

Overview of the New Jersey Patient Safety Reporting System

New Jersey Department of Health
and Senior Services

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NJAASC
Ambulatory Surgery Conference
June 2, 2011

Objectives

- ❖ Review legislation and rules
- ❖ Review reporting requirements
- ❖ Review reporting process
- ❖ Review Root Cause Analysis requirements
- ❖ Allow time for discussion and questions

The Patient Safety Act

- ❖ C.26:2H-12.23 Enacted in April 2004
 - ❖ Enhance Patient Safety
 - ❖ Minimize Number of Adverse Events
 - ❖ Minimize Patient Harm
 - ❖ Improve System/Facility Performance

Confidentiality Protection

- ❖ Patient Safety Act encourages honest, critical self-analysis and restricts:
 - ❖ Discoverability
 - ❖ Admissibility
 - ❖ Disclosure of documents, materials and information

Patient Safety

Rules and Requirements

- ❖ N.J.A.C. 8:43E Subchapter 10 requires facilities to do the following:
 - ❖ Establish Patient Safety Committee
 - ❖ Establish Patient Safety Plan
 - ❖ Report Adverse Events to DHSS
 - ❖ Conduct Analyses of Adverse Events
 - ❖ Submit Analyses of Adverse Events to DHSS

Reporting Requirements

- ❖ Event Report to the Patient Safety Reporting System (PSRS) within 5 business days of discovery
- ❖ PSRS determines acceptance
- ❖ If event accepted by PSRS, RCA submitted to PSRS within 45 calendar days from initial event report

Ambulatory Surgery Center Reporting

- ❖ October 2008
 - ❖ Expansion of reporting to New Jersey licensed ambulatory surgery centers
- ❖ April through June 2009
 - ❖ ASC Work Group assembled to provide recommendations related to reportable adverse events

General Reporting Recommendations for ASCs

- ❖ Surgical events (wrong site, procedure, etc.)
- ❖ Aspiration
- ❖ Pneumothorax
- ❖ Perforation of an organ
- ❖ Cardiac and/or respiratory issues
- ❖ Moderate to severe bleeding
- ❖ Infections that require intervention
- ❖ Falls with injury

General Reporting

Recommendations for ASCs Cont'd

- ❖ Any patient transferred to the Emergency Department
 - ❖ Transfer from ASC directly to ED
 - ❖ Visit to ED after discharge from ASC
- ❖ Recommend reporting all adverse events
 - ❖ PSRS will determine whether event meets criteria for acceptance

New Online Reporting System

- ❖ Initial Kick-off Meeting
 - ❖ September 2009
- ❖ Start of Development
 - ❖ March 1st 2010
- ❖ Subsystems Developed
 - ❖ Intake
 - ❖ Reporting
 - ❖ Ad-hoc Query
 - ❖ Workflow and Correspondence Management
 - ❖ Application Support
- ❖ Data Conversion

Patient Safety Reporting System

Goals of System

- ❖ Ease of Use
- ❖ Improved and Streamlined Communications
- ❖ Ensure Completeness of Submission
- ❖ Provide Data Access to Facilities for Reports and Analysis – e.g. downloads to Excel
- ❖ Provide Reports
- ❖ Resource Library
- ❖ Provide Standardization of Data

Patient Safety Reporting System

Goals of System (cont.)

- ❖ Automated Notification to Facilities and Patient Safety
- ❖ Reminder Notifications to Facilities
- ❖ Context Based Help Screens
- ❖ Information Resources built into System
- ❖ Ad-hoc Reporting Capability

Next Steps

- ❖ Rollout to facilities
 - ❖ Acute Care (completed)
 - ❖ Specialty (start online reporting 6/1/11)
 - ❖ Surgery Centers (projected training in June)
- ❖ Voluntary Reporting

System Demo



Logged in as: ptrainee5

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Welcome to the NJ Patient Safety Reporting System

NJ is committed to promoting patient safety and preventing serious preventable adverse events. In 2004, the **New Jersey Patient Safety Act** (P.L. 2004, c9) was signed into law. The statute was designed to improve patient safety in hospitals and other health care facilities by establishing a serious preventable adverse event reporting system. This site is designed to help healthcare facilities develop strong patient safety programs, collect and analyze aggregate data and fulfill the law's mandatory reporting requirements

Additional resources may be found on the Patient Safety website at:
<http://nj.gov/health/ps/>

