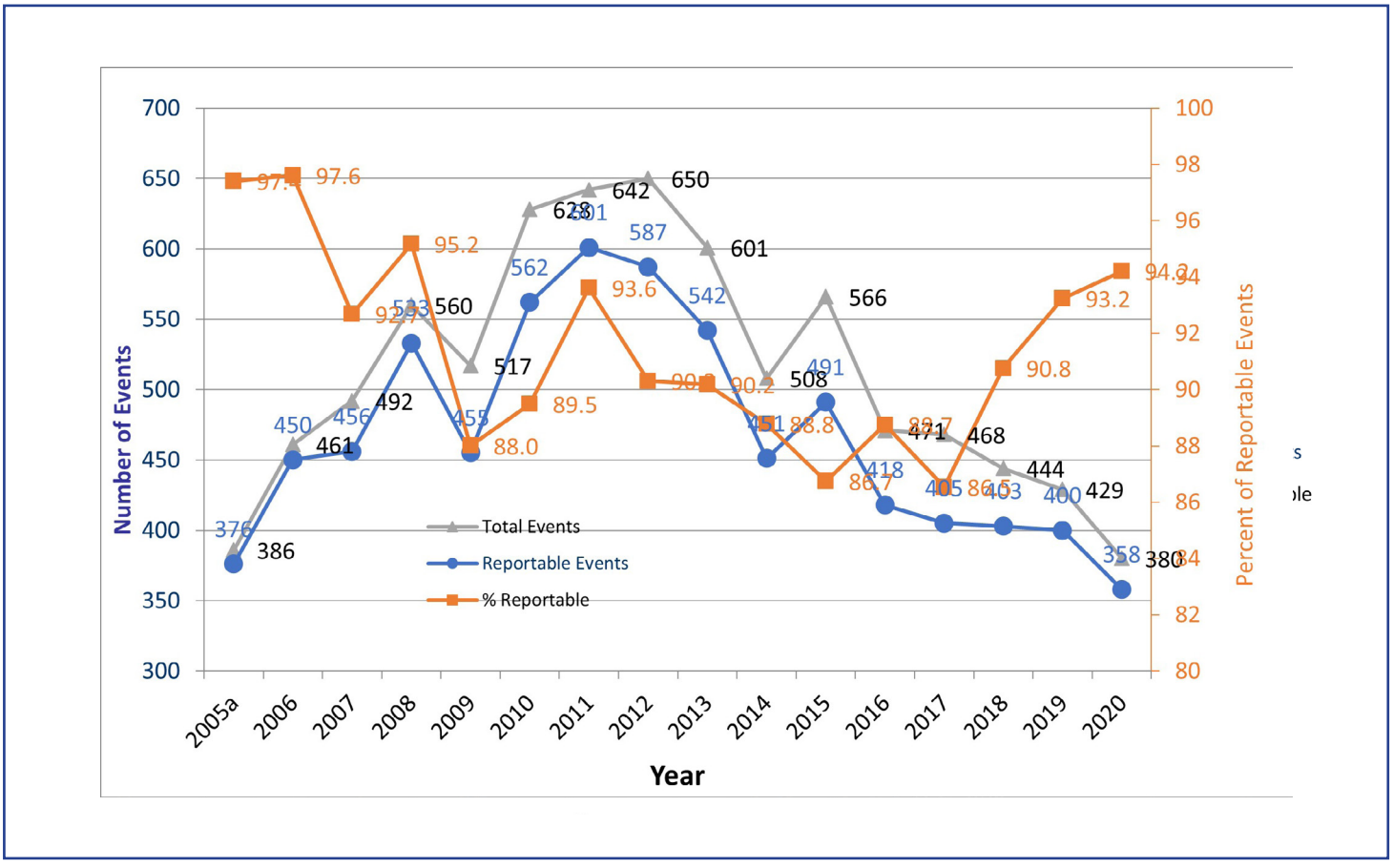
A. Reporting Patterns (2005-2020)

Figure 1 and Table 2 demonstrate the reporting patterns for general acute care hospitals over the past 16 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 even if not reportable.

The percent of not reportable events by general acute care hospitals dropped from 7 percent in 2019 to 5.8 percent in 2020.

Figure 1: General Acute Care Hospitals: Trends of Total and Reportable Events 2005-2020



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

III. General Acute Care Hospitals

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

Reporting Year	Reportable Events	Not Reportable Events	Less Serious/Near Miss Events	Total Events	Percent Not Reportable	Percent Reportable
2005[a]	376	10	NA	386	2.6	97.4
2006	450	11	NA	461	2.4	97.6
2007	456	36	NA	492	7.3	92.7
2008	533	27	NA	560	4.8	95.2
2009	455	62	NA	517	12.0	88.0
2010	562	66	NA	628	10.5	89.5
2011	601	10	31	642	6.4	93.6
2012	587	22	41	650	9.7	90.3
2013	542	5	54	601	9.8	90.2
2014	451	2	55	508	11.2	88.8
2015	491	8	67	566	13.3	86.7
2016	418	4	49	471	11.3	88.7
2017	405	4	59	468	13.5	86.5
2018	403	1	40	444	9.2	90.8
2019	400	1	28	429	6.8	93.2
2020	358	2	20	380	5.8	94.2

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

Patient Safety Reporting System

III. General Acute Care Hospitals

Since reporting began in February 2005, 7417 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 2020.

In 2020, the sixteenth year of reporting, 358 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 2020, 64 general acute care hospitals in New Jersey submitted reportable events. The average number of reports per reporting hospital was 5.6. 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. 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 (2005-2020)

Reporting Year	Number of Reportable Events	Number of Facilities	Number of Facilities Reporting	Percent of Facilities Reporting	Average Number of Reports per Facility	Reportable Deaths	Percent of Deaths
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	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	8.1	84	14.3
2013	542	72	72	100	7.5	84	15.5
2014	451	72	72	100	6.3	75	16.6
2015	491	72	72	100	6.8	96	19.6
2016	418	72	68	94.4	6.1	72	17.2
2017	405	72	72	100	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
2020	358	70	64	91.4	5.6	67	18.7

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

B. Reportable Events and Associated Deaths by Event Category

As indicated earlier in the report, there were 358 adverse events reported by New Jersey general acute care hospitals in 2020. There were 67 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-2020

Event Category	Total Reportable Events	Percent of Total Events	Total Reportable Deaths by Events	Percent of Deaths by Events
A: Care Management	122	34.1	38	56.7
B: Environmental	124	34.6	17	25.4
D: Surgery-Related	51	14.2	11	16.4
C: Product or Device	6	1.7	1	1.5
E: Patient Protection	55	15.4	0	0.0
Total	**358**	**100**	**67**	**100**

Table 4B: General Acute Care Hospitals: Reportable Events and Associated Deaths by Event Category-2020

Event Category & Classification	Total Reportable Events	Total Reportable Deaths per Event
A: Care Management	122	38
Medication Error	8	6
Maternal Labor	4	3
Pressure Ulcers	55	3
Care Management-Other	54	26
B: Environmental	124	17
Burn	2	0
Fall	120	15
Restraints	2	2
C: Product or Device	6	1
D: Surgery Related	51	11
Retained Foreign Object [a]	31	0
Intra/Post-Op Coma/ Death/Other Events	11	5
Surgical Other	8	6
E: Patient Protection	55	0
Suicide/Attempted Suicide	53	0
Total	**358**	**67**

a: Included 3 events of Less Serious or Near Miss.

III. General Acute Care Hospitals

As Tables 4A and 4B demonstrate, the care management event category accounted for the highest number of deaths (38 out of 67) or over one-half of all deaths reported. The second highest category for reported deaths was environmental (17), followed by surgery related (11). Product/ Device malfunction reported one event or death within that event category and Patient Protection reported no death events.

For surgery-related event types, retained foreign objects had the highest number of reported events (31); this was a decrease of 9 from 2019. There are no deaths associated with this event.

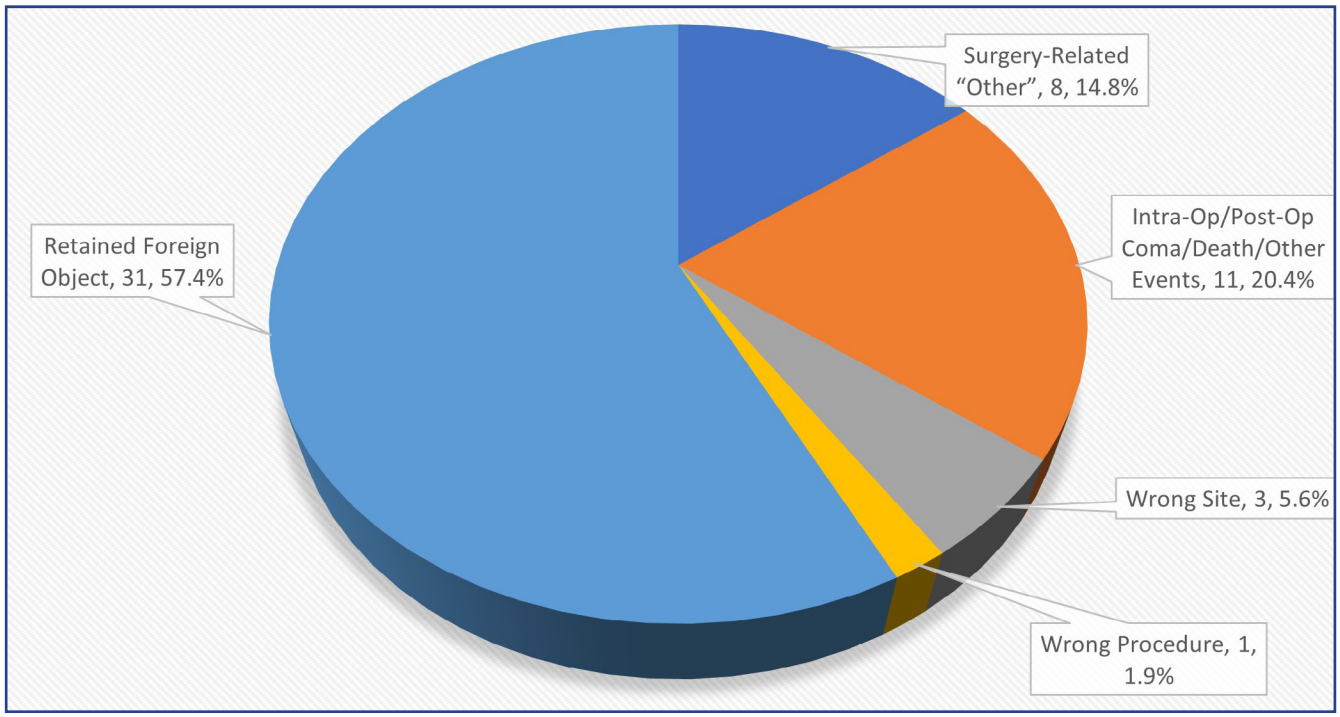
The second highest reported event was for intra-operative or post-operative events (11) with 5 (45.45 %) associated deaths.

Table 5 and Figure 2 show the results.

Table 5: General Acute Care Hospitals: Surgery-Related Event Types with Associated Deaths

Event Type	Reportable Events	Reportable Deaths	Percent of Deaths by Event Types
Surgery-Related "Other"	8	6	75.0
Intra-Op/Post-Op Coma/Death/Other Events	11	5	45.5
Wrong Site	3	0	0.0
Wrong Procedure	1	0	0.0
Retained Foreign Object [a]	31	0	0.0
Total	**51**	**11**	**21.6**

Figure 2: General Acute Care Hospitals: Number and Percent of Surgery-Related Events by Type[a]



a: Retained Foreign Object included 3 events of Less Serious or Near Miss.

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 193 reportable events which represent 53.9 percent of all events reported. However, the total number of deaths associated with these four events was 52 and accounted for almost 78 percent of all deaths reported in 2020.

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

Event Type	Reportable Events	Number of Reportable Deaths	Percent of Deaths by Event Types
Surgery-Related "Other"	8	6	75.0
Care Management - Other	54	26	48.1
Intra-Op/Post-Op Coma, Death or Other Events	11	5	45.5
Fall	120	15	12.5
All Other Event Types	165	15	9.1
Total	**358**	**67**	**18.7**

1. Care Management "Other" Events

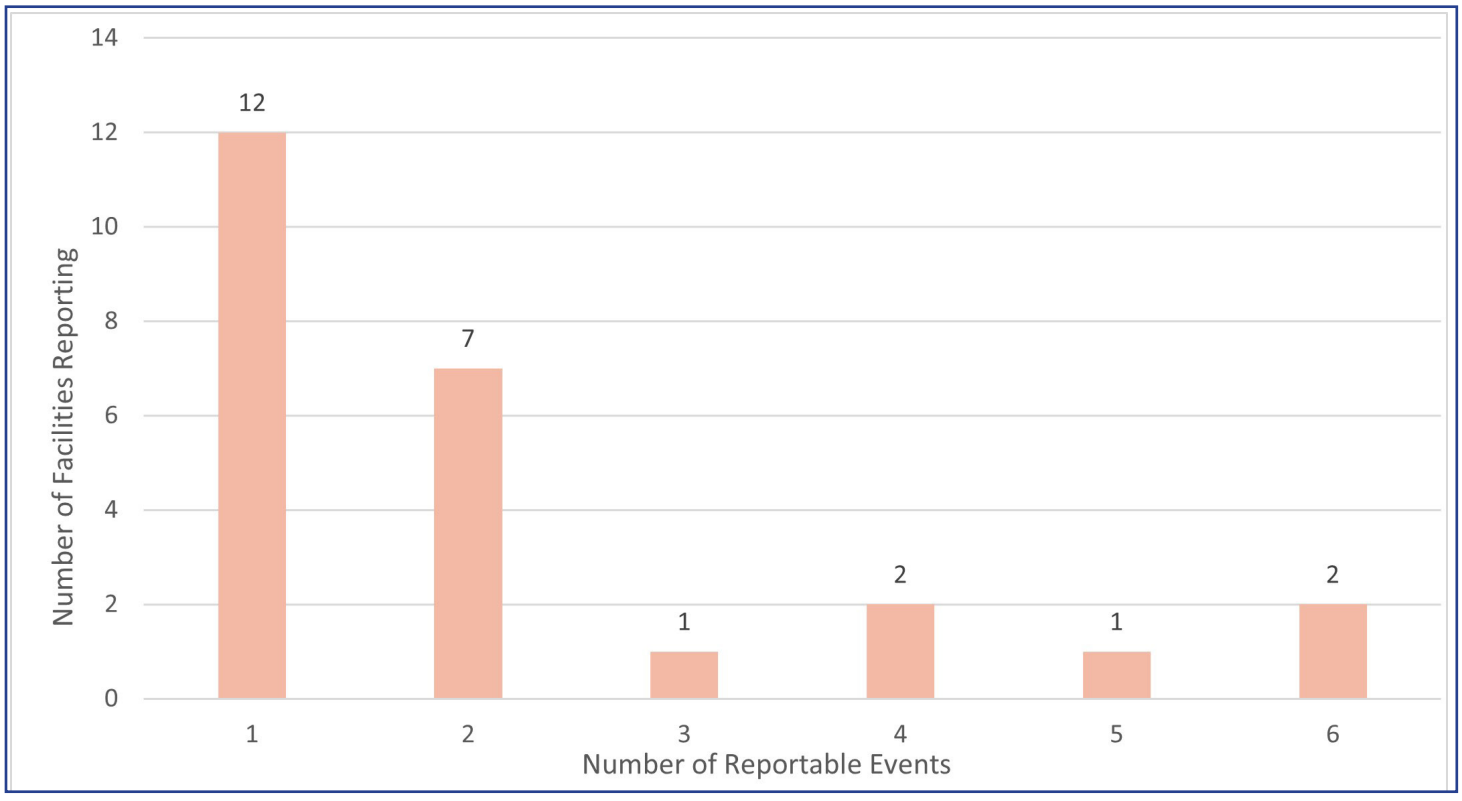
Of the 54 patients who received care in this event category in 2020, 26 (48.1 %) died. In 2019, 26 patients died out of a total of 54. Table 6 shows the results.

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/injuries. 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: General Acute Care Hospitals: Number of Facilities Reported by Number of Reportable Events of Care Management "Other" Events

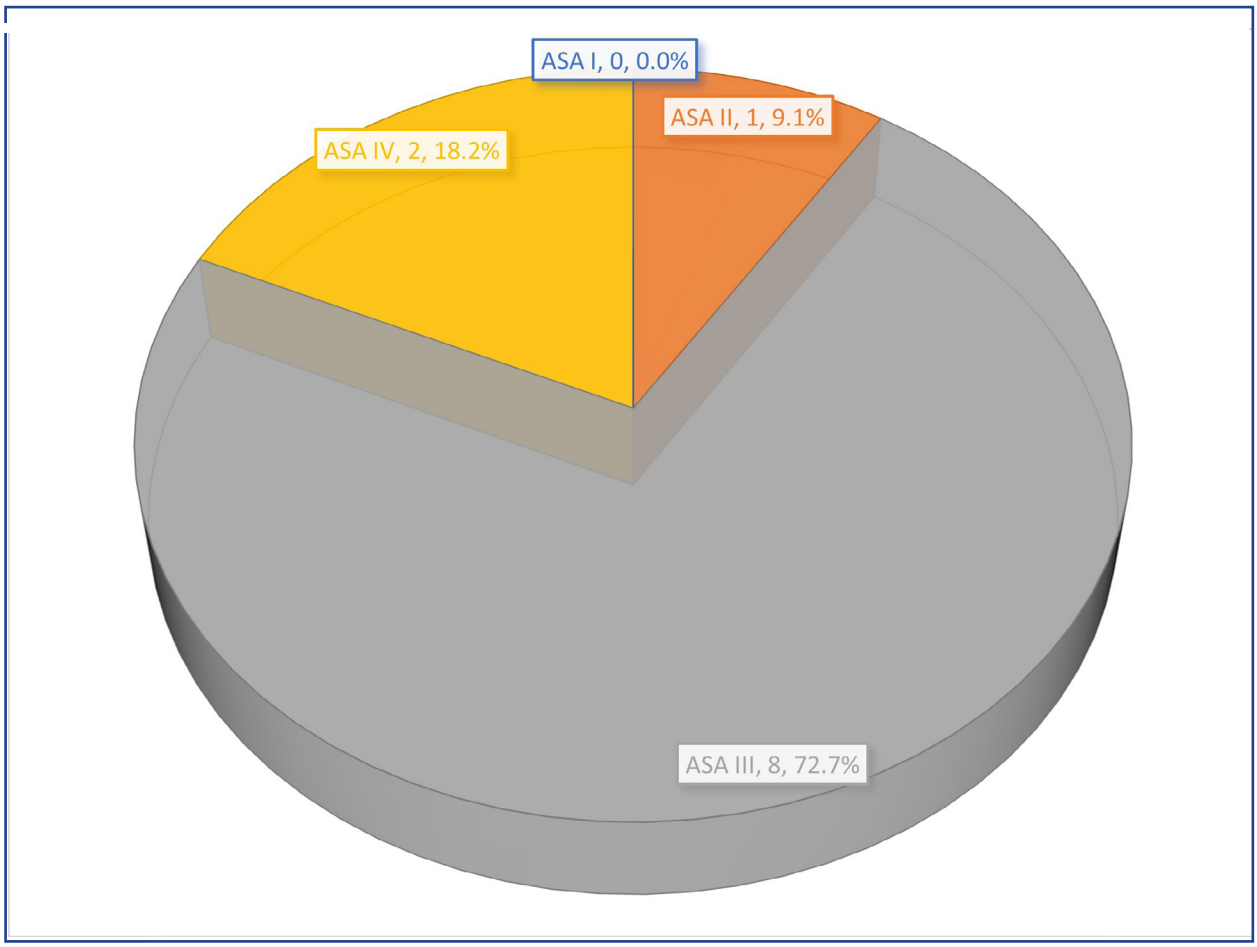


2. Intra-Operative or Post-Operative Coma, Death or Other Serious Preventable Adverse Event

There were 11 reports of intra-operative or post-operative (that is, within 24 hours) coma, death or other serious preventable adverse event in 2020 compared to 18 in 2019. There were 5 deaths in this category in 2020.

