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Patient Safety Reporting System

Health Care Quality Assessment Summary Report for 2021

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Executive Summary

This Patient Safety Annual Summary Report presents the findings from serious preventable adverse events reported to New Jersey Department of Health (NJDOH), 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 from events that occurred in 2021.

This report is designed to present aggregated, de-identified data to determine statewide averages and trends in reported preventable adverse events and near-misses within New Jersey licensed heath care facilities that are required to report serious preventable adverse events. The findings are described by the types of facilities listed below. In this way facilities can compare the types of events they reported, the root causes and outcomes with the statewide aggregates and trends from the same facility type.

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 NJDOH 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 New Jersey currently report to the state 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 2021:

- 813 events were reported to the Patient Safety Reporting System by all facility types.
- 714 events met the statutory definition of (or satisfied the criteria for) a serious preventable adverse event ("reportable").
- Of the 714 reportable events, 693 required a root cause analysis.
- The 99 events that did not meet the statutory definition included less serious or near-miss events, and events that were not associated with the provision of health care ("not reportable").
- 122 deaths were reported and associated with the adverse events.

General Acute Care Hospitals:

- 68 of the 71 General Acute Care Hospitals submitted a total of 444 reportable adverse events in 2021 (compared to 358 events in 2020).
- Of the 444 reportable events, 437 required a root cause analysis.
- The average number of reportable events per reporting hospital was 6.5.
- There were 84 deaths associated with the adverse events.
- Specific events with the highest percent of associated deaths were care management "Other"[1] events (32), fall events (15), as well as surgical intraoperative or postoperative coma, death, or other serious preventable adverse events (13).
- The most frequently reported events were falls (164), suicide/attempted suicide (59), pressure ulcers (58), care management "Other" events (56), retained foreign objects (40).
- Adverse events most often had the following root causes as identified by reporting facilities: care planning process, communication among staff members, orientation and training of staff, patient observation procedures, and physical assessment process.
- The most frequent consequences of the adverse events were additional laboratory testing or diagnostic imaging, additional patient monitoring in current location, increased length of stay and major surgery.

Comprehensive Rehabilitation Hospitals:

- Eight of the 14 comprehensive rehabilitation hospitals submitted a total of 38 reportable events with two deaths that were associated with a fall and a care management "Other" event.
- Of the 38 reportable events, 25 required a root cause analysis.
- The most frequent root causes, as identified by reporting facilities, were communication among staff members, care planning process,

1. Refer to Appendix 1 for detailed classifications and definitions of all serious preventable event categories and types. Refer to the Introduction section on page 7 for a description of "Other" event types.

This report is designed to present aggregated, de-identified data to determine statewide averages and trends in reported preventable adverse events and near-misses within New Jersey licensed heath care facilities that are required to report serious preventable adverse events.

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orientation and training of staff, patient observation procedures, behavioral assessment processes, and equipment maintenance/ management.

- More than half of the adverse events resulted in additional laboratory testing or diagnostic imaging, visit to the emergency department, hospital admission, and increased length of stay. Nearly half of the events resulted in transfer to more intensive level of care, disability-physical or mental impairment, or major surgery.

Psychiatric Hospitals[2]:

- Four of the 10 psychiatric hospitals submitted a total of five reportable events with two deaths.
- All five reportable events required a root cause analysis.
- The most frequent root cause, as identified by reporting facilities, was patient observation procedures.
- The impact of these events included major surgery and death.

Special Hospitals:

- Seven reportable events were submitted by six of the 16 special hospitals. None of the events resulted in death.
- Six of the seven reportable events required a root cause analysis.
- The most frequent root cause, identified by reporting facilities, was communication among staff members.
- The most frequently reported impacts for special hospitals include disability-physical or mental impairment, visit to the emergency department, system or processes delay care to the patient, loss of bodily functions, increased length of stay, and additional patient monitoring in current location.

Ambulatory Surgery Centers:

- 78 of the 251 ambulatory surgical centers submitted a total of 180 reportable events with seven deaths.
- All the deaths were associated with surgical intra-operative or post-operative coma, death or other serious preventable events.
- All 180 reportable events required a root cause analysis.
- The most frequent root cause was care-planning process and physical assessment process.
- The most reported impacts of these adverse events were hospital admission, increased length of stay, additional laboratory testing or diagnostic imaging, and visit to the emergency department.

2. Does not include state-run psychiatric hospitals. Report on state-run psychiatric hospitals can be found in section VII.

End Stage Renal Disease Dialysis Facilities:

- Thirty-three of the 239 end stage renal disease dialysis facilities submitted a total of 40 reportable events with 27 deaths. Almost all the deaths resulted from the care management "Other" events with one death associated with a fall.
- Thirty-eight of the 40 reportable events required a root cause analysis.
- The most frequent root cause was care-planning process.
- The impact of these events included death, visit to the emergency department, hospital admission, transfer to more intensive level of care, additional laboratory testing or diagnostic imaging.

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 NJDOH for the purpose of enhancing patient safety.

Introduction

This Patient Safety Annual Summary Report presents the findings from serious preventable adverse events reported to New Jersey Department of Health, 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 from events occurred in 2021.

This report is one component of NJDOH's commitment to supporting quality through collecting and analyzing information on health care and making this information available for health care providers for the purpose of patient safety improvement. The report is designed to present aggregated, de-identified data to determine statewide averages and trends in reported preventable adverse events and near-misses within New Jersey licensed heath care facilities that are required to report serious preventable adverse events.

The findings are described by the types of facilities listed below. In this way facilities can compare the types of events they reported, and the root causes and outcomes of those events with the statewide aggregates and trends from the same facility type.

For example, facilities are encouraged to look at how many events on average are reported by other facilities with the same facility type; what are the most common event types reported by the same facility type; what event types are associated high number of deaths from the same facility type; and what are the most common root causes and impacts to patients identified by other facilities in the same facility type.

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 NJDOH for the purpose of enhancing patient safety. In addition, health care facilities are required to perform a root cause analysis (RCA) for each reportable event that requires an RCA.

The Patient Safety 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") were divided into five categories:

- Care management
- Environmental
- Product or device-related
- Surgery-related
- Patient protection-related

The classification and definitions of serious preventable events can be found in Appendix 1. The patient safety regulations also require facilities to report, in the appropriate category, serious preventable adverse events that are not specifically listed in that category. 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 Patient Safety 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 who 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 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.

Annually, PSRS receives over 800 event entries for review to determine reportability, whether an RCA is required, and, to ensure that requirements set forth in the Patient Safety Act are met.

The following facility types currently report to the Patient Safety program:

- Acute care hospitals
- Comprehensive rehabilitation centers
- Psychiatric hospitals
- Special hospitals
- Ambulatory surgery centers
- End stage renal dialysis facilities

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

This report is one component of NJDOH's commitment to supporting quality through collecting and analyzing information on health care and making this information available for health care providers for the purpose of patient safety improvement.

Overall Reporting Patterns by Facility Type

This annual report summarizes the 2021 Patient Safety Reporting System (PSRS) reportable events and root cause analyses (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.

Adverse events were designated as reportable if they meet the statutory definition of a serious preventable adverse event and are included in the Classification of Serious Preventable Adverse Events in Appendix 1.

The Patient Safety Act also supports facilities submitting less serious or near miss events, even without the requirement to perform a root cause analysis. In the early years of the reporting program, less serious or near miss events were included in the reportable events designation. Starting in 2011, less serious or near miss events were separated out into a different designation.

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 2021.

Table 1: Reporting Pattern by Facility Type, 2021

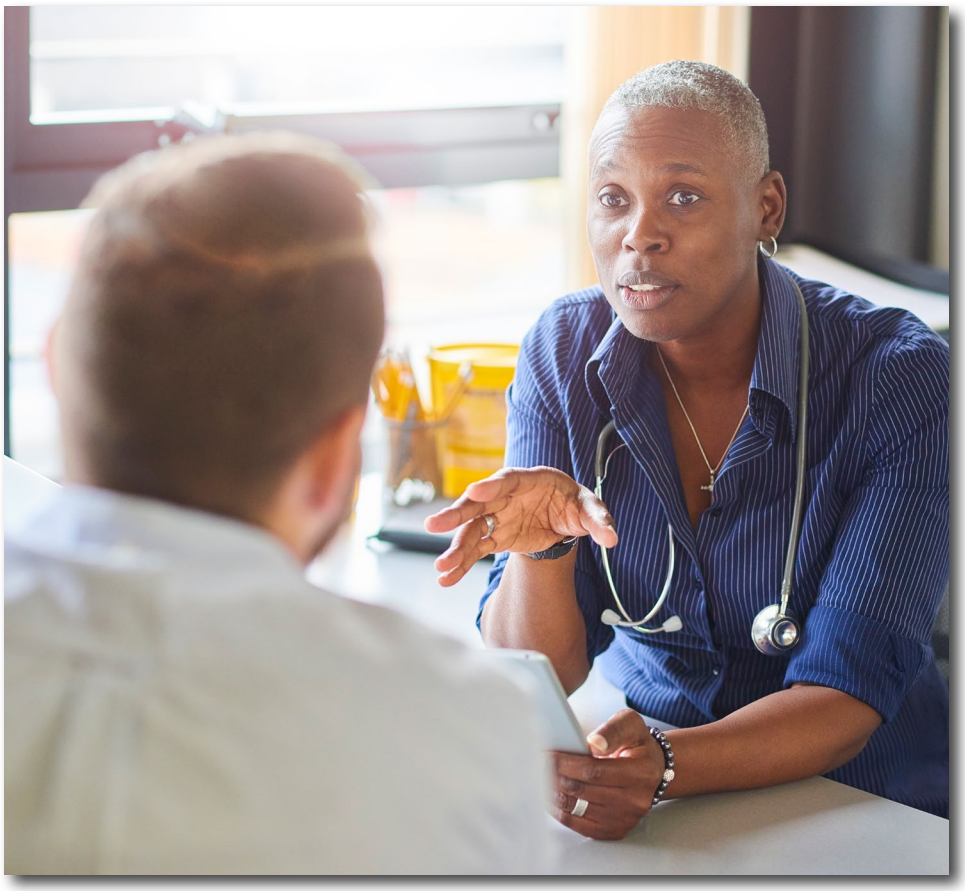
Facility Type	Number of Facilities	Number of Reporting Facilities	Number of Reportable Events	Number of Reportable Events Requiring an RCA	Number of Not Reportable Events	Number of Less Serious/Near Misses	Number of Reportable Deaths
General Acute Care Hospitals	71	68	444	437	0	8	84
Comprehensive Rehabilitation Hospitals	14	8	38	25	0	1	2
Psychiatric Hospitals	10	4	5	5	0	0	2
Special Hospitals	16	6	7	6	0	3	0
Ambulatory Surgery Centers	251	78	180	180	0	77	7
End Stage Renal Dialysis Facilities	239	33	40	40	0	10	27
Total	**601**	**197**	**714**	**693**	**0**	**99**	**122**

The numbers of reportable, not reportable, less serious and near miss events submitted to the Patient Safety Reporting System for 2021 from all facilities totaled 813. This total of 813 reported events includes one event status as indeterminate (indicating that there was insufficient information to make a determination of reportability or if an RCA is required), and seven events that were classified as "RCA unresolved" (indicating that the required components for an RCA were not met).

Of the 813 total events in 2021, 714 were deemed reportable (584 in 2020) with 122 associated deaths (108 in 2020). Number of reportable events increased by 130 (22.2%) from 2020 to 2021, while number of associated deaths increased by 14 (13.0%).

Among the 714 reportable events, 693 require a root cause analysis (RCA); the rest did not require an RCA.

Starting December 2021, a process to count the number of actual events within an initial event report affecting the same patient was initiated (e.g., a care management and a surgical event within the same initial event report). Several patients with event dates in 2021 had multiple hospitalizations as well as discrete reportable events with several classifications associated with an initial event (without any intervening hospital discharge).



The Patient Safety Act also supports facilities submitting less serious or near miss events, even without the requirement to perform a root cause analysis. In the early years of the reporting program, less serious or near miss events were included in the reportable events designation.

General Acute Care Hospitals

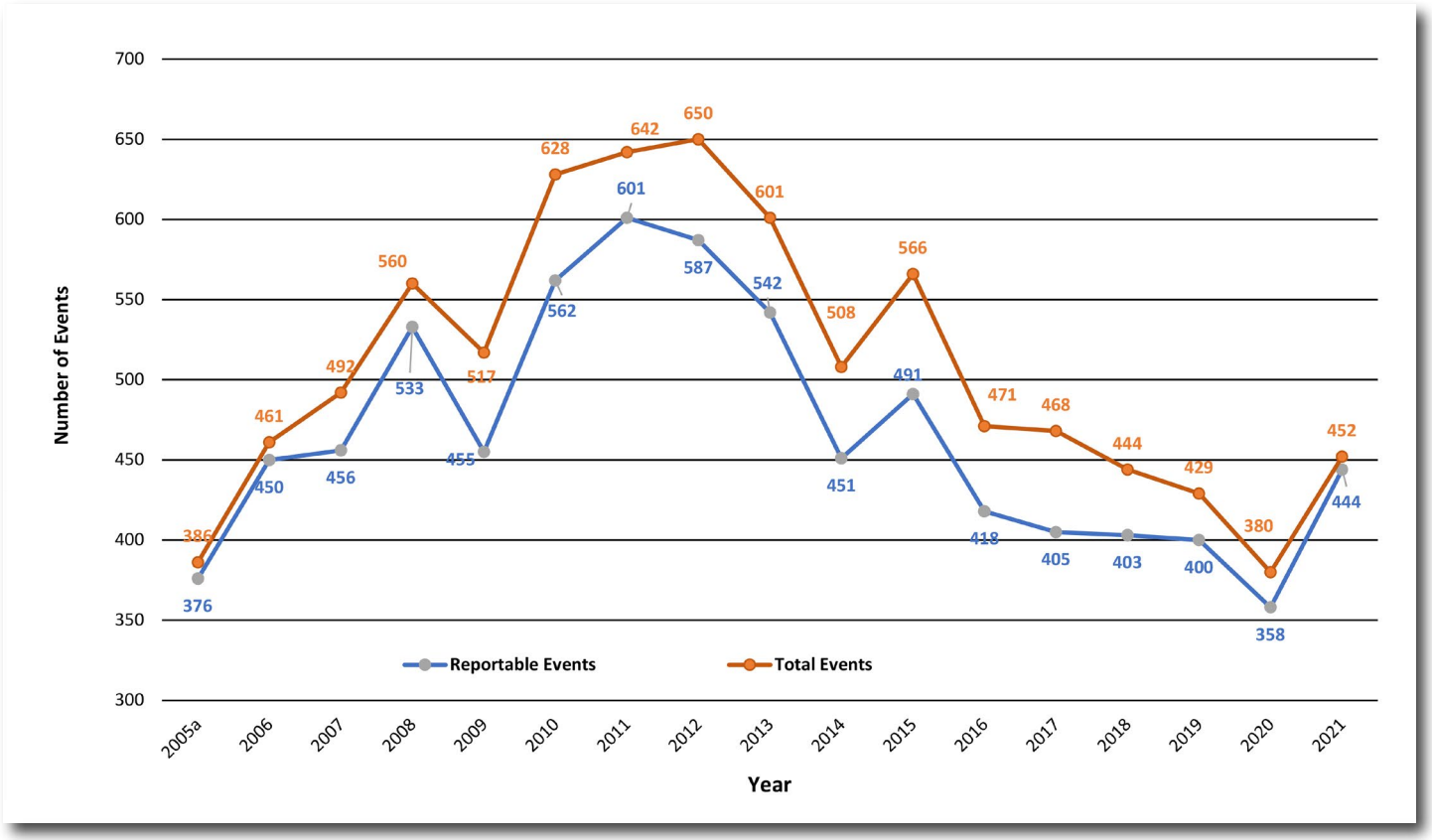
Reporting Patterns (2005-2021)

Figure 1 and Table 2 (page 11) demonstrate the reporting patterns and trend for general acute care hospitals over the past 17 years.