Program staff are also available to speak with you at: 609.633.7759

Action Items

Initial Event Comments

Report Number	Submit Date
No data to display	

RCA Comments

Report Number	RCA Due Date
No data to display	

Other Communications

Report Number	Respond	Comment
No data to display		



Information Resources

- 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

Initial Event RCA

Event Specific Questions [View Initial Event Questions](#)

- Event Specific Questions
- Care Management - Other
- Care Management - Medication Error
- Care Management - Pressure Ulcers
- Environmental - Other
- Environmental - Burn
- Environmental - Fall
- Environmental - Restraints
- Product/Device - Malfunction
- Patient Protection - Suicide\Attempted Suicide
- Surgical - Retained Foreign Object
- Surgical - Intra/Post-Op Coma or Death

Enter a New Event

Report Number:20110007

Event Classification:Environmental - Fall

Patient Information

Facility name:

TEST FACILITY

Patient type:

Inpatient

Admission through: Direct Admission

First name:

BETTY

Middle name:

Last name:

JONES

Patient billing number:

12345

Medical record number:

34567

Street Address:

123 Main St

City:

Trenton

State:

NJ

County: MERCER

Zip code:

08625

Enter a New Event

Date of Birth:

Month:

1

Day:

15

Year - (e.g. 2010):

1936

Gender:

Male Female

Race: ?

Caucasian

Ethnicity: ?

Non-Hispanic/Unable to Determine

Admission date or date of ambulatory encounter (mm/dd/yyyy):

1/4/2011

Admitting ICD-9:

Main Reason for Admission or Ambulatory Encounter: ?

Patient had been admitted as an inpatient for placement of a permanent pacemaker which was successfully performed on January 5, 2011.

300

Characters left

***All Fields are Required**

Save/Next

Department of Health and Senior Services

P.O. Box 360, Trenton, NJ 08625-0360

Phone: (609) 633-7759

Confidential Fax: (609) 984-7707



Submitting a New Event

- Use the 'Report Menu' below to navigate this event.
- The menu will expand as the Event/RCA progresses
- Click on the link next to the red arrow → to continue entering information
- Click on the appropriate link below to edit information

Please click the 'Submit' button below to notify DHSS that this event is ready for review

Initial Event	Root Cause Action
Report Menu:	Patient Info Event Info → Submit Event
Report Number: 2010-0035	
Event Classification: Care Management - Pressure Ulcers	
Patient Information	
<input type="button" value="Edit"/>	

Email Communication

- ❖ Event Accepted and RCA Required Email Text
 - ❖ “Your event has been received and accepted by the Patient Safety Reporting System. Please follow the process for submitting an RCA for this event.
RCA Due Date: 5/18/2011”

Communication



State of New Jersey
Department of Health and Senior Services Patient Safety Reporting System

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Welcome to the NJ Patient Safety Reporting System

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Action Items

Initial Event Comments

Report Number	Submit Date
20103043	12/17/2010
20103041	12/15/2010
20110002	1/4/2011

RCA Comments

Report Number	RCA Due Date
---------------	--------------

No data to display



RCA

Report Menu: [Return to Detail](#)

Report Number: 20110007

Event Classification: Environmental - Fall

RCA: General Information

1. List the individuals on the RCA Team:

Staff nurse, charge nurse and patient safety officer.

1947 Characters left

2. How many similar events has your facility had in the previous 3 years? (numbers only)

0

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

a. What changes did the organization make in response to these previous events?

2000 Characters left

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

2000 Characters left

c. What procedures are in place to ensure that the facility knows about all the reportable events?

2000 Characters left

Save/Next

RCA

Event Classification: Environmental - Fall

RCA Specific Questions

1. Does your facility have a fall team that regularly evaluates your falls program?

Yes No

2. Was a Fall Risk Screening documented at admission?

Yes No

3. When was a fall assessment done?

Date:

Time:

Enter Time in Military

(e.g 1800=6:00PM)

If assessment date is unknown, check here

4. Was a validated, reliable fall risk screening tool used?

Yes No

Which tool?

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. If screening tool did not indicate the patient was at risk for falls:

a. Was patient still 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 universal fall precautions in place?

