Department of Health
Division of Behavioral Health Services
Annual Patient Safety Act Report
January 1, 2024, through December 31, 2024

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 2024, 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. This allows for systematically assessing and mitigating ligature risks, making environmental improvements, installing hardware upgrades, and completing room renovations.
- Each facility requires that the patients it serves recieve clinical care that reflects the latest, evidence-based behavioral healthcare.

Overall Reporting Patterns

From January 1, 2024, through December 31, 2024, a total of 10 events were reported and reviewed. The ten events were between the four facilities. The events consisted of; eight Suicide Attempts, and two Falls with Major Injury.

Focus on Specific Events

a. Attempted Suicides

There were eight suicide attempts in 2024 an 700% increase from year 2023. Three involved female patients and three male patients (one male had four events). The three female patients had a mean age of 23. The male patients mean age was 33.

The suicide attempts between three facilities and zero events occurred at the forensic center 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 in communication amongst staff members in identifying necessary suicide risk precaution interventions. Objectives for long-term and short-term goals for suicide or self-injurious behavior are to be documented. This was noted by a lack of documentation on the comprehensive individualized treatment in the medical record.
- Team Factors: Failure in communication amongst staff members of a previous suicide attempt by the patient. This was noted by a lack of documentation on the 24-hour report and medical record.

Prevention strategies

- Training for the Treatment Planning Administrator, Program Coordinators, and Treatment Team members occurred regarding appropriate planning for suicidal patients.
- Conduct annual training, as well as training after an event, to assess staff competency and implementation of patient observations for increased suicide risk.

b. Fall with Major Injury

There were two falls resulting in a major injury in 2024. The median age for the two female patients was 61 years old with no previous falls recorded with a low risk for falls as per the medical record.

The two falls resulting in a major injury occurred at one facility in 2024.

Root causes:

- Other Environmental Factor: Failure to have alternate flooring options on patient units including bedrooms such as rubber composite decreasing the risk of injury during a fall.

Prevention strategies:

- Annual training of staff and Program Coordinators in patient areas will be provided on the prevention of falls and environmental safety.
- Re-education of staff on policies/procedures and develop competencies involving safety concerns with morning briefings, for handoffs at shift change, and updates of environmental safety issues.
- Re-educate nursing staff on the policy and fall scale as part of the annual fall assessment.
- Provide further training to staff on the Workplace Violence policy and fall prevention factors, specifically targeting those in direct patient care areas and programming.
- Training will be provided on proper patient footwear to prevent falls.
- Re-education of Engineering staff and the Safety Department the policy on pre-construction risk assessment (PCRA) to be conducted prior to all necessary construction projects. Relevant information is communicated to pertinent staff as needed.
- Establishing specific drop-off/pick-up areas that are routinely cleared by the Maintenance Department during snow/ice weather conditions.
- Training of drivers on the specific patient locations designated as drop-off/pick-up areas. These areas will be cleared and maintained during snow/ice conditions.