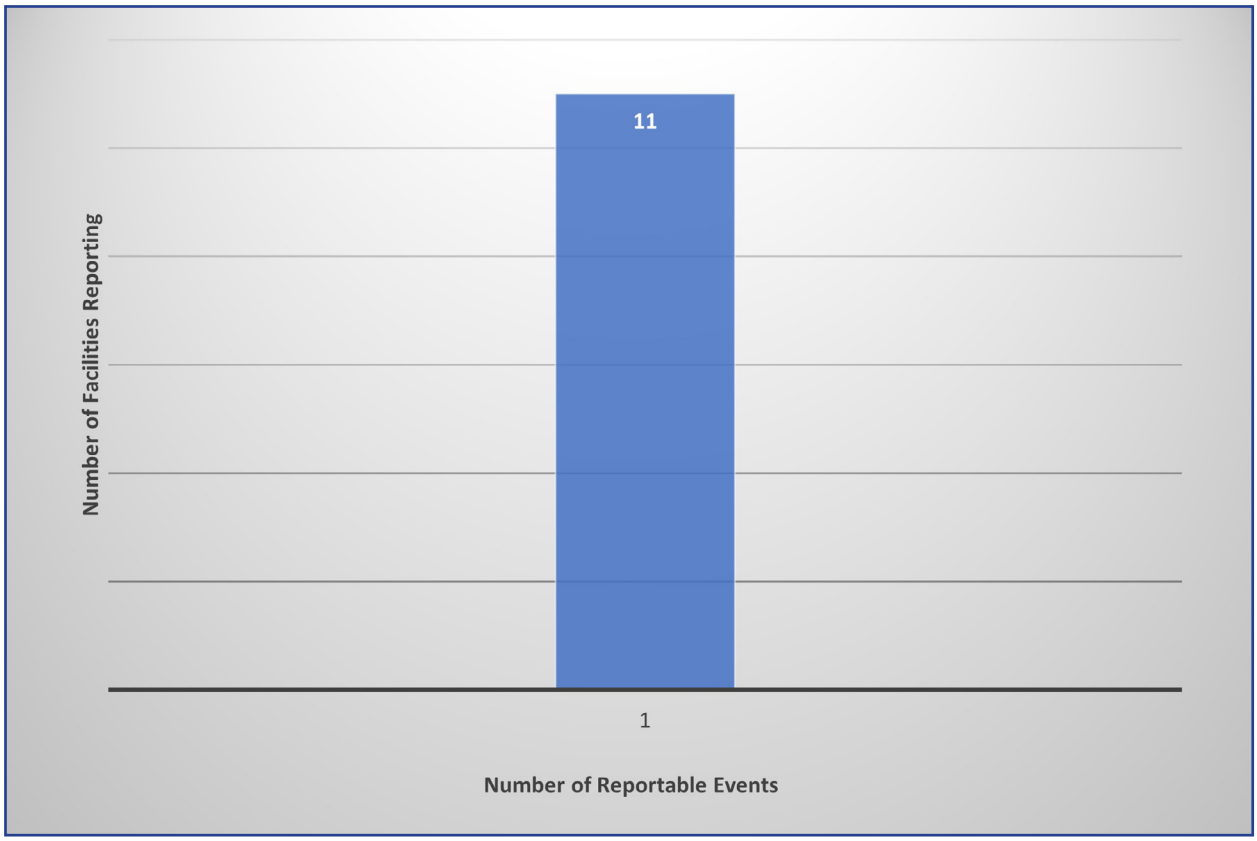
Based on the American Society of Anesthesiology (ASA) classification, the patients fell into the following classifications: ASA Class l: 0, ASA Class ll: 1, ASA Class lll: 8, and ASA Class lV: 2 with zero unknown ASA. See chart below.

Figure 4: General Acute Care Hospitals: ASA Classification



The 11 events were reported by facilities as follows:

Figure 5: General Acute Care Hospitals: Number of Facilities Reporting Intra-Op/Post-Op Events

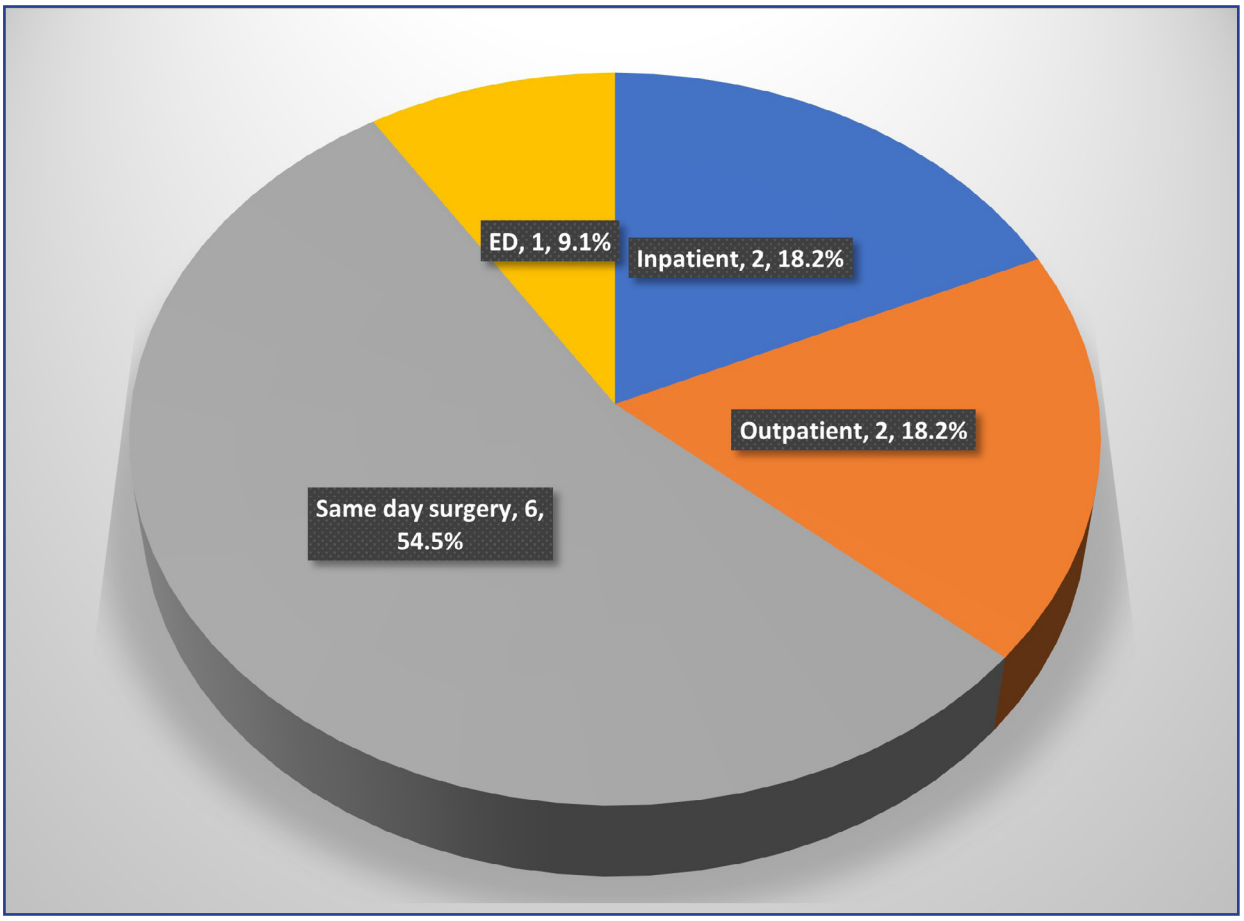


III. General Acute Care Hospitals

The severity of impact 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: General Acute Care Hospitals: Patient Admission Type



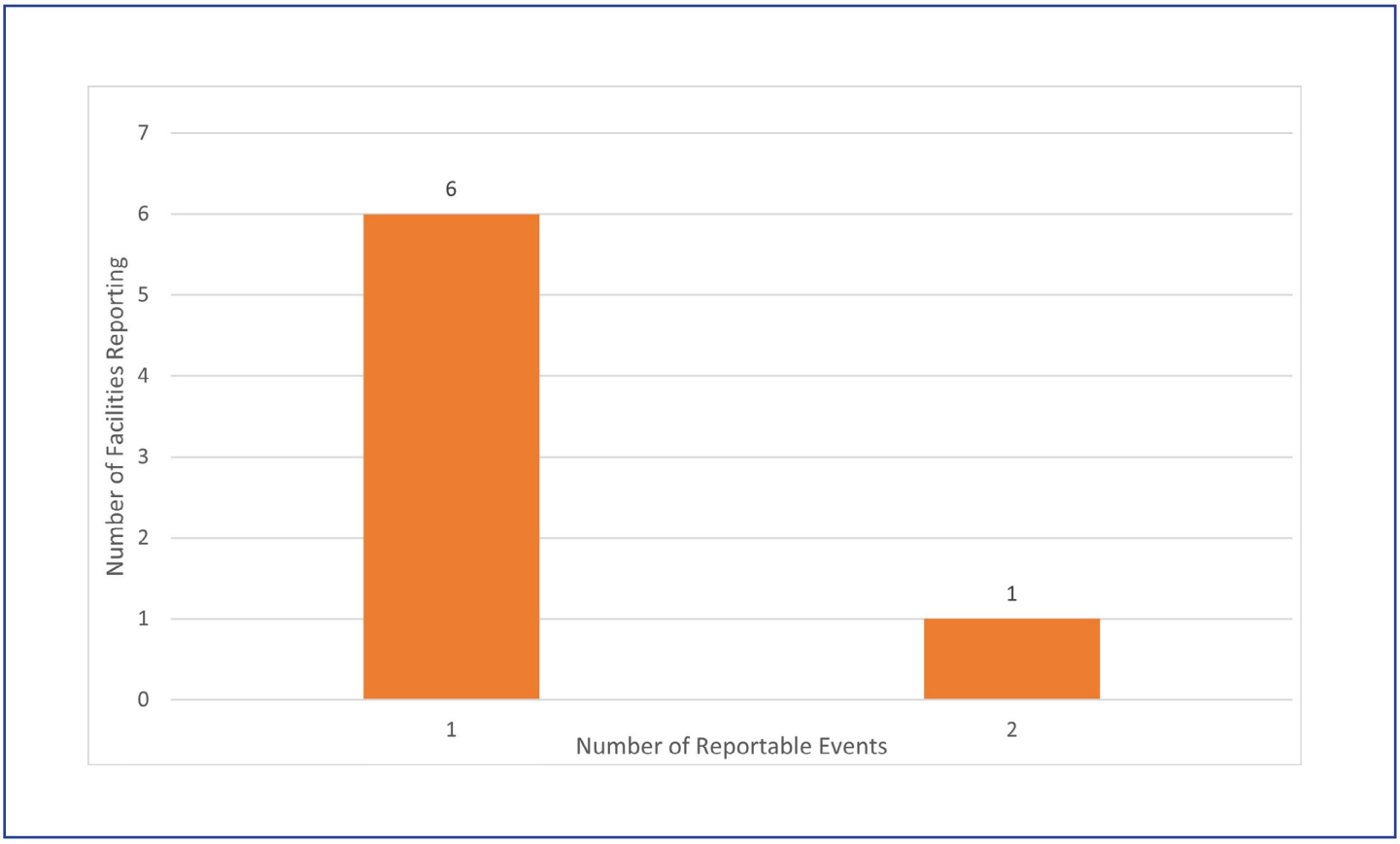
3. Surgery "Other" Events

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 8 in 2020 compared to 9 in 2019.

Seven facilities reported the 8 events as follows: Six facilities reported one event each and one hospital reported two events.

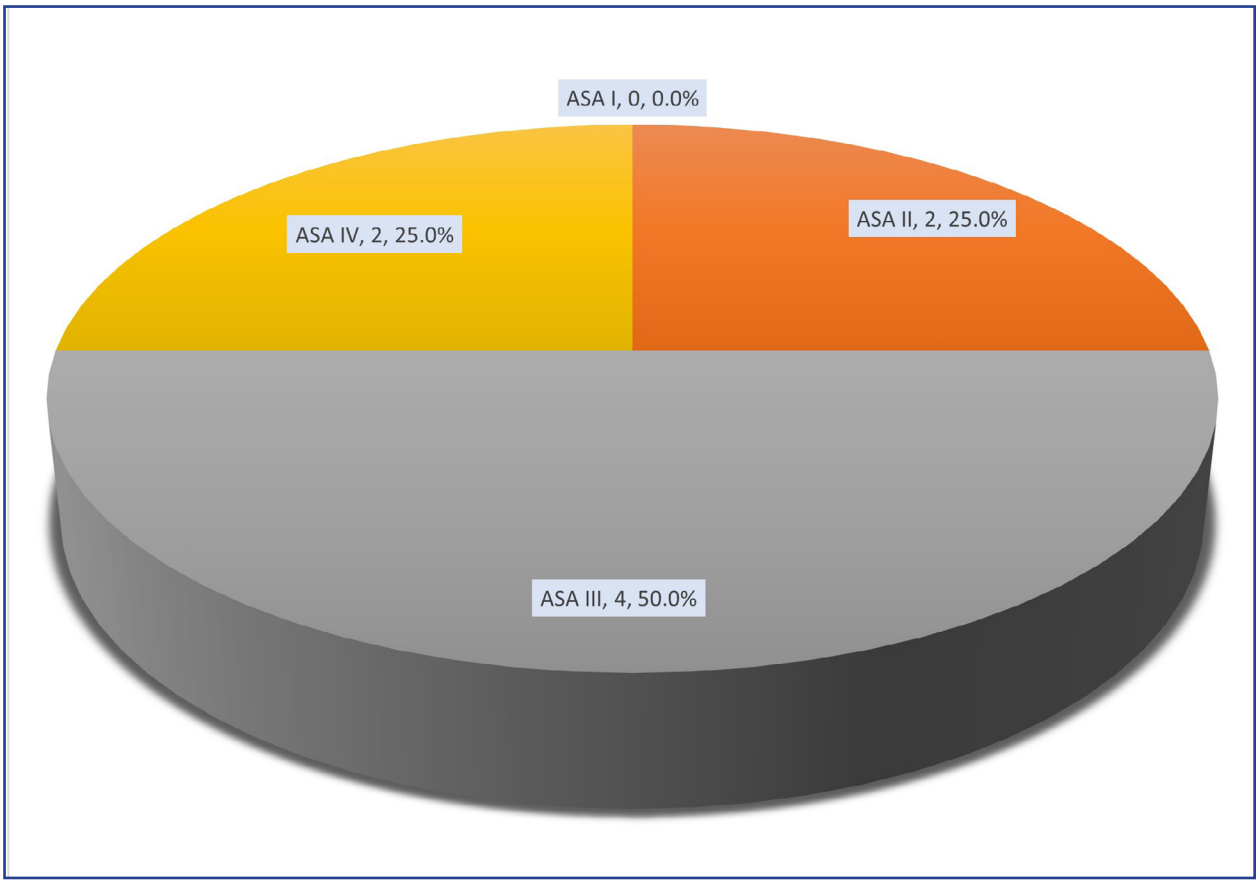
Figure 7: General Acute Care Hospitals: Surgery "Other" Facilities Reporting



Of the 8 events submitted, four of the patients were designated as ASA Class lll (55.6%), two were designated as ASA Class II (33.3%) and two 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: General Acute Care Hospitals: Surgery "Other" ASA Classifications



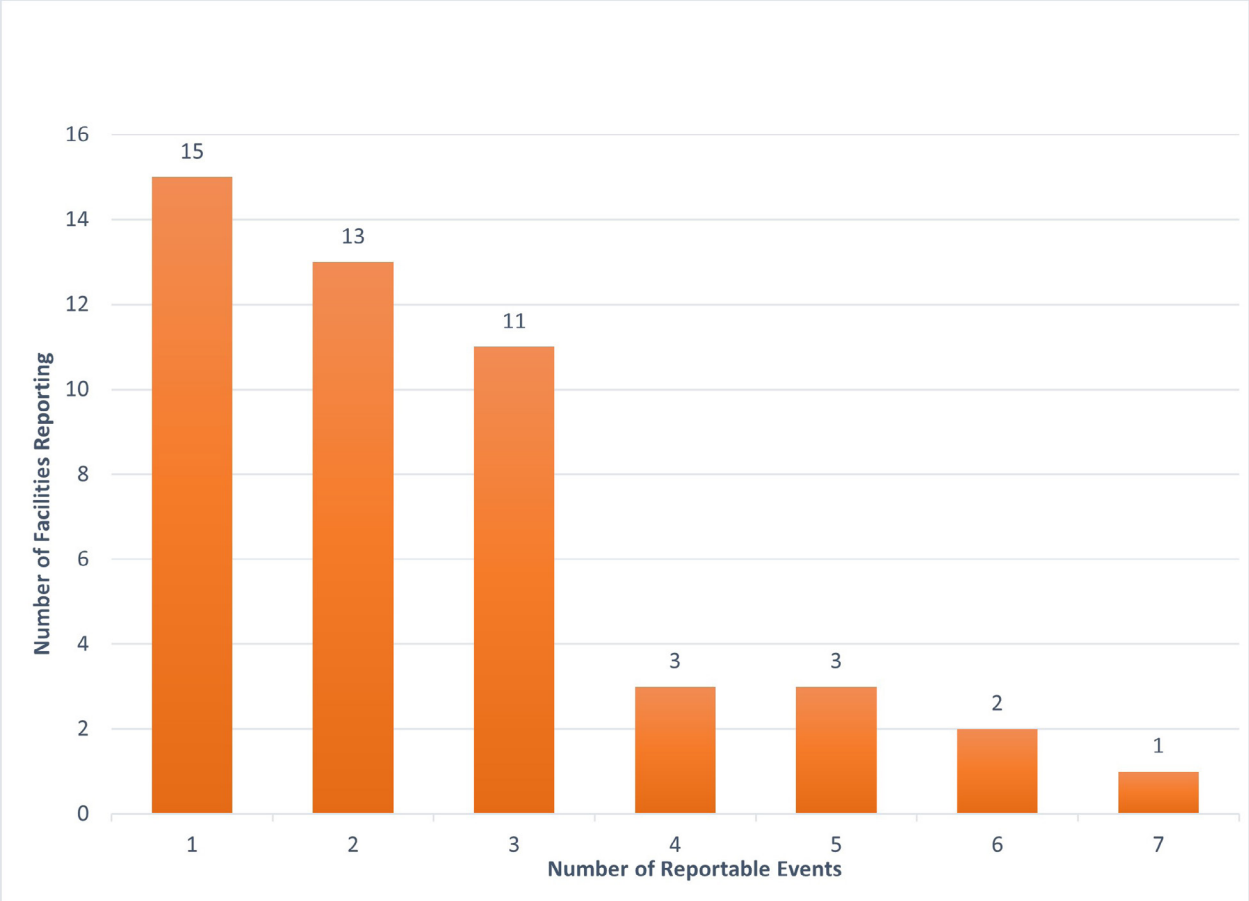
4. Fall Events

Falls continue to be the most frequently reported event submitted to the Patient Safety Reporting System. The number of reported falls in 2020 was 120 compared to 138 in 2019.