Yes No NA

d. Fall Precaution (Check at least one):

RCA

RCA: Root Cause/Causality Statement

1. Use this section to enter the root cause findings
2. Select the first root cause below and enter the corresponding causality statement.
3. Click Save/Next

[Using the Five Rules of Causation](#)

*If no Root Cause, click [HERE](#) to explain the findings

1. Root Cause Categories:

- | | |
|--|---|
| <input type="radio"/> Behavioral assessment process | <input type="radio"/> Patient observation procedures |
| <input type="radio"/> Patient identification process | <input type="radio"/> Staffing levels |
| <input type="radio"/> Care planning process | <input type="radio"/> Competency assessment/credentialing |
| <input type="radio"/> Orientation and training of staff | <input type="radio"/> Communication with patient/family |
| <input type="radio"/> Supervision of staff | <input type="radio"/> Availability of information |
| <input type="radio"/> Communication among staff members | <input checked="" type="radio"/> Equipment maintenance/management |
| <input type="radio"/> Adequacy of technical support | <input type="radio"/> Security systems and processes |
| <input type="radio"/> Control of medications(Storage/access) | <input type="radio"/> Labeling of medications |
| <input type="radio"/> Physical assessment process | <input type="radio"/> Physical environment |

2. Causality Statement:

A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.

1852

Characters left

Save/Next

RCA

Causality Statement: A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.

- Enter the Action Plan for the causality statement displayed above
- Complete all RCA: Action Plan fields
- Click 'Save/Next' when finished

RCA: Action Plan

1. Action Plan:

Environmental Services will do a safety check on bed plugs every week to make sure they are functioning properly. Staff will incorporate bed alarm safety checks as part of their safety rounds each hour.

1795 Characters left

2. Monitoring Strategy: ?

This practice will be monitored through checking for appropriate alarm functioning for all patients with alarms placed.

1881 Characters left

3. Methodology ?

Observational Audits

4. Frequency ?

Monthly

5. Sample Size ?

all beds with bed alarms

6. Implementation Start Date ?

1/17/2011

7. Staff position responsible for implementation:

Nurse manager

RCA

RCA Additional Questions

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

- | | |
|---|--|
| <input type="checkbox"/> Team factors | <input type="checkbox"/> Work environment |
| <input type="checkbox"/> Task factors | <input type="checkbox"/> Staff factors |
| <input type="checkbox"/> Patient characteristics | <input type="checkbox"/> Organization/management |
| <input type="checkbox"/> Medical devices | <input type="checkbox"/> Medications |
| <input checked="" type="checkbox"/> Procedures | <input type="checkbox"/> Transportation |
| <input checked="" type="checkbox"/> Equipment | <input type="checkbox"/> Home care |
| <input type="checkbox"/> Patient record documentation | <input type="checkbox"/> Imaging and X-ray |
| <input type="checkbox"/> Laboratory and diagnostics | <input type="checkbox"/> Other |

Other:

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

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

RCA

- ❖ RCA additional questions
 - ❖ Information Consulted
 - ❖ Gathered and can be viewed under “Resources”

5. Information consulted such as clinical literature/other published guidelines.

1000 Characters left

Reports



State of New Jersey
Department of Health and Senior Services Patient Safety Reporting System

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Welcome to the NJ Patient Safety Report

[All Events](#)

[Status Report](#)

NJ is committed to promoting patient safety and preventing serious preventable adverse events. In 2004, the **New Jersey Patient Safety Act** (P.L. 2004, c9) was signed into law. The statute was designed to improve patient safety in hospitals and other health care facilities by establishing a serious preventable adverse event reporting system. This site is designed to help healthcare facilities develop strong patient safety programs, collect and analyze aggregate data and fulfill the law's mandatory reporting requirements

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Action Items

Initial Event Comments

Report Number	Submit Date
20103043	12/17/2010

RCA Comments

Report Number	RCA Due Date
---------------	--------------



Reports

Logged in as: facAdminUser

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- You can sort the data by clicking on the column headers
- [Hide Customization Window](#) - Use the 'Customization Window' to add/remove fields from the grid.
- [Saved Reports](#) - Click to view your saved reports.
- [Save a Report](#) - Click to save the report.

[Export to Excel](#)

