



Patient Safety Reporting System

*State of New Jersey
Department of Health*

Facility User Guide

Patient Safety Reporting Facility User Guide

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I. Introduction

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

Additional resources may be found on the Patient Safety website at: <http://nj.gov/health/ps/>. Program staff is also available to speak with you at: (609) 633-7759.

This document is a guide for facility users in using the Patient Safety Reporting System.

II. Logging In

Facility users will receive temporary access information from their Facility Admin User; Facility Admin Users will receive temporary access information from the Department of Health (DOH). All new users will use their temporary password to access the system for the first time. When the user accesses the system, they will be asked to create a secret word and reset their password. The secret word will be used if a user forgets their log in information.

After receiving your user name and temporary password, access the My New Jersey Network to register.

- Open a browser (internet) window.
- Enter the URL patientsafety.nj.gov
- Click on "Go To Register"



The screenshot shows the login page for the State of New Jersey Department of Health Patient Safety Reporting System. At the top left is the NJ Health logo. To its right, the text reads "State of New Jersey Department of Health Patient Safety Reporting System". Below this is a dark blue header with the text "Choose the Appropriate Login Option". There are two rows of options: the first row has the text "Click here to login to My New Jersey" and a button labeled "Registered Users"; the second row has the text "Click here to register for the Patient Safety Application" and a button labeled "Go To Register". At the bottom, there is a light blue footer containing the text "Department of Health", "Phone: (609) 633-7759", and "Confidential Fax: (609) 984-7707".

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- Enter all information using the user ID and password provided. The password provided is entered in the **One time user authorization key** box.
- Click “Submit Registration.”



State of New Jersey
Department of Health Patient Safety Reporting System

Registration Information

Business Name	<input type="text"/>
Contact Name	<input type="text"/>
Email Address	<input type="text"/>
Reenter Email Address	<input type="text"/>
User ID	<input type="text"/>
One time user authorization key	<input type="text"/>

Department of Health
P.O. Box 360, Trenton, NJ 08625-0360
Phone: (609) 633-7759
Confidential Fax: (609) 984-7707

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- Fill in Section B to create a “myNewJersey” account.
- Enter the user ID provided.
- Enter a new password; this will be your permanent password.
- Click “Link Patient Safety Reporting to My Account” button.

The screenshot shows a web interface with a red header bar containing three steps: 1. Request access to Patient Safety Reporting, 2. Link your Patient Safety Reporting service to your myNewJersey account, and 3. Use Patient Safety Reporting. Below the header, a text prompt asks the user to use the page to tell about their myNewJersey account by picking one of three choices. Choice A is for existing accounts, and Choice B is for new accounts. Choice B is highlighted with a black border. Below Choice B, there is a note that all items in B are required for new accounts.

1. Request access to Patient Safety Reporting 2. Link your Patient Safety Reporting service to your myNewJersey account 3. Use Patient Safety Reporting

Use this page to tell us about your myNewJersey account by picking one of the three choices below:

A. I already have a myNewJersey account. Link it to my DHSS Patient Safety Reporting information:

My Log On ID is and my password is

B. I don't have a myNewJersey account yet. I'll create a new one now and link it to my DHSS Patient Safety Reporting information:

Pick a Log On ID If you forget your password later, we'll ask you the following question. If you answer it correctly, we'll send a new password.