Since reporting began in February 2005, 7,938 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 2021. As shown in Figure 1 and Table 2, the number of total reported events increased from less than 400 in 2005 to around 650 in 2011 and 2012, declined to around 400 in 2019 and 2020, and increased to 452 in 2021. Most of the events are reportable, as evidenced by over 90%, sometimes close to 100%, of reportable events among total events.

In 2021, the 17th year of reporting, 452 total events were submitted by 68 general acute care hospitals, of which 444 were reportable events, and eight were less serious or near miss events.

Figure 1:
General Acute Care Hospitals: Trends of Total and Reportable Events, 2005-2021



2005 data Represents 11 months since the program started on February 1, 2005.
Note: Starting 2020, data includes the actual number of events which occurred in that year. In prior years, data were based on the year events were reported.

Table 2:
General Acute Care Hospitals: Reportable, Less Serious Events/Near Misses and Not Reportable Events by Year[a], 2005-2021

Reporting Year	Reportable	Not Reportable	Less Serious/Near Misses	Total Events	Percent Reportable
2005[a]	376	10	NA	386	97.4%
2006	450	11	NA	461	97.6%
2007	456	36	NA	492	92.7%
2008	533	27	NA	560	95.2%
2009	455	62	NA	517	88.0%
2010	562	66	NA	628	89.5%
2011	601	10	31	642	93.6%
2012	587	22	41	650	90.3%
2013	542	5	54	601	90.2%
2014	451	2	55	508	88.8%
2015	491	8	67	566	86.7%
2016	418	4	49	471	88.7%
2017	405	4	59	468	86.5%
2018	403	1	40	444	90.8%
2019	400	1	28	429	93.2%
2020	358	2	20	380	94.2%
2021	444	0	8	452	98.2%

a. 2005 data Represents 11 months since the program started on February 1, 2005.
Note: Starting 2020, data includes the actual number of events which occurred in that year. In prior years, data were based on the year the event was reported.

In 2021, 68 of the 71 general acute care hospitals in New Jersey submitted reportable events, as shown in Table 3 (page 12). In most of the years, over 95% hospitals reported adverse events. It is noticeable that percentage of facilities reporting dipped to 91.4% in 2020.

The average number of reportable events per reporting hospital was 6.5 in 2021. This average shows how often reportable events were happening in reporting hospitals on average. In recent years, average number of reportable events varied from 5.5 to 6.5 per reporting hospital.

Eighty-four (18.9%) deaths occurred among the 444 reportable events in 2021. In recent years, the percent of deaths had declined from 19.6% in 2015 to 14.0% in 2019, then rose to 18.7% in 2020 and 18.9% in 2021.

Table 3:
General Acute Care Hospitals: Reporting Patterns, 2005 - 2021

Reporting Year	Number of Reportable Events	Number of Facilities	Number of Reporting Facilities	Percent of Facilities Reported	Average Number of Reportable Events per Facility	Number of Deaths	Percent of Deaths
2005a	376	82	68	82.9	5.5	57	15.2%
2006	450	81	71	87.7	6.3	47	10.4%
2007	456	80	75	93.8	6.1	72	15.8%
2008	533	72	72	100.0	7.4	75	14.1%
2009	455	72	68	94.4	6.7	74	16.3%
2010	562	72	71	98.6	7.9	85	15.1%
2011	601	72	69	95.8	8.7	89	14.8%
2012	587	72	72	100.0	8.2	84	14.3%
2013	542	72	72	100.0	7.5	84	15.5%
2014	451	72	72	100.0	6.3	75	16.6%
2015	491	72	72	100.0	6.8	96	19.6%
2016	418	72	68	94.4	6.1	72	17.2%
2017	405	72	72	100.0	5.6	75	18.5%
2018	403	71	68	95.8	5.9	75	18.6%
2019	400	71	67	94.4	6.0	56	14.0%
2020	358	70	64	91.4	5.6	67	18.7%
2021	444	71	68	95.8	6.5	84	18.9%

a. Year 2005 Represents 11 months of data since the program started on February 1, 2005.
Note: Starting 2020, data includes the actual number of events which occurred in that year. In prior years, data were based on the year the event was reported.

Reportable Events and Associated Deaths by Event Category

As indicated in last section, 444 adverse events occurred in New Jersey general acute care hospitals in 2021. There were 84 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 4 (page 13) and Table 5 (page 14) provide an overview of the number of reportable events and number for deaths by each of the event categories for general acute care hospitals in 2021. Please see Appendix 1 for detailed descriptions of the five event categories.

A shown in Table 4, the care management category is associated with the highest number deaths of 41, almost half of all deaths from general acute care hospitals. Twenty deaths were surgery-related and 19 were related to unsafe environments that the patients were in, accounting for 23.8% and 22.6% respectively of deaths from this facility type. Four deaths were associated with patient protection. None of the deaths were product or device related.

Table 4:
General Acute Care Hospitals:
Reportable Events and Associated Deaths by Event Category, 2021

Event Category	Reportable Events	Proportion of Reportable Events	Deaths	Proportion of Deaths
A: Care Management	123	27.7	41	48.8
B: Environmental	171	38.5	19	22.6
C: Product or Device	2	0.5	0	0.0
D: Surgery-Related	81	18.2	20	23.8
E: Patient Protection	67	15.1	4	4.8
Total	**444**	**100**	**84**	100.0

As shown in Table 5 (page 14), pressure ulcers and care management "Other" account for the highest number of reportable events in the care management category, 58 and 56 respectively out of 123 of the same categories. In addition, care management "Other" is associated with the highest number of deaths (32) in the category (41).

In the environment category, fall is associated with the highest number of reportable events (164 out of 171), as well as the highest number of deaths (15 out of 19) in the environment category.

Of the 67 reportable events in the patient protection category, 59 are suicides/attempted suicides, five are elopements, and three are "Other." Three out of the four deaths are elopement events; one is a suicide/attempted suicide.

General Acute Care Hospitals

Table 5: General Acute Care Hospitals: Reportable Events and Associated Deaths by Event Type, 2021

Event Category	Reportable Events	Deaths
A: Care Management	123	41
Care Management "Other"	56	32
Maternal Labor	1	1
Medication Error	8	5
Pressure Ulcers	58	3
B: Environmental	171	19
Burn	1	0
Fall	164	15
Restraints	5	3
Wrong Gas	1	1
C: Product or Device	2	0
Air Embolism	2	0
D: Surgery Related	85	20
Intra/Post-Op Coma/Death/ Other Events	19	13
Retained Foreign Object [a]	40	0
Surgical Other	10	7
Wrong Procedure	3	0
Wrong Site	13	0
E: Patient Protection	67	4
Elopement	5	3
Other	3	0
Suicide/Attempted Suicide	59	1
Total	**448**	**84**

a. Included four events of Less Serious or Near Miss.

Regarding the surgery-related category, as shown in Table 6 (page 15) retained foreign objects had the highest number of reported events (40); which was an increase of nine from 2020 (31) (data not shown in this report). However, there were no deaths associated with this event type.

The second highest reported event type was intra-operative or post-operative events (19) with 13 associated deaths.

Table 6:
General Acute Care Hospitals: Surgery-Related Event Types with Associated Deaths, 2021

Event Type	Reportable Events	Deaths
Intra-Op/Post-Op Coma/ Death/Other Event	19	13
Surgery "Other"	10	7
Retained Foreign Object [a]	40	0
Wrong Site	13	0
Wrong Procedure	3	0
Total	**85**	**20**

a. Included four events of Less Serious or Near Miss.

Event Types Associated with Highest Percentages of Deaths for General Acute Care Hospitals

Table 7 shows the event types with the highest percentage of deaths. In aggregate, the eight event types identified below had a total of 105 reportable events and 65 deaths, resulting in a percentage of deaths at 61.9%. For all the other event types combined, labeled *"All Other Event Types,"* there were 19 deaths out of 339 reportable events, resulting in a percentage of deaths at 5.6%.

Table 7:
General Acute Care Hospitals: Event Types Associated with Highest Percentages of Deaths, 2021

Event Type	Reportable Events	Deaths	Percent Deaths
Care Management "Other"	56	32	57.1%
Intra-Op/Post-Op Coma, Death or Other Event	19	13	-
Surgery-Related "Other"	10	7	-
Medication Error	8	5	-
Restraints	5	3	-
Elopement	5	3	-
Maternal Labor	1	1	-
Wrong Gas	1	1	-
Subtotal	105	65	61.9%
All Other Event Types	343	19	5.5%
Total	**444**	**84**	**18.9%**

a. Percent deaths is calculated when there are 30 or more reportable events.

The average number of reportable everts per reporting hospital was 6.5 in 2021. This average shows how often reportable events were happening in reporting hospitals on average.

General Acute Care Hospitals

Care Management "Other" Events

Of the 56 reportable events in the care management "Other" event type in 2021, 32 (57.1 %) had associated deaths (Table 7), compared to 54 reportable events and 26 associated deaths (48.1%) in 2020 (data not shown).

The 56 reportable events were submitted by 29 general acute care hospitals, averaging 2.3 events per reporting facility (data not shown).

Care management "Other" events include care management related events which do not meet the definition of the specific care management event types as listed in Appendix 1, 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 number of deaths as well as the highest percentage of deaths in each year.

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.

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

There were 19 reports of intra-operative or post-operative (that is, within 24 hours) coma, death or other serious preventable adverse event from general acute care hospitals in 2021, compared to 11 in 2020. There were 13 deaths in this event type in 2021 (Table 7) compared to five deaths in 2020 (data not shown).

The 19 reportable events were submitted by 16 general acute care hospitals, averaging 1.2 events per reporting facility (data not shown).

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, and perforations during or immediately (within 24 hours) following surgery (data not shown).

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

The number of reported events for this event type was 10 in 2021 compared to eight in 2020. There were seven deaths in this event type in 2021 (Table 7) compared to six deaths in 2020 (data not shown).

The 10 reportable events were submitted by six general acute care hospitals, averaging 1.7 events per reporting facility (data not shown).

Most Frequently Reported Event Types

As shown in Table 8, the highest number of events submitted in 2021 were for the following specific events: fall (164, 36.6%), suicide/ attempted suicide (59, 13.2%), care management "Other" (56, 12.5%), pressure ulcer (58, 12.9%), retained foreign object (40, 8.9%) and surgical intra/post-op coma/ death or other serious events (19, 4.2%).

Cumulatively, these events were the most frequently reported and accounted for almost 90 percent (88.4 %) of all 2021 reportable events.

There were 19 reports of intra-operative or post-operative (that is, within 24 hours) coma, death or other serious preventable adverse event from general acute care hospitals in 2021, compared to 11 in 2020.

Table 8:
General Acute Care Hospitals: Most Frequently Reported Event Types, 2021

Event Type	Reportable Events	Proportion of Reportable Events
Fall	164	36.6
Suicide/Attempted Suicide	59	13.2
Care Management "Other"	56	12.5
Pressure Ulcer	58	12.9
Retained Foreign Object [a]	40	8.9
Surgical Intra/Post-Op Coma, Death or Other Serious Adverse Events	19	4.2
Subtotal	396	88.0
All Other Events	52	13.3

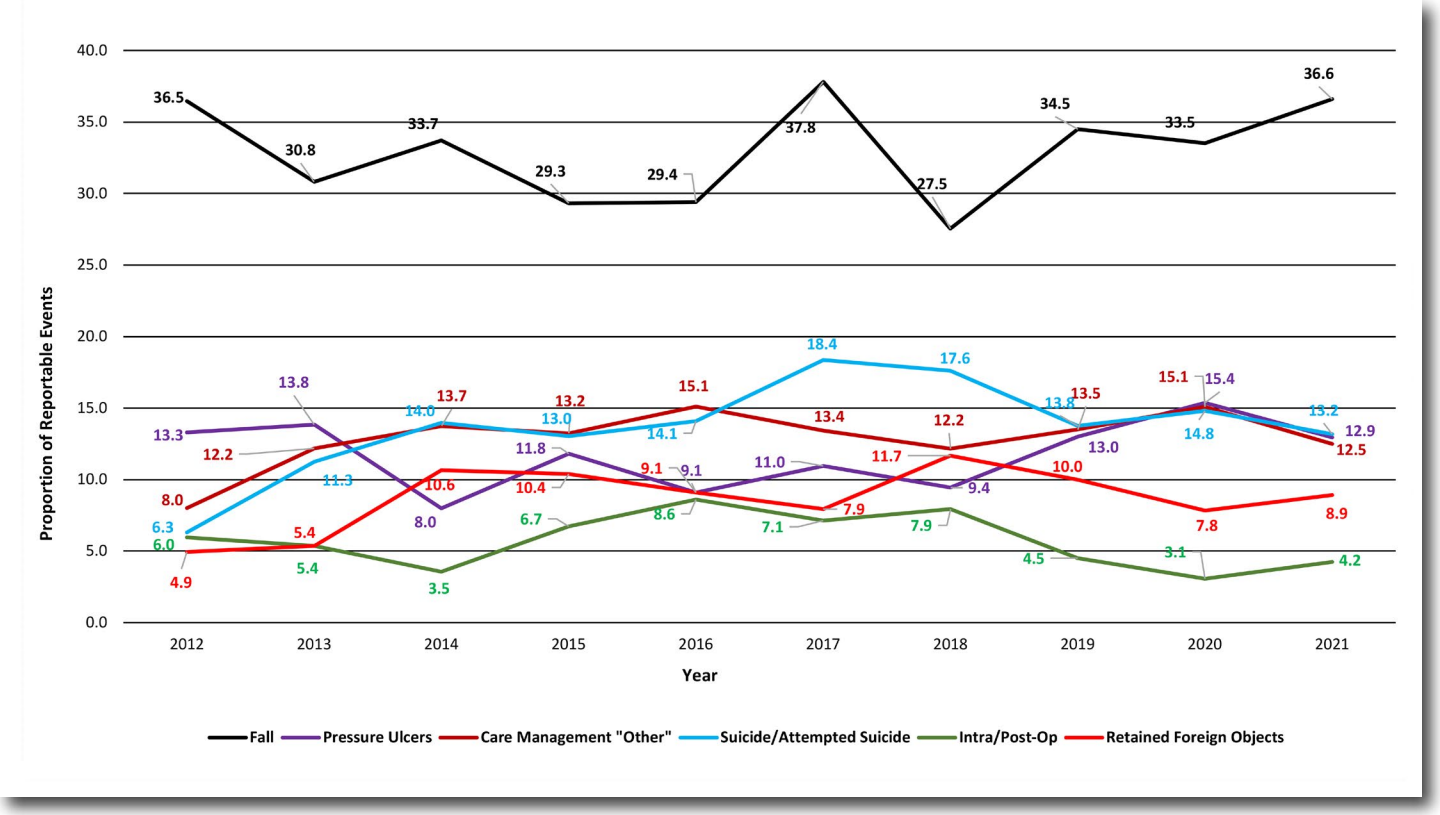
a. Included four events of Less Serious or Near Miss.