There were fifteen reported deaths from these events, compared to eight in 2019.

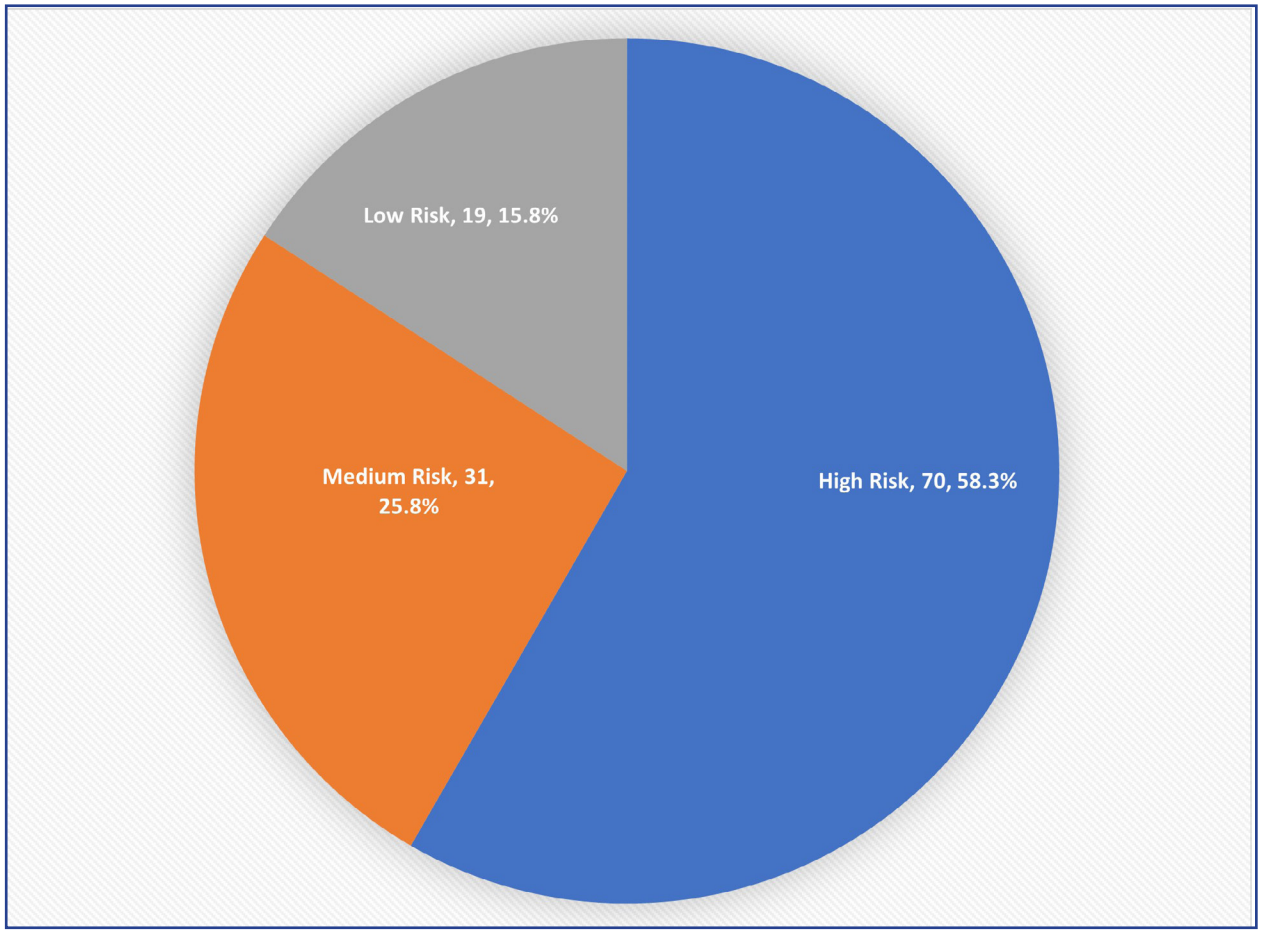
A total of 48 hospitals submitted these fall events as displayed below:

Figure 9: General Acute Care Hospitals: Number of Facilities Reporting Fall Events



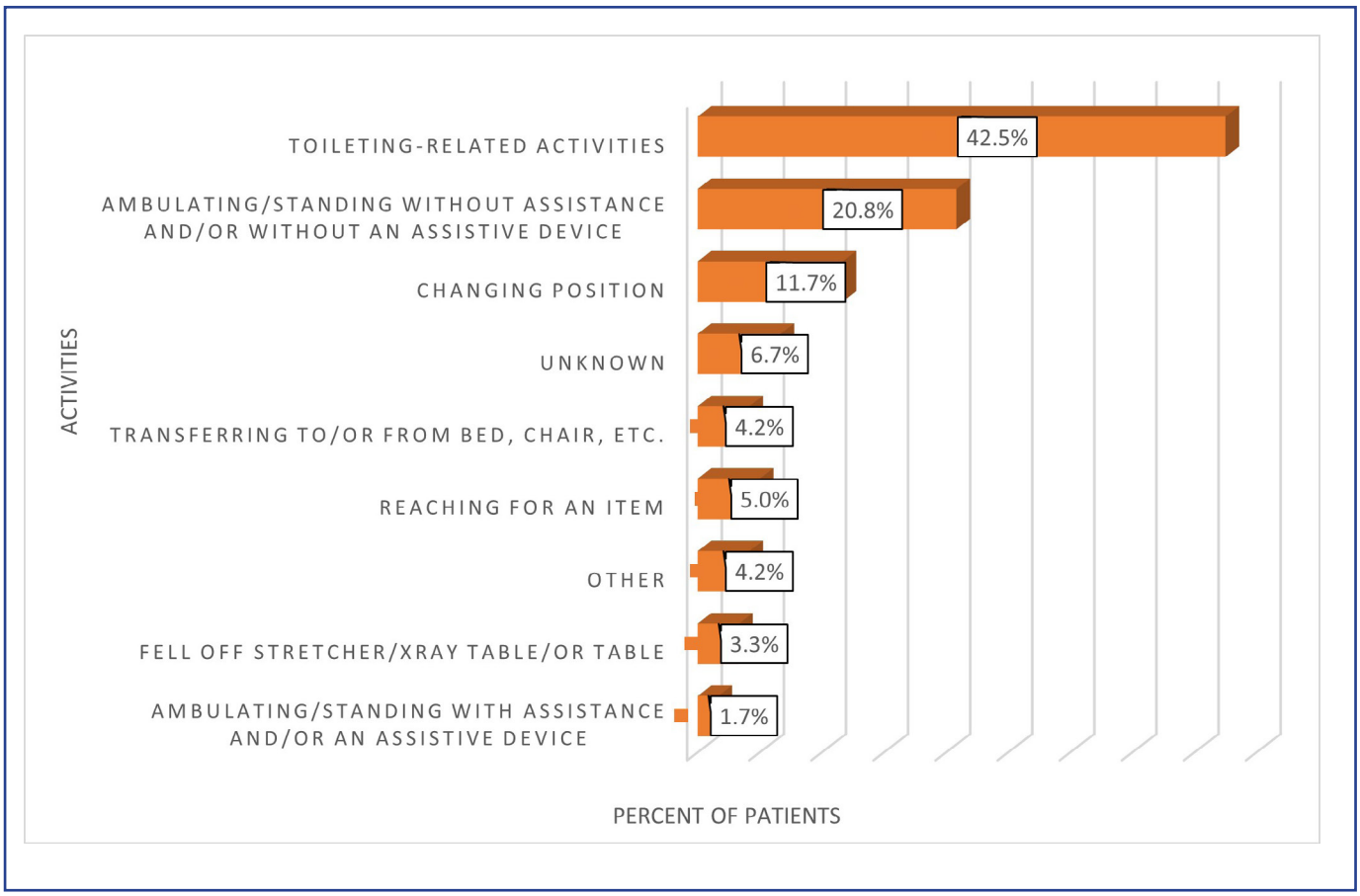
Prior to the fall, 70 patients (58.3 %) were known to be at high risk; 31 (25.8 %) were at medium risk; and 19 or 15.8 %) were considered to be at low risk for falls.

Figure 10: General Acute Care Hospitals: Fall Risk Categories



The chart below shows the various activities the patients were engaged in prior to the fall:

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



III. General Acute Care Hospitals

As in the past, 40.0 fall risk screening tool was used to assess the patient's risk prior to the fall. The most prevalent screening tool was the Johns Hopkins Fall Risk Assessment Tool (48 %), followed by Morse Falls Risk Assessment (40, 38.3 %) followed by the Hendrich Scale (14, 11.7%).

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 12A: General Acute Care Hospitals: Percent of Patient Fall Locations

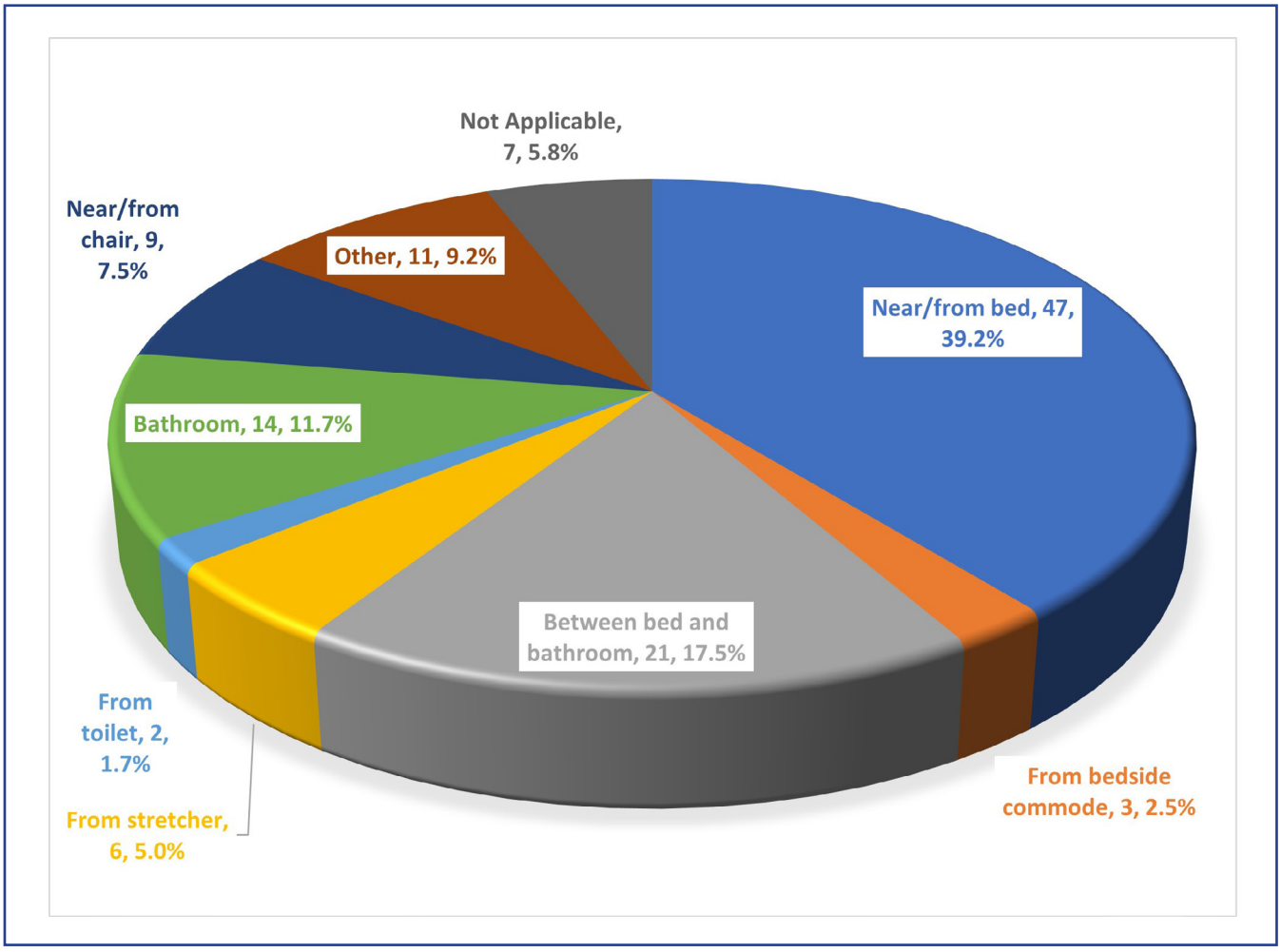


Figure 12B: General Acute Care Hospitals: Percent of Patient Fall Risk Assessment by Tools

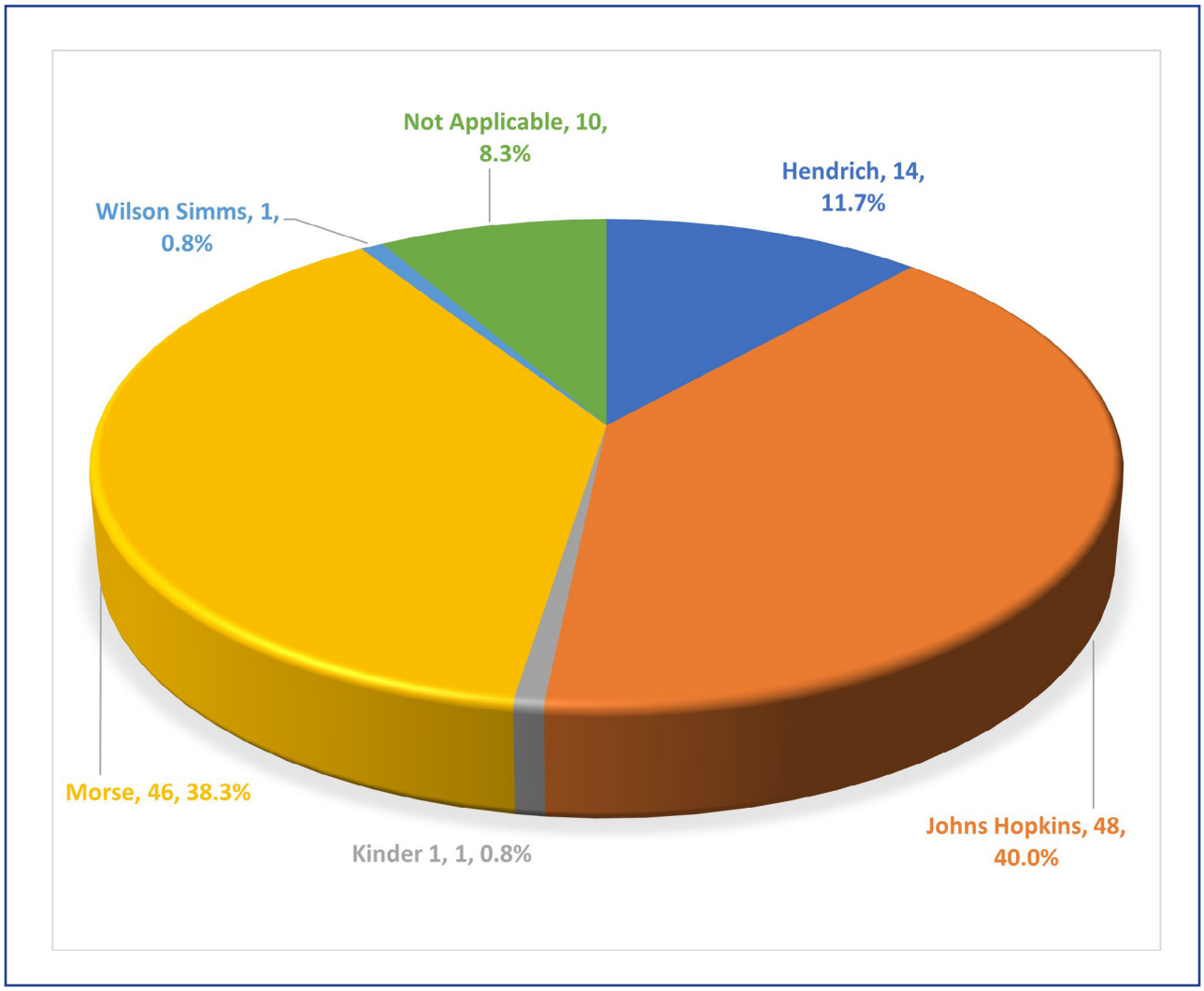
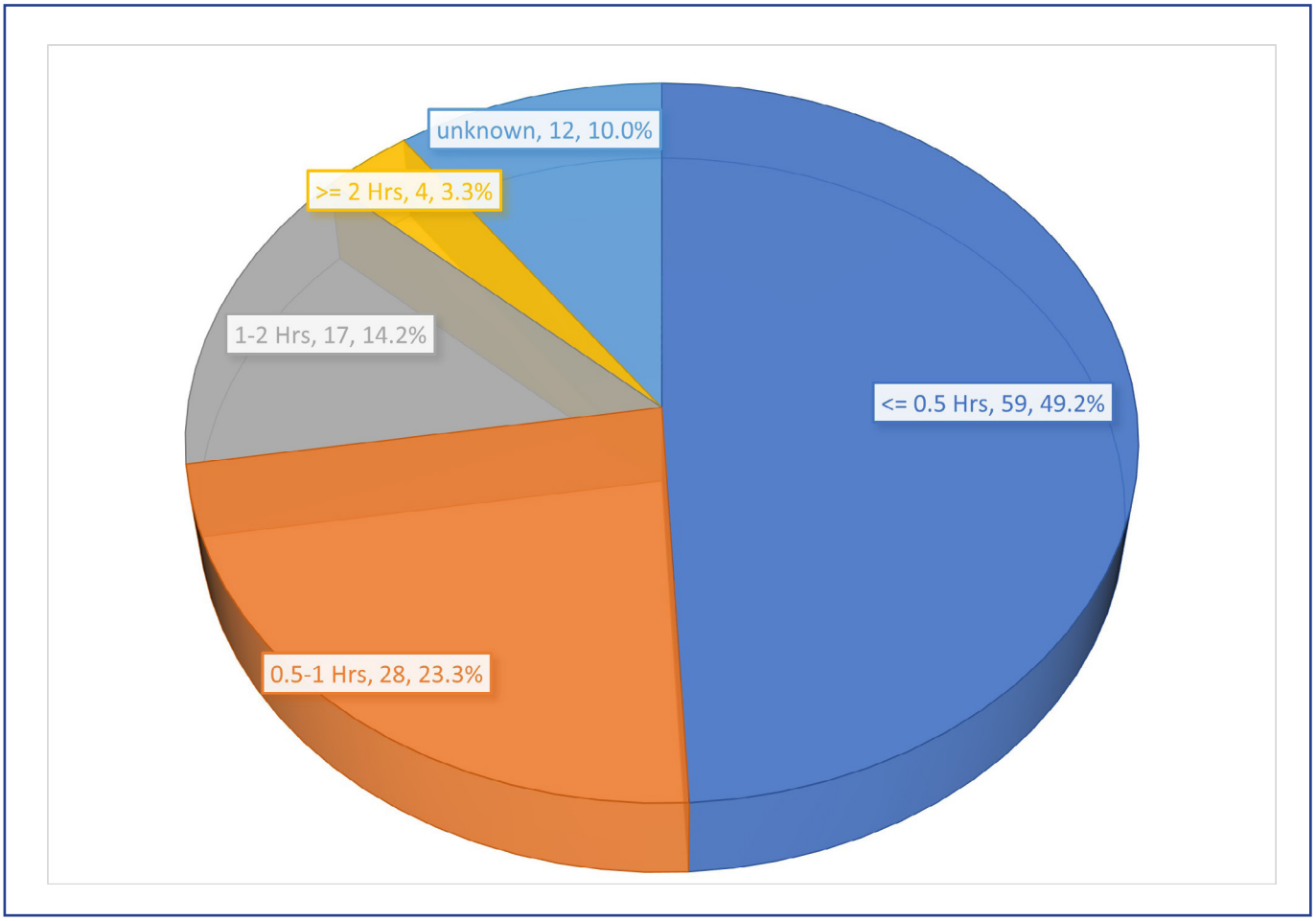


Figure 12C: General Acute Care Hospitals: Percent of Time Lengths Prior to Patient Fall



D. Most Frequently Reported Event Types

As shown in Table 7, the highest number of events submitted in 2020 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 (89.7 %) of all events reported in 2020.