Pick a password Question you want us to ask

Retype your password Your answer

First name Email address

Last name Retype your email address

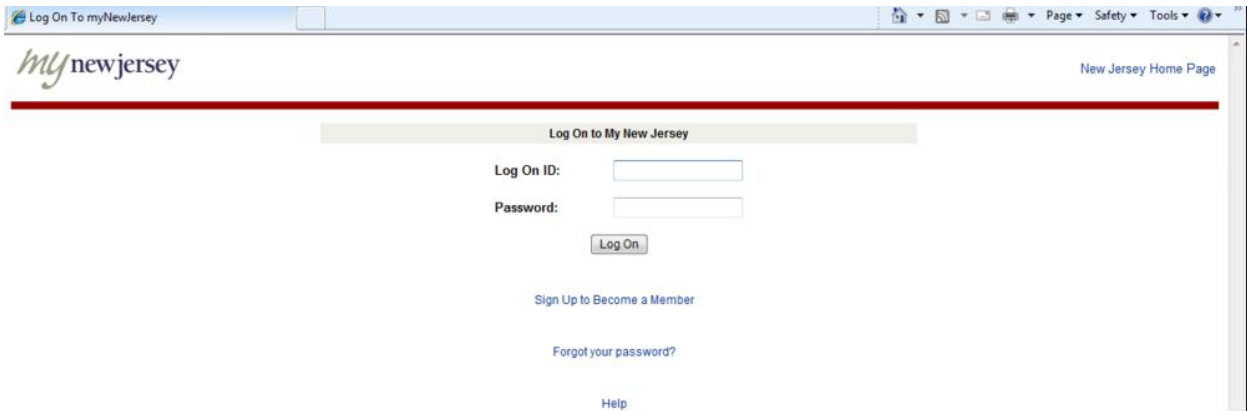
* All items in B are required if you're creating a new account. Your name and email address are filled in based on Step 1, but ignore them and use choice A instead if you already have an account.

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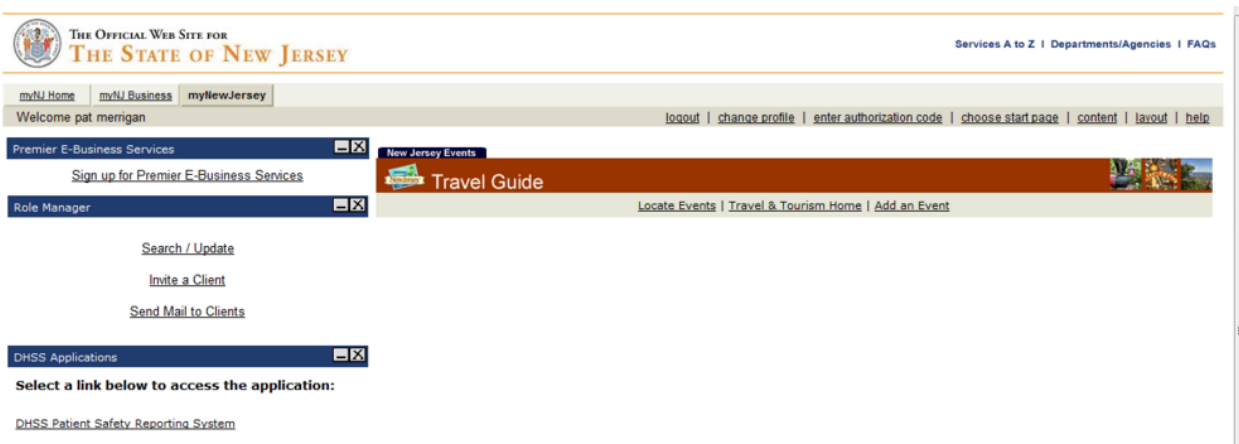
A. Established Users logging in through the My New Jersey Network

After the one time registration process is complete, use the My New Jersey network to access the Patient Safety System.

- Open a browser (internet) window
- Enter the URL for the My New Jersey network nj.gov



- Enter user name and password
- Click on “Log On”
- **NOTE: The system will automatically log out in 2 hours from this point. Please make sure to keep track of time and save all entries. The 2 hours does not depend on actively using the system.**



- Click on “DHSS Patient Safety Reporting System” link

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B. Managing Facility User Information — Used by Facility Administrative User (Facility Admin) Only

Each facility will have a designated Facility Administrative User (Facility Admin).

- Facility Admin users will be created by DOH.
- The Facility Admin will be responsible for assigning users and user roles for their organization.
- Notification on event reports will be done via email to the Facility Admin. It is critical that the email addresses for Facility Admins are kept up-to-date in the system.
- Notifications **will always** be made to the Facility Admins even for event reports submitted by other users within their facility.