General Acute Care Hospitals

Figure 2 shows the reporting trends for these event types from 2012 to 2021. Of note, falls were consistently the top reported event type in all years. Other consistently highly reported event types include suicide/attempted suicide, care management "Other," pressure ulcers, and retained foreign objects.

Care management "Other" and surgical intra-op/post-op coma, death or other serious adverse have been described in detail in the prior section titled "Event Types Associated with the Highest Percentage of Deaths."

Figure 2:
General Acute Care Hospitals: Percentage of Most Frequently Reportable Event Types, 2012-2021



Fall Events

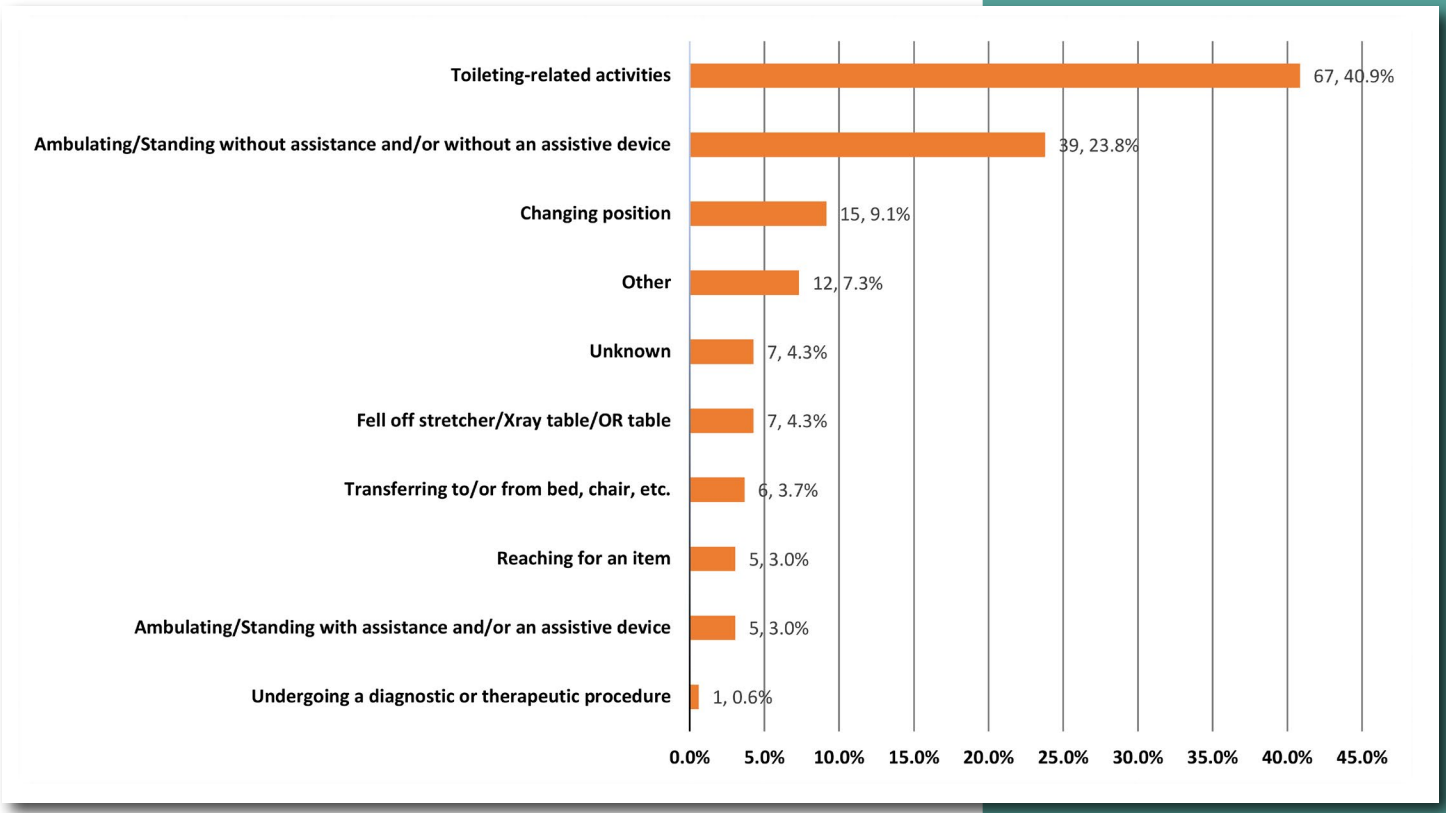
Falls continue to be the most frequently reported event submitted to the Patient Safety Reporting System by general acute care hospitals. The number of reported falls in 2021 was 164, an increase of 36.7% from 120 in 2020. There were 15 reported deaths from fall events in 2021 (Table 8), the same as in 2020.

The 164 reportable fall events were submitted by 58 general acute care hospitals, averaging 2.9 falls per facility (data not shown).

It is a standard for general acute care hospitals to use an evidence-based falls screening tool to identify risk and to implement fall prevention strategies based on risk. Prevalent screening tools most frequently used by facilities included the Johns Hopkins Fall Risk Assessment Tool and the Morse Falls Risk Assessment, followed by the Hendrich II Scale (data not shown). Statewide, almost half of falls were from high risk patients (data not shown).

For patients who suffered a fall with injury requiring an RCA in general acute care hospitals, Figure 3 shows the various activities the patients were engaged in prior to the fall. 40.9% of falls occurred when patients were engaged in toileting-related activities, 23.8% when patients were ambulating/standing without assistance and/or without an assistive device. Other activities patients were engaged in before falls included 9.1% during the process of changing position, 4.3% fell off stretcher/table, 3.7% during transferring to/or from bed or chair, 3.0% when patients were ambulating/standing with assistance and/or an assistive device, 3.0% when patients were reaching for an item. Facility should focus fall prevention specially on these activities.

Figure 3:
General Acute Care Hospitals: Activities Prior to Fall, 2021

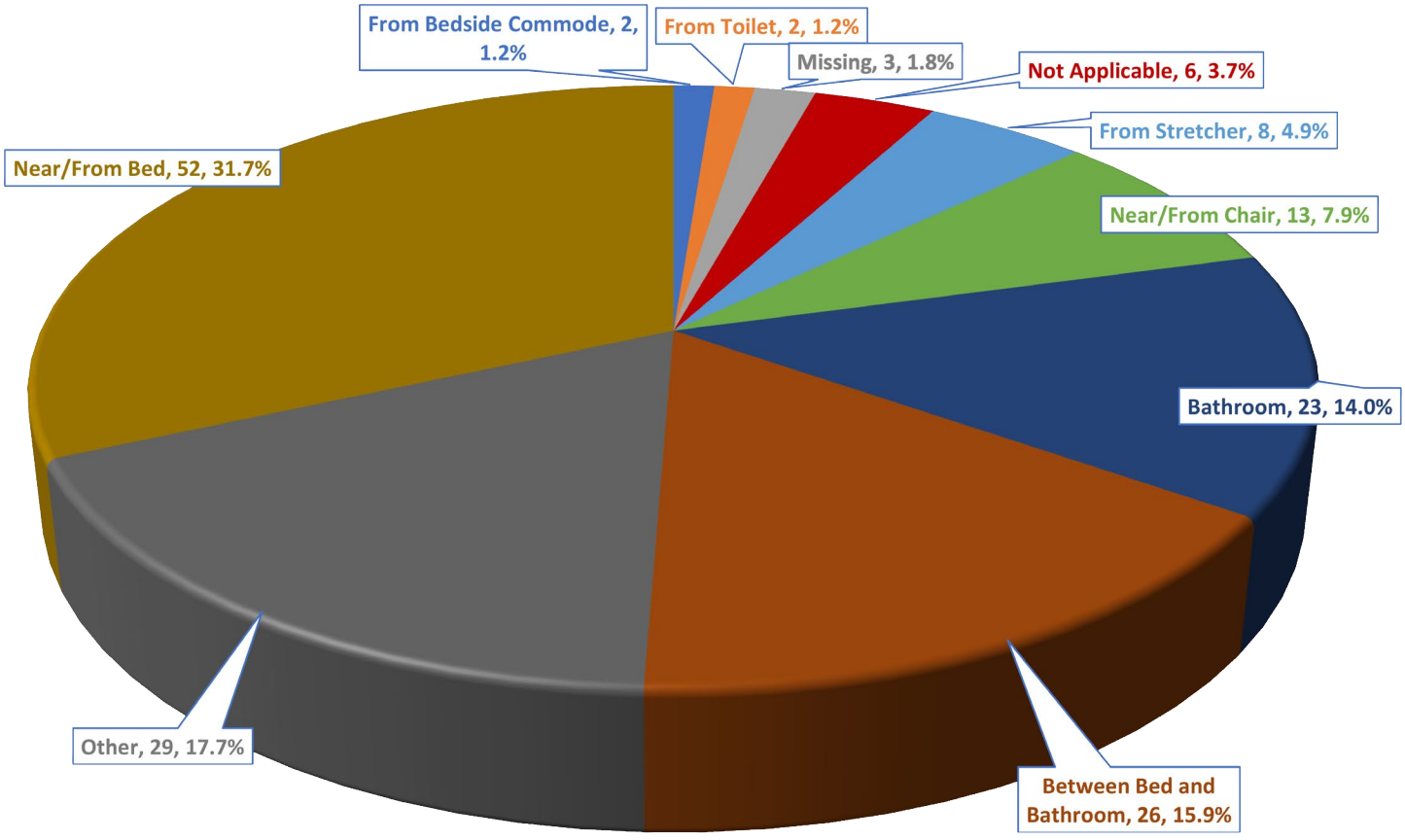


General Acute Care Hospitals

Figure 4 shows the locations where most of the falls occurred. Most falls occurred near or from bed (31.7%), followed by between bed and bathroom (15.9%), going to the bathroom, coming from the bathroom, or in the bathroom (14.0%), near or from chair (13.7%), or transferring to/from a stretcher (4.9%). Facility should focus fall prevention specially on activities around these locations.

Patients at risk for falls require increased observation, a strategy utilized in falls prevention for patients at risk. Providing increased patient rounding by staff members at shorter scheduled intervals by an assigned staff member, such as a patient care tech, to check on patients to identify any needs that might prompt a patient to get out of bed without assistance is a standard practice. However, it appears that more than three-quarters of falls still occurred to patients who were observed within one hour or less prior to fall (data not shown). This aggregated trend may indicate that additional strategies are needed to minimize the risk of falls.

Figure 4:
General Acute Care Hospitals: Percent of Patient Fall Locations, 2021



General Acute Care Hospitals: Suicide/Attempted Suicide Events

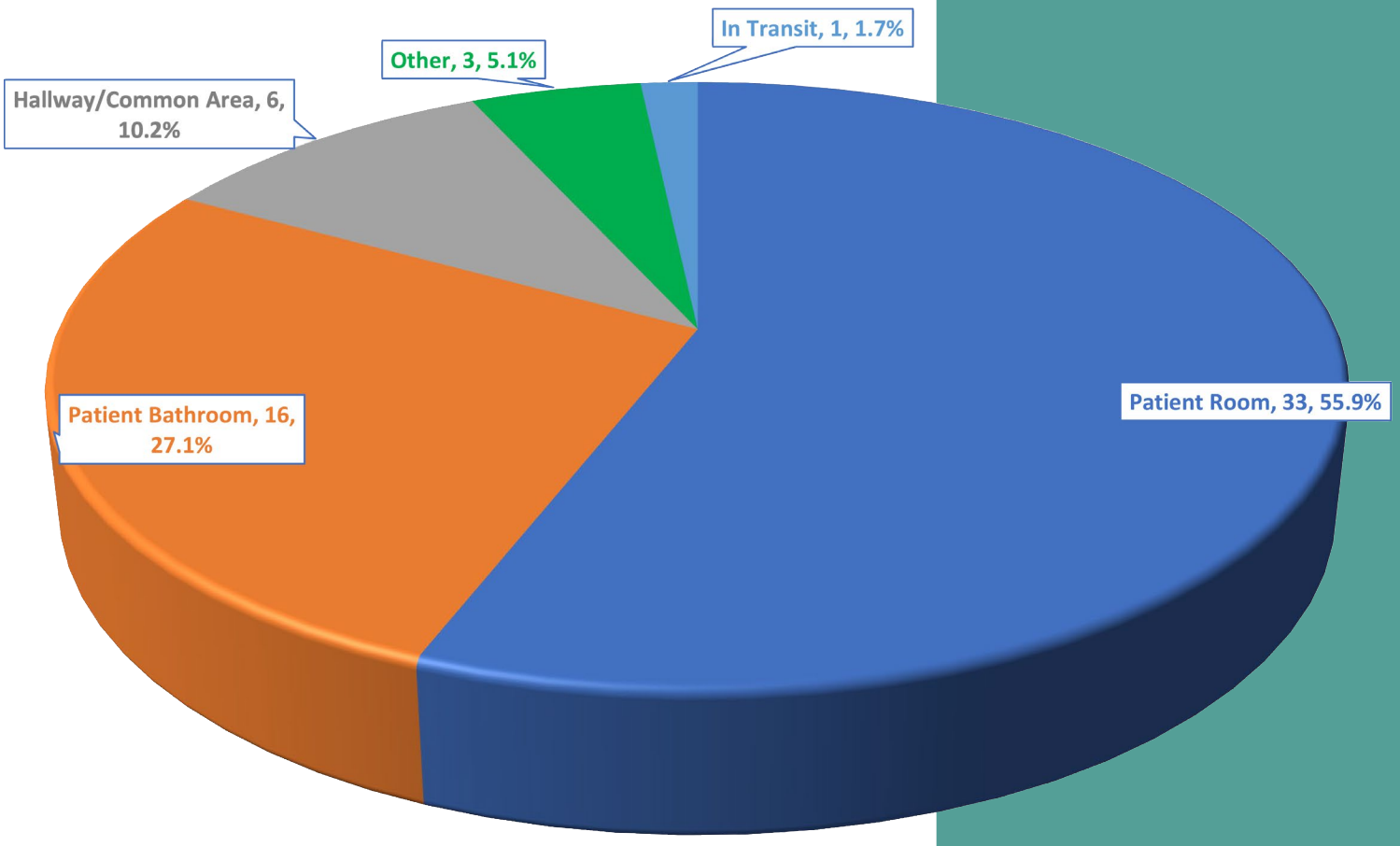
As previously shown in Table 8, there were 59 suicide/attempted suicide events in 2021 with one death, compared to 53 events with no death in 2020, an increase of six events and one death.

