State of New Jersey
Department of Health

Patient Safety Reporting System

Module 3 – Root Cause Analysis

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Governor

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Commissioner

Revised November 2018

Patient Safety Reporting System

Course Contents

I. Preparing to Enter Root Cause Analysis and Action Plan

II. Enter Root Cause Analysis and Action Plan

III. PSRS review of RCA

IV. Other Communications about the RCA

I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

1. **Log into the system**
2. **Access the "Resources" tab from the Main Menu**
3. **"Resources" Tab Menu**
   - Information Consulted
   - Report Questions
   - User Guide
4. **Select Event Type**
5. **View Initial RCA Questions**
6. **Information needed will be displayed**

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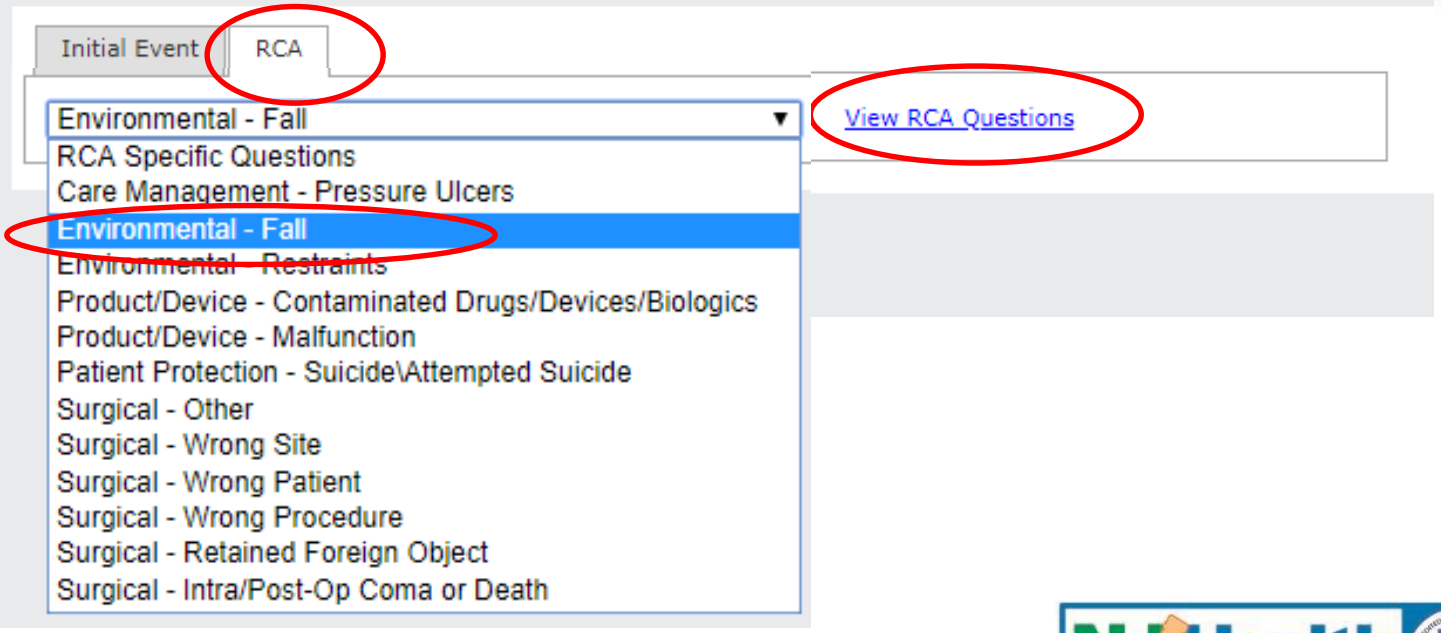
I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

7. **Locate Comments from the Event Reviewer**
   - **Locate Event for which an RCA is required**
     - Home Page: enter Event/RCA number
     - View Events: all Events and RCAs listed
       - Click on 'Detail'
8. **Comments from Event Reviewer can be accessed by:**
   - **A comment link in the Initial Event**
     - Only visible in sections of the Event with PSRS comments
     - Click on 'Comments' link
   - **A link to the comment through the Communication Log**
     - 'View All Comments'

I. Preparing to Enter Root Cause Analysis and Action Plan

RCA Questions

- These are the questions that are required in order to submit an Event/RCA
- Click on the tab below to change between Initial Event and RCA
- Choose an item from the dropdown to see Event/RCA specific questions



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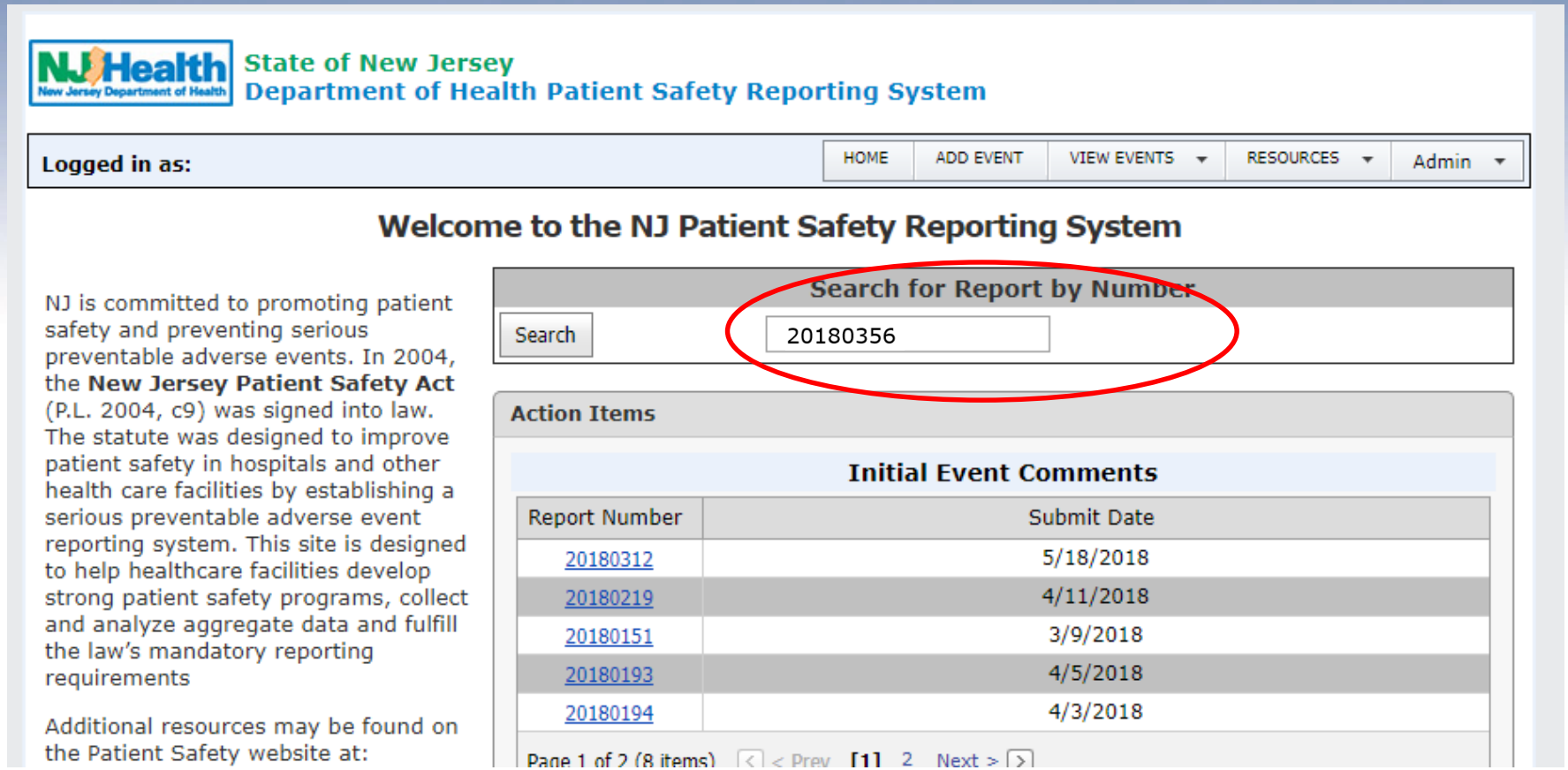
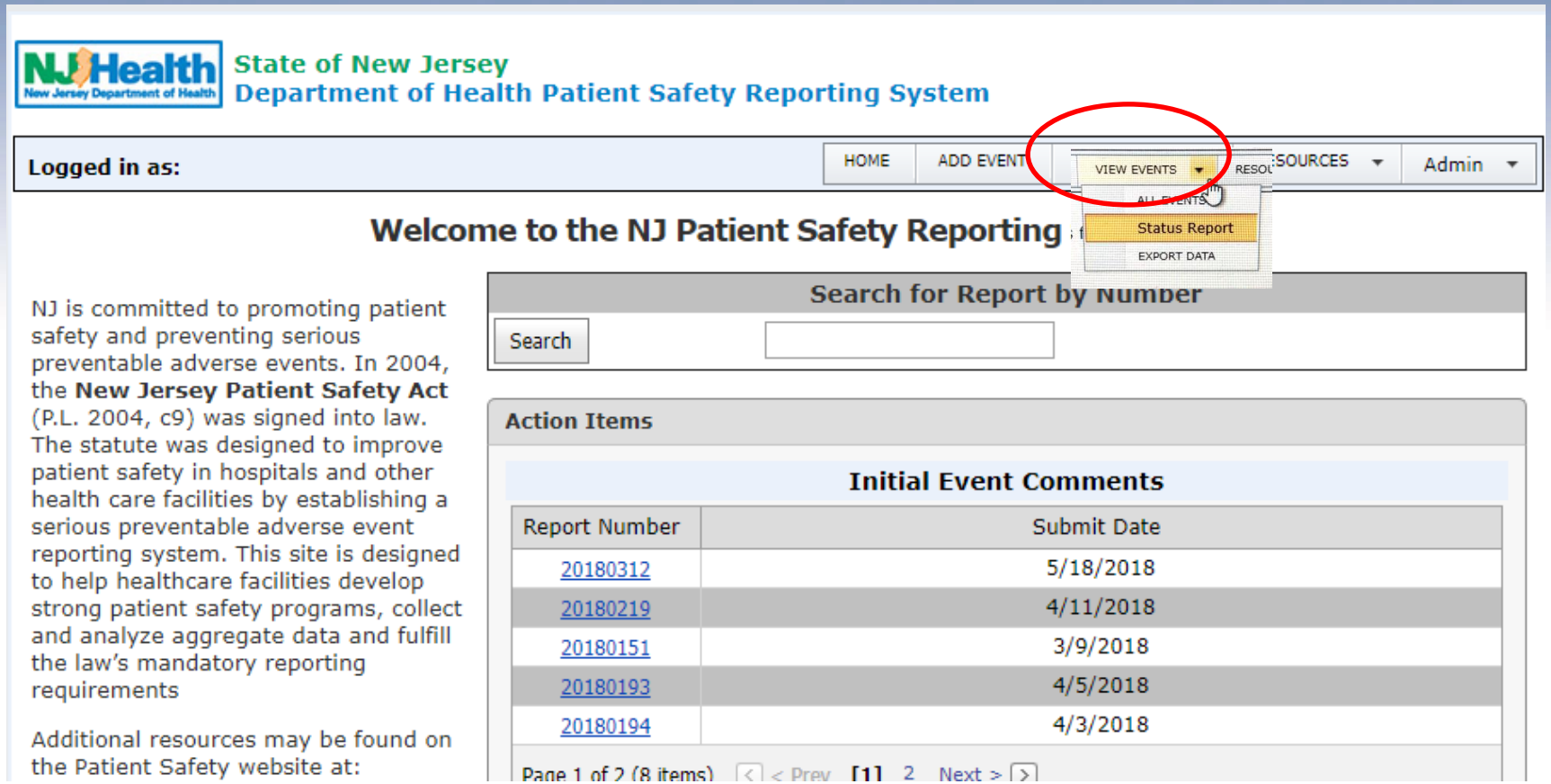
I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