Figure 13 shows the reporting trends for these event types from 2012 to 2020.

Table 7: General Acute Care Hospitals: Most Frequently Reported Event Types (2020)

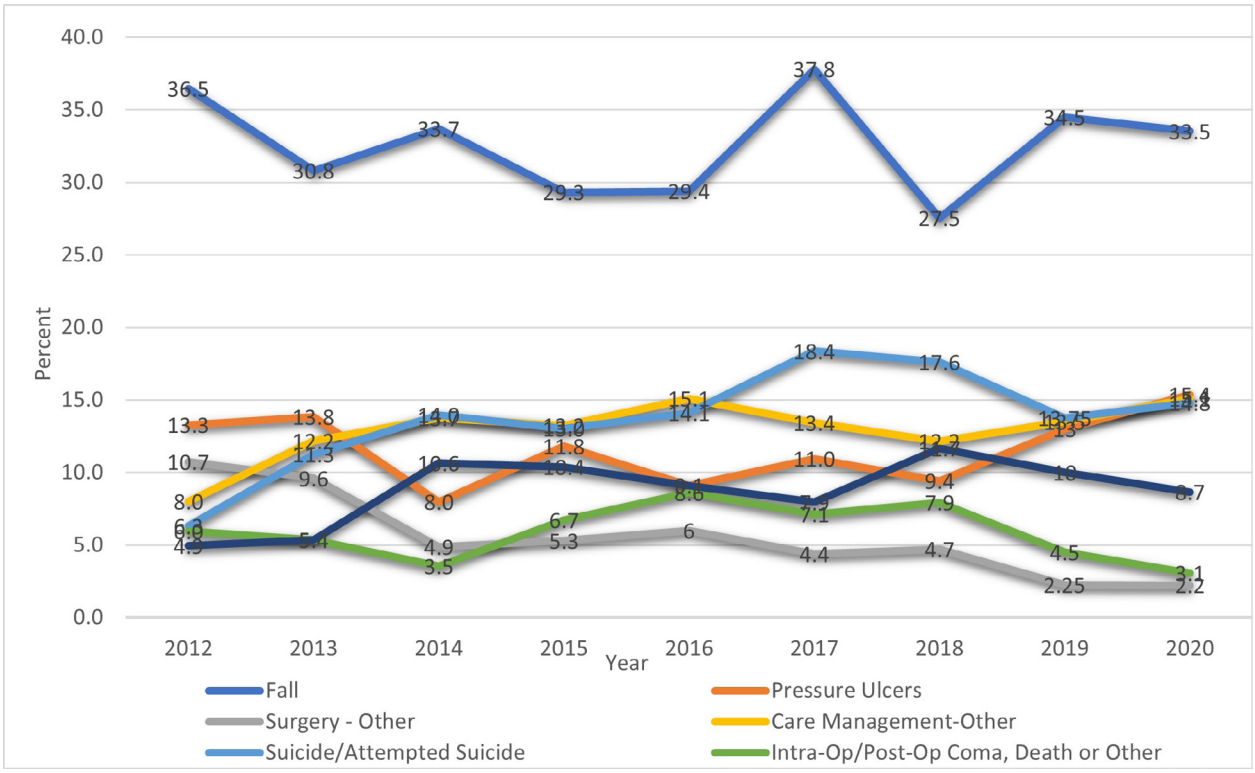
Event Type	Number of Reportable Events	Percent of Events [a]
Fall	120	33.5
Pressure Ulcer	55	15.4
Care Management Other	54	15.1
Suicide/Attempted Suicide	53	14.8
Retained Foreign Object [b]	31	8.7
Surgical Intra/Post-Op Coma, Death or Other Serious Adverse Events	11	3.1
All Other Events	37	10.3
Total	**358**	**100**

Note:

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

b. Included 3 events of Less Serious or Near Miss.

Figure 13: General Acute Care Hospitals: Percentage of Most Frequently Reportable Event Types 2012-2020[a]



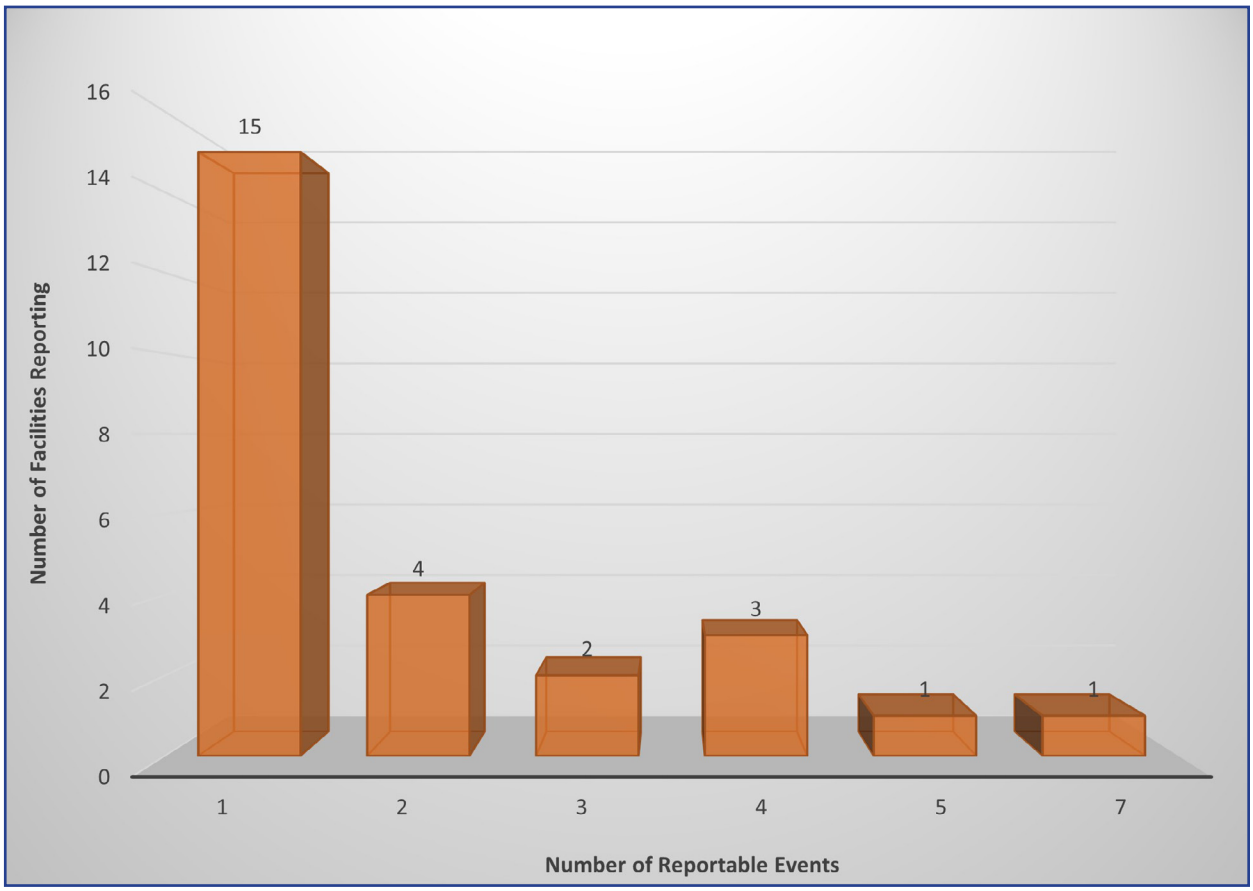
a: Retained Foreign Object included 3 events of Less Serious or Near Miss.

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

There were 53 reportable adverse events for this event type in 2020; a decrease of 2 from 2019 (55).

The 53 suicides and attempted suicides were submitted by 26 hospitals as shown in the chart below.

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

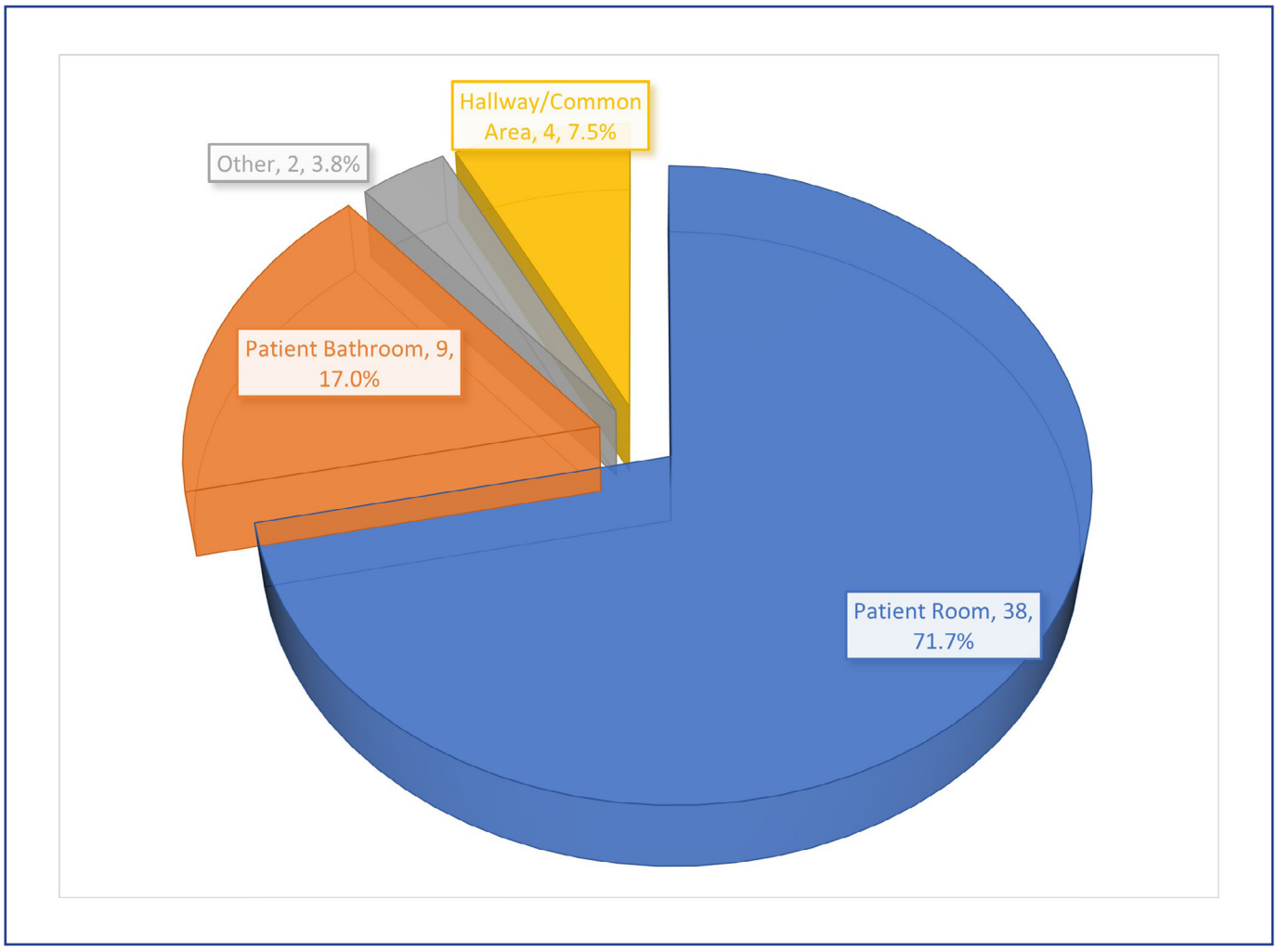


Of the 53 patients, 28 or 52.83 percent were considered at risk of suicide, 42 were seen by a psychiatrist.

Figure 15, shows the locations where the suicide/attempted suicides mostly occurred. The Patient's room accounted for 38 out of 53 reported events. This was followed with 9 in the Patient's Bathroom and 4 in the Hallway/Common Area.

There were no reported deaths in 2020.

Figure 15: General Acute Care Hospitals: Suicide/Attempted Suicide Event Locations



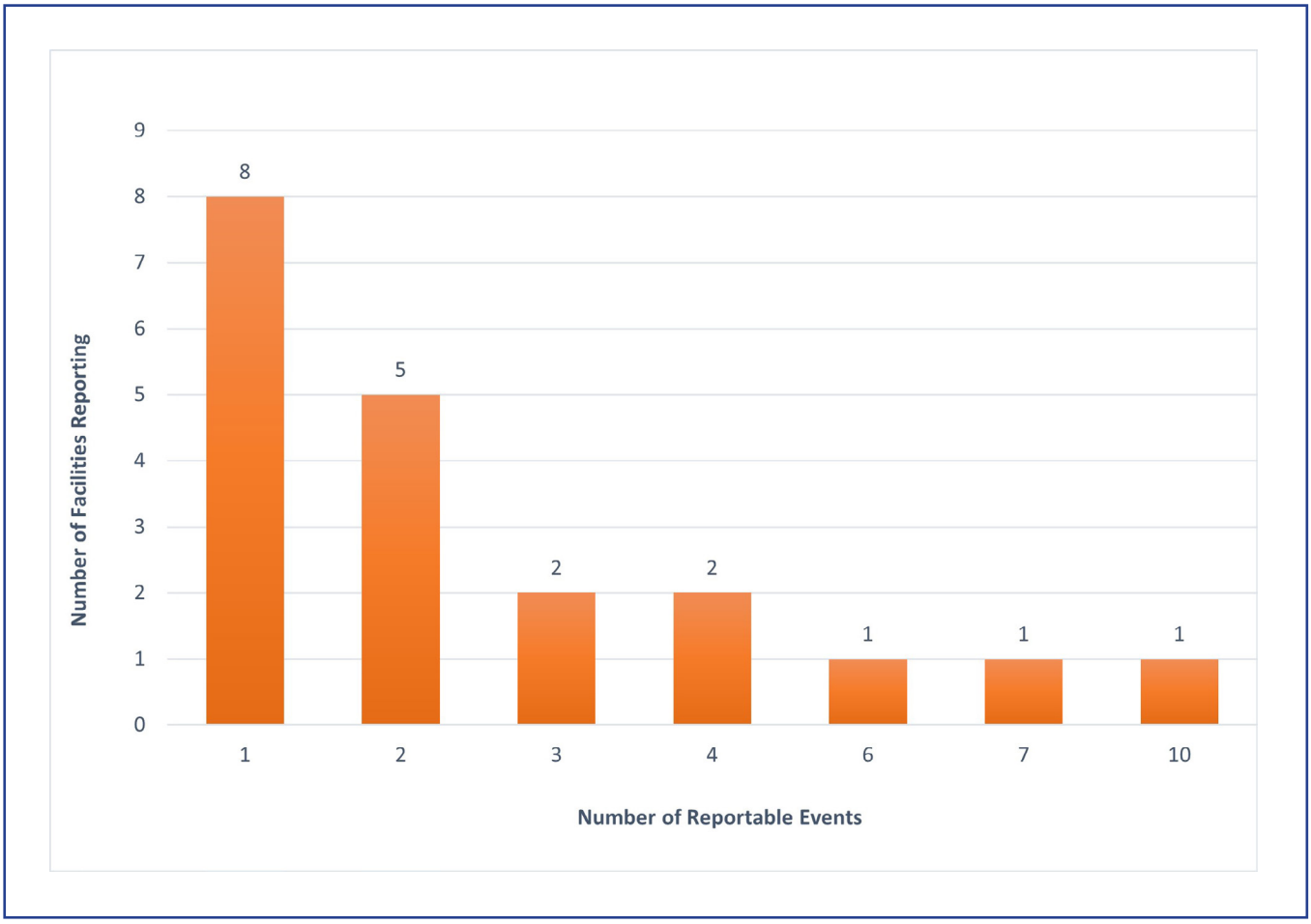
2. Pressure Ulcers

In 2020, there were 55 healthcare associated pressure ulcers compared to 52 in 2019, an increase of 3 events. There were three reported deaths associated with this event type.

The 55 pressure ulcer events were submitted by 20 hospitals. The table below shows the submission by facilities.

Thirty out of the 55 (54.5 %) of the pressure ulcers reported were located in the sacrum, one was on the buttocks, two were on the occipital area, three were sacrum-other, five in the sacrum/buttocks and the rest were classified as "other".