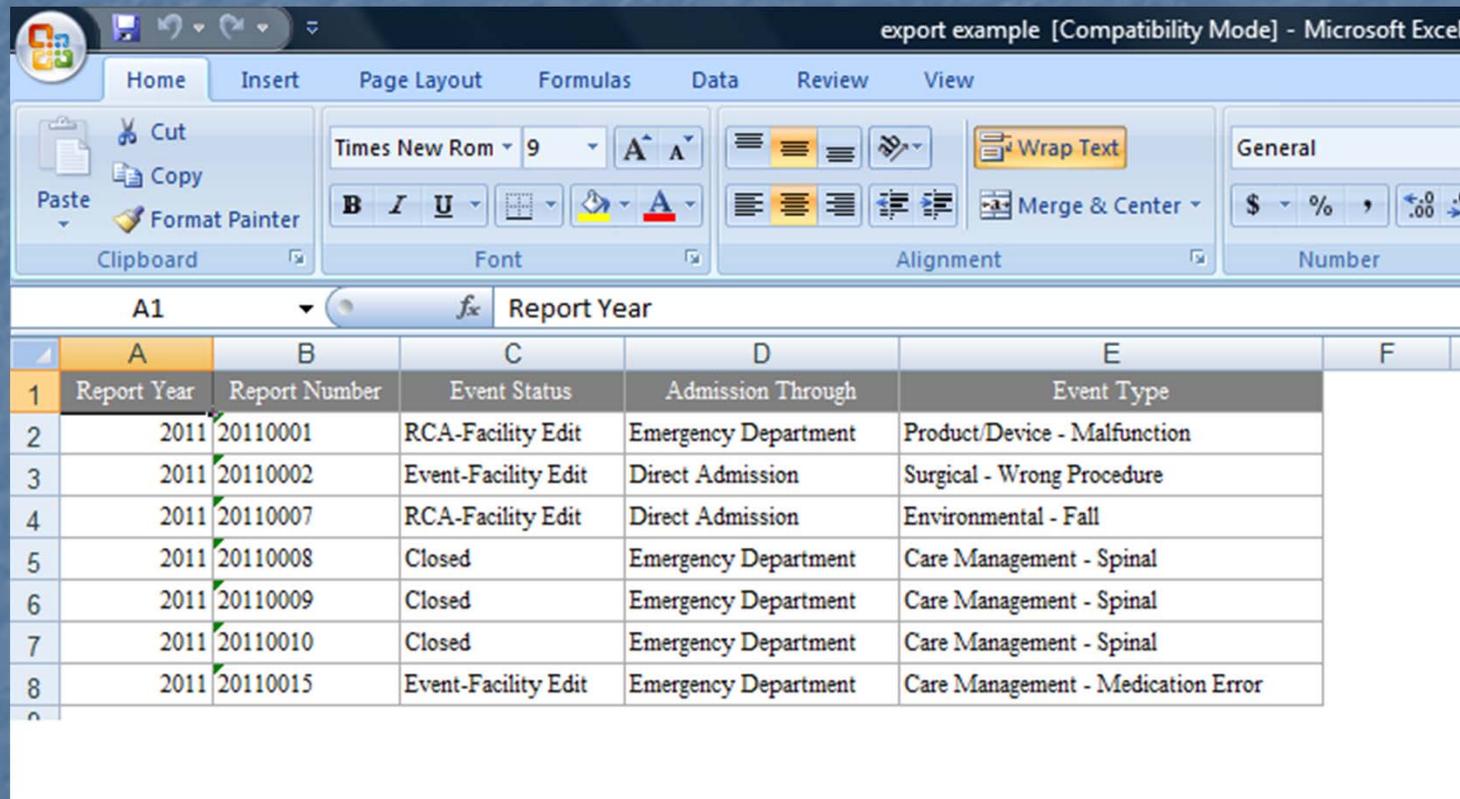
Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Date Discover	Event
Clear	<input type="text"/>	TEST FACILITY	<input type="text"/>	<input type="text"/>	
Detail	2010	TEST FACILITY	2010-0067	9/10/2010	Surgic or De
<input checked="" type="checkbox"/>	[Facility Name] Equals 'TEST FACILITY'				

Field Chooser ✕

- Admission Through
- Admit Date
- Ethnicity
- Event Date
- Event Date Discover L

Reports



The screenshot shows a Microsoft Excel spreadsheet titled "export example [Compatibility Mode] - Microsoft Excel". The ribbon includes Home, Insert, Page Layout, Formulas, Data, Review, and View. The Home ribbon is active, showing options for Clipboard (Cut, Copy, Paste, Format Painter), Font (Times New Roman, size 9, bold, italic, underline, text color, background color), Alignment (Wrap Text, Merge & Center), and Number (currency, percentage, decimal places). The active cell is A1, containing the text "Report Year". The spreadsheet contains a table with the following data:

	A	B	C	D	E	F
1	Report Year	Report Number	Event Status	Admission Through	Event Type	
2	2011	20110001	RCA-Facility Edit	Emergency Department	Product/Device - Malfunction	
3	2011	20110002	Event-Facility Edit	Direct Admission	Surgical - Wrong Procedure	
4	2011	20110007	RCA-Facility Edit	Direct Admission	Environmental - Fall	
5	2011	20110008	Closed	Emergency Department	Care Management - Spinal	
6	2011	20110009	Closed	Emergency Department	Care Management - Spinal	
7	2011	20110010	Closed	Emergency Department	Care Management - Spinal	
8	2011	20110015	Event-Facility Edit	Emergency Department	Care Management - Medication Error	