The 59 suicides and attempted suicides were submitted by 29 hospitals, averaging two events per facility (data not shown).

Of the 59 patients, 32 were considered at risk of suicide, 31 were seen by a psychiatrist and 21 were under 1:1 precaution observation (data not shown).

Figure 5 shows the locations where the suicide/attempted suicides mostly occurred. The patient's room accounted for over half (33, 55.9%) of the sites of the 59 reported events. This was followed with over a quarter (27.1%) in the patient's bathroom and 10 percent (10.2%) in the hallway/common area. Facilities should look at internal trend regarding locations of the reportable suicide/attempted suicide, as well as trend from similar facilities of the same type and develop action plans addressing this.

Figure 5:
General Acute Care Hospitals: Suicide/Attempted Suicide Event Locations, 2021



General Acute Care Hospitals

Pressure Ulcers

As previously shown in Table 8 (page 17), there were 58 reportable health care associated pressure ulcers reported in 2021 compared to 55 in 2020, an increase of three events. There were three reported deaths associated with this event type in 2021, same as in 2020.

The 58 pressure ulcer events were submitted by 22 general acute care hospitals, averaging 2.6 events per facility (data not shown).

Of the 58 events, 45 (77.6 %) were categorized as Stage III and the rest as Stage IV (data not shown).

Twenty-nine (50.0%) of the 58 pressure ulcers reported were located in the sacrum, sacrum/buttocks, sacrum/heels. Nine (15.5%) were only on the buttocks. Three were sacrum-other, one on the occipital area, and the rest were classified as "Other." Of those classified as "Other," six were associated with respiratory equipment and four were associated with fecal management systems (data not shown). Facilities should focus on frequently-occurred locations of pressure ulcers and develop action plans accordingly.

Retained Foreign Objects

As previously shown in Table 8 (page 17), there were 40 retained foreign object (RFO) events occurred in 2021, compared to 31 in 2020. Four less serious and near miss RFO events were included in 2021, three in 2020.

There were no deaths associated with these events.

The 40 RFO events were submitted by 26 general acute care facilities, averaging 1.5 events per facility (data not shown).

The types of retained foreign items left behind included sponges/gauze, guidewires, lap pads, catheters, balloons, drain, and "others" such as surgical towel, PICC line, ureteral stent, 6-inch pliable ruler, hemovac drain, whisper wire, and fractured drill bit (data not shown). Facilities should develop action plans on preventing all RFOs during surgeries.

Of the 40 patients who suffered the unintended retention of foreign object, 23 (57.5 %) required a second surgery to remove the object (data not shown).

Major Root Causes for All Events

In 2021, 437 out of 444 reportable events required a root cause analysis (RCA). Table 9 (page 23) shows the major types of root causes reported and the percent of all adverse events caused by each. Based on 437 events requiring an RCA, 137 events were related to the care planning process (31.4%). Communication among staff members and orientation and training

of staff accounted for 15.8% and 10.3% respectively. Patient observation procedures and physical assessment process accounted for 8.9% and 8.7%. 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 (data not shown).

Table 9:
General Acute Care Hospitals: Major Root Causes for All Events[a], 2021

Root Cause	Number of Events	Percent of RCA Events
Care Planning Process	137	31.4%
Communication Among Staff Members	69	15.8%
Orientation and Training of Staff	45	10.3%
Patient Observation Procedures	39	8.9%
Physical Assessment Process	38	8.7%
"Other"	17	3.9%

a. Data drawn from 437 reportable events requiring an RCA for acute care hospitals in 2021

Contributing Factors to All Events

Table 10 (page 24) shows the most frequently identified factors that contributed to the adverse events reported to the Patient Safety Reporting System by general acute care hospitals, as identified by reporting facilities during their root cause analyses (RCAs). Each RCA could contain multiple contributing factors and are not dependent on event types. The most common contributing factors are patient factors that may include confusion, co-morbidities, and the patient's choice to refuse care (66.8%), and task factors that may include tasks performed incorrectly, omitted by the care takers or complexity of the task (66,1%). Other contributing factors include team factors such as inadequate communications among the care team (47.8%), staff factor such as inadequate staffing levels (35.0%), organization and management factors such as unclear policies and a lack of support from leadership (29.1%), and diagnostic or interventional procedures that contributed to the event (24.3%). Other less common contributing factors include medical devices (10.3%), inappropriate administrated or not administrated medication or wrong dosage of medication (8.7%), work environment (8.7%), imaging (5.0%), laboratory and diagnostics (5.0%), transportation (2.5%), and home care (0.2%).

The types of retained foreign items left behind included sponges/gauze, guidewires, lap pads, catheters, balloons, drain, and "others" such as surgical towel, PICC line, ureteral stent, 6-inch pliable ruler, hemovac drain, whisper wire, and fractured drill bit (data not shown). Facilities should develop action plans on preventing all RFOs during surgeries.

General Acute Care Hospitals

Table 10: General Acute Care Hospitals: Contributing Factors to All Events[a], 2021

Contributing Factors	Number of Events	Percent of RCA Events
Patient characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	292	66.8%
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	289	66.1%
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	209	47.8%
Staff Factirs *(May include training, experience and inadequate staffing levels.)*	153	35.0%
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	127	29.1%
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	106	24.3%
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs.)*	65	14.9%
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	62	14.2%
Medical Devices *(May include inappropriate administration, dose and prescribed medications not administered.)*	45	10.3%
Medications *(May include inappropriate administration, dose and prescribed medications not administered.)*	38	8.7%
Work Environment	38	8.7%
Other *(May Include factors not identified in the other categories.)*	35	8.0%
Imaging and X-ray	22	5.0%
Laboratory and diagnostics	22	5.0%
Transportation	11	2.5%
Home Care	1	0.2%

a. Data were from 437 reportable events requiring an RCA for acute care hospitals in 2021.

Impacts of All Events on Patients

Table 11 shows the impacts of all events on patients reported by acute care general hospitals in 2021. Of the 437 RCAs, around half needed additional lab testing or diagnostic imaging (51.9%), or additional patient monitoring in current location (47.4%), or increased length of stay (46.9%). More than a quarter of the events needed major surgery (28.1%) or had disability-physical or mental impairment (26.5%).

There were 83 deaths, which represent 19.0% of the 437 reportable events requiring an RCA. In addition, there were 12.6% hospital admissions.

Table 11:
General Acute Care Hospitals: Impact of All Events on Patients[a], 2021

Impact/Outcome	Number of Events	Percent of RCA Events
Additional Lab Testing or Diagnostic Imaging	227	51.9
Additional Patient Monitoring in Current Location	207	47.4
Increased Length of Stay	205	46.9
Major Surgery	123	28.1
Disability-Physical or Mental impairment	116	26.5
Transfer to more Intensive Level of Care	105	24.0
Death	83	19.0
Other additional diagnostic testing	71	16.2
Hospital admission	55	12.6
Minor surgery	48	11.0
System or processes delay care to patient	40	9.2
Other	36	8.2
Visit to Emergency Department	25	5.7
Loss of bodily function(s)	15	3.4
Loss of sensory function(s)	10	2.3
To be determined	7	1.6
Loss of body part(s)	5	1.1
Loss of digit(s)	1	0.2
Loss of organ(s)	1	0.2

a. Data drawn from 437 reportable events requiring an RCA for acute care hospitals in 2021.

More than a quarter of the events needed major surgery (28.1%) or had disability-physical or mental impairment (26.5%). There were 83 deaths, which represent 19.0% of the 437 reportable events requiring an RCA. In addition, there were 12.6% hospital admissions.

Overall Reporting Patterns for Specialty Hospitals

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

As previously shown in Table 1, there were 50 reportable events submitted from specialty hospitals in 2021 (same as in 2020).

Eight comprehensive rehabilitation hospitals submitted 38 reportable events (Table 12). The average event reports per this facility type was 4.8. There were two deaths associated with this facility type.

Four psychiatric hospitals submitted five reportable events in 2021 (Table 12); an average of 1.3 events per facility. There were two deaths associated with this facility type. Please note that only NJDOH licensed psychiatric hospitals are included in this section. For reports on state-run psychiatric hospitals, see section VII, Division of Behavioral Health Services 2021 Report.

Six special hospitals submitted seven reportable events averaging 1.2 reports per facility (Table 12). There were no deaths associated for this facility type.

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

Table 12:
Specialty Hospitals: Overall Reporting Pattern in 2021[a]

Facility Type	Number of Facilities	Number of Facilities Reporting	Number of Reportable Events	Average Number of Reportable Events per Facility	Number of Deaths
Comprehensive Rehabilitation	14	8	38	4.8	2
Psychiatric [b]	10	4	5	1.3	2
Special Hospitals	16	6	7	1.2	0
Total	**40**	**18**	**50**	**2.8**	**4**

a: Data were from 6 reportable events requiring an RCA for special hospitals in 2021.
b: Only DOH licensed psychiatric hospitals are included in this section.

Comprehensive Rehabilitation Hospitals

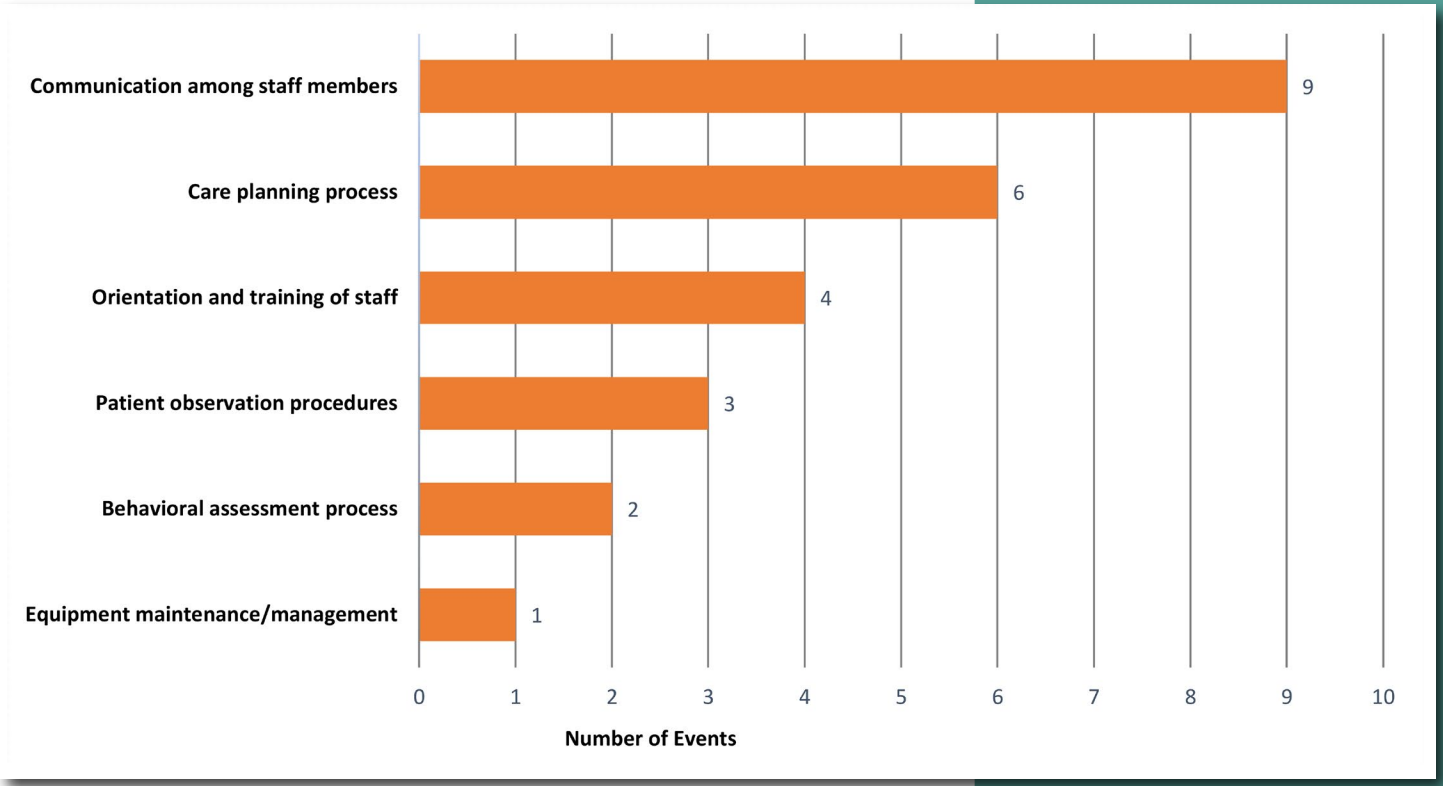
Of the 14 comprehensive rehabilitation hospitals in the state, eight reported 38 reportable events in 2021 (Table 12). There two deaths associated with these events.