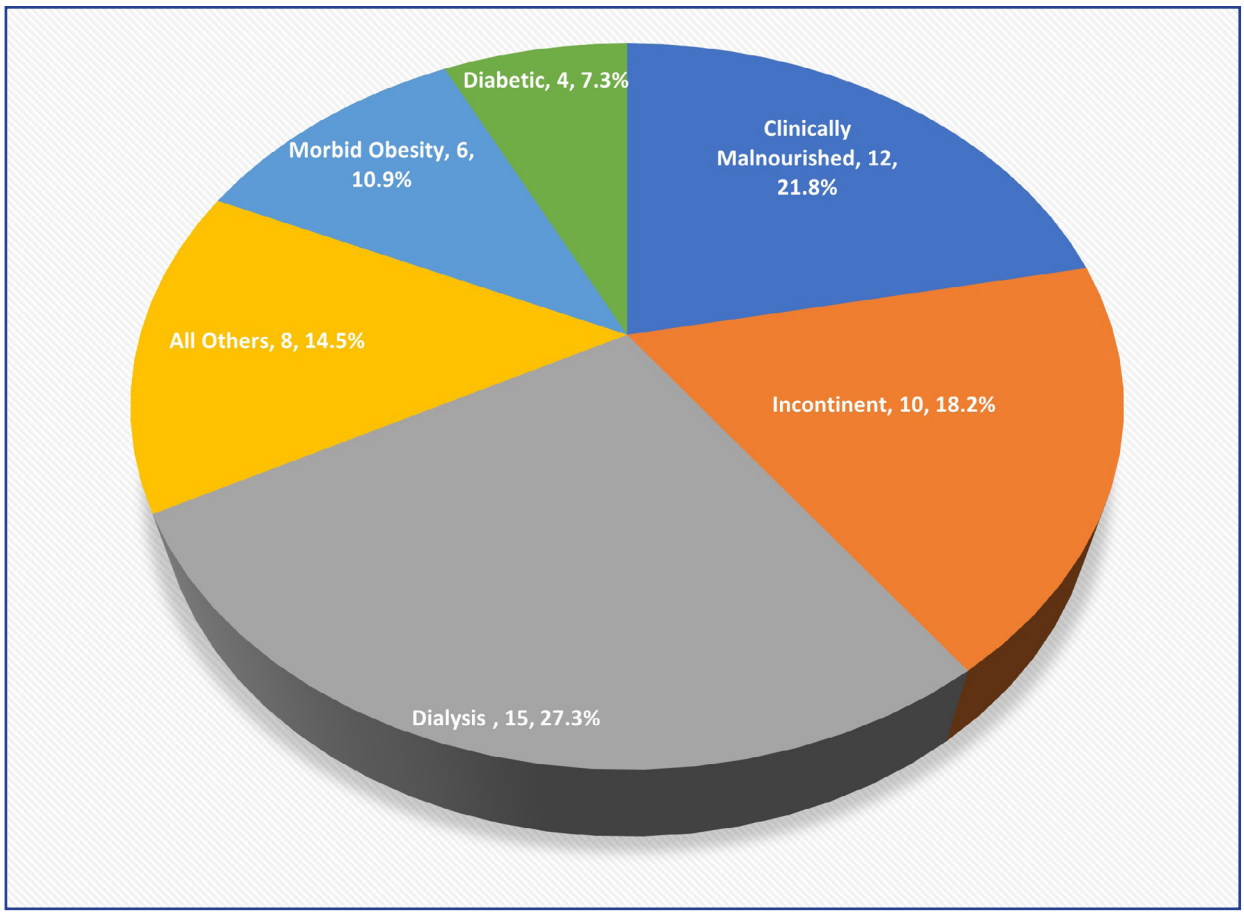
Figure 16: General Acute Care Hospitals: Number of Facilities Reporting Pressure Ulcer Events



2a. Reportable Pressure Ulcer/Injury Patient Characteristics:

Nearly one-half of the patients (25 out of 55) who had a pressure ulcer was diagnosed as being on dialysis and incontinent; twelve were clinically deemed malnourished and 10 were classified as incontinent. Six 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".

Figure 17: General Acute Care Hospitals: Patient Characteristics Categories



3. Retained Foreign Objects

There were 31 retained foreign object (RFO) events submitted in 2020 compared to 40 in 2020.

There were no deaths associated with these events.

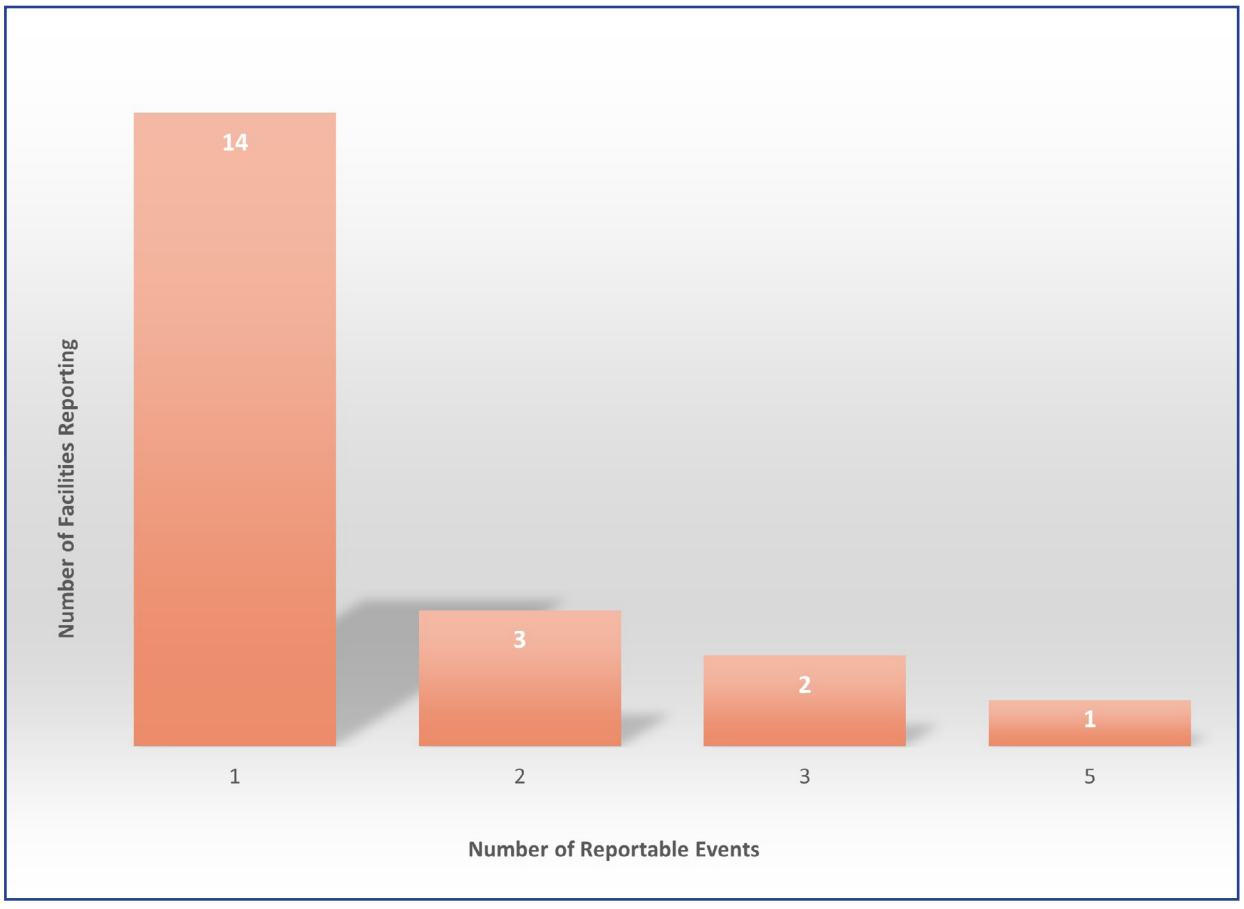
Figure 18 shows the number of facilities reporting the events.

Of the 31 RFOs, 4 were sponges/gauze, two were needles, one lap pad, one clamp, 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.

Of the 31 patients who suffered the unintended

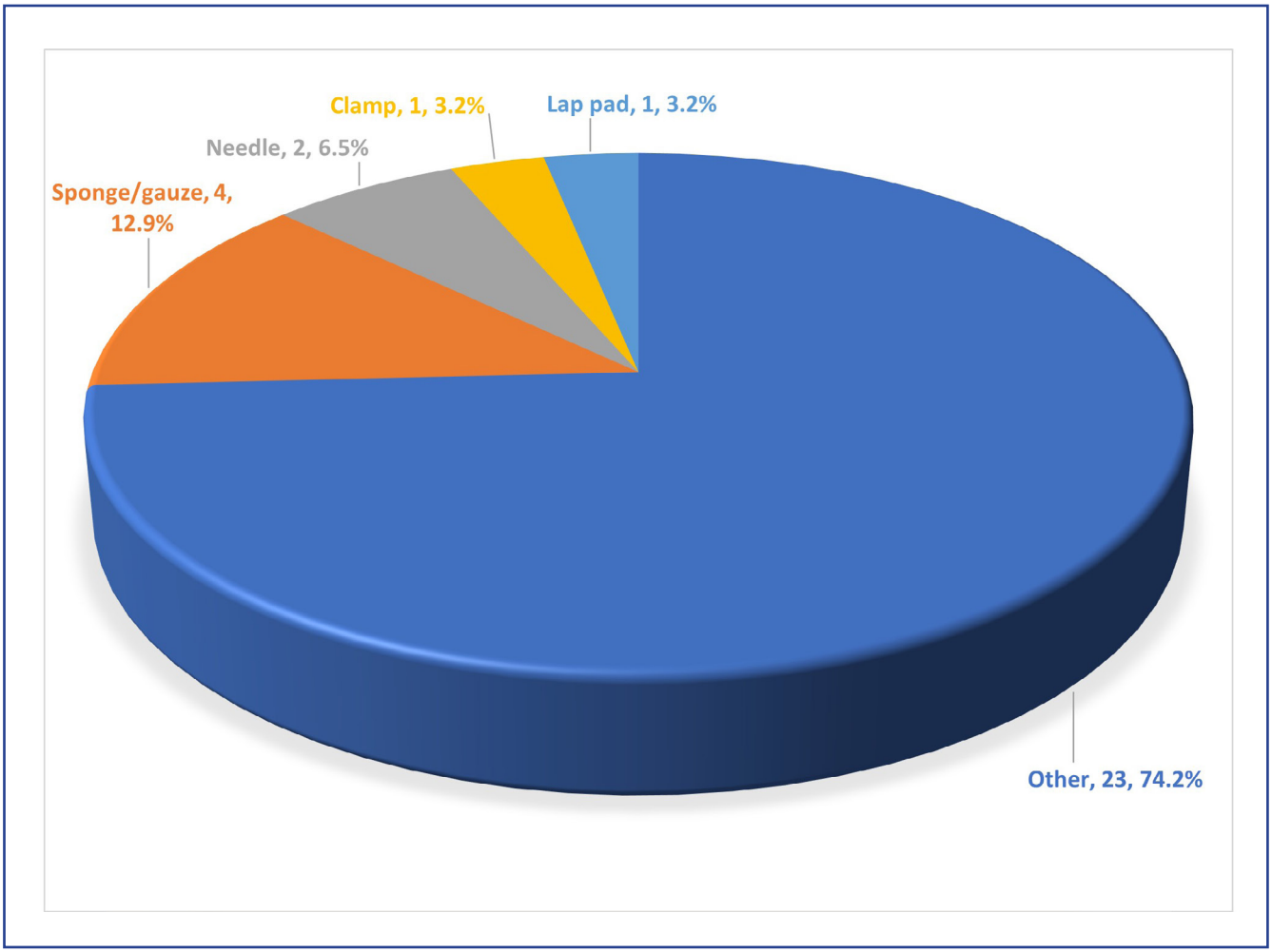
Figure 18: General Acute Care Hospitals: Retained Foreign Objects Events[a]



a: Included 3 events of Less Serious or Near Miss

retention of foreign object, 24 (77.4 %) required a second surgery to remove the object.

Figure 19: General Acute Care Hospitals: Retained Foreign Object Items[a]



a: Included 3 events of Less Serious or Near Miss.

E. Major Root Causes for All Events

In 2020, 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 Causes	Number of Reportable Events	Percent of Events
Care Planning Process	177	49.4
Communication Among Staff Members	91	25.4
Physical Assessment Process	63	17.6
Patient Observation Procedures	55	15.4
"Other"	41	11.5
Orientation and Training of Staff	37	10.3

a: Data drawn from 358 RCAs submitted for 2020 events.

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 Reportable Events	Percent of Events
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	246	68.7
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	201	56.1
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	192	53.6
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	121	33.8
Staff Factors *(May include training, experience and inadequate staffing levels.)*	114	31.8
Procedures *(May include diagnostic or therapeutic interventions thqt contribute to the event.)*	94	26.3
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs.)*	62	17.3
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	61	17.0

a: Data drawn from 358 RCAs submitted for 2020 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 67 deaths which represent 19.0 percent of the 358 reportable events submitted

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

Impact/Outcome	Number of Reportable Events	Percent of Events
Additional Lab Testing or Diagnostic Imaging	184	51.4
Increased Length of Stay	179	50.0
Additional Patient Monitoring in Current Location	174	48.6
Major Surgery	104	29.1
Transfer to more Intensive Level of Care	98	27.4
Disability-Physical or Mental Impairment	95	26.5
Death	67	18.7

a: Data drawn from 358 RCAs submitted for 2020 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 50 reportable events submitted from specialty hospitals in 2020 compared to 48 in 2019.

Eight comprehensive rehabilitation hospitals submitted 30 reportable events. The average event reports per this facility type was 3.8. There was one death associated with this facility type.

Six psychiatric hospitals submitted 9 reportable events in 2020; an average of 1.5 per facility. There were two deaths associated with this facility type.

Eight special hospitals submitted eleven 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, 2020[a]

Facility Types	Number of Facilities	Number of Facilities Reporting	Number of Reportable Events	Average Number of Reports per Facility	Number of Deaths
Comprehensive Rehabilitation	14	8	30	3.8	1
Psychiatric	10	6	9	1.5	2
Special Hospitals	16	8	11	1.4	4
Total	**40**	**22**	**50**	**2.3**	**7**

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

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

A. Comprehensive Rehabilitation Hospitals

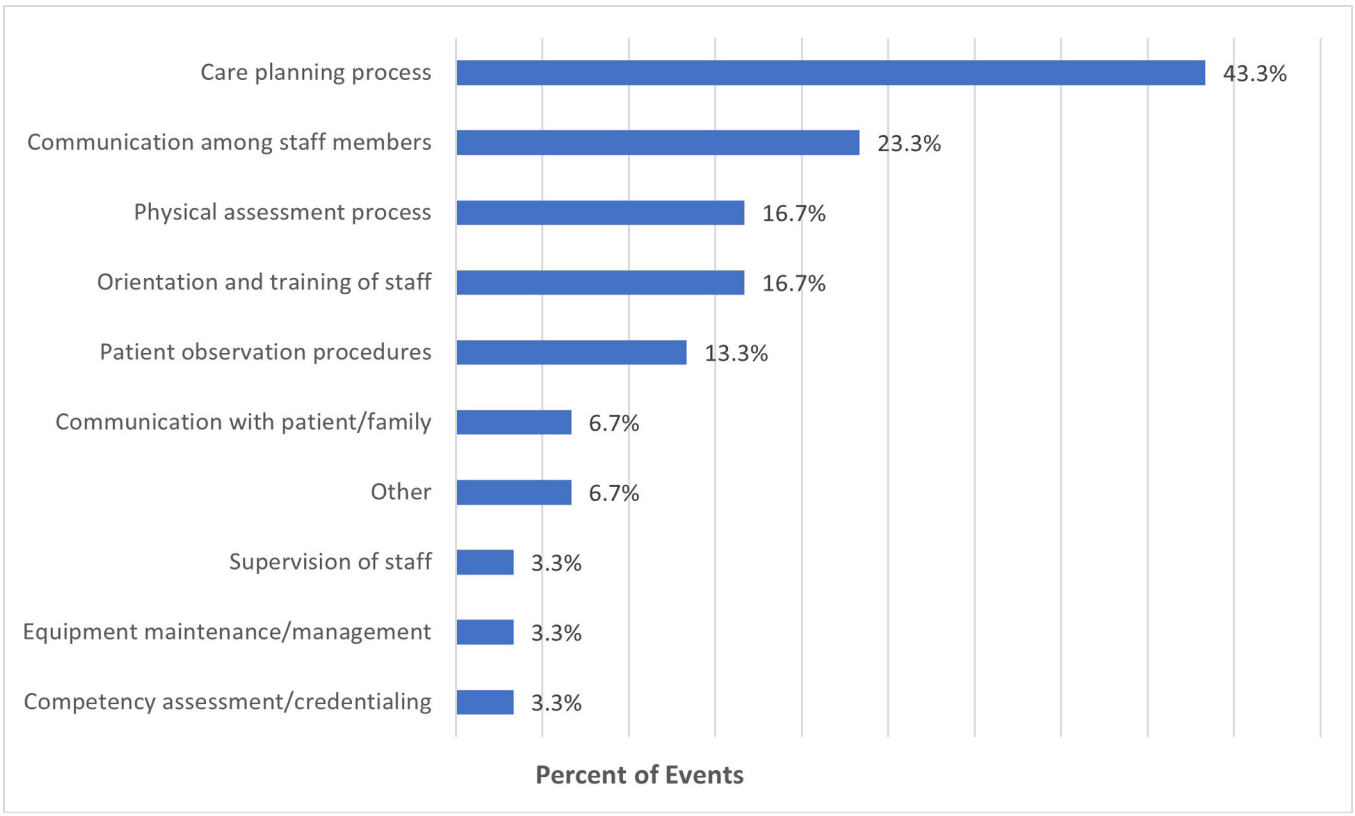
Of the 14 comprehensive rehabilitation hospitals in the state, 8 reported at least one event in 2020. There were 30 reportable events and one death from these facilities.

The reported event types were as follows: falls (18), 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 were drawn from 30 total reportable events submitted for 2020.

2. Contributing Factors to All Events for Comprehensive Rehab Hospitals

In 2020, the most frequently reported contributing factors were team factors, patient characteristics, task factors, staff factors, organization/management, procedures, 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 Reportable Events	Percent of Events
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	19	63.3
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	17	56.7
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	14	46.7
Staff Factors *(May include training, experience and inadequate staffing levels.)*	10	33.3
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	10	33.3
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	8	26.7
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs)*	6	20.0
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	5	16.7

a: Data drawn from 30 RCAs submitted for 2020 events.