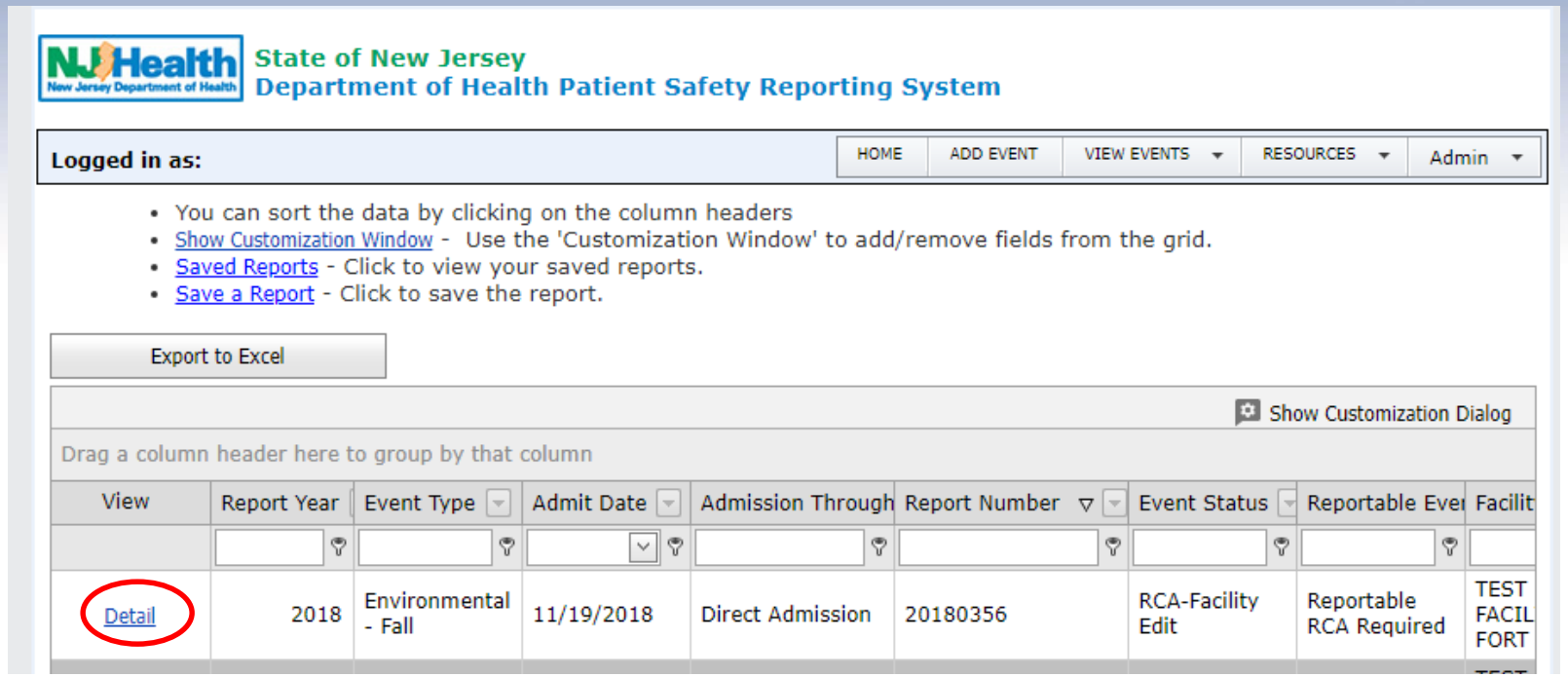


I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*



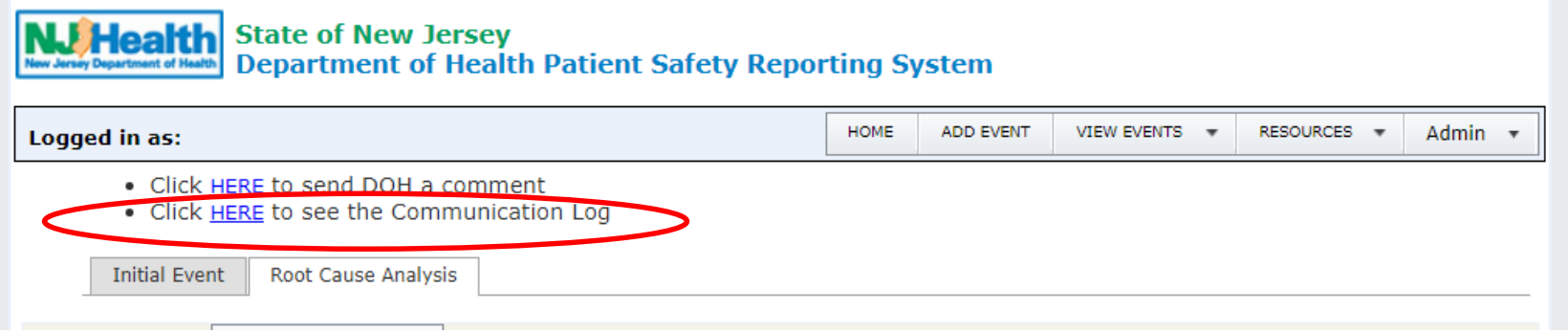
I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

View Events (includes RCAs)



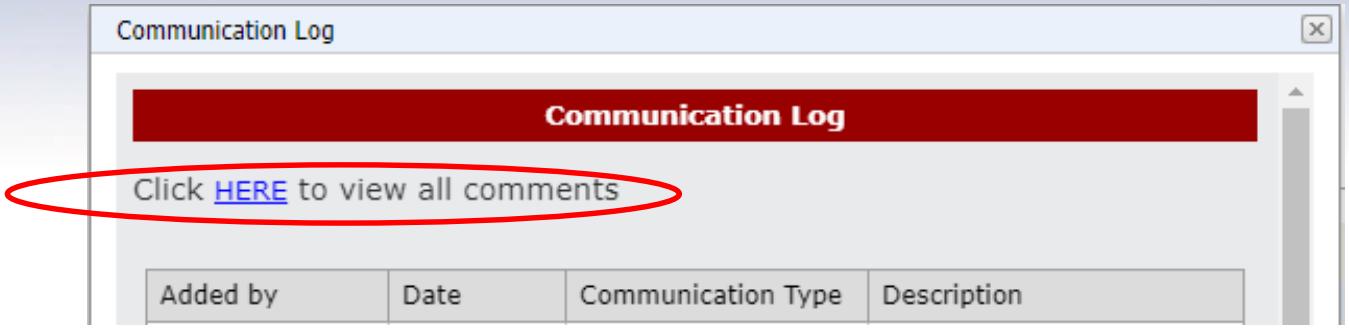
I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

Locate Comments



I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

Communications Log



I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

System Navigation - General

"Main Menu" Bar

- View Events – Event/RCA listing, may create custom reports

"Report Menu" Bar

- Moves you through each report section with an arrow to indicate next step
- RCA Summary page builds as information is entered

"Save/Next" Button

- Move to next screen

II. Enter Root Cause Analysis and Action Plan

The "Report Menu" will guide you through the RCA

- A red arrow will indicate the next step in the process

Complete fields for:

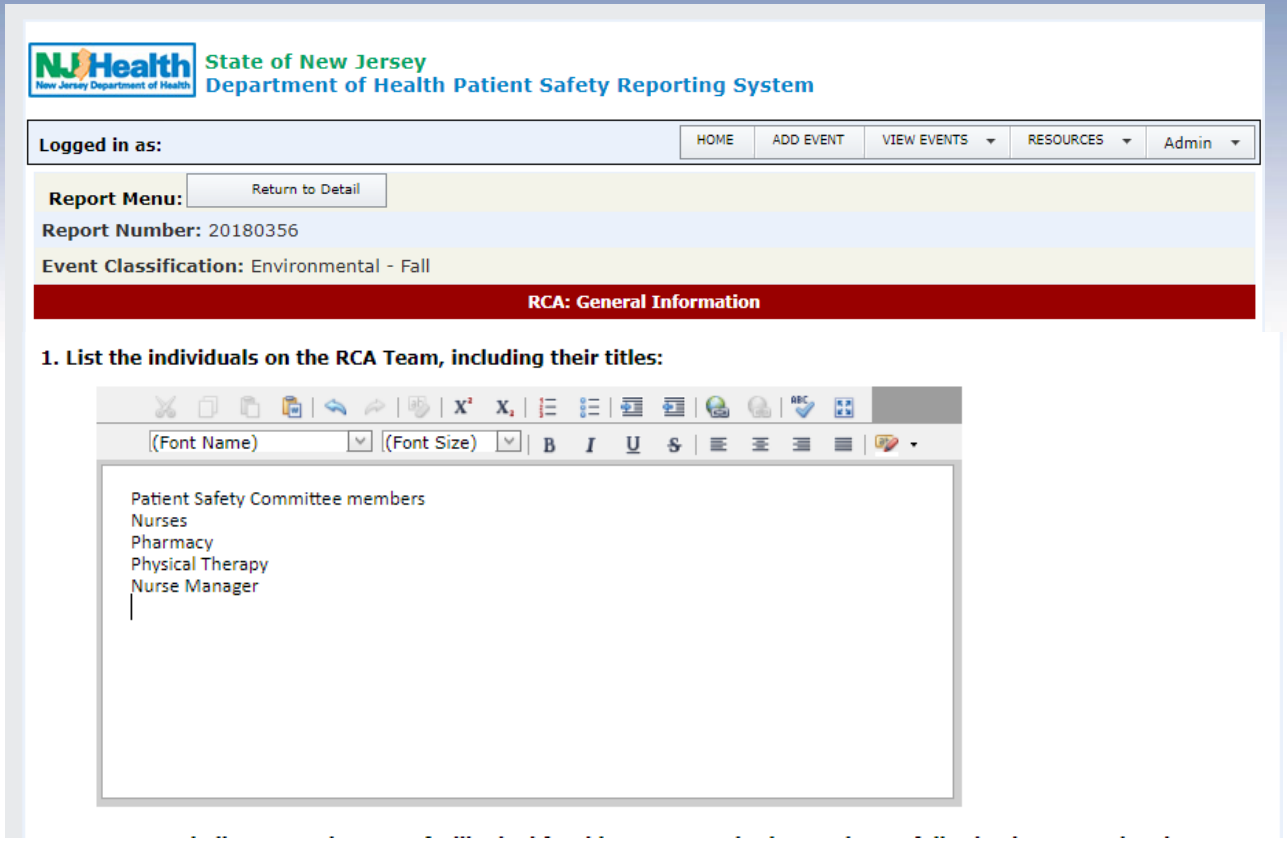
- RCA General information
- RCA Facts of the Event
- RCA Specific Questions

Create Documents to copy information into the RCA screens

- All required fields must be completed to save screen
- *Two Hour Time Out Window*

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: General Information



Note this example is an illustration of an insufficient description of the individuals on the RCA Team. In later slides, PSRS will show you how to modify this entry to reflect best practices.

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: General Information

2. How many similar events has your facility had for this event type in the previous 3 full calendar years plus the current year? Do not include the current case in this count. (numbers only)

2

If your facility has similiar events, please answer the following questions

a. What changes did the organization make in response to these previous events? If this is an 'Other' event type, only include changes relevant for the specific situation. Examples include, but are not limited to, perforation, infection, delay in care).

1. Staff re-education on the Morse fall risk assessment using nursing judgment to determine if a patient is at risk for fall.
2. Fall huddles immediately after any fall on all units.

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b. How are you tracking the effectiveness of these changes?

1. Effectiveness monitored through random observation of patients at high risk for a fall for appropriate fall prevention interventions. Conducted an audit of the Morse Score and the prevention strategies in place.
2. The effectiveness is tracked when all falls are discussed at the weekly Fall Huddle. Aggregate data is collected on falls by the Unit and/or Department on a monthly basis and analyzed for trends. All patient falls, with or without injury, are tracked.

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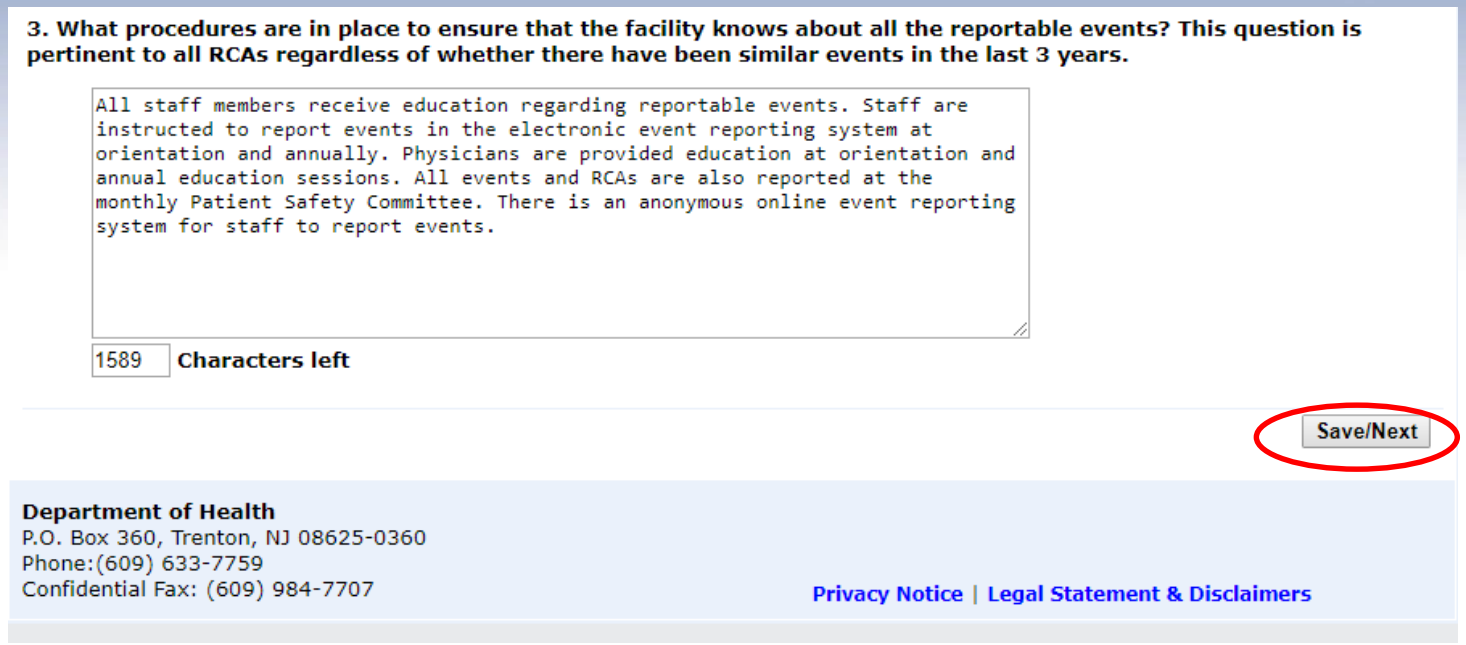
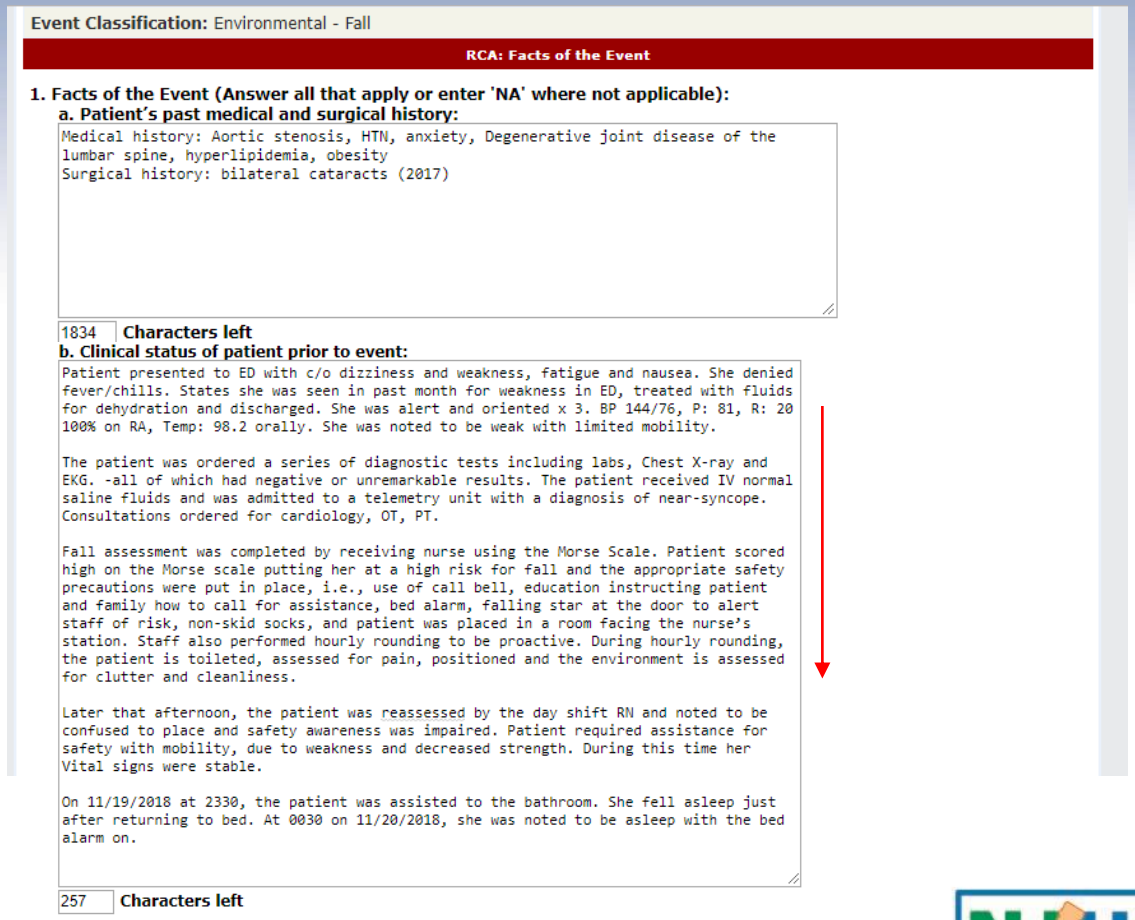
II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: General Information