The reported event types were as follows: 18 falls, 15 pressure ulcers, three care management "Other" events, one care management-medication error, and one patient protection suicide/attempted suicide (data not shown). These events are consistent with previous years' reporting.

Root Causes for All Events

Twenty-five reportable events required a root cause analysis (RCA) for comprehensive rehabilitation hospitals in 2021. Figure 6 shows the major causes for the events reported by this facility type. Communication among staff members and the care planning process remain the top two root causes for comprehensive rehabilitation hospitals in 2021 (nine events and six events respectively).

Figure 6:
Comprehensive Rehabilitation Hospitals: Root Causes for All Events[a], 2021



a. Data were from 25 reportable events requiring an RCA for comprehensive rehabilitation hospitals in 2021.

Contributing Factors to All Events for Comprehensive Rehabilitation Hospitals

Table 13 (page 28) shows the most frequently reported contributing factors. Of the 25 reportable events requiring an RCA, 18 events had issues with patient characteristics, 18 with team factors, 14 with task factors, and 13 with staff factors. Other contributing factors included organization/management (eight), equipment (seven), procedures (five), and medications (four). Facilities during the RCA review processes identified these issues with various processes, communication, leadership, etc., which are often addressed in their action plans.

Overall Reporting Patterns for Specialty Hospitals

Table 13:
Comprehensive Rehabilitation Hospitals: Contributing Factors to All Events[a], 2021

Contributing Factors	Number of Events
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	18
Team Factors *(May include factors which interfere with the care team working together, such as inadequate*	18
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	14
Staff Factors *(May include training, experience and inadequate staffing levels.)*	13
Organization/management *(May include unclear policies and a lack of support from leadership.)*	8
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs.)*	7
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	5
Medications *(May include inappropriate administration, dose and prescribed medications not administered.)*	4
Imaging and X-ray	2
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	2
Transportation	2
Medical Devices *(May include inappropriate administration, dose and prescribed medications not administered.)*	1

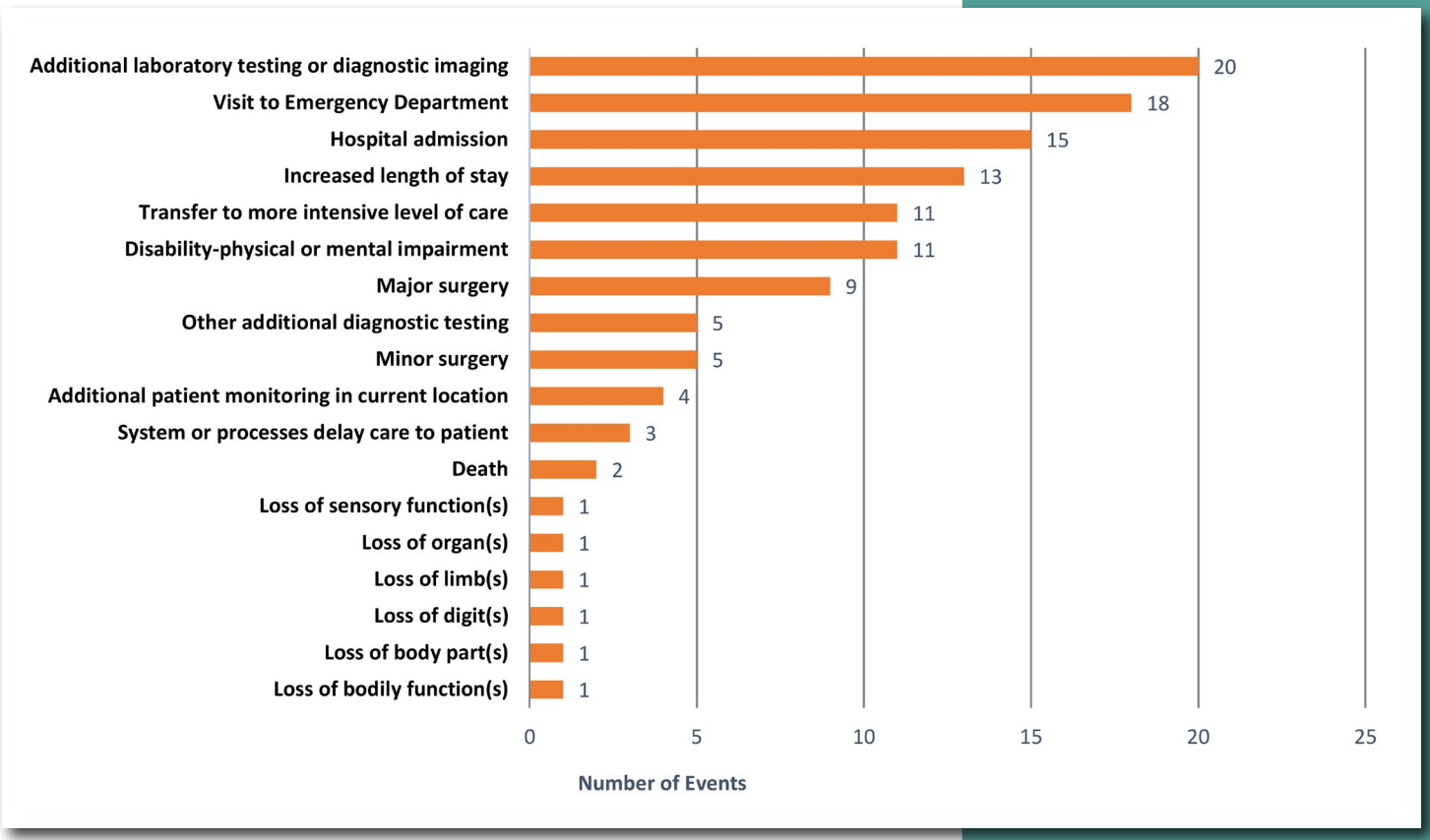
a. Data were from 25 reportable events requiring an RCA for comprehensive rehabilitation hospitals in 2021.

Impact of All Events for Comprehensive Rehabilitation Hospitals

Figure 7 shows the impacts associated with adverse events from comprehensive rehabilitation hospitals. As a result of these adverse events, 20 patients from the 25 reportable events requiring an RCA experienced additional laboratory testing or diagnostic imaging; 18 had visit to the emergency department; 15 had hospital admission, and 13 had increased length of stay. Other common impacts included transfer to a more intensive level of care (2), disability-physical or mental impairment (2), and major surgery (nine).

There were two deaths reported from this facility type.

Figure 7:
Comprehensive Rehabilitation Hospitals: Impact of All Events[a], 2021



a. Data were from 25 reportable events requiring an RCA for comprehensive rehabilitation hospitals in 2021.

Overall Reporting Patterns for Specialty Hospitals

Psychiatric Hospitals

As previously shown in Table 1 (page 8), four out of the 10 NJDOH licensed psychiatric hospitals reported at least one event during 2021. A total of five reportable events, all requiring a root cause analysis, were submitted with two associated with falls, two associated with care management "Other," and one with patient protection suicide/attempted suicide. There were two deaths reported for this facility type (data not shown).

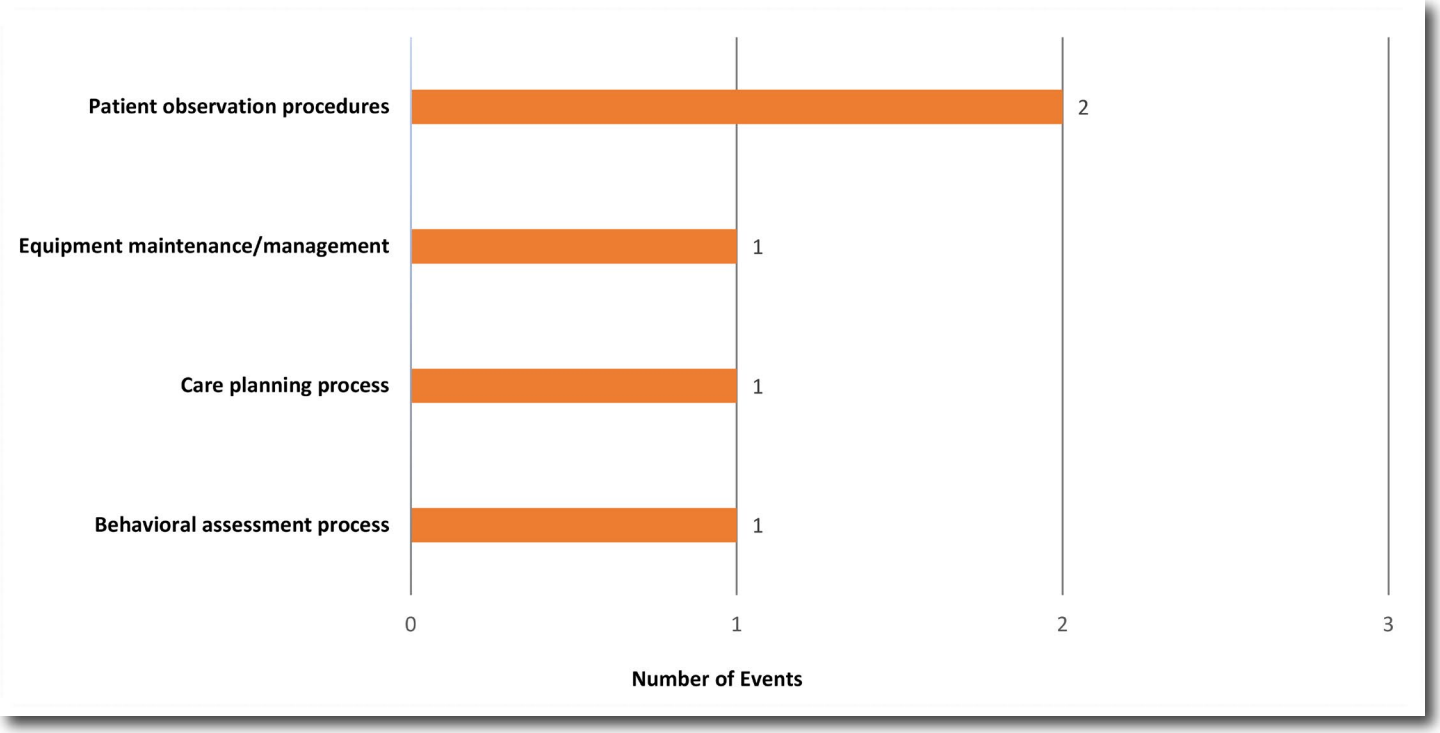
The average number of submissions by this facility type was 13.

Please note that state-run psychiatric hospitals are not described in this section. Report on state-run psychiatric hospitals can be found starting on page 46.

Root Causes for All Events

Figure 8 shows the most reported root causes for the events that occurred in non-state-run psychiatric hospitals. For psychiatric hospitals, patient observation procedures were identified as the most common root cause (two out of five) for the facilities reporting.

Figure 8:
Psychiatric Hospitals: Root Causes for All Events[a], 2021



a. Data were from five reportable events requiring an RCA for licensed psychiatric hospitals in 2021.

Contributing Factors to All Events

Table 14 shows the most frequently reported contributing factors associated with the five reportable events requiring an RCA for psychiatric hospitals. The top contributing factors for psychiatric hospitals were equipment (three) and patient characteristics (three), followed by organization/management (two) and staff factors (two).

Table 14:
Psychiatric Hospitals: Contributing Factors to All Events[a], 2021

Contributing Factors	Number of Events
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs.)*	3
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	3
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	2
Staff Factors *(May include training, experience and inadequate staffing levels)*	2
Other *(May Include factors not identified in the other categories.)*	1
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	1
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	1

a. Data drawn from five reportable events requiring an RCA for psychiatric hospitals in 2021.

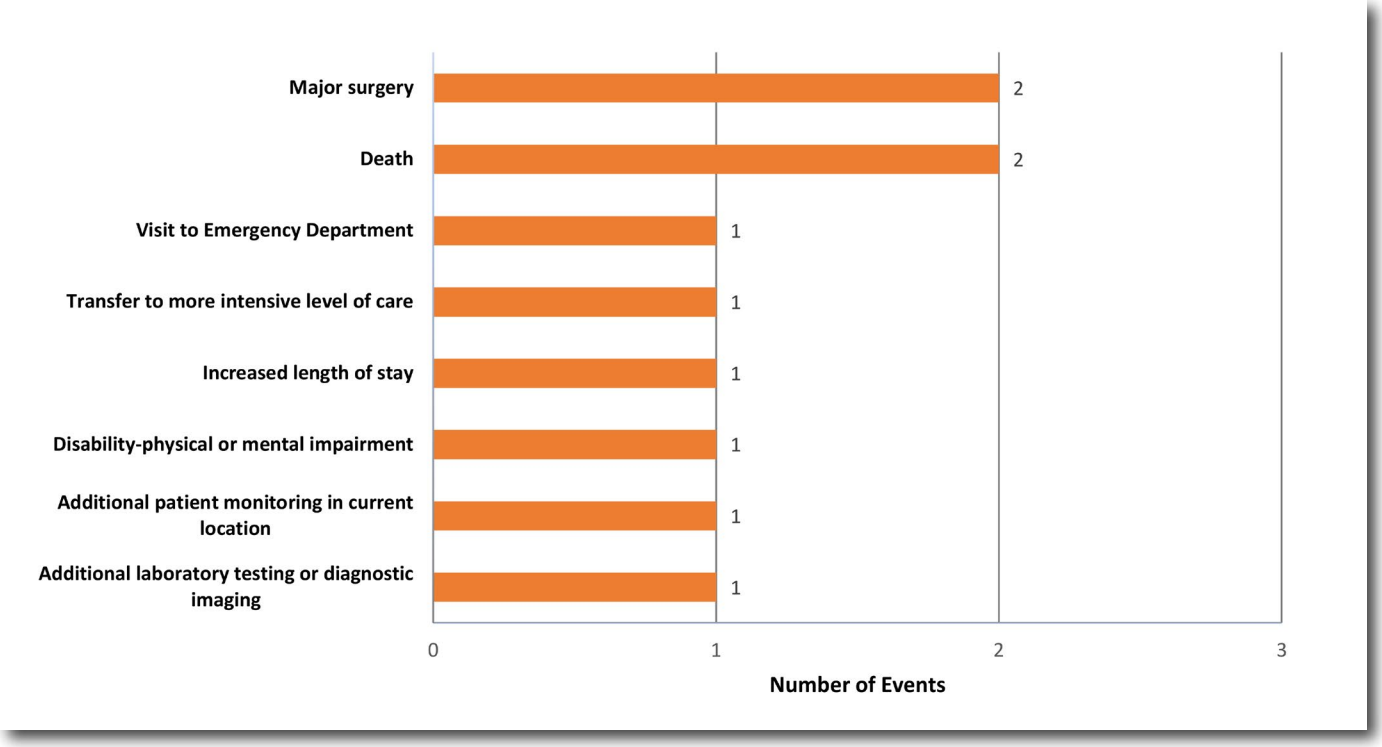
As previously shown in Table 1 (page 8), four out of the 10 NJDOH licensed psychiatric hospitals reported at least one event during 2021. A total of five reportable events, all requiring a root cause analysis, were submitted with two associated with falls, two associated with care management "Other," and one with patient protection suicide/ attempted suicide.