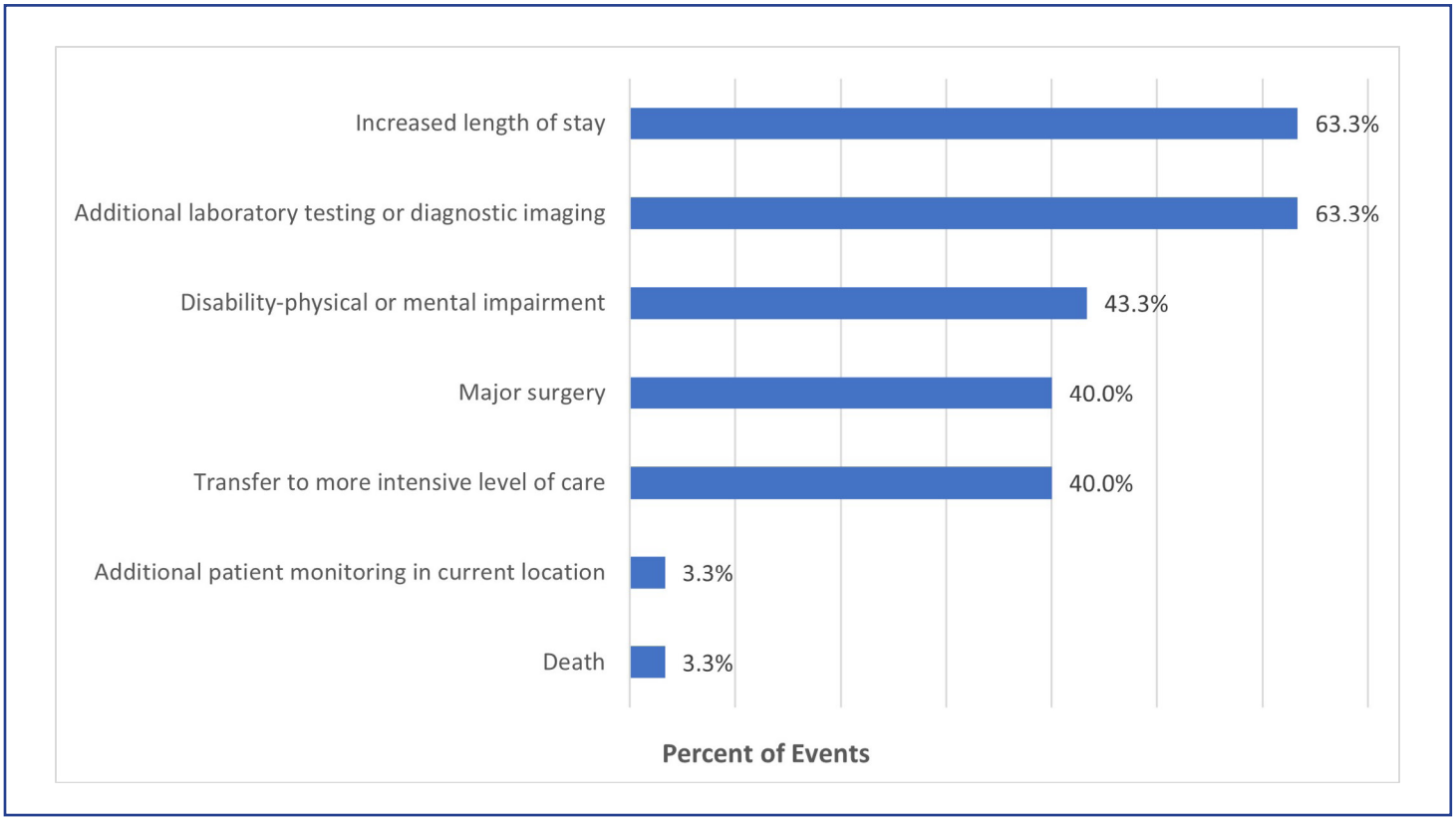
3. Impact of All Events for Comprehensive Rehabilitation Hospitals

As a result of these adverse events, more than one-half (63.3%) of the patients experienced additional laboratory testing or diagnostic imaging, increased length of stay. Other impacts included disability-physical or mental impairment, major surgery, transfer to a more intensive level of care.

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 were drawn from 30 total reportable events submitted for 2020.

B. Psychiatric Hospitals

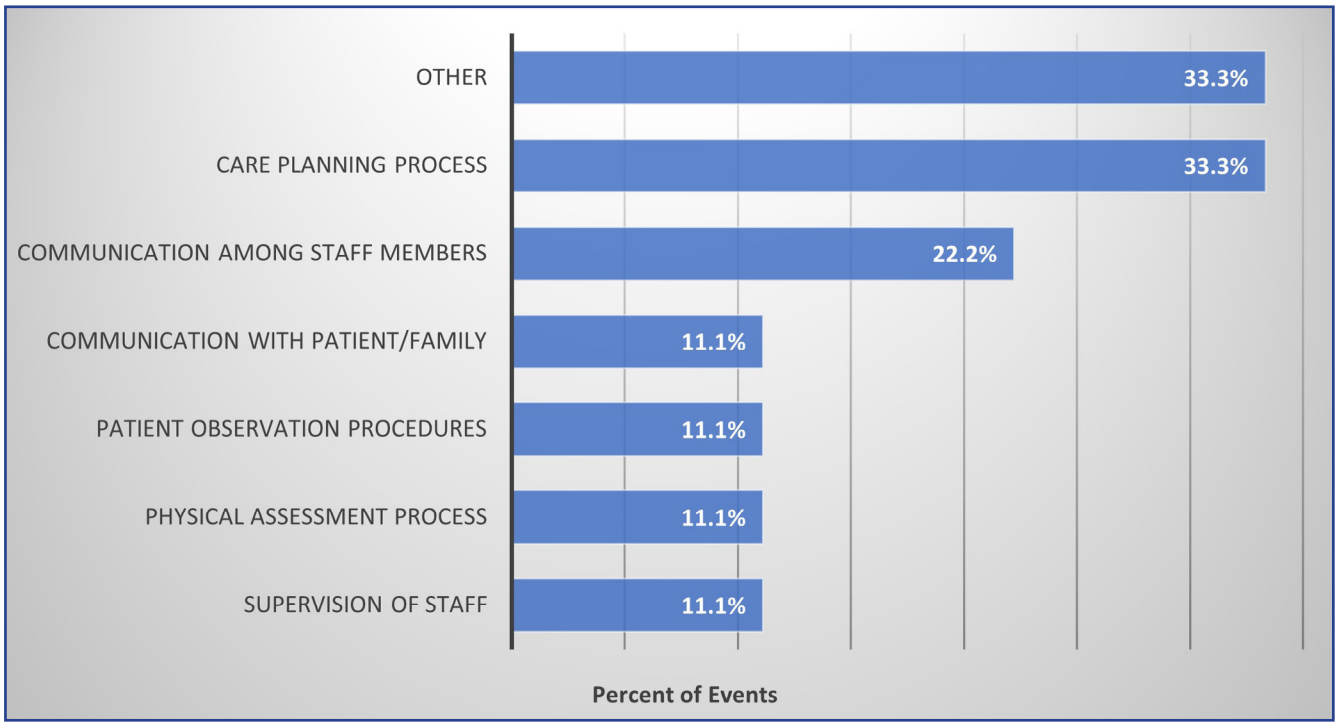
Six out of the 10 psychiatric hospitals reported at least one event during 2020. A total of 9 reportable events were submitted and were all related to falls. There were two deaths reported.

The average submission by this facility type was 1.5.

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 were drawn from 9 total reportable events submitted for 2020.

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]

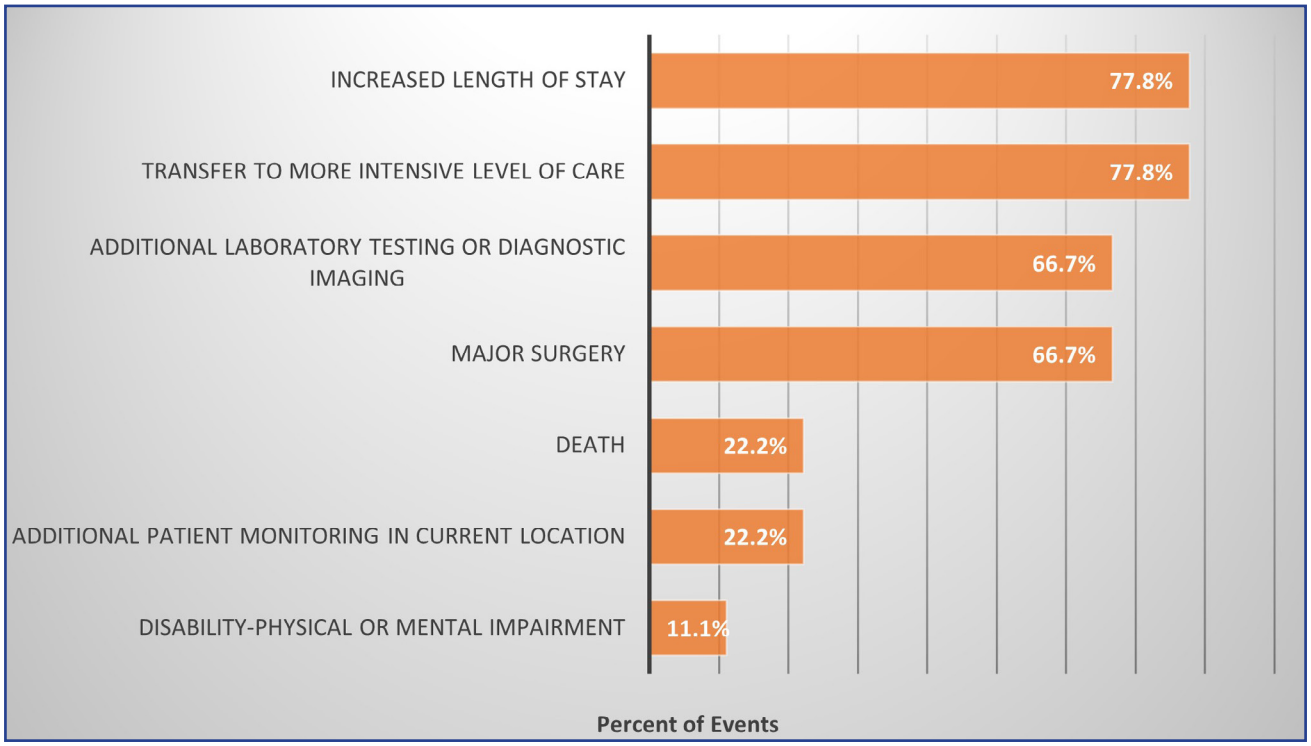
Contributing Factors	Number of Reportable Events	Percent of Events
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	5	55.6
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	4	44.4
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	4	44.4
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	3	33.3
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	2	22.2
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	1	11.1
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs)*	1	11.1
Staff Factors *(May include training, experience and inadequate staffing levels)*	1	11.1

a: Data drawn from 9 RCAs submitted for 2020 events.

3. Impact of All Events

Figure 23 shows the most frequently reported impact from the events. There were two deaths reported.

Figure 23: Psychiatric Hospitals: Impact of All Events[a]



a: Data were drawn from 9 total reportable events submitted for 2020.

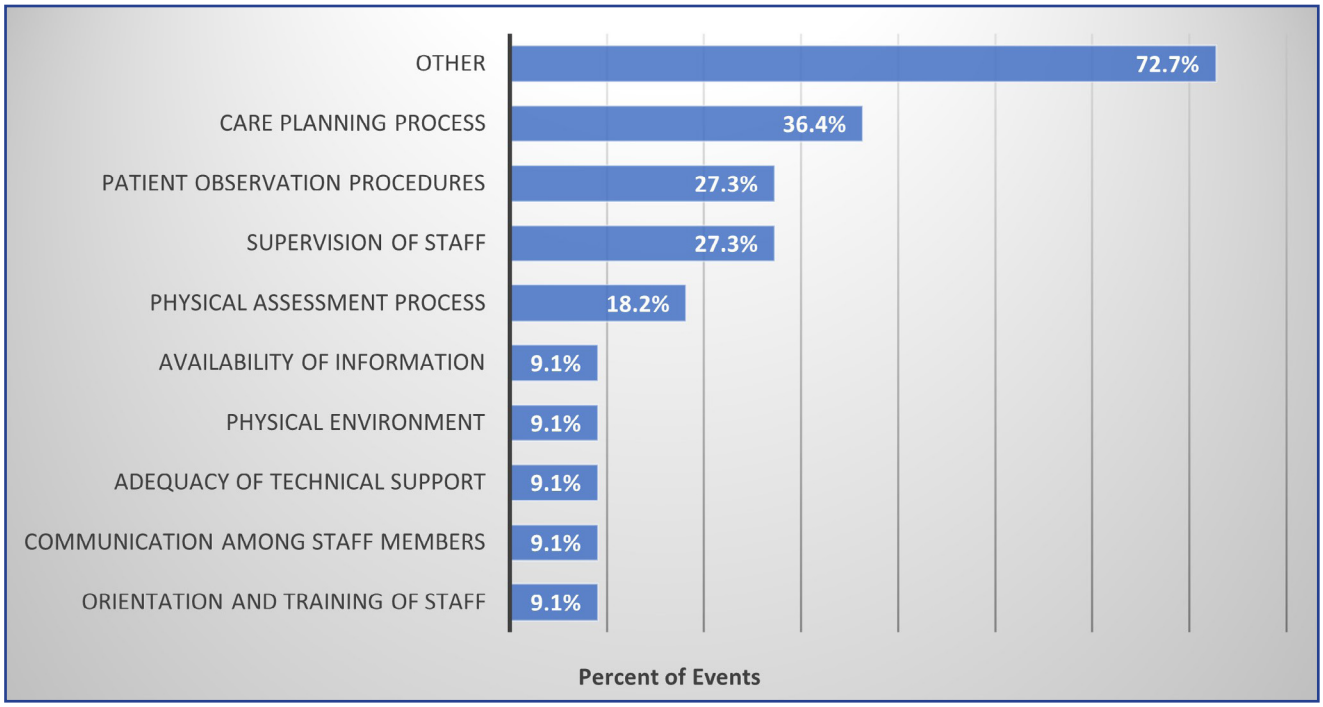
C. Special Hospitals

There were eleven reportable events submitted by special hospitals in 2020. 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 were drawn from 11 total reportable events submitted for 2020.

2. Contributing Factors to All Events

Table 14 shows the most frequent contributing factors to the events reported by special hospitals in 2020. The most frequently reported contributing factors patient characteristics, staff factors, organization/management, team factors, task factors, procedures, patient record documentation.

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

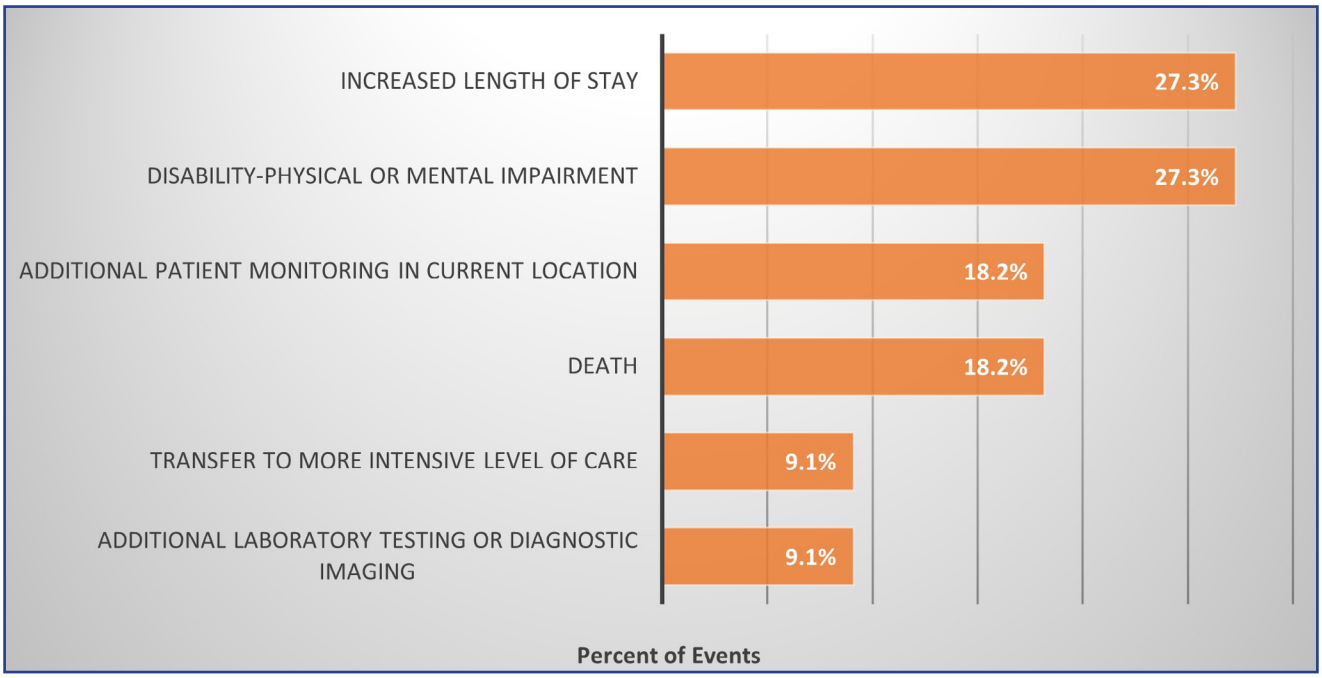
Contributing Factors	Number of Reportable Events	Percent of Events[a]
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	7	63.6
Staff Factors *(May include training, experience and inadequate staffing levels.)*	6	54.5
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	6	54.5
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	5	45.5
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	4	36.4
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	4	36.4
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	2	18.2

a: Data drawn from 11 RCAs submitted for 2020 events.

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 were drawn from 11 total reportable events submitted for 2020.

V. Ambulatory Surgery Centers

New Jersey licensed ambulatory surgery centers (ASCs) began reporting serious preventable adverse events to PSRS as of October 1, 2008. During 2020, the COVID pandemic likely was associated with a change in the number of surgeries performed and therefore likely impacting the number of events reported. Of the 251 ambulatory surgery centers in New Jersey, 74 facilities submitted events in 2020. A total of 187 events were submitted of which 132 were deemed reportable (70.6%). Note 265 events were reported from 87 facilities in 2019.

There were six deaths and were all related to intra-op or post-op coma, death or other serious preventable adverse events in 2020.

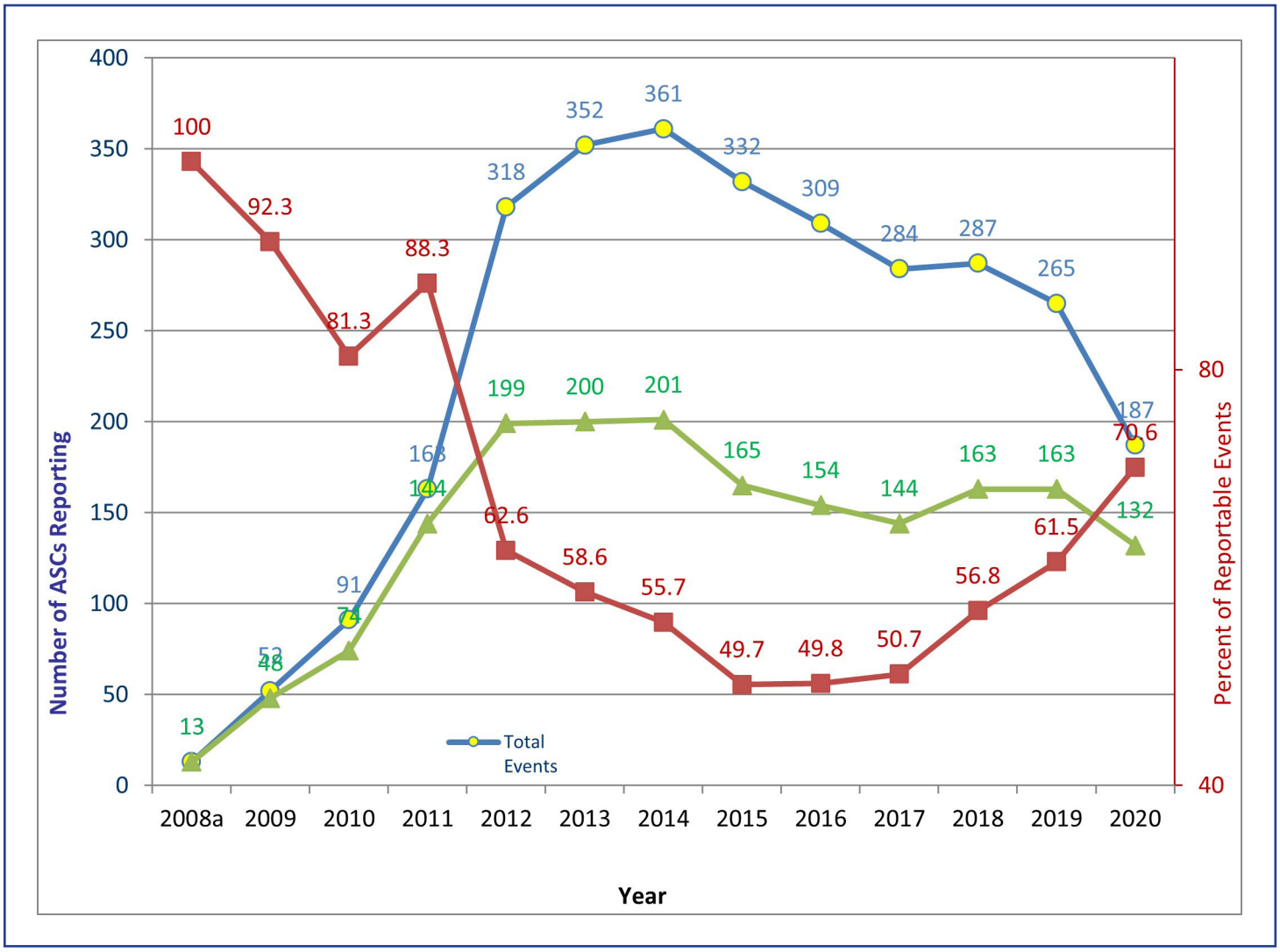
Table 15 and Figure 26 show the reporting patterns for the period 2008 to 2020.