State of New Jersey
Department of Health Patient Safety Reporting System

Logged in as: **facadminuser** [Home](#) [Add Event](#) [View Events](#) [Report](#) [User Maintenance](#)

User\Facility Maintenance

- This screen is used for maintaining users and facilities
- [Create New User](#)

Detail	User Name	Email	Is Approved	Create Date	Last Login Date
<input type="checkbox"/>			<input type="checkbox"/>		
<input checked="" type="checkbox"/> View	facAdminUser		<input checked="" type="checkbox"/>	3/22/2010	9/16/2010
<input checked="" type="checkbox"/> View	facReader	fa@aol.com	<input checked="" type="checkbox"/>	6/30/2010	6/30/2010
<input checked="" type="checkbox"/> View	facUser	pm@me	<input checked="" type="checkbox"/>	3/22/2010	7/20/2010
<input type="checkbox"/> View	zippy	pm@me	<input checked="" type="checkbox"/>	9/14/2010	9/15/2010

#	Name	Address	City	State	Zip	OPENDATE	CLOSEDDATE
New Delete	TEST FACILITY	33 WEST 33RD	FORT LEE				

1. To View Existing Users:

- Click on the “User Maintenance” link (*see graphic above*).
- Click on the plus [+] symbol to show the facilities assigned to the user.
- Click on the “View” link to display the user information.

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2. To Edit User Information:

- Click on the “Edit User Info” button (see graphic below).
- Edit information and click “Update.”

The screenshot shows a web form titled "User Information". It is divided into two main sections: "Roles" and "Main Info".

Roles:

- facAdmin
- rptWriter
- rptReader

Main Info:

User Name	zippy
Email	pm@me
Is Approved	<input checked="" type="checkbox"/>
Is Online	<input type="checkbox"/>
CreationDate	9/14/2010 12:30:05 PM
LastActivityDate	9/15/2010 9:22:30 AM
LastLoginDate	9/15/2010 9:22:30 AM

Below the "Main Info" table is an "Edit User Info" button. At the bottom right of the form are three buttons: "Approve User", "Delete User", and "Return".

3. To Delete User:

The “Delete User” button will remove the user from the system. Use the “Return” button to return to the previous screen (see graphic above).

4. To Add New User:

- Click on “User Maintenance.”
- Select “Create New User” link.
- Select the user roles. The majority of users will be assigned the roles of Report Reader (rptReader) and Report Writer (rptWriter).
 - **Report Reader:** User has access to read event report information for their assigned facility.
 - **Report Writer:** User has access to submit and edit event report information for their assigned facility.
 - **Facility Admin:** User receives automated event report correspondence for facility event reports; and manages other facility users.
- Enter user name and email address.
- Select one or more facilities for the user.
- Click on “Create User” button.

Assigning the user will generate a user name and temporary password which the Facility Admin will communicate to the new user. The user will now need to go through the self registration process to gain access to the “myNewJersey network” and the application as described in [Section II](#).

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III. What to Report

The following events must be reported:

Care Management

- **Medication Error**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with a medication error.
- **Wrong Blood Product**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
- **Maternal Labor**
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.
- **Hypoglycemia**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the health care facility.
- **Neonate Hyperbilirubinemia**
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.
- **Pressure Ulcers**
Stage III or IV pressure ulcers acquired after admission of the patient/resident to a health care facility. This does not include skin ulcers that develop as a result of an underlying vascular etiology, including arterial insufficiency, venous insufficiency and/or venous hypertension; or develop as a result of an underlying neuropathy, such as a diabetic neuropathy. Also excludes progression from Stage II to Stage III, if Stage II was recognized and documented upon admission.
- **Spinal**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with spinal manipulative therapy provided in a health care facility.
- **Other**
Other patient care management-related adverse preventable event resulting in patient death, loss of a body part, disability, or loss of bodily function lasting more than seven days or still present at the time of discharge not included within the definitions above.

Environmental

- **Electric Shock**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with any shock while being cared for in a health

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care facility. Excludes events involving planned treatments, such as electric counter shock (heart stimulation).

- **Wrong Gas**
Any incident in which a line designated for oxygen or other gas to be delivered to a patient/resident contains the wrong gas or is contaminated by toxic substances and results in patient/resident death, loss of body part, disability or loss of bodily function lasting more than seven days or still present at discharge.
- **Burn**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with a burn incurred from any source while in a health care facility.
- **Fall**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with a fall while in a health care facility.
- **Restraints**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with the use of restraints or bedrails while in a health care facility.
- **Other**
Other environmentally-related adverse preventable events resulting in patient/resident death, loss of a body part, disability, or loss of bodily function lasting more than seven days or still present at the time of discharge not included within the definitions above.