II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event



Event Classification: Environmental - Fall

RCA: Facts of the Event

1. Facts of the Event (Answer all that apply or enter 'NA' where not applicable):

a. Patient's past medical and surgical history:

Medical history: Aortic stenosis, HTN, anxiety, Degenerative joint disease of the lumbar spine, hyperlipidemia, obesity
Surgical history: bilateral cataracts (2017)

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b. Clinical status of patient prior to event:

Patient presented to ED with c/o dizziness and weakness, fatigue and nausea. She denied fever/chills. States she was seen in past month for weakness in ED, treated with fluids for dehydration and discharged. She was alert and oriented x 3. BP 144/76, P: 81, R: 20 100% on RA, Temp: 98.2 orally. She was noted to be weak with limited mobility.

The patient was ordered a series of diagnostic tests including labs, Chest X-ray and EKG. -all of which had negative or unremarkable results. The patient received IV normal saline fluids and was admitted to a telemetry unit with a diagnosis of near-syncope. Consultations ordered for cardiology, OT, PT.

Fall assessment was completed by receiving nurse using the Morse Scale. Patient scored high on the Morse scale putting her at a high risk for fall and the appropriate safety precautions were put in place, i.e., use of call bell, education instructing patient and family how to call for assistance, bed alarm, falling star at the door to alert staff of risk, non-skid socks, and patient was placed in a room facing the nurse's station. Staff also performed hourly rounding to be proactive. During hourly rounding, the patient is toileted, assessed for pain, positioned and the environment is assessed for clutter and cleanliness.

Later that afternoon, the patient was reassessed by the day shift RN and noted to be confused to place and safety awareness was impaired. Patient required assistance for safety with mobility, due to weakness and decreased strength. During this time her Vital signs were stable.

On 11/19/2018 at 2330, the patient was assisted to the bathroom. She fell asleep just after returning to bed. At 0030 on 11/20/2018, she was noted to be asleep with the bed alarm on.

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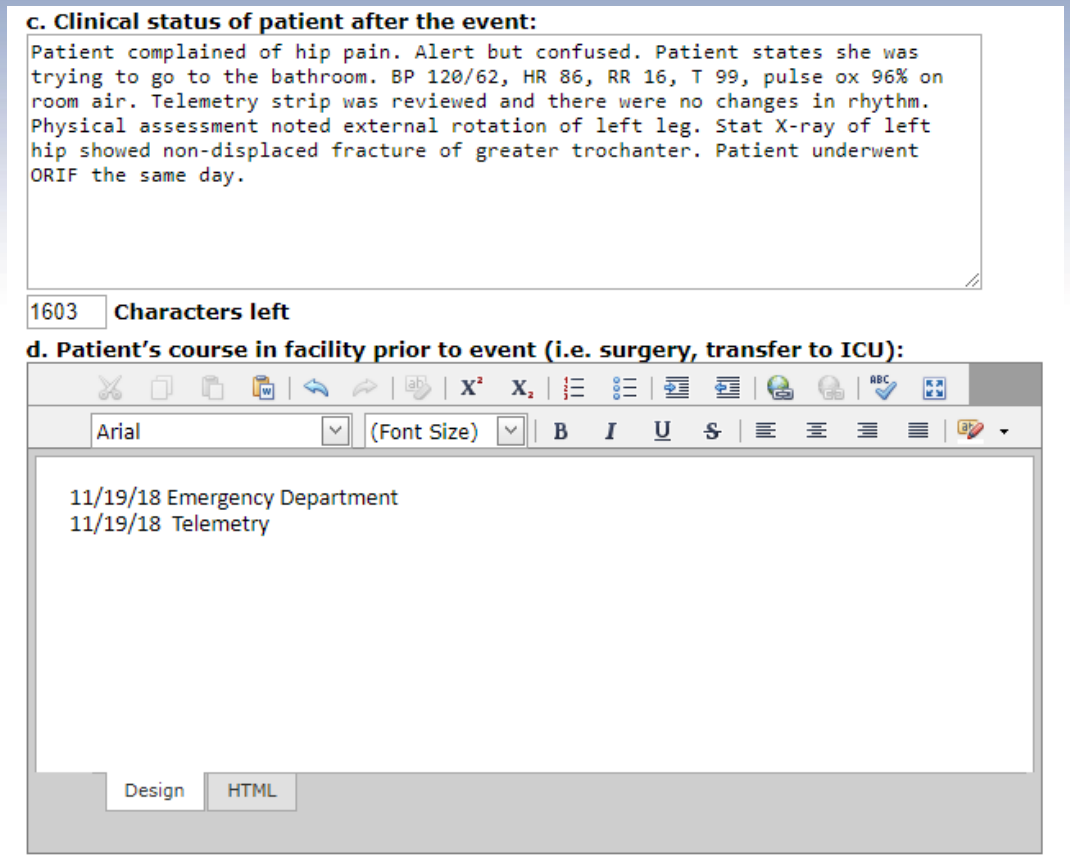
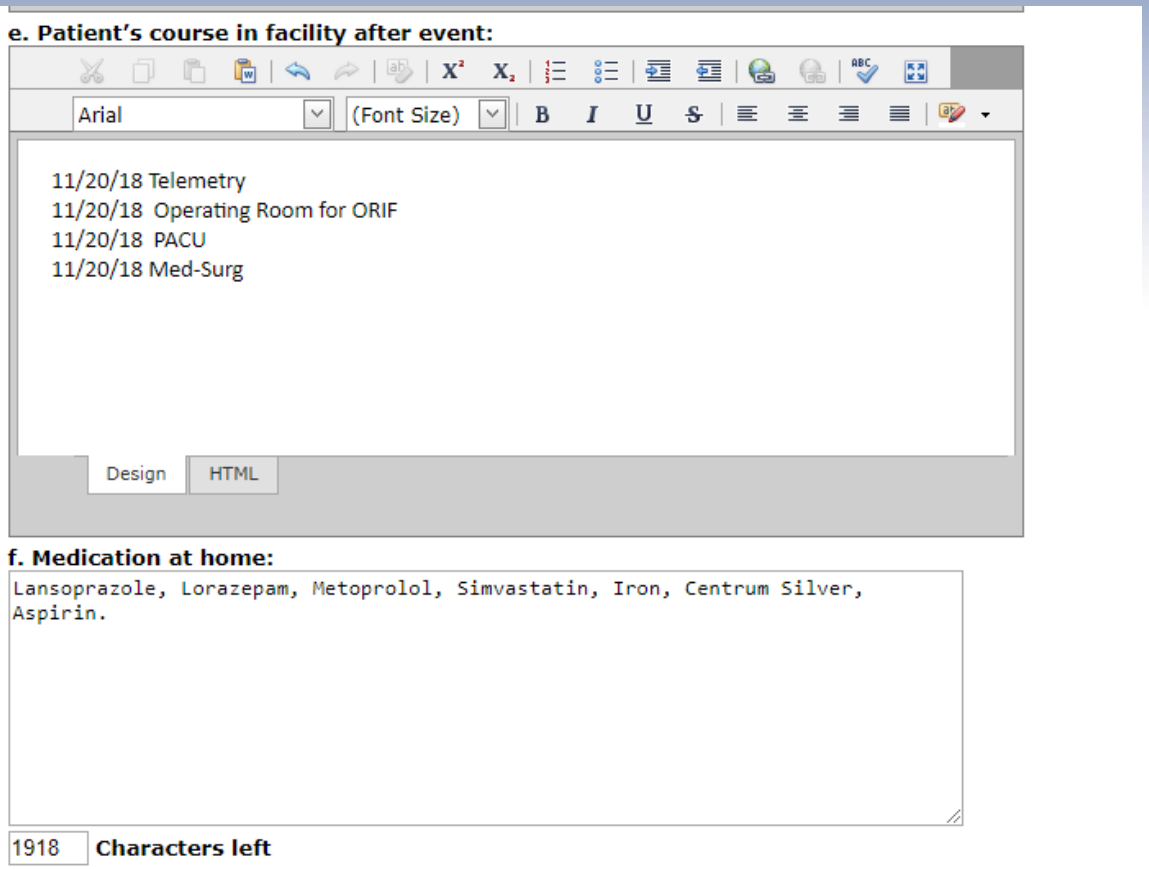
II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event



II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event



II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event

g. Medication at facility: . If this is a fall event, please include the time the last dose of any high fall risk medications were administered prior to the fall

Lansoprazole, Lisinopril, Lorazepam, Metoprolol, Simvastatin, Iron, Centrum Silver, Aspirin, percocet

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h.Other factors contributing to the event. Please include detailed information about staffing. Please include appropriate lab results.

Staff factors were discussed in relationship to staffing levels, training and orientation, competency and supervision. Staffing at the time of the patient's fall was 6 RN's and 4 PCA's for 36 patients. The day shift RN assigned to the patient has been employed by the hospital for 6 years and all mandatory competencies are up to date. The RCA team determined that staff factors, including staffing levels were neither contributory nor causal to the event.

CBC and BMP obtained, results were within normal limits. Lab results not contributory.

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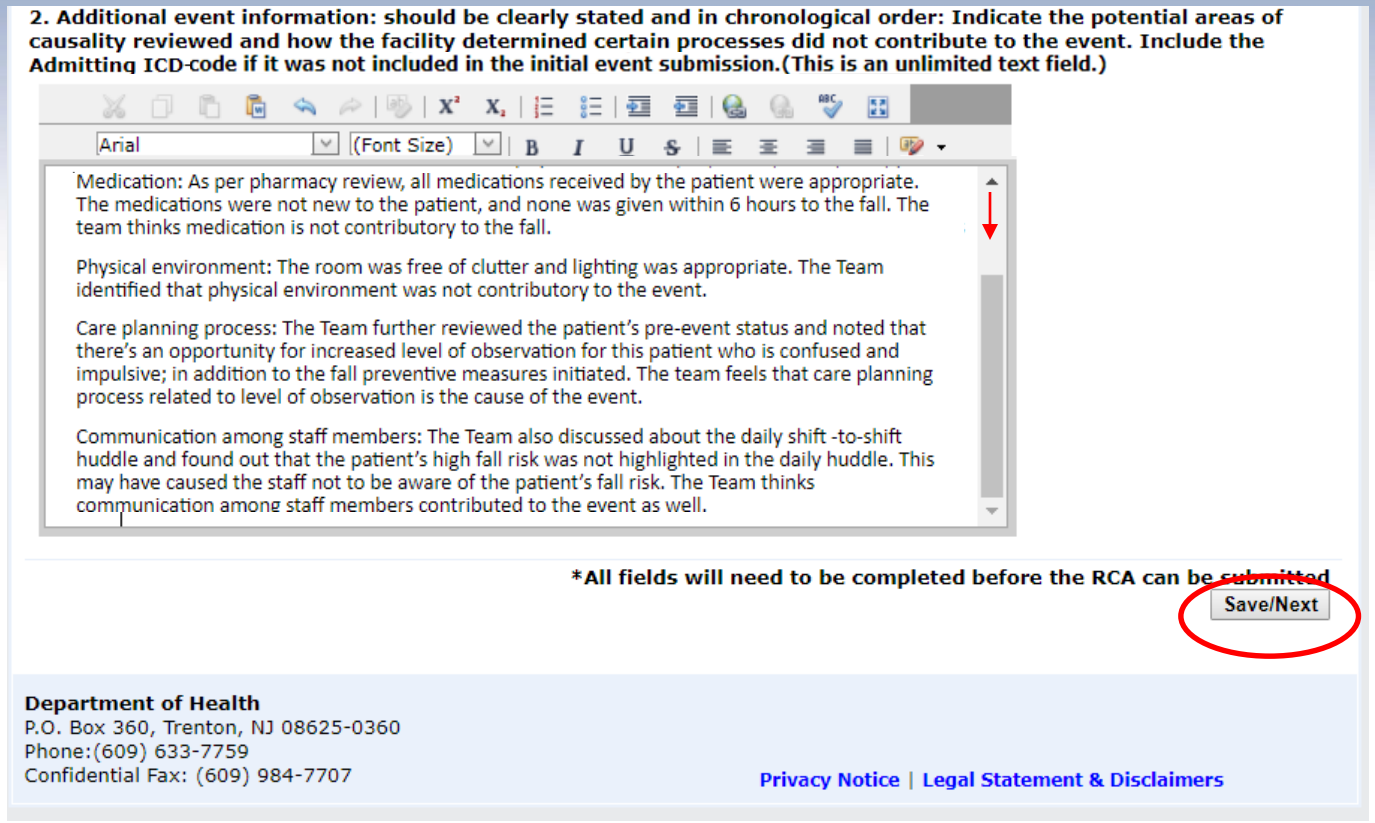
II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event