Table 15: Ambulatory Surgery Centers: Reporting Patterns (2008-2020)[a]

Year	Total Reportable Events	Not Reportable Events	Less Serious/Near Miss Events	Total Events	Percent of Not Reportable	Percent of Reportable
2008[a]	13	0	NA	13	0	100
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
2020	132	1	54	187	29.4	70.6

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

Figure 26: ASC Trends in Reportable and Not Reportable Events 2008-2020[a]



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

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 six 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 2020

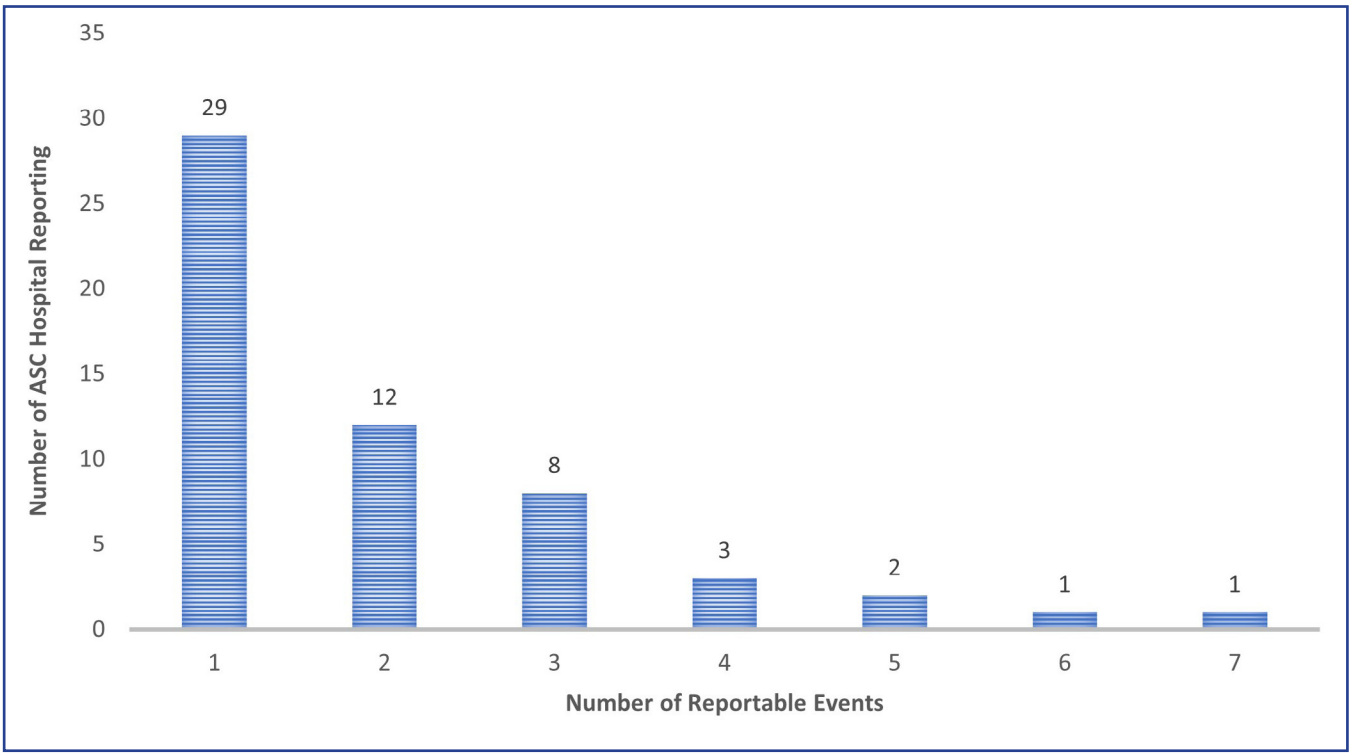
Event Types	Number of Major Reportable Events	Percent of Major Reportable Events to Total Reportable Events	Number of Deaths
Intra-Operative or Post-Operative Coma, Death or "Other" serious preventable adverse event	112	88.9	6
Surgery-Related "Other" Event	7	5.6	0
Wrong Procedure	3	2.4	0
Retained Foreign Object [a]	3	2.4	0
Total [b]	**124**	**98.4**	**6**

a. Included one event of Less Serious or Near Miss
b. Omitted one Wrong Site & One wrong Patient events while total reportable events is 126

V. Ambulatory Surgery Centers

There were 112 intra-operative/ post-operative events submitted by 56 ambulatory surgery facilities. The chart below shows the reporting pattern by ambulatory surgery facilities. For example, 29 facilities reported one event each while 12 facilities reported a total of 24 events (i.e. two events per facility).

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

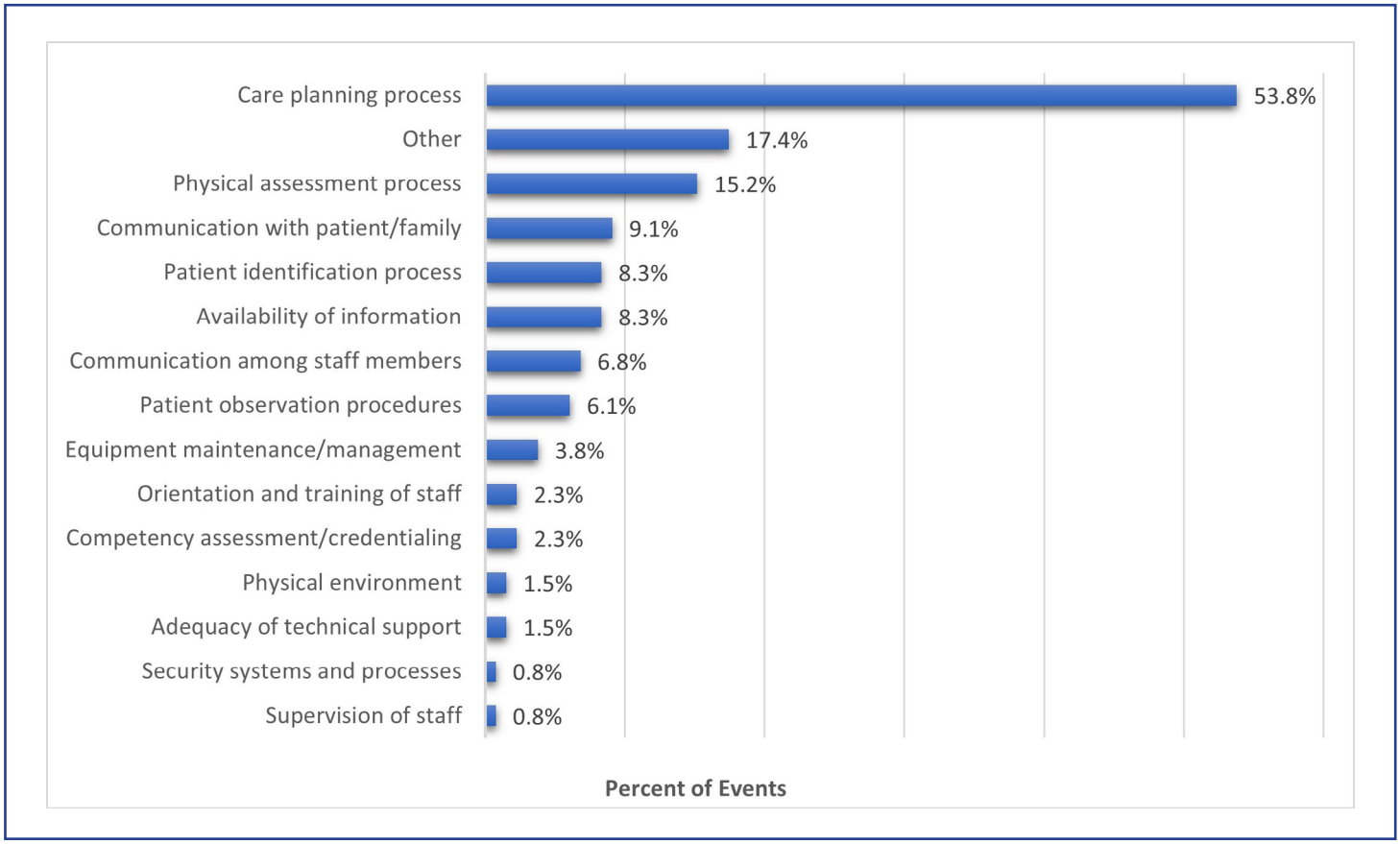


V. Ambulatory Surgery Centers

A. Root Causes for All Events

Figure 28 shows the most frequently identified root causes of the events reported by ambulatory surgery centers in 2020.

Figure 28: Ambulatory Surgery Centers: Root Causes for All Events[a]



a: Data were drawn from 132 total reportable event submitted for 2020.

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]

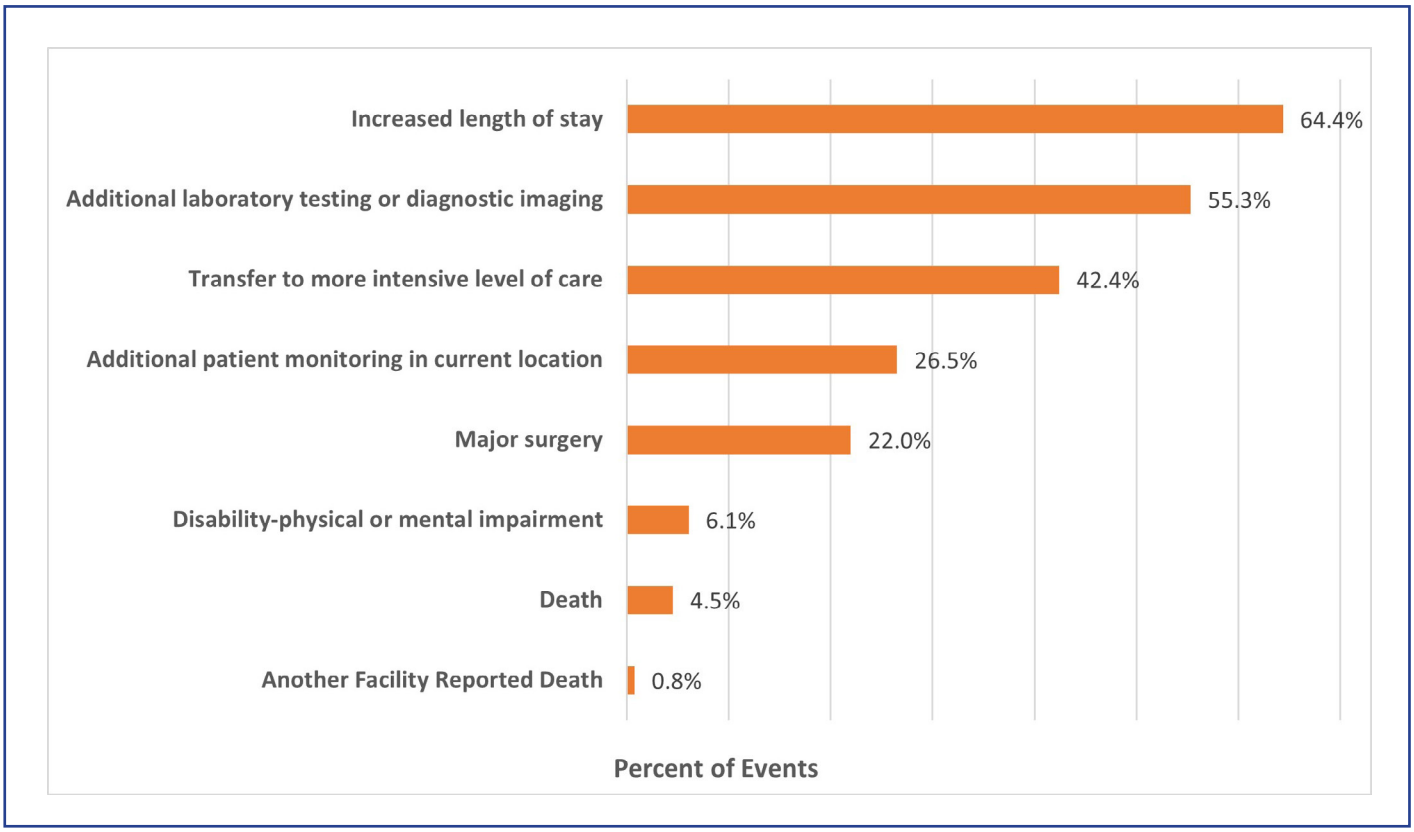
Contributing Factors	Number of Reportable Events	Percent of Events[a]
Patient Characteristics *(May include confusion, co-morbidities and the Patient's choice to refuse care.)*	79	59.8
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	68	51.5
Team Factors *(May include factors which interfere with the care teamworking together, such as inadequate communication.)*	34	25.8
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	28	21.2
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	26	19.7

a: Data drawn from 132 RCAs submitted for 2020 events.

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]



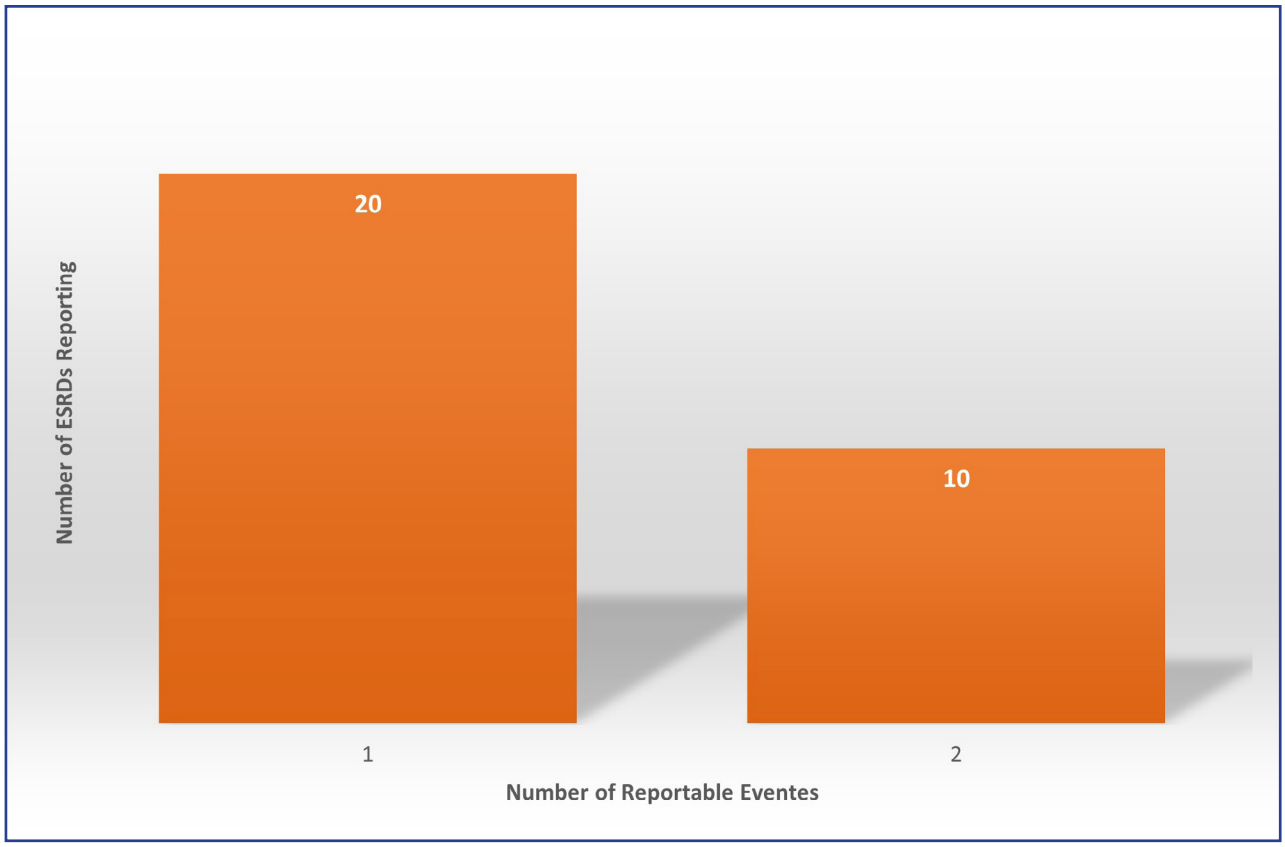
a: Data were drawn from 132 total reportable event submitted for 2020.