Overall Reporting Patterns for Specialty Hospitals

Impact of All Events

Figure 9 shows the most frequently reported impact from all events. There were two deaths reported. Death and major surgery were reported in two of the five reportable events requiring an RCA. Other impacts included one case each of a visit to emergency room, transfer to more intensive level of care, increased length of stay, disability-physical or mental impairment, additional patient monitoring in current location, and additional laboratory testing or diagnostic imaging.

Figure 9:
Psychiatric Hospitals: Impact of All Events[a], 2021



a. Data were drawn from five total reportable events requiring an RCA for psychiatric hospitals in 2021.

Special Hospitals

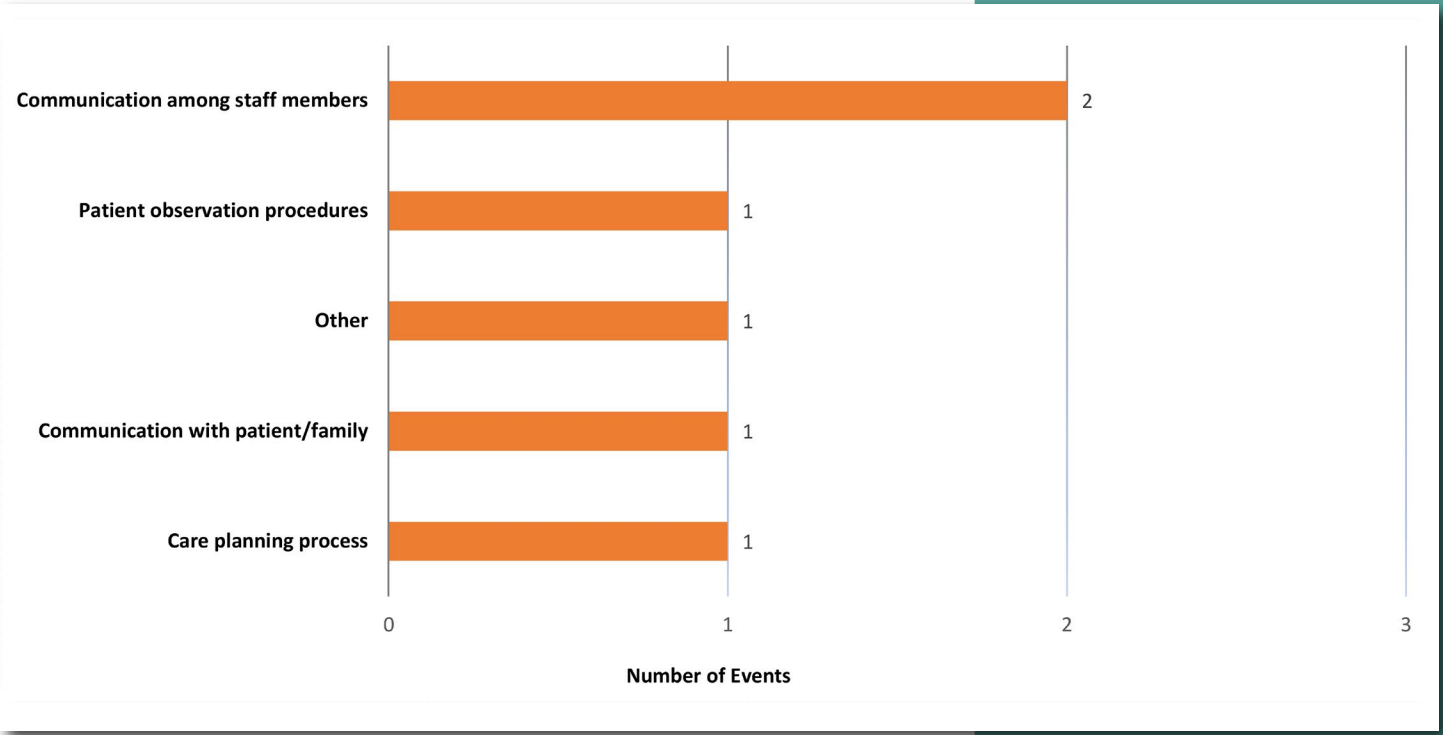
As previously shown in Table 1 (page 8), there were seven reportable events submitted by six of the 16 special hospitals in 2021. This low reporting is consistent with prior years. There were no deaths reported for this facility type.

Root Causes for All Events

Six of the seven reportable events required a root cause analysis. Figure 10 (page 33) shows the most frequent root causes of events within

this facility type. Communication among staff members was identified as a root cause from two RCAs. Patient observation procedures, communication with patient and family, care planning process, and "Other" were also identified for one of the six events.

Figure 10:
Special Hospitals: Root Causes for All Events[a], 2021



a: Data were drawn from six total reportable events requiring an RCA for specialty hospitals in 2021.

Contributing Factors to All Events

Table 15 (page 34) shows the most frequent contributing factors to the six events occurred in special hospitals in 2021. The most frequently identified contributing factors include: patient characteristics (four), task factors (four), staff factors (three), medications (two), patient record documentation (two), and team factors (two). Laboratory and diagnostic (one), medical devices (one), management (one), and "Other" were also identified as contribution factors.

Overall Reporting Patterns for Specialty Hospitals

Table 15:
Special Hospitals: Contributing Factors to All Events[a], 2021

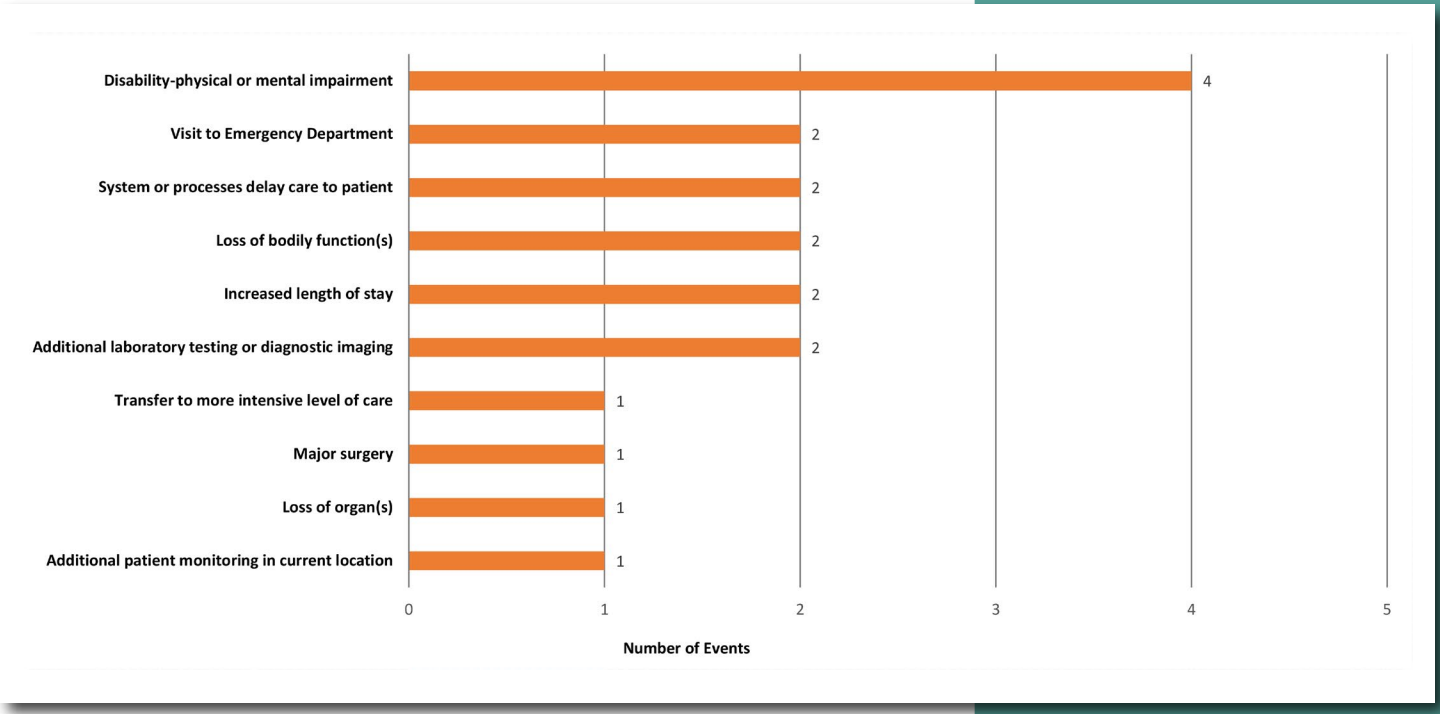
Contributing Factors	Number of Events
Patient Characteristics *(May include confusion, co-morbidities and the patient's choice to refuse care.)*	4
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	4
Staff Factors *(May include training, experience and inadequate staffing levels.)*	3
Medications *(May include inappropriate administration, dose and prescribed medications not administered.)*	2
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	2
Team Factors *(May include factors which interfere with the care team working together, such as inadequate communication.)*	2
Laboratory and diagnostics	1
Medical Devices *(May include inappropriate administration, dose and prescribed medications not administered.)*	1
Organization/management *(May include unclear policies and a lack of support from leadership.)*	1
Other *(May Include factors not identified in the other categories.)*	1

a. Data were from six reportable events requiring an RCA for special hospitals in 2021..

Impact of All Events

Figure 11 exhibits the most frequently identified impacts from the reportable adverse events requiring an RCA submitted by special hospitals. Disability-physical or mental impairment was noted in four of the six RCAs. Visit to an emergency room, system of process delay care to patient, loss of bodily function(s), increased length of stay, and additional laboratory testing or diagnostic imaging were each reported in two cases. Major surgery, loss of organ, transfer to more intensive level of care, and additional patient monitoring in current location were each noted in one case. Note there was no death reported as an impact in this facility type for 2021.

Figure 11:
Special Hospitals: Impact of All Events[a], 2021



a. Data were from six reportable events requiring an RCA for special hospitals in 2021.

Ambulatory Surgery Centers

New Jersey Department of Health licensed ambulatory surgery centers (ASCs) began reporting serious preventable adverse events to the Patient Safety Reporting System as of October 1, 2008. Of the 251 ambulatory surgery centers licensed in New Jersey, 78 facilities submitted events that occurred in 2021. A total of 257 events were submitted of which 180 were deemed reportable (Table 16), all requiring an RCA.

There were seven deaths as shown in Table 17 later, one more death than in 2020. All seven deaths were related to intra-op or post-op coma, death or other serious preventable adverse events in 2021 (data not shown).

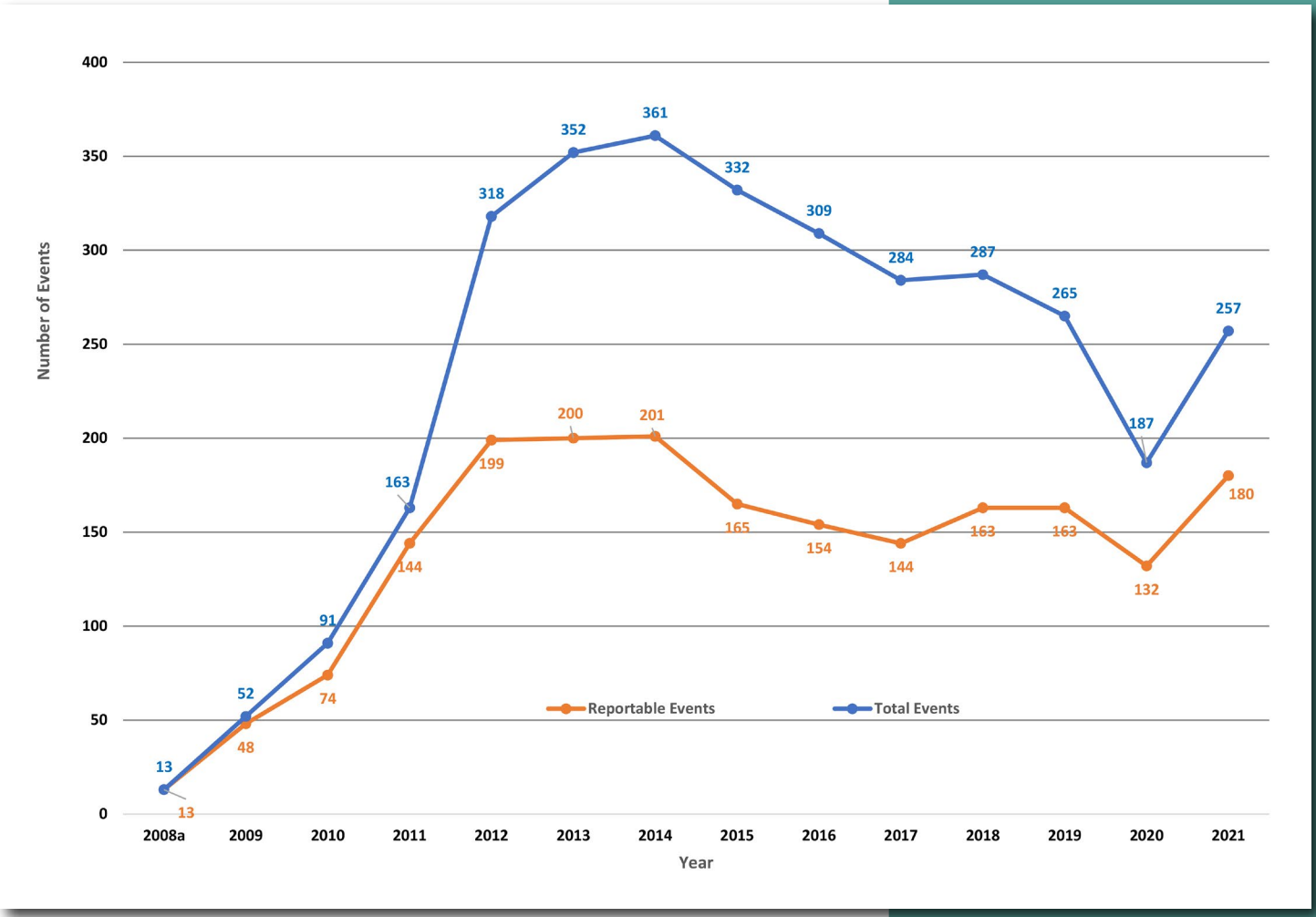
Table 16 and Figure 12 show the reporting trend for the period 2008 to 2021. NJDOH licensed ambulatory surgery centers in New Jersey were noted to report an increasing number of total events, reportable events, as well as less serious/near misses up till around 2014, dipped and fluctuated from 2015 to 2019, then dropped further in 2020. Event reporting went up in 2021. There has been a steady decline in number of less serious/near miss events and not reportable events since 2015 and 2016 respectively.