II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Specific Questions

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Specific Questions

5. Did the screening tool indicate that the patient was at risk for a fall? ○ Yes ◉ No ○ NA

a. Does the patient have a history of a fall prior to admission? ○ Yes ◉ No

6. Please respond to the following questions related to the patient's risk for falls:

a.Was patient placed at risk due to clinical judgment? ○ Yes ◉ No ○ NA

b. If yes, what were the additional factors that placed the patient at risk

c. Were the facility's universal fall precautions in place for this patient at the time of the fall? ◉ Yes ○ No ○ NA

d. Fall Precaution (Check all that apply):

- ☐ 1:1 observation
- ☐ Bed alarms on and functioning
- ☐ Fall alert arm band
- ☑ Floor conditions were dry and free of clutter
- ☑ Items placed within patient's reach
- ☑ Lighting was adequate
- ☑ Patient room close to nurse's station
- ☐ Personal alarms on and functioning
- ☑ Room clear of clutter

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II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Specific Questions

7. Was patient re-evaluated:

- **a. During each nursing shift?** (•) Yes ( ) No ( ) NA
- **b. Upon transfer between units?** (•) Yes ( ) No ( ) NA
- **c. Upon change in status?** (•) Yes ( ) No ( ) NA
- **d. Post-fall?** (•) Yes ( ) No ( ) NA

8. Was there a visual indication alerting staff to patient's at-risk status? ( ) Yes (•) No

9. Was a fall prevention intervention plan documented? (•) Yes ( ) No

10. Did the intervention plan focus on the patient's specific risk factors? (•) Yes ( ) No

11. Was patient/family education completed? (•) Yes ( ) No

12. When was patient rounding last conducted for this patient to check for pain, positioning and toileting? <=30 minutes prior to fall ▾

13. Was the following equipment used to reduce falls for this patient <u>at the time</u> of the event :

- **a. Side rails in proper position?** (•) Yes ( ) No ( ) NA
- **b. Were restraints used?** ( ) Yes (•) No
- **c. If no, were restraints considered?** ( ) Yes (•) No
- **d. Was the pt wearing non-skid foot wear?** (•) Yes ( ) No
- **e. Did foot wear fit properly?** (•) Yes ( ) No ( ) NA
- **f. Other**

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II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Specific Questions

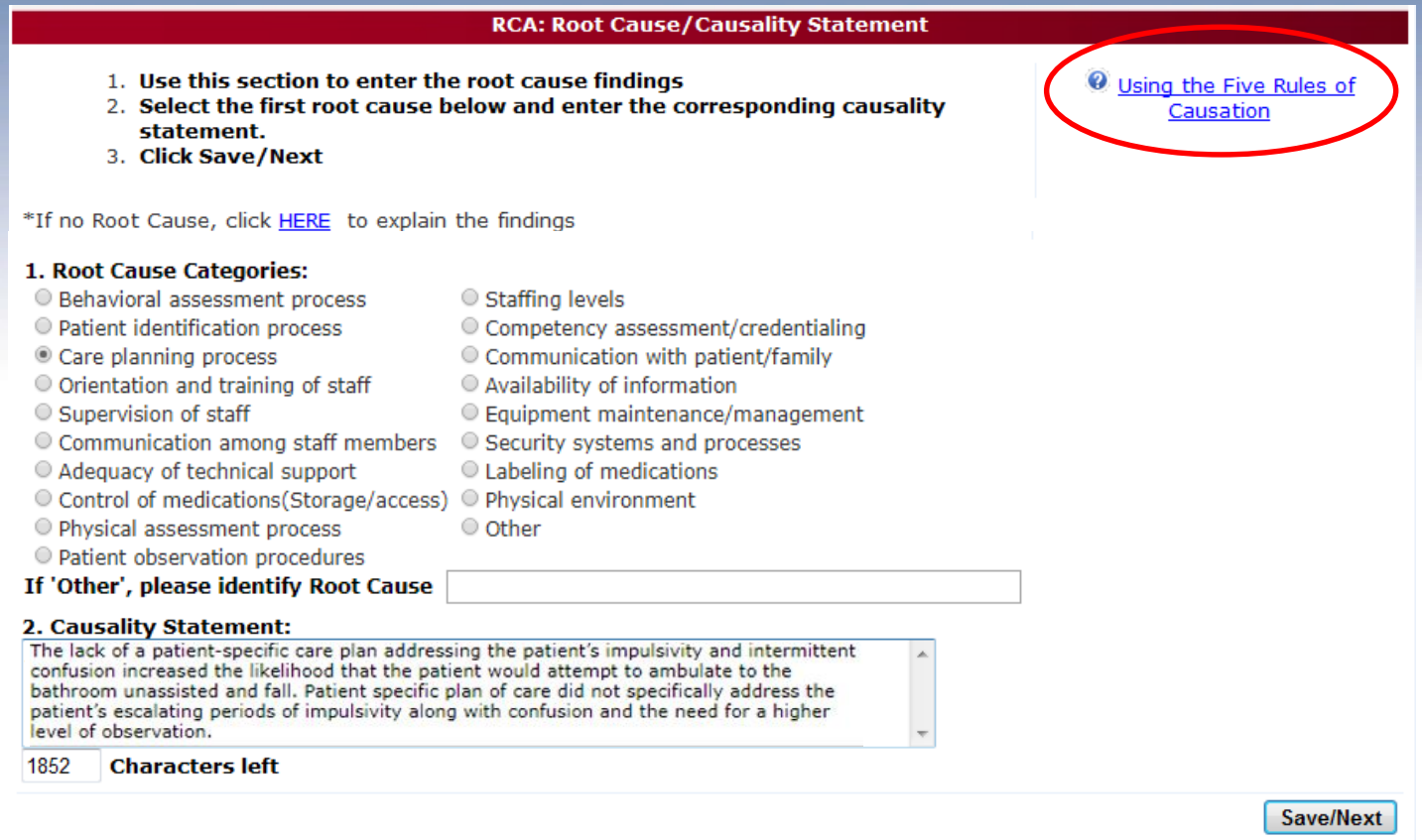
II. Enter Root Cause Analysis and Action Plan – *continued*

Root Cause/Causality Statement

1. **For each RCA you may have:**
   - More than one Root Cause
     - *Each root cause will have a causality statement*
   - More than one Action Plan per Root Cause
     - *Each Action Plan will have one Methodology*
2. **Work through one Root Cause at a time with the corresponding Action Plan(s)**

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Root Cause/Causality Statement



II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Five Rules of Causation

Using the Five Rules of Causation*

*Adapted for patient safety from David Marx.

The five rules of causation are designed to improve the RCA process by creating minimum standards for where an investigation and the results should be documented. The rules are created in response to the very real biases we all bring to the investigation process.

- Rule 1 - Causal Statements must clearly show the "cause and effect" relationship.

  This is the simplest of the rules. When describing why an event has occurred, you should show the link between your
  outcome, and each link should be clear to the RCA
  on showing the link from your root cause to the un
  outcome you are investigating. Even a statement li
  fatigued" is deficient without your description of h
  slip or mistake. The bottom line: the reader needs
  in linking your causes to the outcome.

- Rule 2 - Negative descriptors (e.g., poorly, inadequ
  causal statements.

  As humans, we try to make each job we have as ea
  Unfortunately, this human tendency works it way i
  process. We may shorten our findings by saying "
  poorly written" when we really have a much more
  our mind. To force clear cause and effect descripti
  inflammatory statements), we recommend against
  descriptor that is merely the placeholder for a mor
  description. Even words like "carelessness" and "
  choices because they are broad, negative judgmer
  describe the actual conditions or behaviors that le

- Rule 3 - Each human error must have a preceding

  Most of our mishaps involve at least one human er
  discovery that a human has erred does little to aid
  You must investigate to determine WHY the human error occurred. It can be a system-induced error (e.g., step not included in medical procedure) or an at-risk behavior (doing task by memory, instead of a checklist). For every human error in your causal chain, you must have a corresponding cause. It is the cause of the error, not the error itself, which leads us to productive prevention strategies.

- Rule 4 - Each procedural deviation must have a preceding cause.

  Procedural violations are like errors in that they are not directly manageable. Instead, it is the cause of the procedural violation that we can manage. If a clinician is violating a procedure because it is the local norm, we will have to address the incentives that created the norm. If a technician is missing steps in a procedure because he is not aware of the formal checklist, work on education.

- Rule 5 - Failure to act is only causal when there was a pre-existing duty to act.

  We can all find ways in which our investigated mishap would not have occurred - but this is not the purpose of causal investigation. Instead, we need to find out why this mishap occurred in our system as it is designed today. A doctor's failure to prescribe a medication can only be causal if he was required to prescribe the medication in the first place. The duty to perform may arise from standards and guidelines for practice; or other duties to provide patient care.

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II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Action Plan

Report Number: 20180356

Event Classification: Environmental - Fall

Causality Statement: The lack of a patient-specific care plan addressing the patient's impulsivity and intermittent confusion increased the likelihood that the patient would attempt to ambulate to the bathroom unassisted and fall. Patient specific plan of care did not specifically address the patient's escalating periods of impulsivity along with confusion and the need for a higher level of observation.

- Enter the Action Plan for the causality statement displayed above
- Complete all RCA: Action Plan fields
- If more than one methodology is required (i.e. chart review and observational audits) a separate Action Plan is required for each.
    - See next screen for instructions on adding a new action plan.
- Click 'Save/Next' when finished

RCA: Action Plan

1. Action Plan:

Re-education of Fall Prevention Program including reassessment of fall risk when there is a change in patient behavior specifically focusing on clinical triggers with implementation of additional prevention measures such as 1:1 observation. Correlate clinical picture with falls risk.

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II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Action Plan

2. Monitoring Strategy:

Nurse managers/designees will review a designated number of fall risk assessments weekly and conduct validation to determine the accuracy of the assessments and the appropriateness of the measures selected for the identified risk category (low, moderate or high risk). Data will be reported monthly at unit council meetings, Nursing Quality/Outcomes/Peer Review Council meetings, and aggregated for quarterly reporting at Hospital Performance Improvement Committee meetings.

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3. Methodology Chart Audit

4. Frequency Weekly

5. Sample Size 30

6. Implementation Start Date 12/3/2018

7. Staff position responsible for implementation:

Nurse Manager/Designee

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II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Action Plan

8.Duration: 6 months sustained 100% compliance and

9. Goal 100%

10. Threshold 100%

11. How will effectiveness be monitored over time? :

Effectiveness will be monitored by the robust review processes at the weekly Quality Huddles, the hospital's Patient Safety Committee, and the hospital's Performance Improvement Committee.

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12. How will the Action Plan be communicated within and across departments? :

The plan will be communicated to staff by staff meetings, small group departmental discussions, Nursing PI Committee, and the hospital's Performance Improvement Committee.

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***All Fields are Required**

Save/Next

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II. Enter Root Cause Analysis and Action Plan – *continued*

Edit/Add Root Cause Findings

When the first Root Cause and Action Plan are complete, you can add an additional Action Plan to the Root Cause or edit the first Root Cause.

Report Menu: Return to Detail

Report Number: 20180356

Event Classification: Environmental - Fall

Use this section to edit/add root cause findings

- **To Edit a Root Cause** - Edit the root cause by clicking 'Edit' on the the appropriate row in the grid below .
- **To Add an Action Plan** - Click on ⊞ below to expand root cause then click on 'Add Action Plan'
- **To Add a Root Cause** - Click to enter an additional Root Cause.
- **To Continue** - When the RCA(s) and Action Plan(s) information is complete, click the button below to answer final RCA questions.

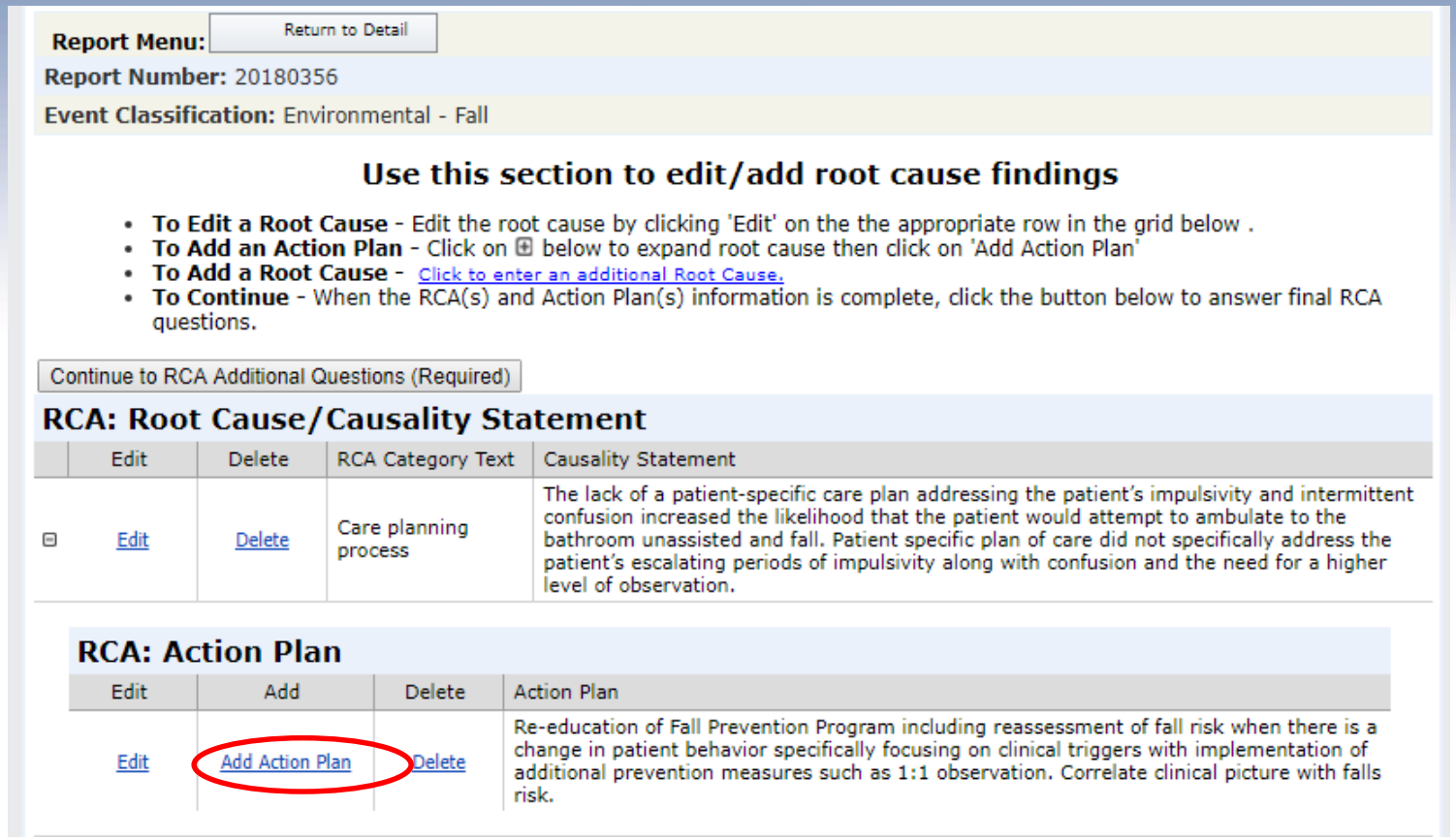
Continue to RCA Additional Questions (Required)

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
⊟	Edit	Delete	Care planning process	The lack of a patient-specific care plan addressing the patient's impulsivity and intermittent confusion increased the likelihood that the patient would attempt to ambulate to the bathroom unassisted and fall. Patient specific plan of care did not specifically address the patient's escalating periods of impulsivity along with confusion and the need for a higher level of observation.