VI. End Stage Renal Dialysis Facilities

End Stage Renal Dialysis (ESRD) facilities began reporting preventable adverse events as of January 1, 2019. Of the 239 licensed facilities, a total of 55 events were submitted of which 40 were deemed reportable (72.7 %). Thirty of the events occurred in the Care Management "Other" category while the remaining five events were related to falls. There were 28 deaths associated with these reported events. All 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

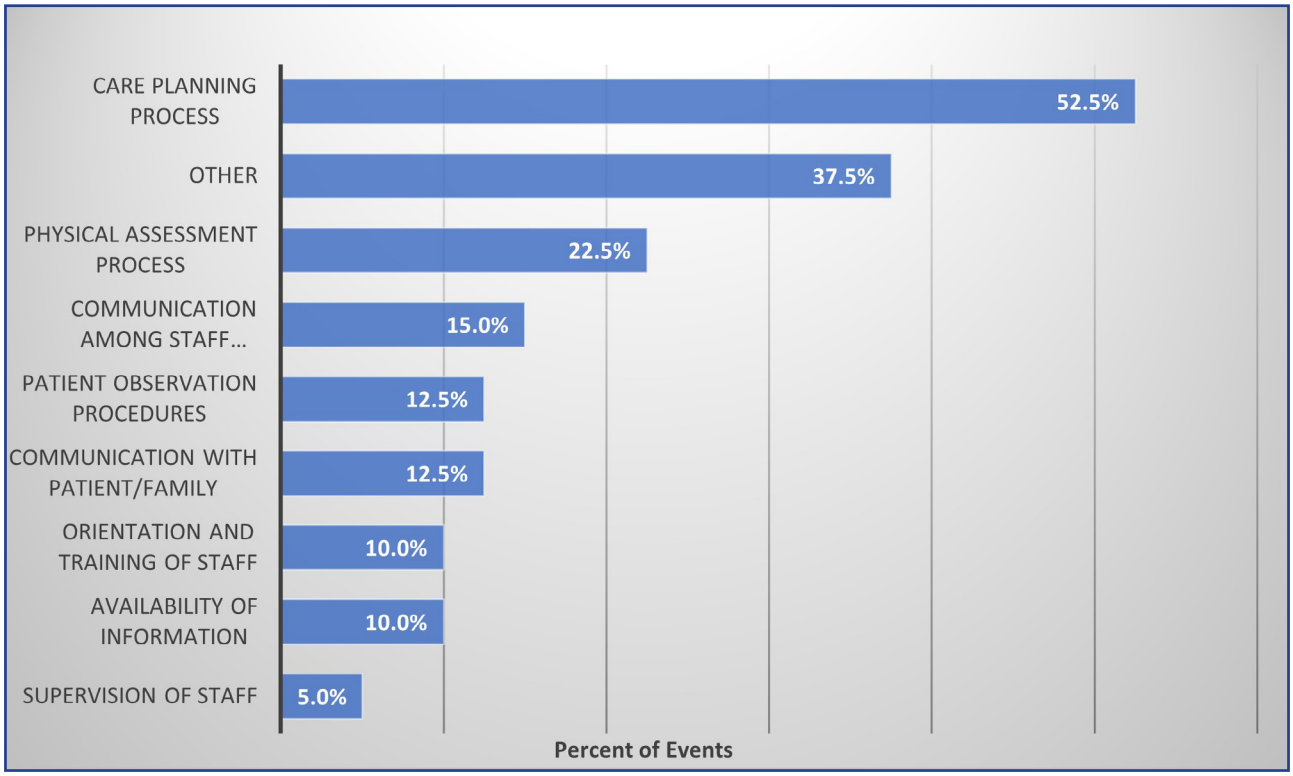


VI. End Stage Renal Dialysis Facilities

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 were drawn from 40 total reportable events submitted for 2020.

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]

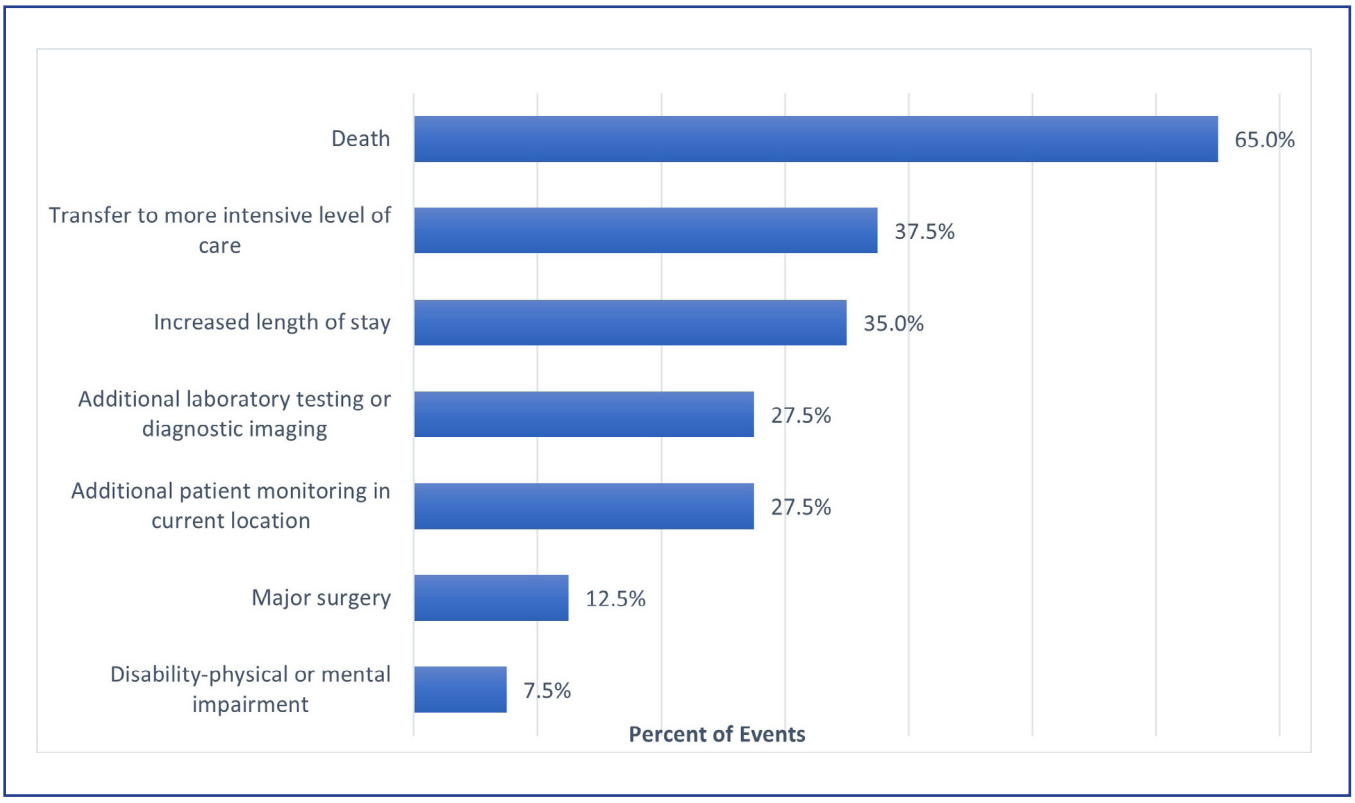
Contributing Factors	Number of Reportable Events	Percent of Events[a]
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	28	70.0
Team Factors *(May include factors which interfere with the care teamworking together, such as inadequate communication.)*	27	67.5
Patient Characteristics *(May include confusion, co-morbidities and the Patient's choice to refuse care.)*	22	55.0
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	13	32.5
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	12	30.0
Staff Factors *(May include training, experience and inadequate staffing levels.)*	7	17.5

a: Data drawn from 40 RCAs submitted for 2020 events.

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 were drawn from 40 total reportable events submitted for 2020.

VII. Division of Behavioral Health Services 2020 Report

Department of Health
Division of Behavioral Health Services
Annual Patient Safety Act Report
January 1, 2020 through December 31, 2020

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 2020, system initiatives/improvements that are expected to decrease the number of incidents reportable under the PSA in the hospitals included the following:

- The Division implemented various programs across the system that promote violence prevention through using active treatment and behavioral management skills.
- The Central Violence Prevention Committee meets monthly to review data across the system on all assaults, all injury levels. Recommendations for implementation of specific initiatives and/or strategies to reduce violence across the system are provided.
- Each facility has systematically improved safety conditions while adhering to CDC guidelines for COVID-19 precautions
- Each facility actively recruits qualified medical staff to fill any vacant positions and maintain the established standardized ratios.
- Each facility monitors possible risks and to improve the environment of care for patients by systematically assessing and mitigating ligature risks, making environmental improvements, installing hardware upgrades, and completing room renovations.
- Each facility requires that the patients it serves are receiving clinical care that reflects the latest, evidence-based behavioral healthcare.
- Each facility is training all staff in basics of Suicide Prevention and the requirements of the accompanying Administrative Bulletin (AB3.14) and Question, Persuade, and Refer (QPR) when joining the facility workforce during New Employee Orientation (NEO) and annually thereafter during the centralized training fair via a standardized training program with follow-up competency assessments.

- Each facility has at least 30% of all psychologists trained in Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP) and receive supervision on this treatment modality as needed.
- Each facility has reengineered its psychology services to increase the clinical treatment hours to patient. Additionally, Ann Klein contracted with a national expert to review its clinical care assessments with the intent to improve current processes and increase patient competency.
- Each facility has ensured that staff are cognizant of the basic concepts of Zero Suicide by knowing that
  a) deaths by suicide are preventable
  b) every staff plays a role in achieving this goal that no deaths by suicide occur to patients while under the care of the regional NJ state psychiatric hospitals or the forensic psychiatric center.
- The team at Ancora Psychiatric Hospital is doing excellent work on the Electronic Health Record "EHR" project and have developed a functioning order entry system for medications and ancillary orders. Other elements of the EHR and associated projects are well underway.

Overall Reporting Patterns

From January 1, 2020, through December 31, 2020, a total of fourteen (14) events were reported and reviewed. Ten (10) out of the fourteen (14) events occurred at one (1) facility, the remaining four (4) were dispersed between two other facilities. There were no PSA related events at Forensic Center in 2019. The events consisted of; thirteen (13) suicide attempts (an 86% increase from 2019) and one (1) assault.

Focus on Specific Events

a. Attempted Suicides

There was a total of thirteen (13) suicide attempts in 2020. Nine (9) involved female patients and two (2) male patients. Ages ranging between 20 and 41; with a mean age of 26.5, a median age of 20, and mode of twenty (20).

Ten (10) suicide attempts occurred at one (1) facility, and the remaining three (3) were split at two (2) other facilities. Of the ten (10) suicide attempts four (4) of the six (6) patients had two (2) suicide attempts and accounted for 80% (8/10) in 2020.

Four (4) events involved patients tying objects around their necks, an article of clothing, elastic band curtain or bed sheet. Four (4) events involved using a razor to lacerate at forearm area. Two (2) events involved ingestion of a foreign object (pen/battery). One (1) event involved a piece of clock to slash neck area. One (1) event involved falling backwards on steps that resulted in a closed head injury with cerebral concussion and L1 vertebral fracture. One (1) event involved an accidental drug overdose. Six (6) events occurred in the bathroom, five (5) events occurred in a patient's bedroom, one (1) event occurred outside of Cottage and one (1) occurred in the stairway.

Root causes:

- Team Factors: Failure to refer the patient to psychology for appropriate treatment recommendations as per Administrative Bulletin (AB) 3:41 Screening, Assessment, Management and Treatment of Suicidal and Non-Suicidal Self-directed Violence as evidenced by lack of documentation in the medical record.
- Team Factors: Failure to identify necessary suicide risk precaution interventions and objectives (long-term and short-term goals) for self-injurious behavior as evidenced by lack of documentation on the comprehensive individualized treatment in the medical record. Team Factors: Failure to request a clinical review for a comprehensive review of the patient and alternative recommendation in the plan of care.
- 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.
- Team Factors: Failure in communication among staff members regarding the patient's lack of participation in programming as evidenced by lack of documentation on the comprehensive individualized treatment in the medical record.
- Task Factor: Failure in the proper de-escalation techniques and application of patient's safety plan as evidenced by lack of documentation on comprehensive individualized treatment in the medical record.
- Task Factors: Failure to place patient on precautions after identified as an increased risk for suicide by the After-hours Medical Officer on Duty as evidenced by lack of documentation in the medical record.
- Task Factors: Failure in the transfer and admission after regular business hours process as evidenced by lack of documentation of the patient's increased risk for suicide in the medical record.
- Task Factors: Failure to refer a newly admitted patient for psychology services as evidenced by lack of documentation in the medical record evidenced by lack of documentation on patient's individual sessions with a psychologist in the medical record.
- Task Factors: Failure in identifying patients under 22 for psychology sessions as evidenced by lack of documentation on individual sessions and on the comprehensive individualized treatment plan in the medical record.
- Task Factors: Failure to implement Behavioral Support Plan regarding engaging in programming patient as evidenced by lack of documentation in the medical record, including and on the comprehensive individualized treatment plan.
- Task Factors: Failure to provide coverage in the absence of a psychologist as evidenced by lack of as evidenced by lack of documentation on patient's individual sessions in the medical record.
- Task Factor: Failure in the process of conducting contraband searched of patients' bedroom identified at for suicide as evidenced by the seven (7) events that occurred by patients using objects for self-harm.
- Task Factor: Failure in the monitoring of shaving as evidenced by staff distributed a total of nine (9) razors to staff assigned to monitor shaves, when only four (4) should have been distributed. In addition, one (1) razor was missing fortwo (2) days prior to the event

- Other (Environmental) Factors: Failure to remove identified environmental risks as evidenced by patients using objects found in the environment for self-harm and/or suicide attempt.

Prevention strategies:

- 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.
- Remediation of the Assessment/Reassessment Policy to ensure the patient is thoroughly assessed when the patient is highly assaultive, refusing programming and/or exhibiting behaviors that are high for suicide behavior.
- 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/revise procedure for placing patients on a specialized level of observation.
- Review and reeducate all nursing staff on policy and procedures regarding contraband checks.
- Revise transfer/admission criteria/protocol with other State psychiatric hospitals to include admissions accepted only prior to 2 PM on regular business days.
- 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, identified areas of risk, and objects that can be used for self-harm.
- Assign additional staff to monitor patient ADL activities to ensure safety and return of objects that can be utilized for self-harm.
- In-service staff on the use of specialized teams to intervene/engage with the most difficult patients when they pose a danger to self/others.

b. Assault with Major Injury

Root causes

- Team Factors: Failure in communication among staff members regarding the patient’s multiple incidents of assaultive behaviors as evidenced by lack of documentation on comprehensive individualized treatment in the medical record.

- Task Factors: Failure to implement Behavioral Support Plan regarding engaging in programming patient as evidenced by lack of documentation in the medical record, including and on the comprehensive individualized treatment plan.
- Team Factors: Failure to request a clinical review for a comprehensive review of the patient and alternative recommendation in the plan of care.
- Task Factor: Failure in the patients triggers, proper de-escalation techniques and application of patient's safety plan as evidenced by lack of documentation on comprehensive individualized treatment in the medical record.

Prevention strategies

- Remediation of the Assessment/Reassessment Policy to ensure the patient is thoroughly assessed when the patient is highly assaultive, refusing programming and/or exhibiting behaviors that are high for assaultive behavior.
- 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.
- Provide ongoing annual and after an event training and assess competency of staff implementation of observation of patient at an increased risk of assault.
- Re-education of staff on policies/procedures and develop competencies involving identifying triggers and using proper de-escalation techniques with a of patient at an increased risk of assault.

DBHS Report Preparation Team

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

Appendix 1: Classification of Serious Preventable Adverse Events

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.

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.

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.

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.

Appendix 2: Required Components of a Root Cause Analysis

New Jersey Department of Health Review of Root Cause Analyses

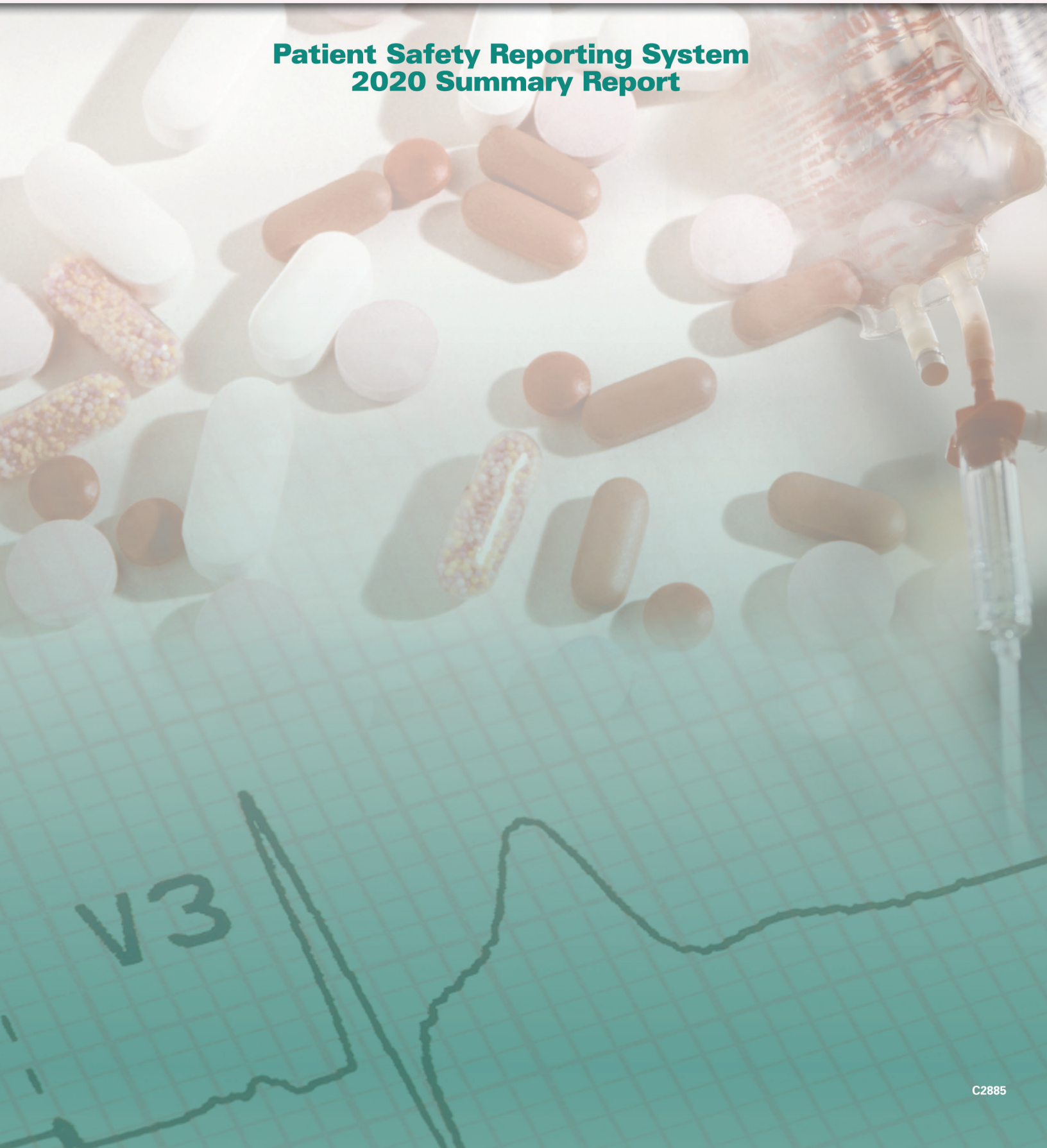
N.J.A.C. 8:43E-10.6(m)

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.

Limited copies of this report are available by writing to the New Jersey Department of Health, Office of Health Care Quality Assessment, P.O. Box 360, Trenton, NJ 08625, by calling (800) 418-1397, by e-mailing hcqa@doh.nj.gov or by fax at (609) 984-7735. The report is also posted on the New Jersey Department of Health's website at: https://www.nj.gov/health/healthcarequality/health-care-professionals/patient-safety-reporting-system/

Patient Safety Reporting System
2020 Summary Report



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