Product/Device

- **Contaminated Drugs/Devices/Biologics**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with use of generally detectable contaminated drugs, devices, or biologics provided by the health care facility, regardless of the source of contamination and/or product.
- **Malfunction**
Patient death, loss of body part, disability, or loss of bodily function lasting more than seven days or still present at discharge, associated with use or function of a device (including new single-use device or a reprocessed single-use device) in patient/resident care in which the device is used or functions other than as intended. This includes and is not limited to catheters, drains, and other specialized tubes, infusion pumps, and ventilators. Indicate whether the device was new or had been reprocessed.
- **Air Embolism**
Intravascular air embolism that occurs while the patient/resident is in the facility. However, this does not include deaths or disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
- **Other**
Other product or device-related adverse preventable event resulting in patient death, loss of a body part, disability, or loss of bodily function lasting more than seven days or still present at the time of discharge not included within the definitions above.

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Patient Protection

- **Infant Discharge**
Discharge of an infant to the wrong person, excluding patient/resident abductions.
- **Elopement**
Any patient death, loss of body part, disability, or loss of bodily function lasting more than seven days associated with patient/resident elopement.
- **Suicide\Attempted Suicide**
Patient suicide or attempted suicide while in a health care facility. However, this does not include deaths or disability resulting from self-inflicted injuries that were the reason for admission to the health care facility.
- **Other**
Other patient/resident protection-related adverse preventable event resulting in patient death, loss of a body part, disability, or loss of bodily function lasting more than seven days or still present at the time of discharge not included within the definitions above.

Surgical

- **Wrong Site**
Surgery initiated (whether or not completed) on the wrong body part.
- **Wrong Patient**
A surgical procedure (whether or not completed) intended for a different patient of the facility.
- **Wrong Procedure**
A wrong surgical procedure initiated (whether or not completed) on a patient.
- **Retained Foreign Object**
Retention of a foreign object in a patient after surgery, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.
- **Intra/Post-Op Coma or Death**
Intraoperative or postoperative (i.e., within 24 hours) coma, death or other serious preventable adverse event for an ASA Class I inpatient or for any ASA Class same-day surgery patient or outpatient. Includes all patient deaths, comas or other serious preventable adverse events in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.
- **Other**
Other surgery-related adverse preventable event resulting in patient death, loss of a body part, disability, or loss of bodily function lasting more than seven days or still present at the time of discharge not included within the definitions above.

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IV. When to Report

- The initial event information must be reported to the State through the web-based registry within **5 business days** of the event discovery date.
- An RCA must be prepared by the patient safety committee exploring the underlying causes and contributing factors to the event and must be submitted to DOH within **forty-five (45) days** from the date when the initial event report was submitted to DOH.
- What is the discovery date?
 - The discovery date is the date the facility first becomes aware of the occurrence of a reportable event. Example: a sponge is retained during a procedure (event date) but is not discovered until the patient returns to the emergency department two days later (discovery date).
 - The discovery date is **not** the date that risk management or administration becomes aware of the event, but the date that **any** person at the facility becomes aware of the occurrence.

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V. System Navigation

Navigating around the system is accomplished by using the main menu found on many screens. The main menu is located on the top right of the screen.

Welcome to the NJ Patient Safety Reporting System

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

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

Patient Safety Program staff are available to speak with you regarding clinical questions at: 609.633.7759.

Technical staff are available to speak with you regarding any technical issues related to the reporting system at: 651-659-1419.

Search for Report by Number

Search

Action Items

Initial Event Review

Report Number	Submit Date
20130469	5/31/2013
20130446	5/22/2013
20130475	6/3/2013
20130472	6/3/2013
20130449	5/23/2013

Page 1 of 4 (17 items) < < Prev [1] 2 3 4 Next > >

After logging into the system, the home page will appear. Use the menu located on the top right of the screen to select the section of the system to enter. Each of these options will be explained in detail in later sections.