II. Enter Root Cause Analysis and Action Plan – *continued*

Edit/Add Root Cause Findings



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RCA: Action Plan

Edit	Add	Delete	Action Plan
Edit	Add Action Plan	Delete	Re-education of Fall Prevention Program including reassessment of fall risk when there is a change in patient behavior specifically focusing on clinical triggers with implementation of additional prevention measures such as 1:1 observation. Correlate clinical picture with falls risk.

II. Enter Root Cause Analysis and Action Plan – *continued*

Add an Additional Root Cause

Use this section to edit/add root cause findings

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- **To Add an Action Plan** - Click on ⊞ below to expand root cause then click on 'Add Action Plan'
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Continue to RCA Additional Questions (Required)

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RCA: Action Plan

Edit	Add	Delete	Action Plan
Edit	Add Action Plan	Delete	Re-education of Fall Prevention Program including reassessment of fall risk when there is a change in patient behavior specifically focusing on clinical triggers with implementation of additional prevention measures such as 1:1 observation. Correlate clinical picture with falls risk.

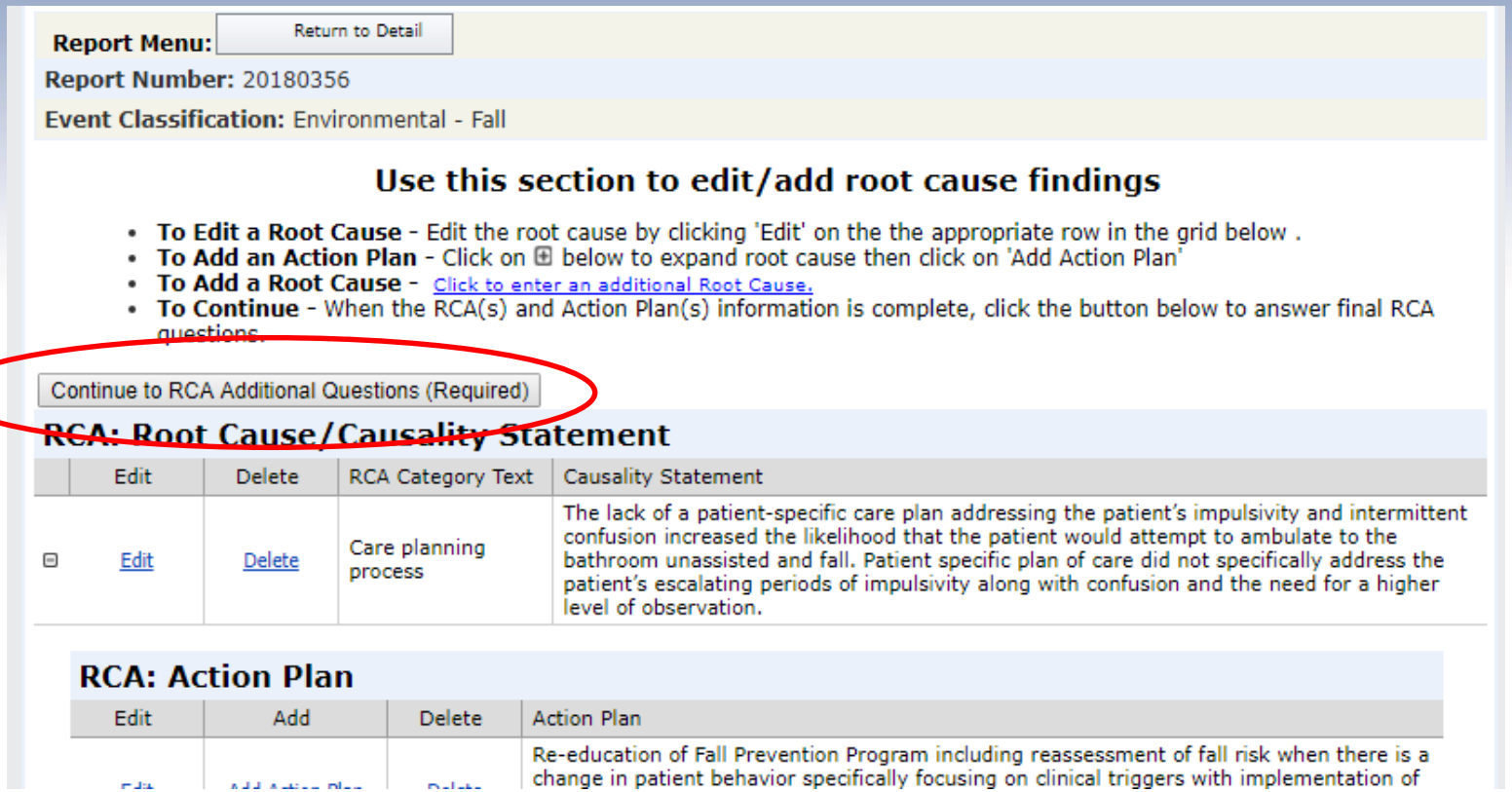
II. Enter Root Cause Analysis and Action Plan – *continued*

When all Root Causes and Action Plans are complete:

- Complete RCA Additional Questions
- Submit to PSRS for review
- You will receive an error message if any required information is not completed

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Additional Questions



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Event Classification: Environmental - Fall

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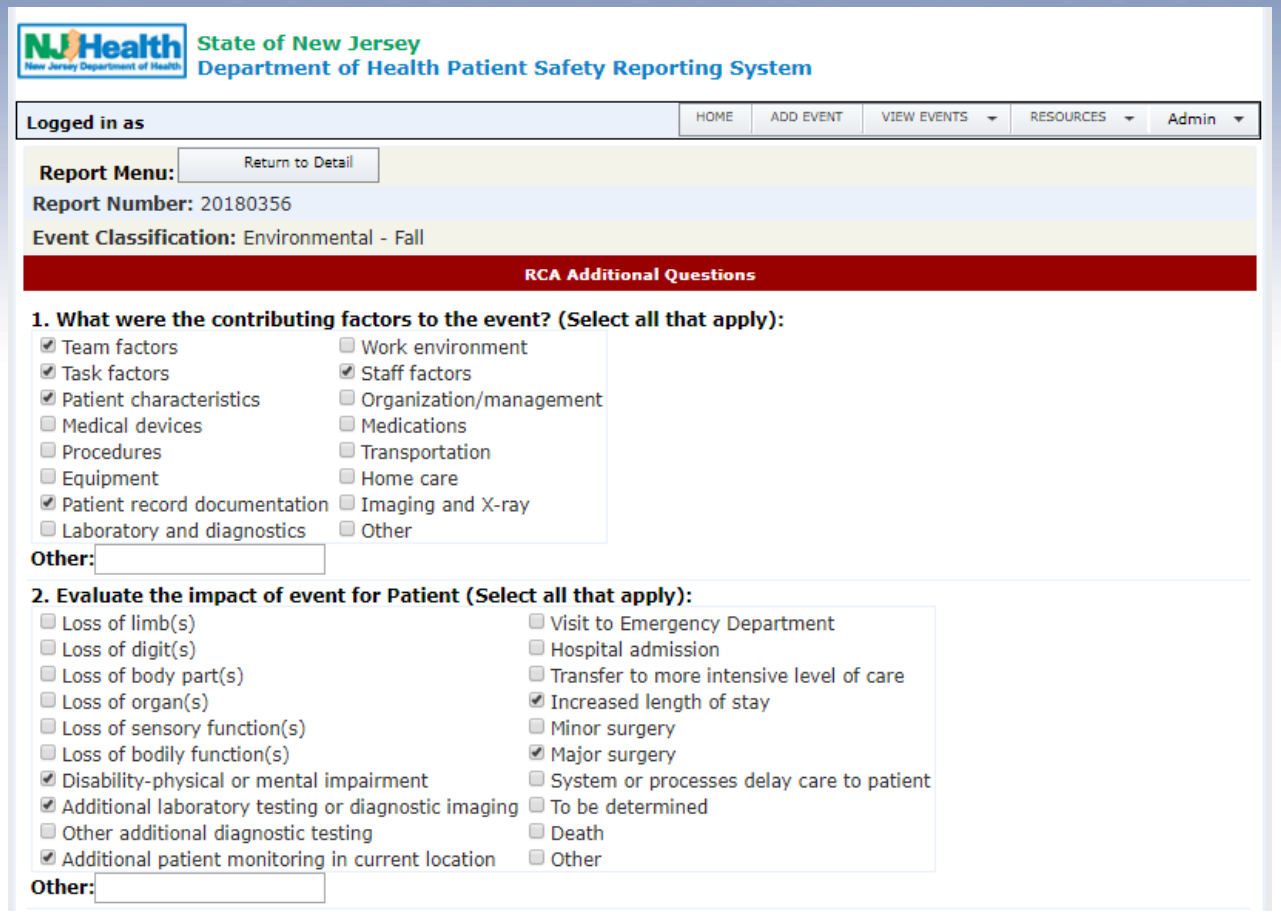
RCA: Action Plan

Edit	Add	Delete	Action Plan
			Re-education of Fall Prevention Program including reassessment of fall risk when there is a change in patient behavior specifically focusing on clinical triggers with implementation of

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Additional Questions



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Logged in as | HOME | ADD EVENT | VIEW EVENTS | RESOURCES | Admin

Report Menu: Return to Detail

Report Number: 20180356

Event Classification: Environmental - Fall

RCA Additional Questions

1. What were the contributing factors to the event? (Select all that apply):

- [x] Team factors
- [x] Task factors
- [x] Patient characteristics
- [ ] Medical devices
- [ ] Procedures
- [ ] Equipment
- [x] Patient record documentation
- [ ] Laboratory and diagnostics
- [ ] Work environment
- [x] Staff factors
- [ ] Organization/management
- [ ] Medications
- [ ] Transportation
- [ ] Home care
- [ ] Imaging and X-ray
- [ ] Other

Other:

2. Evaluate the impact of event for Patient (Select all that apply):

- [ ] Loss of limb(s)
- [ ] Loss of digit(s)
- [ ] Loss of body part(s)
- [ ] Loss of organ(s)
- [ ] Loss of sensory function(s)
- [ ] Loss of bodily function(s)
- [x] Disability-physical or mental impairment
- [x] Additional laboratory testing or diagnostic imaging
- [ ] Other additional diagnostic testing
- [x] Additional patient monitoring in current location
- [ ] Visit to Emergency Department
- [ ] Hospital admission
- [ ] Transfer to more intensive level of care
- [x] Increased length of stay
- [ ] Minor surgery
- [x] Major surgery
- [ ] System or processes delay care to patient
- [ ] To be determined
- [ ] Death
- [ ] Other

Other:

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Additional Questions

3. ICDCodes resulting from event:

820.8

995 **Characters left**

4. Diagnosis resulting from event:

Closed fracture of the left hip.

968 **Characters left**

5. Information consulted such as clinical literature/other published guidelines (please provide specific citations otherwise leave blank): This information is automatically entered into the 'Information Consulted' document in the Resources tab and is accessible to all facilities.

Preventing Patient Falls: A Systematic Approach from the Joint Commission Center for Transforming Healthcare Project. NJ Fall TIPS Collaborative

Preventing Falls in Hospitals: A toolkit for improving Quality of Care (http://www.ahrq.gov/research/ltc/fallpxtoolkit/fallpxtoolkit.pdf)(AHRQ - Agency for Healthcare Research and Quality).