Table 16:
Ambulatory Surgery Centers: Reporting Patterns, 2008 -2021[a]

Year	Reportable	Not Reportable	Less Serious/Near Misses	Total Events	Percent Reportable
2008[a]	13	0	NA	13	100.0%
2009	48	4	NA	52	92.3%
2010	74	17	NA	91	81.3%
2011	144	10	9	163	88.3%
2012	199	31	88	318	62.6%
2013	200	17	135	352	56.8%
2014	201	6	154	361	55.7%
2015	165	5	162	332	49.7%
2016	154	14	141	309	49.8%
2017	144	10	130	284	50.7%
2018	163	10	114	287	56.8%
2019	163	7	95	265	61.5%
2020	132	1	54	187	70.6%
2021	180	0	77	257	70.0%

a. Year 2008 represents three months of data since reporting started on October 1, 2008.

Figure 12:
Ambulatory Surgery Centers Trends in Reportable Events, 2008[a]-2021



a. Year 2008 represents three months of data since reporting started on October 1, 2008.

Table 17 (page 38) shows the highest reportable cases were intra-operative or post-operative coma, death, or other serious preventable adverse events with 141 events. The second highest event type was surgery-related "Other" events with 23 events.

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

All 180 reportable events required an RCA.

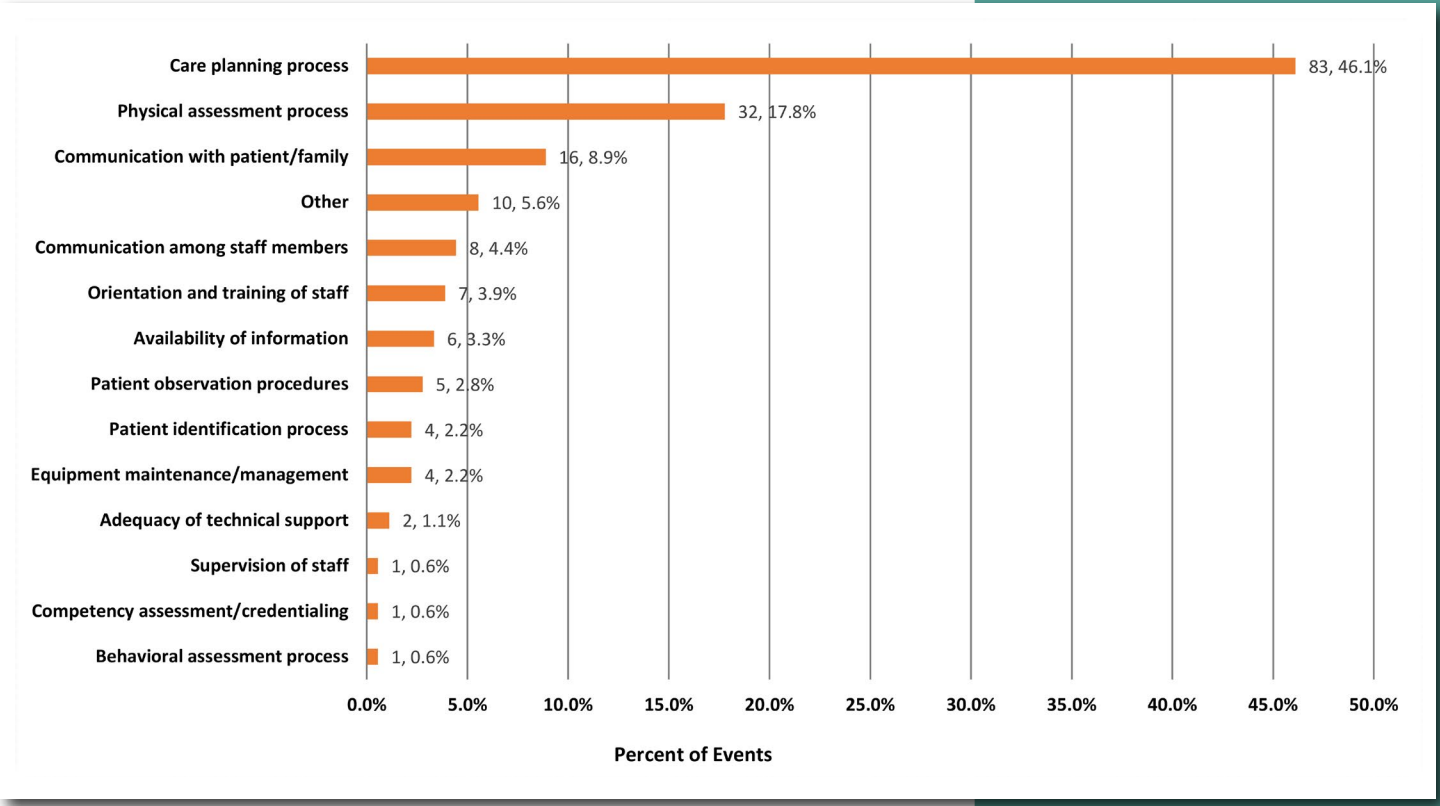
Table 17:
Ambulatory Surgery Centers: Events Reported, 2021

Event Type	Number of Reportable Events	Portion of Reportable Events	Number of Deaths
Intra-Operative or Post-Operative Coma, Death or "Other" serious preventable adverse event	141	78.3%	7
Surgery-Related "Other" Event	23	12.8%	0
Surgical-Wrong Site	5	2.8%	0
Surgical-Wrong Procedure	4	2.2%	0
Environmental - Fall	3	1.7%	0
Care Management "Other"	1	0.6%	0
Product/Device - Contaminated Drugs/Devices/Biologics	1	0.6%	0
Product/Device-Malfunction	1	0.6%	0
Care Management-Medication Error	1	0.6%	0
Total	**180**	**100.0%**	**7**

Root Causes for All Events

Of the 180 reportable events occurred in ambulatory surgery centers in 2021, all required a root cause analysis (RCA). Figure 13 (page 39) shows the most frequently identified root causes. For ambulatory surgery centers, care planning process accounted for almost half of all RCAs in 2021. Physical assessment process accounted for 17.8%.

Figure 13:
Ambulatory Surgery Centers: Root Causes for All Events[a], 2021



a. Data were from 180 reportable events requiring an RCA for ambulatory surgery centers in 2021.

Contributing Factors to All Events

Table 18 (page 40) shows the most frequently reported contributing factors at ambulatory surgery centers. The mostly commonly associated contributing factors in order were task factors (63.9%), patient characteristics (60.0%), procedures (50%), staff factors (37.2%), organization/management (31.7%), and team factors (26.7%).

Ambulatory Surgery Centers

Table 18: Ambulatory Surgery Centers: Contributing Factors to All Events[a], 2021

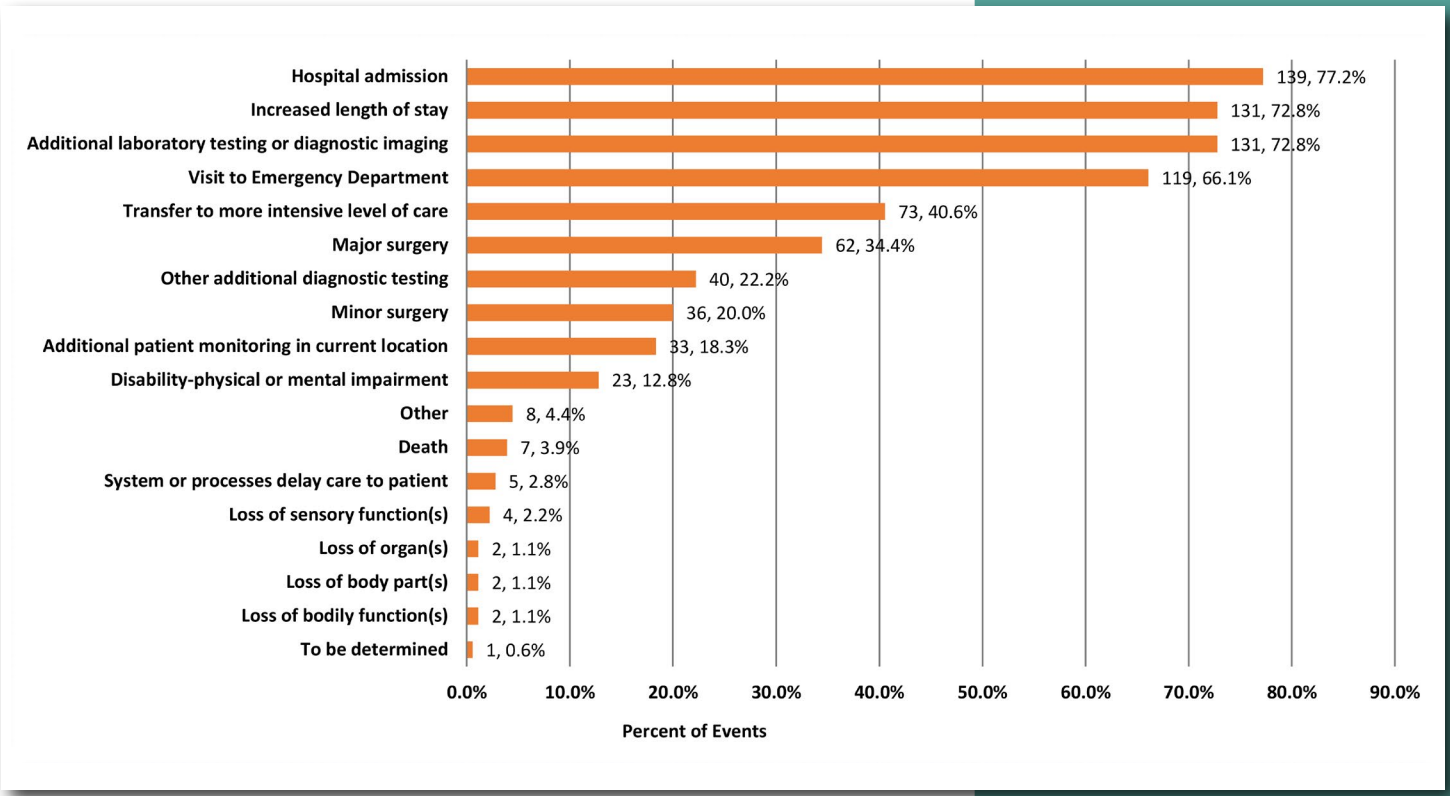
Contributing Factors	Number of Events	Percent of RCA Events[a]
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	115	63.9%
Patient Characteristics *(May include confusion, co-morbidities and the Patient's choice to refuse care.)*	108	60.0%
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	90	50.0%
Staff factors	67	37.2%
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	57	31.7%
Team Factors *(May include factors which interfere with the care teamworking together, such as inadequate communication.)*	48	26.7%
Patient Record Documentation *(May include missing or inaccurate information in the medical record.)*	30	16.7%
Other Factors *(May Include factors not identified in the other categories.)*	25	13.9%
Medications *(May include inappropriate administration, dose and prescribed medications not administered.)*	15	8.3%
Home Care	12	6.7%
Medical Devices *(May include inappropriate administration, dose and prescribed medications not administered.)*	12	6.7%
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs.)*	11	6.1%
Laboratory and Diagnostics	5	2.8%
Imaging and X-ray	3	1.7%
Transportation	1	0.6%
Work Environment	1	0.6%

a. Data were from 180 reportable events requiring an RCA for ambulatory surgery centers in 2021.

Impact of All Events

Figure 14 displays the most frequently reported impact of adverse events at ambulatory surgery centers in 2021. In over 70% of the RCAs, patients experienced hospital admission (77.2%), increased length of stay (72.8%), additional laboratory testing or diagnostic imaging (72.8%). Sixty-six percent of the RCAs were associated with a visit to the emergency department. Other impact of events included transfer to a more intensive level of care (40.6%), major surgery (34.4%), followed by other additional diagnostic testing (22.2%), minor surgery (20.0%), additional patient monitoring in current location (18.3%), and disability-physical or mental impairment (12.8%).

Figure 14:
Ambulatory Surgery Centers: Impact of All Events[a], 2021



a. Data were from 180 reportable events requiring an RCA for ambulatory surgery centers in 2021.

End Stage Renal Disease Dialysis Facilities

End stage renal disease (ESRD) facilities began reporting preventable adverse events as of January 1, 2019. Of the 239 licensed facilities, 27 facilities submitted a total of 50 events. Forty of the submitted events were deemed reportable, all requiring an RCA (Table 19).

Thirty-six of the events occurred in the Care Management "Other" category, while the remaining four events were related to falls.

There were 27 deaths associated with these reported events in 2021. All but one of the 26 deaths were related to Care Management "Other."

The number reportable events in 2021 remained the same as in 2020 with one less death (data not shown).