- **Add Event** – enter a new event report.
- **View Events** – provides a list of all events for a facility; a list of events by status (e.g. under review by DOH; needs additional information from facility).
- **Resources** – provides a list of resources consulted for event reports. Also contains information required to be entered for all of the types of events.
- **User Maintenance** – only available to Facility Admins.

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Listing and Selecting Events – “View Events”

The View Events menu presents the events in the system. All events are listed for the current year with a status showing where the event is in the process. To select an event use the link under the VIEW column (*see below*).

Entering information into the boxes under the column heading will limit the list of events shown. In the screen displayed below, events are limited to 2010 and facilities that start with “test”. To list all events click on the “Clear” link in the VIEW column. This will remove all limitations on the list.

Logged in as: Ptraine3 [Home](#) [Resources](#) [Add Event](#) [View Events](#) [User Maintenance](#)

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

[Export to Excel](#)

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type	Event Description
Clear	2010	test				
Detail	2010	TEST FACILITY	2010-0090	RCA-DHSS Review	Environmental - Fall	Description
Detail	2010	TEST FACILITY	2010-0091	Closed	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0092	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0093	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0094	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0095	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0100	Event-Facility Edit	Surgical - Retained Foreign Object	Description

VI. Prior to Adding an Event

It is recommended that prior to entering a new event the user should check the Resources tab to understand the information required for the event type.

Logged in as: facilityWriterA [Home](#) [Resources](#) [Add Event](#) [View Events](#) [User Maintenance](#)

Report Menu: [Return to Detail](#)

Report Number: 2010-0100

[Information Consulted](#)
[Report Questions](#)

- Click on “Report Questions” under the Resources menu option.

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

The screenshot shows a user interface with two tabs: 'Initial Event' and 'RCA'. Below the tabs is a dropdown menu currently displaying 'Event Specific Questions'. The dropdown list includes the following options: 'Event Specific Questions', 'Care Management - Other', 'Care Management - Medication Error', 'Care Management - Pressure Ulcers', 'Environmental - Other', 'Environmental - Burn', 'Environmental - Fall', 'Environmental - Restraints', 'Product/Device - Malfunction', 'Patient Protection - Suicide\Attempted Suicide', 'Surgical - Retained Foreign Object', and 'Surgical - Intra/Post-Op Coma or Death'. To the right of the dropdown is a blue hyperlink labeled 'View Initial Event Questions'.

- Choose Initial Event or RCA tab for the questions pertaining to that section.
- Use the drop down list to select the type of event.
- Click on “View Initial Event Questions” to display the information required for the event type selected.

****DOH recommends that the initial event information and the RCA information be entered into a word processing document. This will allow the use of cut and paste to then transfer the information into the Patient Safety System. This will also speed the entry process into the system and help to alleviate the two hour time window for using the system for a given logon.***

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VII. How to Report an Event

Reporting of the event and RCA is categorized into four different steps within the system:

STEP I: Initial Event Information Submission by Facility

- Within **five (5) business days** of event discovery, the facility submits new event information. The new event information contains patient information, event information and event-specific information.
- DOH receives an automated email notification when the event is submitted.

STEP II: Event Review by DOH

- DOH is notified of event submission via email. DOH determines reportability.
- DOH selects reportability decision option generating an automatic email to Facility Admin User(s) describing the reportability decision and next steps.
- If the event is determined to be not reportable by DOH, the email message indicates reasons for non-reportability, the event is closed and no further action is required.
- If the event is determined to be reportable by DOH, the email message indicates the event is reportable and directs the facility to submit an RCA and generates a due date for submission of the RCA. The due date is 45 calendar days from event submission.
- If DOH requires more information for a decision, the email indicates that additional information is required by the facility. A link will be provided in the email to the patient safety system to access comments and edit the information that was previously provided.
- More information required:
 - The facility user resubmits event information to DOH.
 - DOH receives an automated email notification when the event is resubmitted.

STEP III: RCA Submission by Facility Including Causality Statement and Action Plan

- The facility user submits the RCA information within 45 days of initial event submission.
- DOH receives an automated email notification when the RCA is submitted.