494 **Characters left**

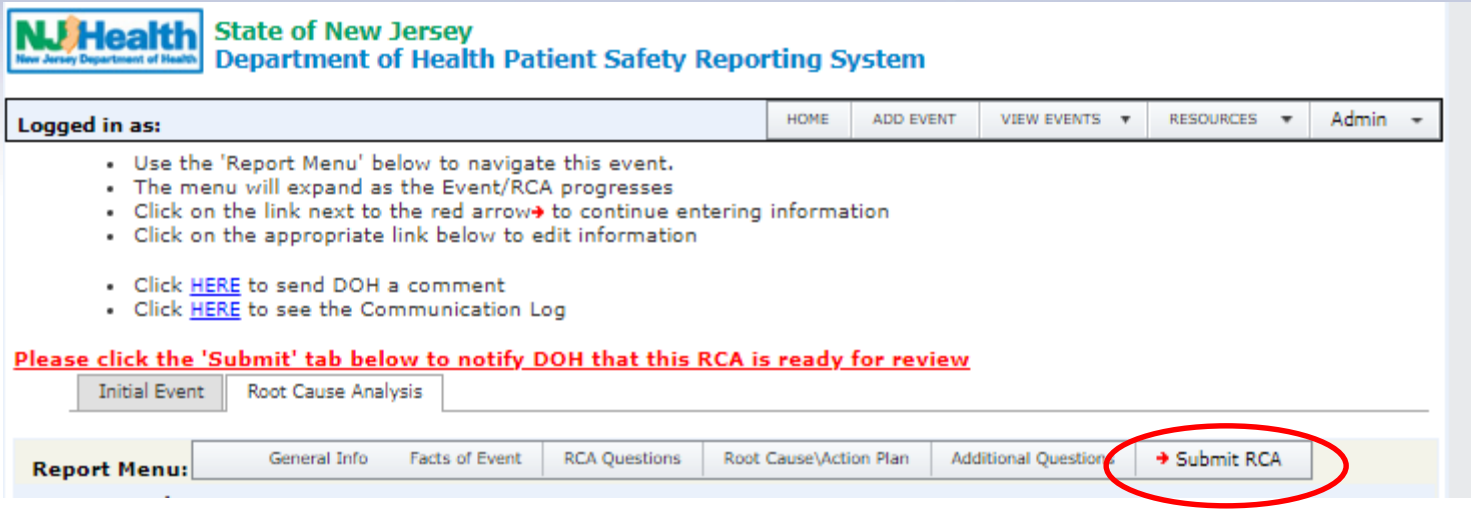
***All Fields are Required**

Save/Next

NJ Health New Jersey Department of Health

II. Enter Root Cause Analysis and Action Plan – *continued*

Submit RCA to PSRS



III. RCA Review by PSRS

1. **Automated e-mail sent to PSRS when RCA is submitted**
2. **PSRS reviews the RCA**
3. **Possible Review Outcomes:**
   - Email: RCA Comment Process
   - Email: RCA Complete

III. RCA Review by PSRS - *continued*

Email: RCA Comment process:

1. **Additional information is needed**

2. **PSRS makes comments to determine if the RCA contains the required components of an RCA**

3. **An email is sent to the FacAdmins**
   - *Comments are available on this RCA. Please log into the Patient Safety Reporting System to view the details and respond accordingly.*
   - Note: PSRS must be added as a safe sender so PSRS emails do not go to your spam folder

4. **A Facility User must log into the PSRS and open the Communication log for that RCA to view the email and read the comments**

III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

5. **Comments can be accessed by:**
   - **A comment link in the RCA**
     - Only visible in sections of the RCA with PSRS comments
     - Click on 'Comments' link
   - **A link to the comment through the Communication Log**
     - Click **HERE** to see the Communication Log
     - Click **HERE** to view all comments

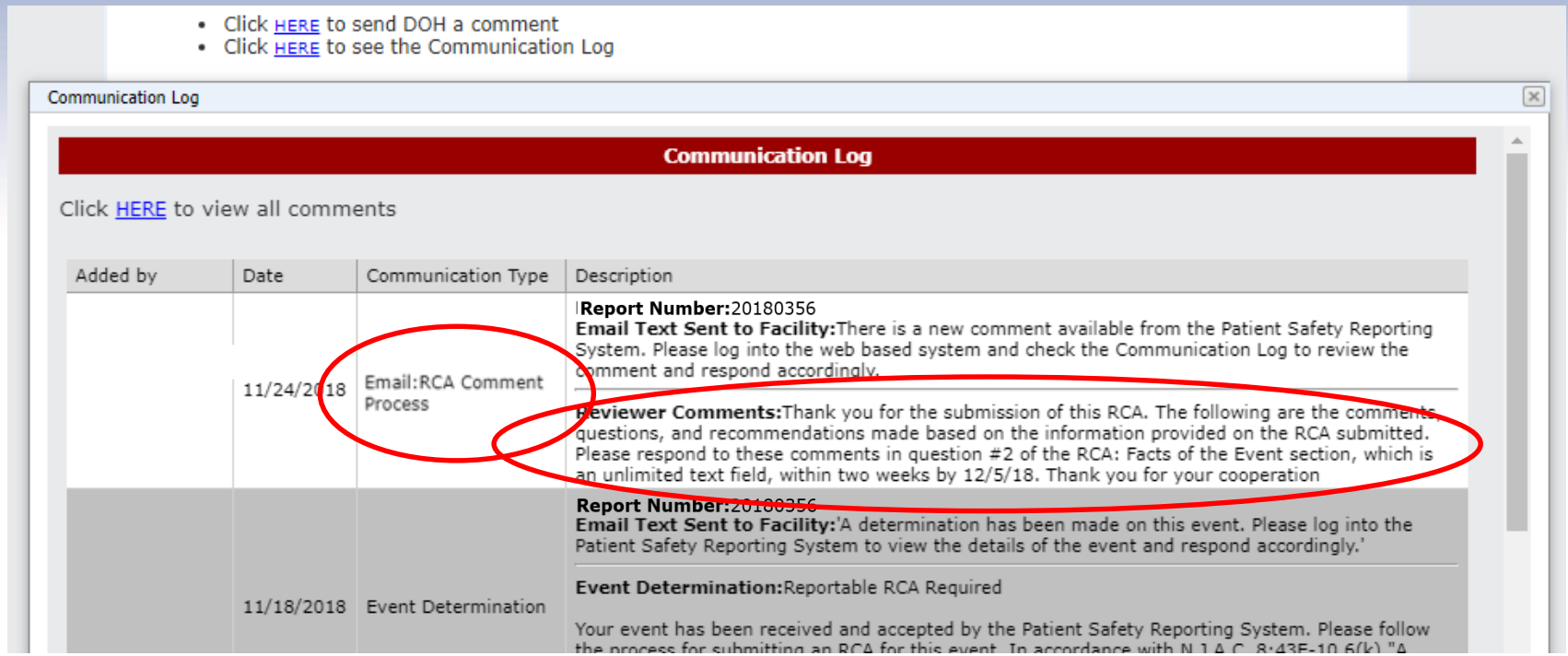
III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

6. **Respond to all comments *by editing* the RCA**
   - Click on 'Edit' in the section(s) with the Comments
   - Provide responses to the Comments/Questions
   - The RCA: Facts of the Event section question #2 is an unlimited text field
7. **Resubmit the RCA to PSRS**
   - Click on 'Save' to keep the changes
   - Click on the 'Submit RCA' tab to resend the RCA to PSRS
8. **There may be more than 1 cycle of responding to comments**

III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*



- Click HERE to send DOH a comment
- Click HERE to see the Communication Log

Communication Log

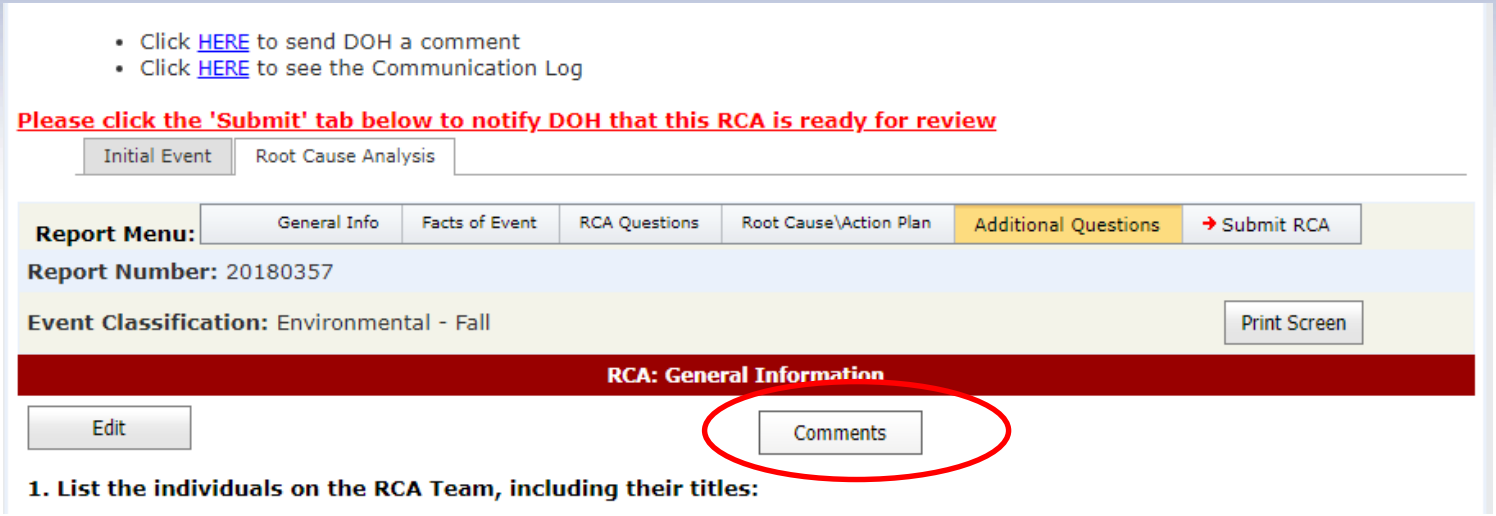
Communication Log

Click HERE to view all comments

Added by	Date	Communication Type	Description
	11/24/2018	Email:RCA Comment Process	**Report Number:**20180356 **Email Text Sent to Facility:**There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly. **Reviewer Comments:**Thank you for the submission of this RCA. The following are the comments, questions, and recommendations made based on the information provided on the RCA submitted. Please respond to these comments in question #2 of the RCA: Facts of the Event section, which is an unlimited text field, within two weeks by 12/5/18. Thank you for your cooperation
	11/18/2018	Event Determination	**Report Number:**20180356 **Email Text Sent to Facility:**'A determination has been made on this event. Please log into the Patient Safety Reporting System to view the details of the event and respond accordingly.' **Event Determination:**Reportable RCA Required Your event has been received and accepted by the Patient Safety Reporting System. Please follow the process for submitting an RCA for this event. In accordance with N.J.A.C. 8:43E-10.6(k) "A

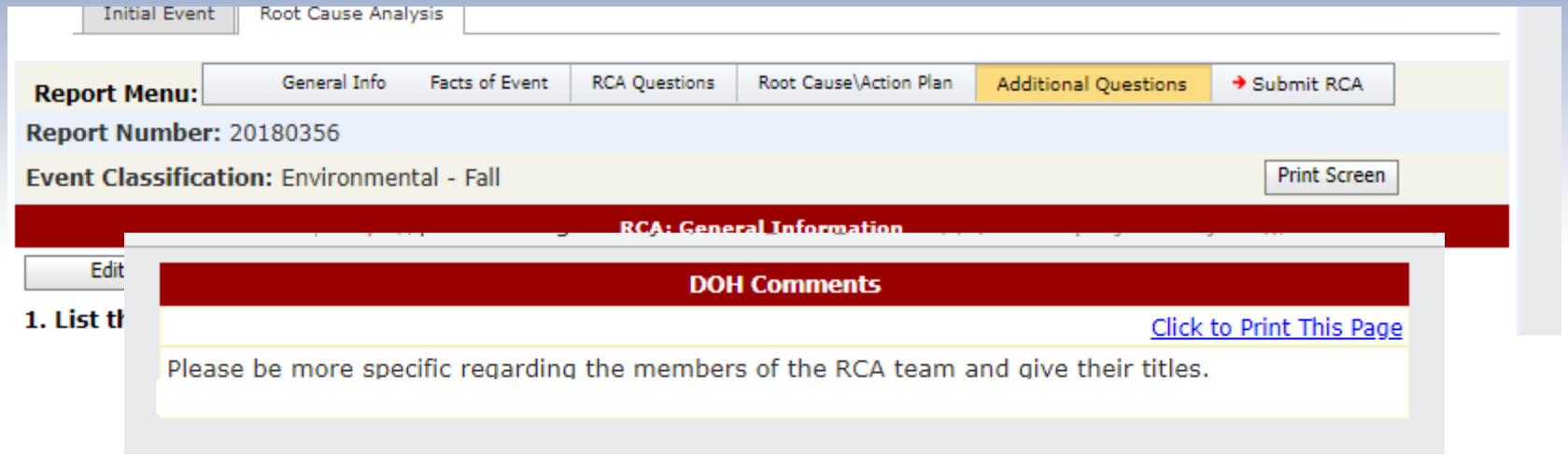
III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*



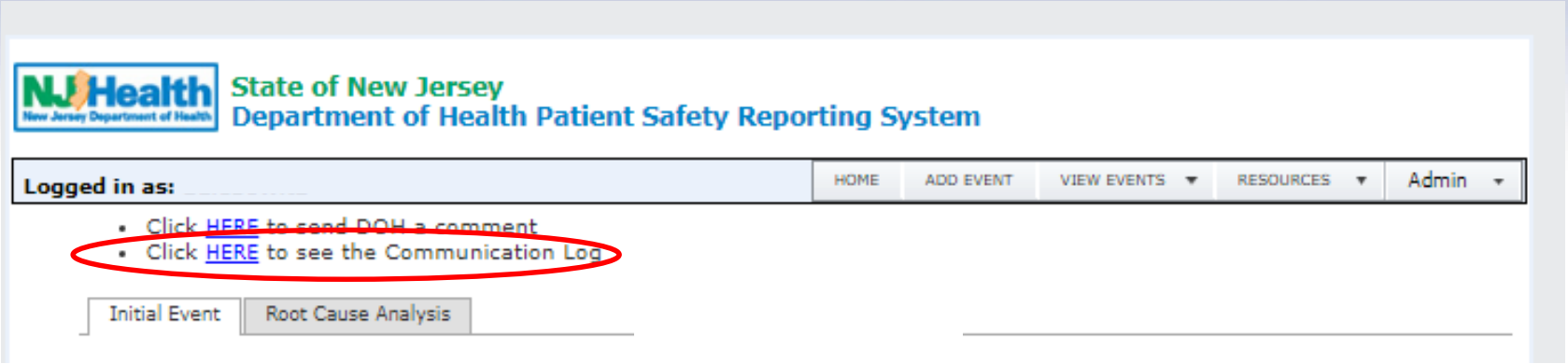
III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*



III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*



III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

III. RCA Review by PSRS - *continued*

Review All Comments Link

Comments

Comment Section: General Comment
Added by:
Report Number:20180356
Email Text Sent to Facility: There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly.

Reviewer Comments:'PSRS has received your additional information and will review and respond. Thank you for your submission.'