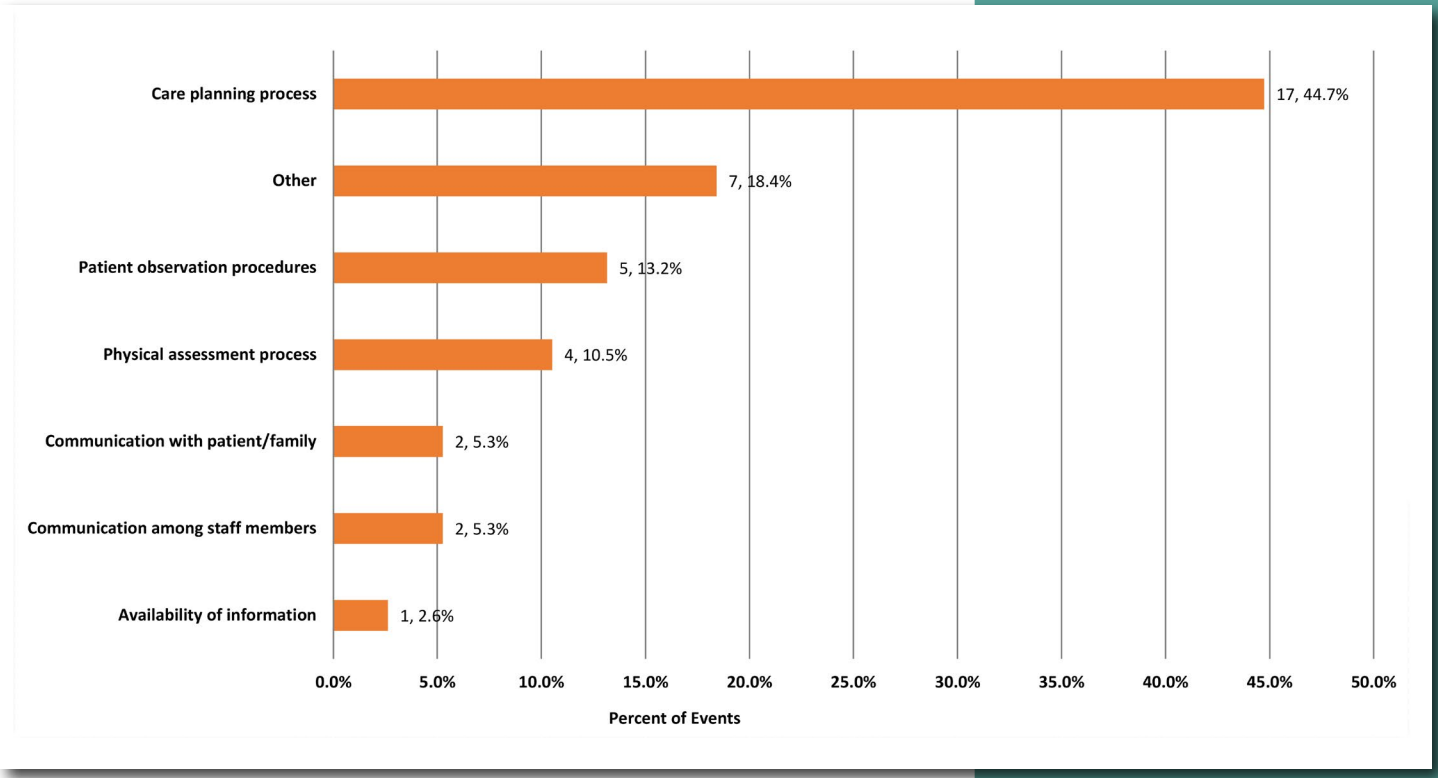
Table 19:
End Stage Renal Dialysis Facilities: Reportable Events and Associated Deaths in 2021

Event Type	Number of Reportable Events	Proportion of Reportable Events	Number of Deaths
Care Management "Other"	36	90.0	26
Environmental - Fall	4	10.0	1
Total	**40**	**100.0**	**27**

Root Causes for All Events

Figure 15 (page 43) shows the major root causes of events for ESRD facilities. Care planning process is identified as the most common root cause (44.7%). "Other" (18.4%), patient observation procedures (13.2%), and physical assessment process (10.5%) were among other identified root causes.

Figure 15:
End Stage Renal Disease Facilities: Root Causes for All Events[a], 2021



a. Data were from 38 reportable events requiring an RCA for end stage renal disease dialysis facilities in 2021.

Contributing Factors for All Events Associated with End Stage Renal Dialysis Facilities

Table 20 (page 44) shows the most frequently reported contributing factors at end stage renal disease dialysis facilities. The most commonly reported contributing factors in order of greatest to least include task factors (60.5%), procedures (52.6%), team factors (52.6%), patient characteristics (50%). Other contributing factors included management (28.9%), staff factors (26.3%), "Other" factors (21.1%), and patient record documentation (15.8%).

End Stage Renal Disease Dialysis Facilities

Table 20:
End Stage Renal Disease Dialysis Facilities: Contributing Factors to All Events[a], 2021

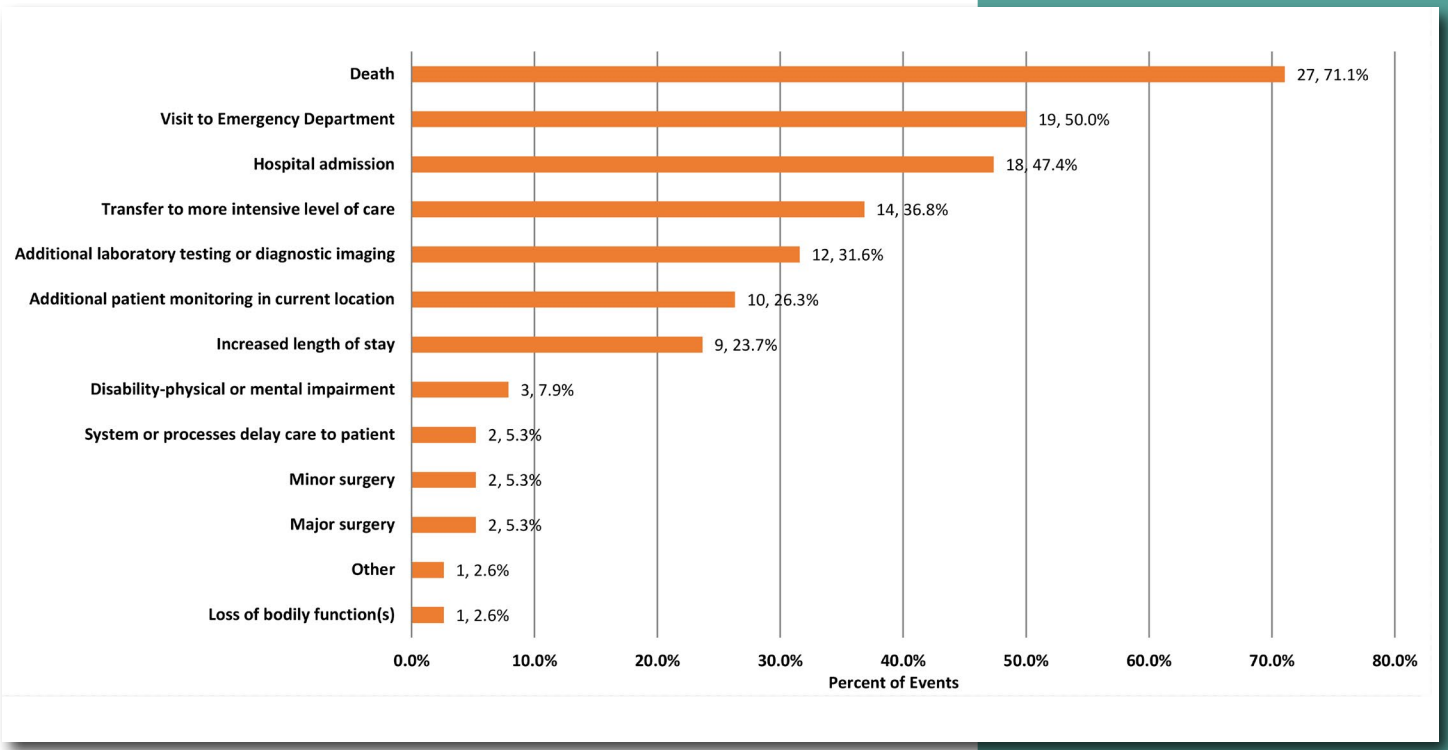
Contributing Factors	Number of Events	Percent of RCA Events[a]
Task Factors *(May include tasks performed incorrectly, omitted or characteristics of the task such as complexity.)*	23	60.5%
Procedures *(May include diagnostic or therapeutic interventions that contribute to the event.)*	20	52.6%
Team Factors *(May include factors which interfere with the care teamworking together, such as inadequate*	20	52.6%
Patient Characteristics *(May include confusion, co-morbidities and the Patient's choice to refuse care.)*	19	50.0%
Organization/Management *(May include unclear policies and a lack of support from leadership.)*	11	28.9%
Staff Factors *(May include training, experience and inadequate staffing levels.)*	10	26.3%
Other Factors *(May Include factors not identified in the other categories.)*	8	21.1%
Patient record documentation *(May include missing or inaccurate information in the medical record.)*	6	15.8%
Laboratory and diagnostics	2	5.3%
Transportation	2	5.3%
Equipment *(May include inappropriate use and malfunction of items such as stretchers, bed alarms and wheelchairs.)*	1	2.6%
Home Care	1	2.6%
Imaging and X-ray	1	2.6%
Medical Devices *(May include inappropriate administration, dose and prescribed medications not administered.)*	1	2.6%
Medications *(May include inappropriate administration, dose and prescribed medications not administered.)*	1	2.6%
Work Environment	1	2.6%

a. Data were from 38 reportable events requiring an RCA for end stage renal disease dialysis facilities in 2021.

Impact of All Events

Figure 16 displays the most frequently reported impact of adverse events at end stage renal disease dialysis facilities. The most common impacts to the patient for the reportable events requiring an RCA for end stage renal dialysis facilities include, in order of most to least, frequent death (71%), visit to the emergency department (50%), hospital admission (47.4), transfer to more intensive level of care (36%), additional lab testing or diagnostic imaging (31.6), additional patient monitoring in current location (26.3%), and increased length of stay (23.7%).

Figure 16:
End Stage Renal Disease Dialysis Facilities: Impact of All Events[a], 2021



a. Data were from 38 reportable events requiring an RCA for end stage renal disease dialysis facilities in 2021.

Division of Behavioral Health Services 2021 Report

Annual Patient Safety Act Report

January 1, 2021 through December 31, 2021

Implementation

The Division of Behavioral Health Services (DBHS) 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 regional NJ state psychiatric hospitals and one forensic psychiatric center. A log of PSA-related events is maintained by DBHS to monitor the timely submission and review of submitted RCAs.

The review committee, which consists of members of various disciplines including psychiatry, psychology, nursing, and rehabilitation services, assesses the RCAs 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 2021, 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, and for 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 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 health care.
- Each facility is training all staff in the basics of Suicide Prevention and the requirements of the accompanying Administrative Bulletin 3:14 and the 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), who 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 Forensic Center contracted with a national expert to review its clinical care assessments with the intent of improving 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; and
  b) every staff plays a role in achieving this goal, so 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 Physician Order Entry System (POES) project, and have developed a functioning order entry system for medications and ancillary orders. Other elements of the POES and associated projects are well underway.

Overall Reporting Patterns

From January 1, 2021, through December 31, 2021, a total of 14 events were reported and reviewed. Ten out of the 14 events occurred at one facility, and the remaining four were dispersed between two other facilities. There were no PSA-related events at the Ann Klein Forensic Center in 2020. The events consisted of 13 suicide attempts in 2021 (an 86% increase from 2020) and one major assault.

Focus on Specific Events

Attempted Suicides

There was a total of 13 suicide attempts in 2021. Nine involved seven female patients and two male patients.

Ten suicide attempts occurred at the psychiatric hospital. Of the 10 suicide attempts, four of the six patients had two suicide attempts and accounted for 80% (8/10) in 2021.

Four events involved patients tying objects around their necks, such as an article of clothing, elastic band curtain or bed sheet. Four events involved using a razor to lacerate the forearm area. Two events involved ingestion of a foreign object (pen/battery). One event involved

The Division of Behavioral Health Services (DBHS) 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 regional NJ state psychiatric hospitals and one forensic psychiatric center.

Division of Behavioral Health Services 2021 Report

using a piece of a clock to slash neck area. One event involved falling backwards on steps that resulted in a closed head injury with cerebral concussion and L1 vertebral fracture. One event involved an accidental drug overdose. Six events occurred in the bathroom, and five events occurred in a patient's bedroom, one event occurred outside of a transitional living unit on the hospital grounds (cottage) and one occurred in the stairway.

Root causes

- Team Factors: Failure to refer the patient to psychology for appropriate treatment recommendations as per Administrative Bulletin 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 the lack of documentation on the comprehensive individualized treatment in the medical record. Team Factors are the 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 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 the lack of documentation on the comprehensive individualized treatment in the medical record.
- Task Factors: 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 the lack of documentation in patient's individual session notes with a psychologist in the medical record.
- Task Factors: Failure in identifying patients under age 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 a Behavioral Support Plan regarding engaging in patient programming, as evidenced by lack of documentation in the medical record, and including on the comprehensive individualized treatment plan.
- Task Factors: Failure to provide coverage in the absence of a psychologist, as evidenced by lack of documentation on patient's individual sessions in the medical record.
- Task Factors: Failure in the process of conducting contraband searches of patients' bedrooms identified at risk for suicide, as evidenced by the seven events that occurred by patients using objects for self-harm.
- Other (Environmental) Factors: Failure to remove identified environmental risks, as evidenced by patients using objects found in the environment for self-harm and/or attempted suicide

Prevention strategies

- Revise assessment policy to follow the requirements included in Administrative Bulletin 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 the 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 procedures for placing patients on a specialized level of observation.
- Review and reeducate all nursing staff on policies and procedures regarding contraband checks.
- Revise transfer/admission criteria/protocol with other State psychiatric hospitals to include admissions accepted only prior to 2:00 p.m. on regular business days.

From January 1, 2021, through December 31, 2021, a total of 14 events were reported and reviewed. Ten out of the 14 events occurred at one facility, the remaining four were dispersed between two other facilities. There were no PSA-related events at the Ann Klein Forensic Center in 2020.

Division of Behavioral Health Services 2021 Report

- 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.

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

Prevention strategies

- Remediate 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 to assess competency of staff implementation of observation of patient at an increased risk of assault.
- Re-educate staff on policies/procedures and develop competencies involving identifying triggers and using proper de-escalation techniques with a patient at an increased risk of assault.

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Appendices

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 kernicterus 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.
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.
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

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.

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.
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.
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.
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)

Note: All event classifications above include the event type of 'other' to include events that do not meet the definitions of the specific event types delineated. See the data accumulated for care management-other, surgical-other, for examples within the report above.

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.
6. How the corrective action(s) will be monitored to assess their impact.

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.

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

Patient Safety Reporting System

Summary Report for 2021
Health Care Quality Assessment

Publishing Date of This Report: May 2025

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NJHealth
New Jersey Department of Health

Patient Safety Reporting System

Health Care Quality Assessment Summary Report for 2021

NJHealth
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