STEP IV: RCA Review by DOH

- DOH reviews the RCA against review criteria.
- If the criteria are met, an automated notification is sent to the Facility Admin User(s) and the event is completed.
- If the criteria are not met, DOH provides comments in sections where additional information or clarification is needed.
- DOH sends a notification email to the Facility Admin User(s) stating that action is required by the facility. A link is provided for the facility user to edit the information that was submitted. The facility user will read the reviewer comments and make changes as appropriate.
- The facility user resubmits the RCA to DOH within 14 calendar days.

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A. Step 1: Enter Initial Event Information

Log-in to the system with user name and password. The main menu for the system is displayed.

The screenshot shows the main menu of the NJ Patient Safety Reporting System. At the top, it indicates the user is logged in as 'facAdminUser' and provides navigation links for Home, Add Event, View Events, and Report. The main heading is 'Welcome to the NJ Patient Safety Reporting System'. Below this, there is a paragraph of text explaining the system's purpose and a link to additional resources. On the right side, there are three sections: 'Action Items' with a sub-section for 'Initial Event Comments' containing a table with one row of data (Report Number: 2010-0061, Submit Date: 9/14/2010), 'RCA Comments' which is currently empty, and a 'Status Report' link.

Report Number	Submit Date
2010-0061	9/14/2010

Report Number	RCA Due Date
No data to display	

- Select "Add Event" from the menu bar on the top right of the screen (see graphic below).
- The list of Adverse Event Types will be displayed.
- Use the drop-down menu to select the Event Type. The Event Type cannot be changed after continuing to the next screen.
 - Click the "HERE" link to display a complete description of each event type.
 - Click the "Continue" button after the selection is made.

The screenshot shows the 'Select Event Type' screen. It features a navigation bar at the top with links for Home, Add Event, View Events, Report, and Admin. Below the navigation bar, there are instructions: '1. Select an Adverse Event Type' and '2. Click the "Continue" button'. A drop-down menu labeled 'Adverse event type:' is open, showing a list of event types: Care Management - Medication Error, Care Management - Wrong Blood Product, Care Management - Maternal Labor, Care Management - Hypoglycemia, Care Management - Neonate Hyperbilirubinemia, Care Management - Pressure Ulcers, and Care Management - Spinal. To the right of the drop-down menu, there is a link 'Click HERE for a complete list of Event Types' and a 'Continue>' button. At the bottom of the screen, there is contact information for the Department of Health and Senior Services.

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1. Patient Information

Fields are comprised of a combination of drop-down menus and text boxes.

- To complete a field with a drop-down menu, click on the arrow for that field, and then click on the appropriate selection.
- To complete a text box, type in the information.
- Use the scroll bar on the right to view the entire screen.
- All patient information fields are required, except Middle Name and Admitting ICD-9.
- County selection will only be used for New Jersey.
- Click on the question mark (?) button for additional information.
- Click the “Save/Next” button at the bottom of the screen to continue.

Home Add Event View Events Report Admin

Patient Information

Facility name: [Dropdown]
Patient type: Please Select [Dropdown]
First name: [Text Box]
Middle name: [Text Box]
Last name: [Text Box]
Patient billing number: [Text Box]
Medical record number: [Text Box]
Street Address: [Text Box]
City: [Text Box]
State: NJ [Dropdown]
County: Please Select [Dropdown]
Zip code: [Text Box]
Date of Birth: Month: Please Select [Dropdown] Day: Please Select [Dropdown] Year - (e.g. 2010): [Text Box]
Gender: Male Female
Race: ? [Dropdown]
Ethnicity: ? [Dropdown]
Admission date or date of ambulatory encounter (mm/dd/yyyy): [Text Box] Admitting ICD-9: [Text Box]
Main Reason for Admission (300 Char Limit): ? [Text Box]
300

*All Fields are Required
Save/Next

Department of Health and Senior Services
P.O. Box 360, Trenton, NJ 08625-0360
Phone: (609) 633-7759
Confidential Fax: (609) 984-7707

Note: The Patient Safety Reporting System **times-out after 2 hours**. If you do not complete the required fields and save the event information, the information that you have entered will be lost after two hours.

The time is based on how long you have been in the “my NewJersey” network. If entering information and the screen is not complete, enter placeholder information (e.g. TBD) to be able to save the screen. You can then return to the same event report at a later time and update any information that was previously omitted.