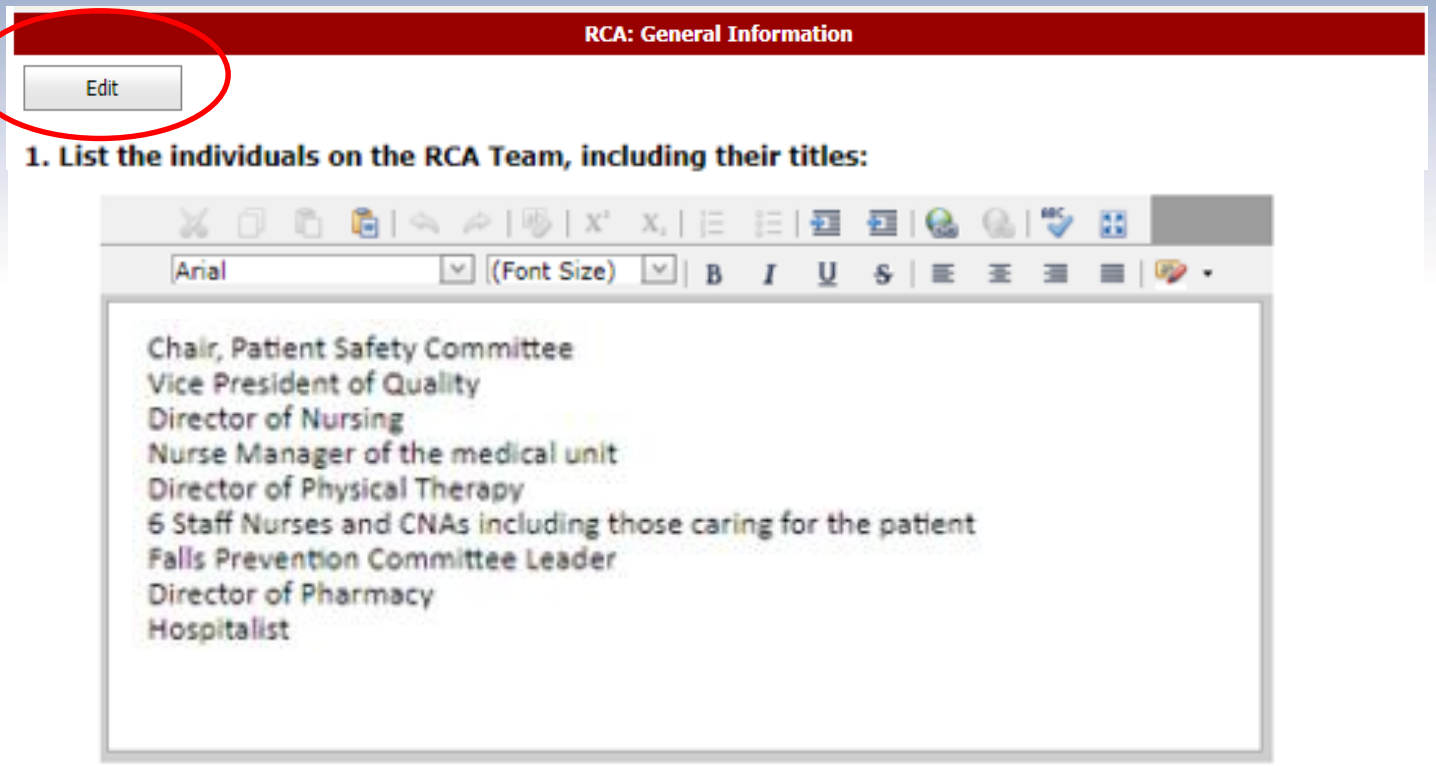
Comment Section: RCA: General Information
Added by:

Reviewer Comments: Please be more specific regarding the members of the RCA team and give their titles.

The comment above was added:11/21/2018 7:04:03 PM by BLiebowitzAdmin

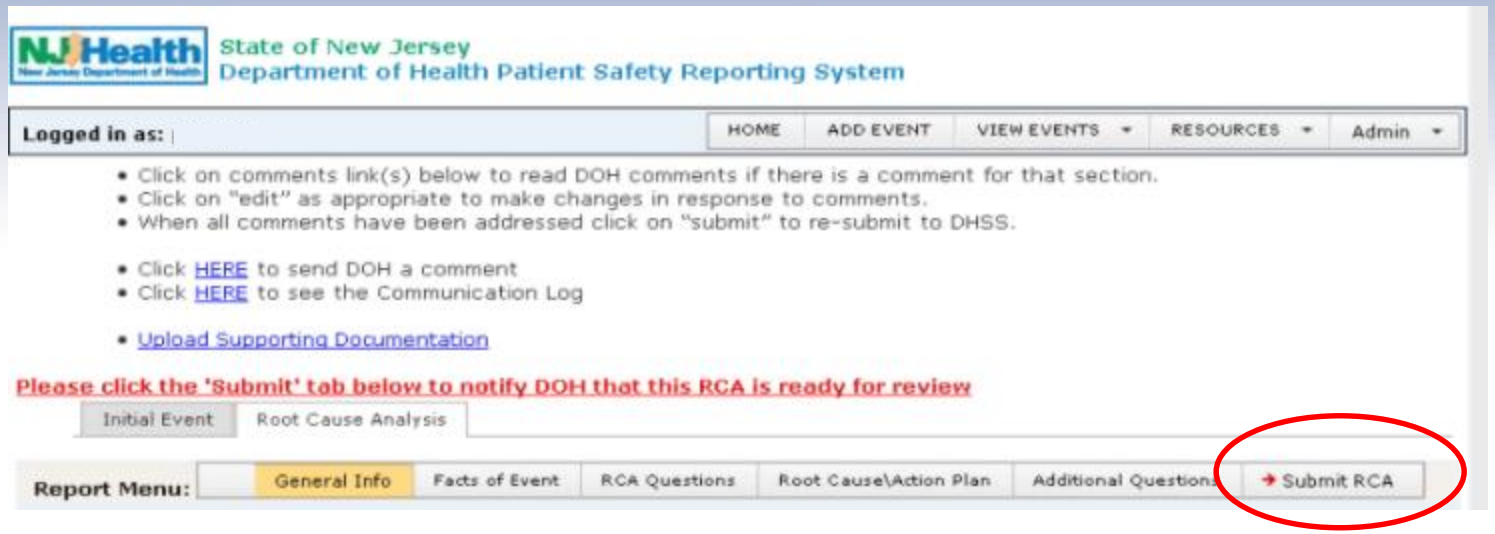
III. RCA Review by PSRS - *continued*

Edit RCA



III. RCA Review by PSRS - *continued*

Re-Submit Edited RCA



III. RCA Review by PSRS - *continued*

Email: RCA Complete:

1. **The RCA is closed**

2. **Additional information or clarification may be requested to complete the RCA Review**

3. **An email is sent to the FacAdmins**
   - *The status of this RCA has changed. Please log into the Patient Safety Reporting System to view the details and respond accordingly.*
   - Note: PSRS must be added as a safe sender so PSRS emails do not go to your spam folder

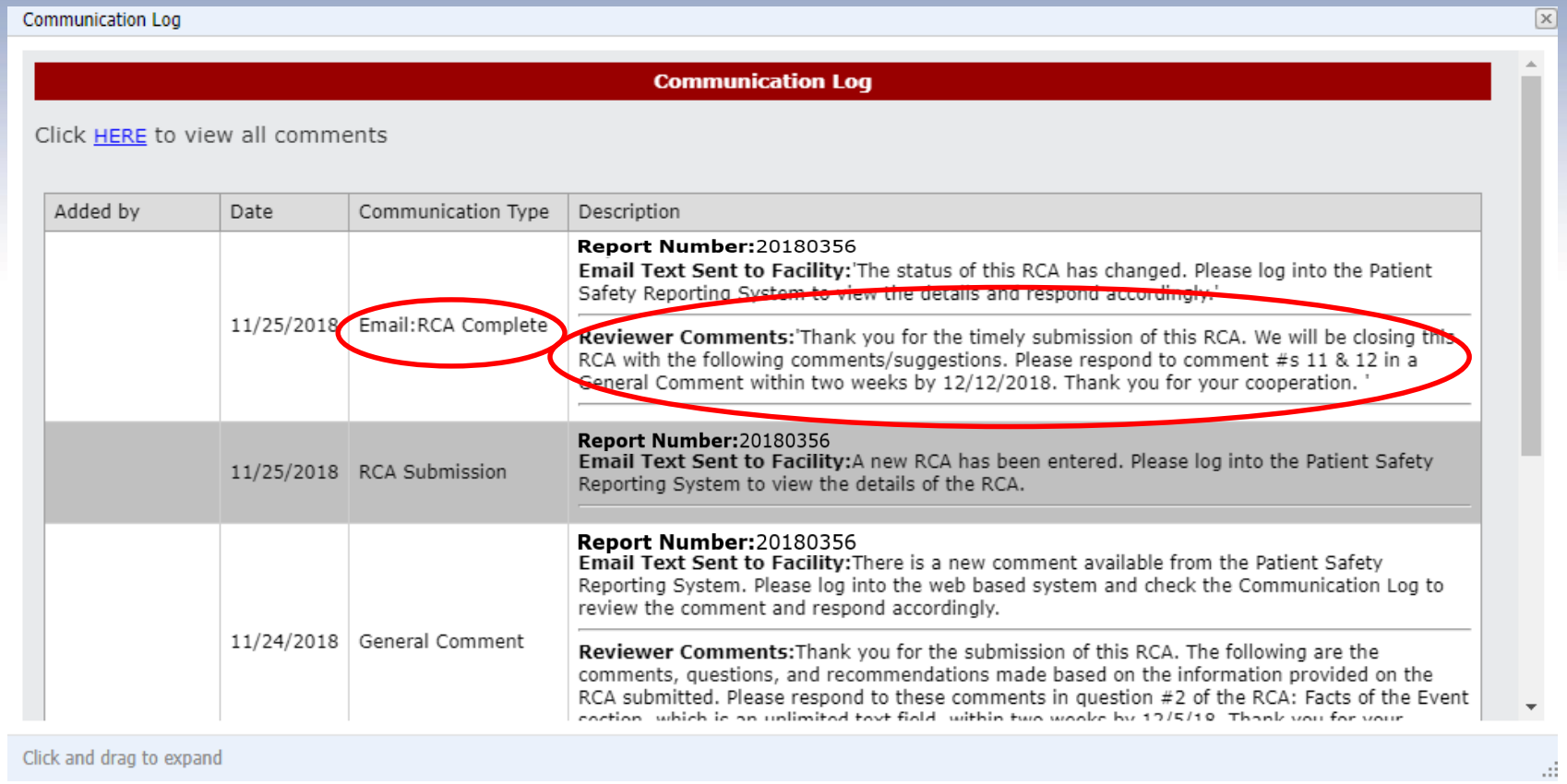
III. RCA Review by PSRS - *continued*

Email: RCA Complete *continued:*

4. **A Facility User must log into the PSRS to read the Status of the RCA, which will be located in the Communication log for that RCA, and respond accordingly.**

5. **If requested, additional information may be sent to PSRS by**
    - **General Comment**
    - **Attachment (Upload Documentation)**
        - **Covered in 'Other Communications about the RCA'**

III. RCA Review by PSRS - *continue*



Communication Log

Communication Log

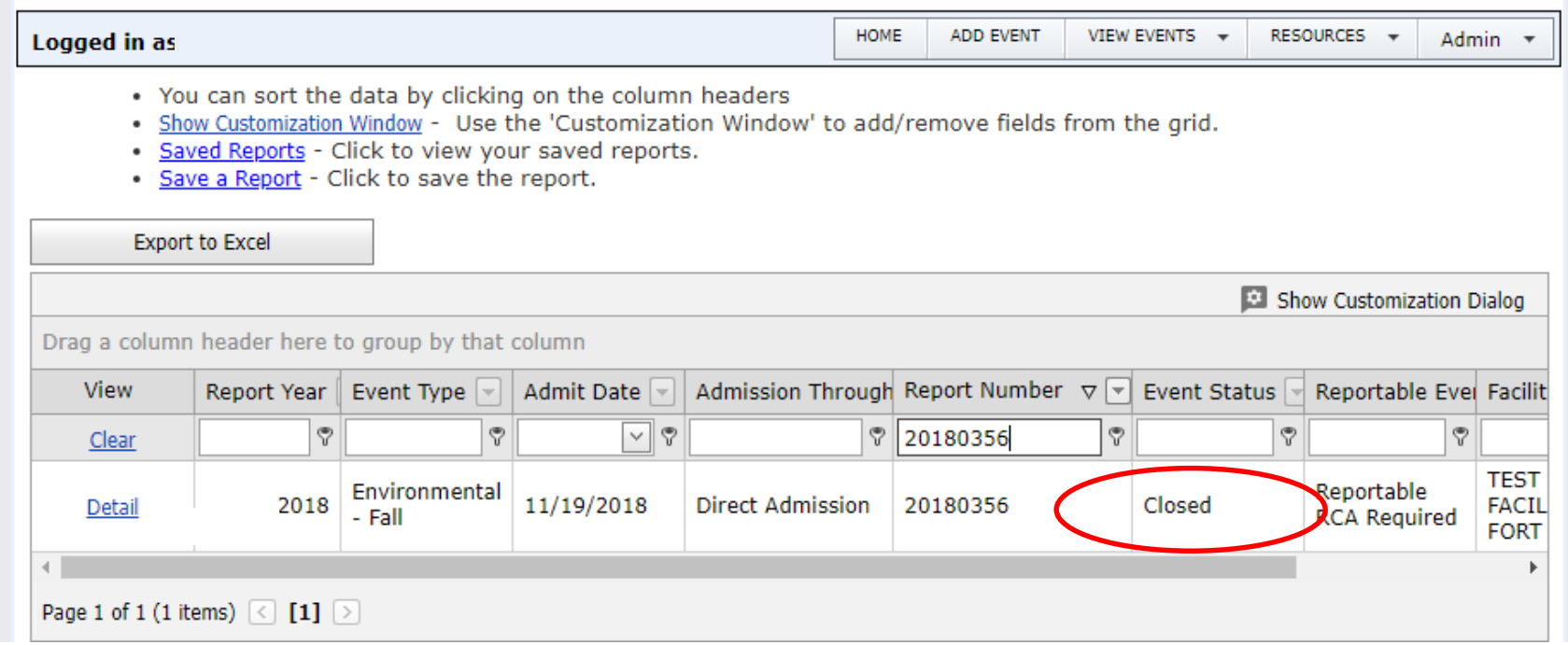
Click HERE to view all comments

Added by	Date	Communication Type	Description
	11/25/2018	Email:RCA Complete	**Report Number:**20180356 **Email Text Sent to Facility:**'The status of this RCA has changed. Please log into the Patient Safety Reporting System to view the details and respond accordingly.' **Reviewer Comments:**'Thank you for the timely submission of this RCA. We will be closing this RCA with the following comments/suggestions. Please respond to comment #s 11 & 12 in a General Comment within two weeks by 12/12/2018. Thank you for your cooperation. '
	11/25/2018	RCA Submission	**Report Number:**20180356 **Email Text Sent to Facility:**A new RCA has been entered. Please log into the Patient Safety Reporting System to view the details of the RCA.
	11/24/2018	General Comment	**Report Number:**20180356 **Email Text Sent to Facility:**There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly. **Reviewer Comments:**Thank you for the submission of this RCA. The following are the comments, questions, and recommendations made based on the information provided on the RCA submitted. Please respond to these comments in question #2 of the RCA: Facts of the Event section, which is an unlimited text field, within two weeks by 12/5/18. Thank you for your