Resources Consulted

- ❖ Use as a reference prior to entering RCA
- ❖ Gathered during RCA entry
- ❖ Grouped by Event Type

- You can sort the data by clicking on the column headers

Drag a column header here to group by that column

#	Event Type <input type="checkbox"/>	Information Consulted
Clear	Surgical - Retained Foreign	
	Surgical - Retained Foreign Object	"The human error: Delayed diagnosis of intravascular loss of guidewires for central venous catheterization." Auwiler, M., Kampe, S., Zahringer, M., B. et. al. Journal of Clinical Anesthesia, Volume 17 (7), 2005, 562-564.

RCA Components

- ❖ Facts of the Event
- ❖ Causality Statement(s)
- ❖ Action Plan(s)
- ❖ Monitoring

RCA Component #1: Facts of the Event

- ❖ Narrative
- ❖ Include relevant information about patient and event

Patient Information

- ❖ Admitting diagnosis
- ❖ Past medical and surgical history
- ❖ Medications
- ❖ Journey through the facility
- ❖ How the pt was affected by the event
- ❖ Other contributing factors to the event
- ❖ Include relevant lab values, vital signs, etc.

Details of the Event

- ❖ Chronological description of the event
- ❖ Include dates and times
- ❖ Include location(s)

Similar Events

- ❖ Include number of similar events in the past 3 years
- ❖ Refers to same category or event type, but event does not need to be exactly the same, e.g. RFO
- ❖ Describe what actions and monitoring facility has implemented

RCA Component #2: Causality Statement(s)

- ❖ Causality statements connect various factors with the event/adverse outcome
- ❖ Identify an actual/potential root cause
- ❖ Each root cause identified should have a separate causality statement

Causality Statement Format

- ❖ Tie root cause to causality statement
- ❖ *(Something)* increased the likelihood of *(something)* happening, which led to the *(adverse event)*

Causality Statement Example

- ❖ *The lack of a procedure to visually confirm that the specimen was placed in the container increased the probability that the surgeon would leave the specimen on the table, and that the specimen would be lost.*

RCA Component #3: Action Plan

- ❖ Each causality statement should have *at least* one action plan
- ❖ Interventions, Actions/Prevention Strategies
- ❖ Specific
- ❖ Quantifiable
- ❖ List person responsible

Action Plan Example

- ❖ By 7/1/11, all specimens will immediately be placed in a pre-labeled container at the time of removal from the patient. The nurse and surgeon will visually confirm the container's contents.

RCA Component #4: Monitoring

- ❖ Specific for each action plan/prevention strategy
- ❖ Specific and quantifiable
 - ❖ What will be monitored?
 - ❖ By whom?
 - ❖ For how long?
 - ❖ What is the goal for compliance?

Monitoring Continued

- ❖ Monitoring should answer the following questions:
 - ❖ How do you know that the interventions are being implemented correctly?
 - ❖ Was the education understood as it was intended?
 - ❖ Is the staff accurate and complete in implementing the action/prevention strategy?

Monitoring Example

- ❖ The Director of Nursing will monitor the action by direct, random observation of at least 5 cases per week of the specimen procedures and review of documentation tools for 100% compliance for 6 months and longer, if necessary, until 100% compliance is achieved.

Common Pitfalls: Root Causes

- ❖ Known complications
- ❖ Patient Characteristics
 - ❖ Can be a contributing factor

Root Cause Pitfalls Cont'd

- ❖ Look for Modifiable Risk Factors
- ❖ Literature Review
 - ❖ Focus on prevention rather than proving this is a known complication
- ❖ Evidence-based Best Practices

Common Pitfalls: Action Plans and Monitoring

- ❖ Education without observation of implementation
 - ❖ Attendance is not understanding
- ❖ Insufficient timeframe
 - ❖ Compliance wanes over time

PSRS Contact Information

- ❖ PSRS Telephone: (609) 633-7759
- ❖ PSRS Website: <http://nj.gov/health/ps/>

PSRS Contacts Cont'd

- ❖ Mary Noble, MD, MPH
 - ❖ Clinical Director
 - ❖ Mary.Noble@doh.state.nj.us
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Discussion and Questions