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2. Event Information

- Use the scroll bar on the right to view the entire screen.
- All information is required.
- Additional questions will be displayed based on the type of the event.
- Click the “Save/Next” button at the bottom of the screen to continue.

The Event Information screen follows on the next page:

Patient Safety Reporting Facility User Guide

Event Classification: Care Management - Pressure Ulcers

Event Information

Event date: Enter Event Time in Military (e.g 1800=6:00PM), if not known, enter 'unknown'

If event date is unknown, check here

Date event discovered: Discovery Time in Military (e.g 0200=2:00AM)

How was the event discovered?

In what unit did the event occur?

In what location did the event occur?

Location of injury (check at least one):

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Hip	<input type="checkbox"/> No Injury
<input type="checkbox"/> Ankle	<input type="checkbox"/> Lower Leg	<input type="checkbox"/> Neck
<input type="checkbox"/> Back/spine	<input type="checkbox"/> Pelvic Region	<input type="checkbox"/> Lower Arm
<input type="checkbox"/> Chest	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Systemic
<input type="checkbox"/> Foot	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Knee
<input type="checkbox"/> Forearm	<input type="checkbox"/> Upper Leg	<input type="checkbox"/> Elbow
<input type="checkbox"/> Hand	<input type="checkbox"/> Wrist	<input type="checkbox"/> Other
<input type="checkbox"/> Head	<input type="checkbox"/> Unresponsiveness	

Other:

Severity of injury (check at least one):

<input type="checkbox"/> Death	<input type="checkbox"/> Cast/immobilization
<input type="checkbox"/> Increased length of stay is anticipated	<input type="checkbox"/> Minor injury

Immediate clinical action(s) taken for patient:

1000 Characters left

Immediate corrective action(s) to prevent future similar events:

1000 Characters left

Location of pressure ulcer (check at least one):

<input type="checkbox"/> Occipital	<input type="checkbox"/> Heels
<input type="checkbox"/> Sacrum	<input type="checkbox"/> Other
<input type="checkbox"/> Buttocks	

Stage

Size of pressure ulcer:

Was this a device related pressure ulcer? Yes No

Was the patient or health care representative notified about the event within 24 hours of event discovery? Yes No

***All Fields are Required**

Patient Safety Reporting Facility User Guide

3. To Submit Event to DOH for Review:

- The patient and event information is displayed for review. Click on the “Edit” button to change any of the information entered.
- Click on the “Submit Event” option in the Report Menu bar to send the event to DOH for review.
- DOH will be notified via email of the event submission.

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

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

Initial Event Root Cause Action

Report Menu: [Patient Info](#) [Event Info](#) [→ Submit Event](#)

Report Number:2010-0035

Event Classification:Care Management - Pressure Ulcers

Patient Information

4. To Save the Event and Not Submit to DOH

To save the event and NOT submit the event to DOH, use the menu bar at the top of the screen to navigate away from the event. Select a main menu bar option such as “Home”.

 [Add Event](#) [View Events](#) [Resources](#) [User Maintenance](#)

To return to the event at a later time use the “View Events” option as shown in this [section](#).

When an event is selected, use the Report Menu to navigate the event. The red arrow in the Report Menu will indicate where the event report is in the process. In this example, Event Info would be the next step in the entry process.

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

Initial Event Root Cause Action

Report Menu: [Patient Info](#) [Event Info](#)

Report Number: 2010-0026

Event Classification: Surgical - Intra/Post-Op Coma or Death

Patient Information

[Edit](#)

B. Step II: Event Review by DOH

DOH will review the event information and determine the next action of the event report. The Facility Admin will be notified via email of the decision and next steps. Options for next steps include:

- No further reporting action needed for the State.
- Additional information is needed to determine reportability.
- RCA required.
- Explanation of information is needed.

1. Additional Information Needed for Review

If additional Information is needed, DOH will send an email with a description of the information needed. The facility can view the comments made about the event report and update the information before re-submitting the event to DOH.

- When entering the reporting system, under the Action Items heading on the home page, click on the Report Number link to display the event.

