Department of Health
Division of Behavioral Health Services
Annual Patient Safety Act Report
January 1, 2023, through December 31, 2023

Implementation

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

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

During 2023, system initiatives/improvements that are expected to decrease the number of incidents reportable under the PSA in the hospitals included the following:

- The Division continued implementing various programs across the system that promote violence prevention through using active treatment and behavioral management skills.
- The Division staff is invited to attend the RCA meetings to assist and provide feedback during the process to decrease the needed to revise once completed and submitted.
- Each facility actively recruits qualified medical staff to fill any vacant positions and maintain the established standardized ratios.
- Each facility monitors possible risks and to improve the environment of care for patients by systematically assessing and mitigating ligature risks, making environmental improvements, installing hardware upgrades, and completing room renovations.
- Each facility requires that the patients it serves are receiving clinical care that reflects the latest, evidence-based behavioral healthcare.
- Each facility has reengineered its psychology services to increase the clinical treatment

Overall Reporting Patterns

From January 1, 2023, through December 31, 2023, a total of 9 events were reported and reviewed. The nine events were between three facilities and zero events occurred at the forensic center. The events consisted of; one Suicide Attempt, three Falls with Major Injury, two Unexpected Deaths, two Sexual Assaults, and one Elopement.

Focus on Specific Events

a. Attempted Suicides

There was one suicide attempt in 2023 an 88% decrease from year 2022. The event involved a 22-year-old female patient.

The suicide attempt occurred at one facility in 2023.

Root causes

- Team Factors: Communication failures amongst staff members of previous suicide attempt by the patient. This was evidenced by lack of documentation in the medical record.
- Team Factors: Failure to request a Clinical Review Team (CRT) for a comprehensive review of the patient and an alternative recommendation in the plan of care. This was also evidenced by a lack of documentation in the medical record.
- Environmental Factors: Failure to remove long sleeve clothing from the patient's room as a risk factor. This was evidenced by a patient using the object for self-harm and/or suicide attempt previously.

Prevention strategies

- Remediation of the Treatment Planning Administrator, Program Coordinators, and Treatment Team members occurred regarding appropriate planning for suicidal patient.
- In-service Treatment Teams provided appropriate communication to all staff regarding Patient's Rights/Denial of Rights approved for a patient
- In- service Nursing and Treatment Team members on communicating to all staff regarding Patient's Rights/Denial of Rights approved for a patient.
- Provide ongoing after an event and annual training to assess competency of staff. Observation of patient at an increased risk of suicide was also implemented.

b. Fall with Major Injury

There were three falls resulting in a major injury in 2023. The median age for the patients (two males and a female) was 58 years old, with no previous falls recorded and a low risk for falls as per the medical record.

Root causes:

- Environmental Factor: Designate drop off areas for patients during snow/ice weather conditions to decrease the risk of falls.

Prevention strategies:

- Remediation of the Assessment/Reassessment Policy to ensure the patient is thoroughly assessed when the patient is highly assaultive, refusing programming and/or exhibiting behaviors that are high for assaultive behavior.
- In-service Treatment Teams on the revised Clinical Review Process Policy emphasizing the requirement of requesting a Clinical Review for a patient who had been on precautions for more than 10 days.
- Implementation of including review of Patient Safety Plan (PSP) in the interim updates to identify triggers and assess availability and effectiveness of coping skills used during the incident.
- Provide ongoing annual and after an event training and assess competency of staff implementation of observation of patient at an increased risk of assault.
- Re-education of staff on policies/procedures and develop competencies involving identifying triggers and using proper de-escalation techniques with a of patient at an increased risk of assault.
- Re-education of staff on mock code drills and assess competency of staff response and actions taken.

c. Unexpected Death

There were two unexpected deaths in 2023. The median age for the patients (a male and a female) was 63.5 years old. The two unexpected deaths were determined to be unknown.

Root causes:

- Task Factor: Failure to adhere to the "Code Blue" policy and respond to changes in patient condition. This was noted as a lack of documentation in the medical record.
- Task Factor: Lack of clear guidelines for ongoing patient identification, appropriate monitoring, documentation in the medical record, and communication among staff members for high-risk patients.

Prevention strategies:

- Re-education of staff on policies/procedures. Develop competencies involving code blue medical emergencies and responses to changes in patients' medical conditions.
- Ongoing education for physicians regarding appropriate documentation of all medical diagnoses are documented on proper forms. All noncompliance triggers a Focused Professional Practice Evaluation (FPPE).

d. Sexual Assault

There were two sexual assaults in 2023. The median age for the patients (a male and a female) was 35.5 years old.

Root causes:

- Team Factor: Communication; Inadequate Initial Assessment.
- Task Factor: Inadequate treatment and management of sexually aggressive behavior as related to the Sexuality Policy.

Prevention strategies:

- Implementation of additional strategies to reduce, treat, and manage patient's sexual violence which includes the following:
    - Training of a sex offender treatment entitled, "The Good Lives" to all psychologist and social workers, designed to assist identified sex offenders. This patient education offers self-regulation and reduces their risk of recidivism.
    - All psychiatrists and Advanced Practice Nurses (APN's) were trained on the Medical Management of Hypersexual Behaviors.
    - The Transitional Group for Sex Offenders was re-instated. All patients who meet the criteria for this group have it listed on their Treatment Plans and are encouraged to attend.
    - All psychologists were trained on revised Violence Risk Assessment.

e. Elopement

There was one elopement in 2023. The event involved a 54-year-old male patient.

Root causes:

- Team Factors: Failure in communication among staff members of previous elopement attempt by the patient. This was noted by a lack of documentation on the medical record.

Prevention strategies:

- Incorporate the Elopement Risk Decision Tree into the Assessment/Reassessment policy.
- Include elopement risk in the Emergency Information Sheet if there is a prior history of elopement
- Place signage at all entry/exit doors to promote awareness of patient elopement risk.
- Conduct hospital-wide staff education on elopement risks and behaviors. Review observed behaviors and appropriate code activation during emergencies