Click and drag to expand

IV. Other Communications About the RCA - *continued*

Email: RCA Complete



Patient Safety Reporting System

IV. Other Communications About the RCA

Communication <u>from</u> PSRS

- FacAdmins receive notification via email there is a communication from PSRS

1. **General Comment or Email:Other**
   - *There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly*

2. **Access Communications using the Communication Log**

IV. Other Communications About the RCA - *continued*

Email: Other


Communication Log

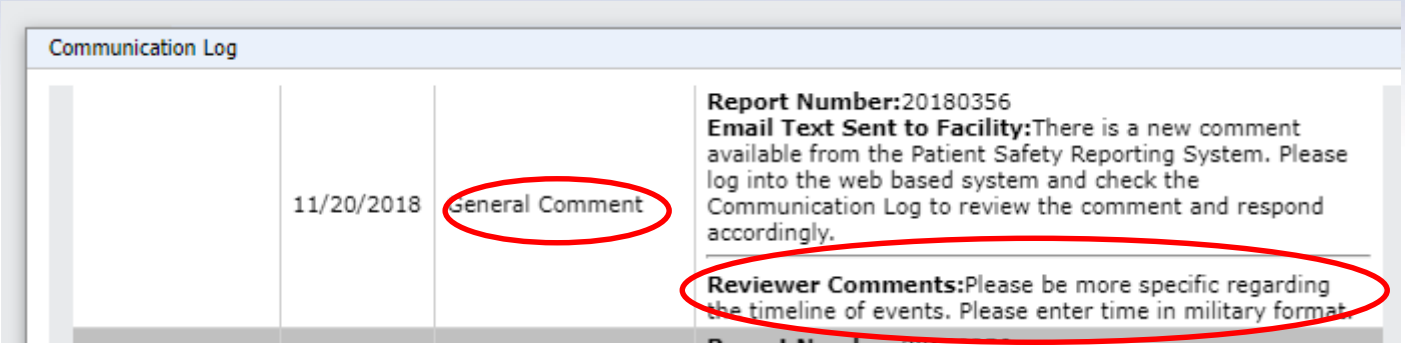
Communication Log

Click HERE to view all comments

Added by	Date	Communication Type	Description
	11/21/2018	Email:Other	**Report Number:**20180356 **Email Text Sent to Facility:**'There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly.' **Reviewer Comments:**'Thank you for submitting your RCA. We will review and get back to you with our determination.'

IV. Other Communications About the RCA - *continued*

Email: General Comment



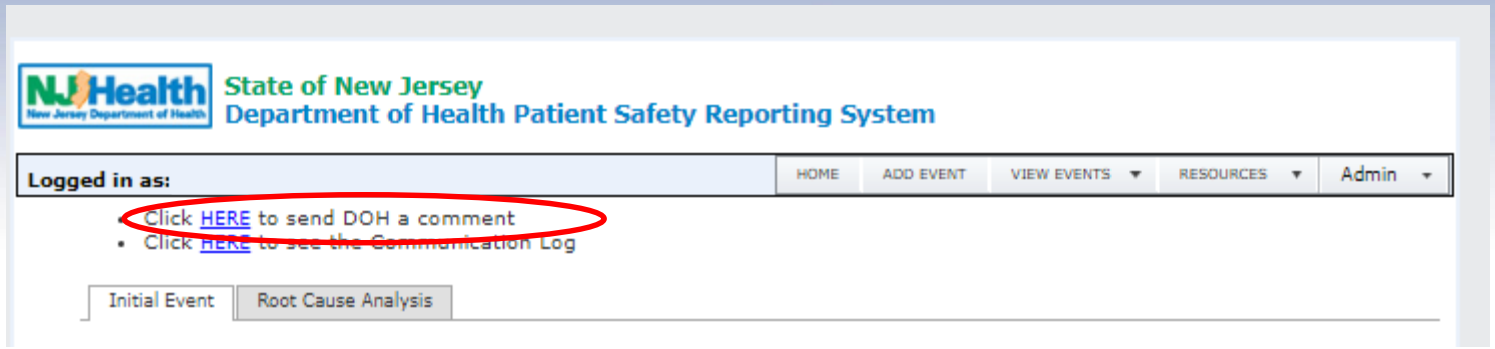
IV. Other Communications About the RCA - *continued*

Communication to PSRS

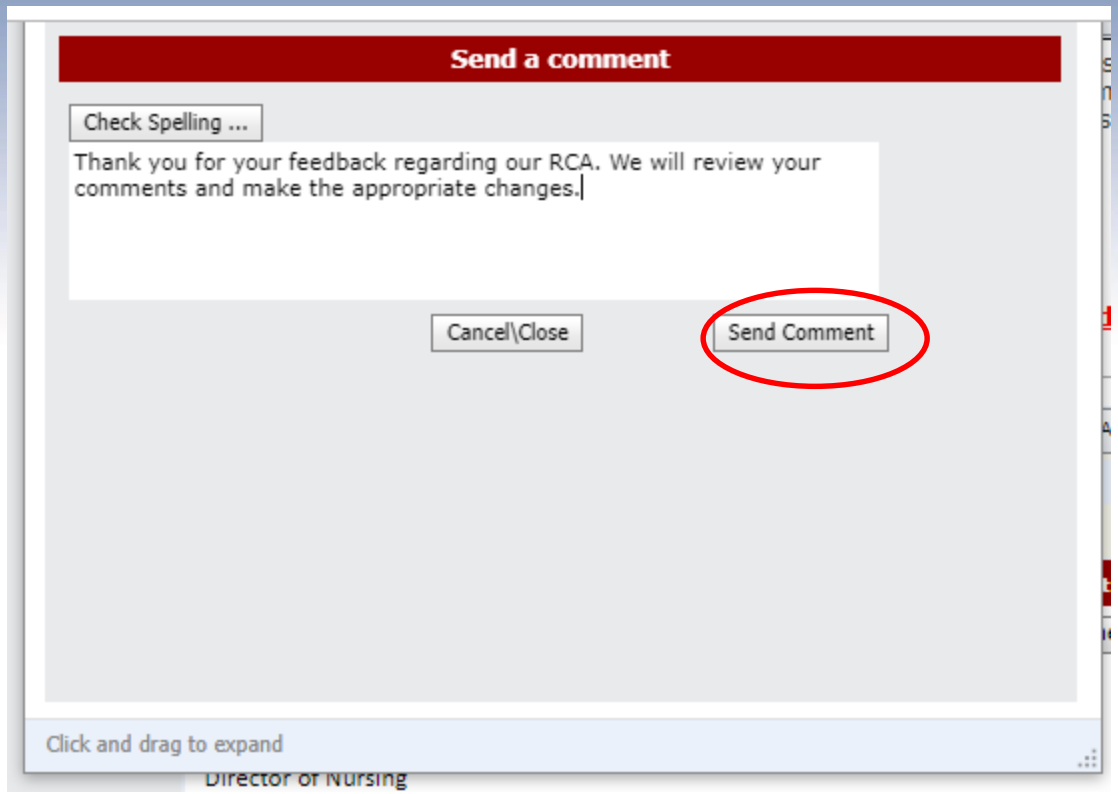
- PSRS will receive email notification that there is a communication from the facility about a specific Event
- Be sure to send communication for the correct Event number

1. **General Comment**
2. **Respond to PSRS Comment**
3. **Send Communication through the Communication Log**

IV. Other Communications About the RCA - *continued*



IV. Other Communications About the RCA - *continued*



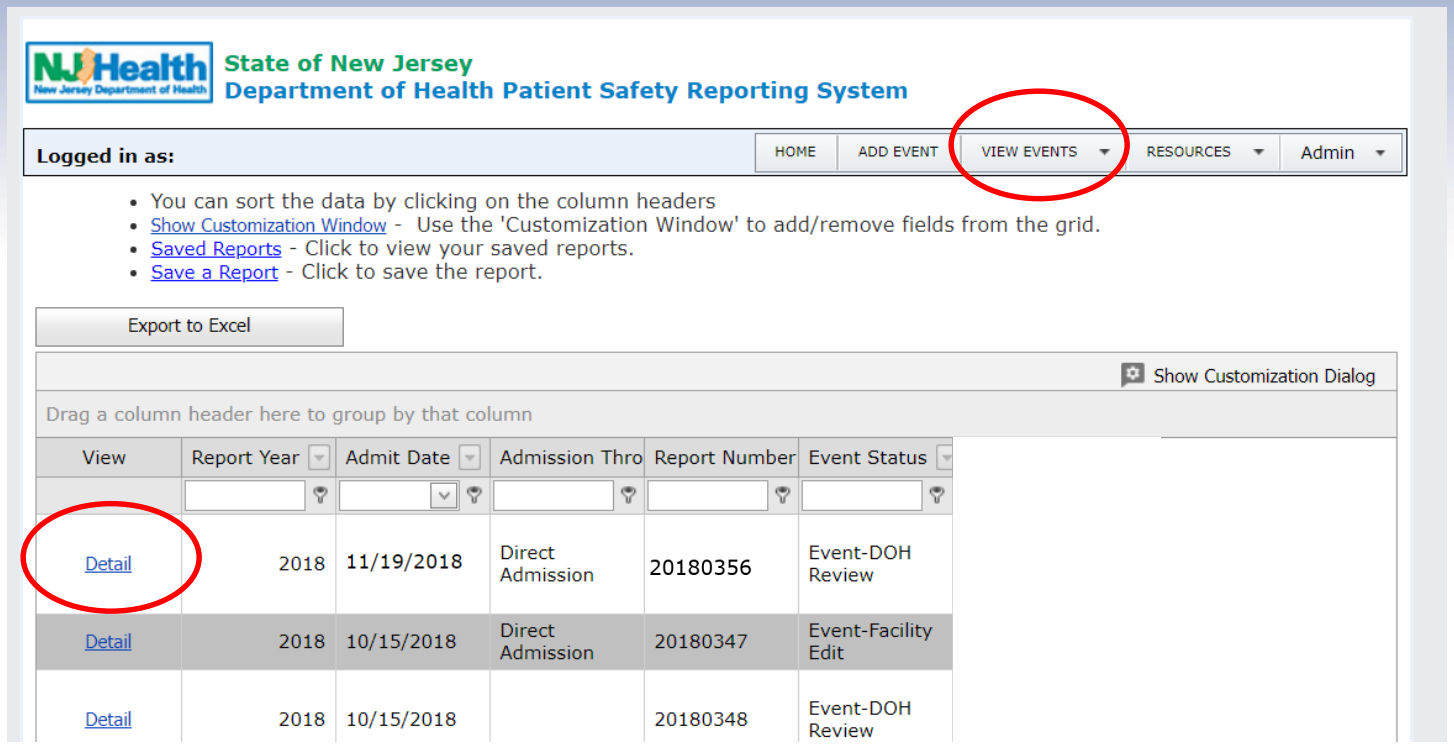
IV. Other Communications About the RCA – *continued*

Upload Supporting Documentation

- Documents can be attached to the RCAs; contact PSRS through the PSRS Communication Log to enable the attachment function
- Applies to a single Event or RCA
- Do NOT attach medical records
- Attachment titles cannot contain special characters, for example: @ ! ? *

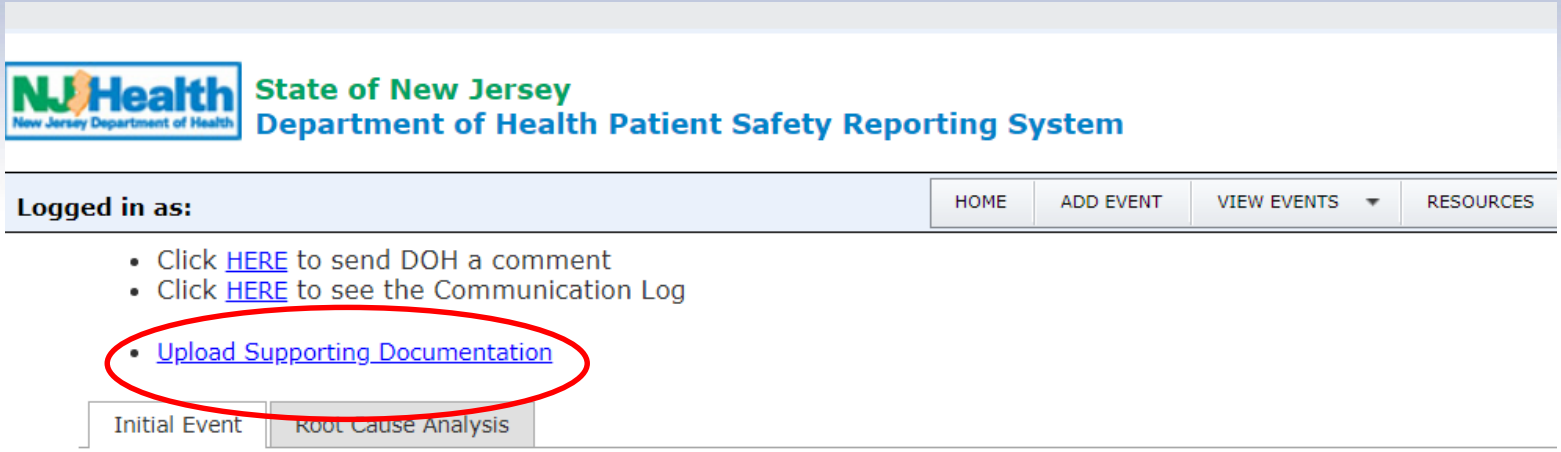
IV. Other Communications About the RCA – *continued*

Upload Supporting Documentation



IV. Other Communications About the RCA – *continued*

Upload Supporting Documentation



Note: This link is not available unless the attachment function is enabled by PSRS.

REVIEW

1. Use “View Events” menu to find Event requiring RCA
2. Enter Root Cause and Action Plan
3. Multiple Root Causes and Action Plans can be entered
4. PSRS reviews RCA and responds with next step
5. Review PSRS comments and respond accordingly

Next Module

I. System Navigation

II. Reports

III. Resources and Support