Welcome to the NJ Patient Safety Reporting System

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

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

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

Action Items	
Initial Event Comments	
Report Number	Submit Date
2010-0061	9/14/2010
RCA Comments	
Report Number	RCA Due Date
No data to display	
Status Report	
Status Report	

- Under each section there will be an indicator if comments were made for that section. The partial screen below shows how to access comments for the Event Information section.
- Click on the "Comments" link to view the reviewer's comments.

Patient Safety Reporting Facility User Guide

- Click the “Edit” link to make changes in order to address the reviewer’s comments for that section.
- When completed with addressing comments, save the changes and click on the “Submit Event” option to resend the event to DOH as shown in this [graphic](#).
- There may be more than one cycle of responding to comments for the initial review process if the reviewer needs additional information to complete the event review.

Event Information			
Edit		Comments	
Event date:	9/13/2010	Event Time:	8:00 AM
Date event discovered:	9/13/2010	Discover Time:	4:30 PM
How was the event discovered?	Report by staff/physician		
In what unit did the event occur?	Operating Room		
In what location did the event occur?	NA		
Location of injury (check at least one):	Shoulder		

2. Submit RCA for Less Serious or Near Miss Event

If the determination is made that an event is less serious or near miss than an RCA can be submitted for those events. The regulations require the facility's patient safety committee to conduct annually at least one RCA for a less serious preventable adverse event or a near miss that is not subject to the mandatory reporting. Contact DOH to provide an RCA for these type of events. The steps for providing an RCA will be the same as for those events requiring an RCA.

3. Explanation Needed for Event Report Without Changes

DOH may request an explanation of some of the event report information. The facility will receive an email indicating that a further explanation is needed. The event report cannot be updated and the response to the email will be made in the system.

Events reports that need an explanation will be displayed on the home page when entering the system. See the screen displayed below:

Patient Safety Reporting Facility User Guide

Logged in as: facilityWriterA [Home](#) [Resources](#) [Add Event](#) [View Events](#) [User Maintenance](#)

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Action Items

Initial Event Comments	
Report Number	Submit Date
No data to display	

RCA Comments	
Report Number	RCA Due Date
No data to display	

Other Communications		
Report Number	Respond	Comment
20103012	Respond	Please explain how gas delivery will be checked. Report Number:20103012

- Click on “Respond” to enter a response and then send response to DOH:

Logged in as: facilityWriterA [Home](#) [Resources](#) [Add Event](#) [View Events](#) [User Maintenance](#)

Welcome to the NJ Patient Safety Reporting System

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

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

Action Items

Initial Event Comments	
Report Number	Submit Date
No data to display	

RCA Comments	
Report Number	RCA Due Date
No data to display	

Other Communications		
Report Number	Respond	Comment
20103012	Respond	Please explain how gas delivery will be checked. Report Number:20103012

Respond to Comment

Reviewer Comments	
Please explain how gas delivery will be checked. Report Number:20103012	
<input type="text"/>	
<input type="button" value="Cancel/Close"/>	<input type="button" value="Save"/>

Click and drag to expand

Report Number	Respond	Comment
20103012	Respond	checked. Report

- Enter a response.
- Click on “Save” to send the response to DOH.

NOTE: The event report is still being reviewed by DOH and cannot be updated.

Patient Safety Reporting Facility User Guide

C. Step III: RCA Submission by Facility including Causality Statement and Action Plan

If the DOH review of the initial event information determines that an RCA is required for the event, the facility will complete the RCA section of the event.

- To begin the RCA entry process, click on “View Events” .
- Use the drop down for Event Status to select “RCA – Facility Edit” for the event status column.
- Events requiring an RCA will be displayed.

Logged in as: **facilityWriterA** [Home](#) [Resources](#) [Add Event](#) [View Events](#) [User Maintenance](#)

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

[Export to Excel](#)

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type
Clear	2010				(Non blanks)
Detail	2010	TEST FACILITY	20103004	Closed	Closed
Detail	2010	TEST FACILITY	20103005	Closed	Event-Facility Edit
Detail	2010	TEST FACILITY	20103006	Closed	RCA-DHSS Review
Detail	2010	TEST FACILITY	20103007	RCA-DHSS Review	RCA-Facility Edit
Detail	2010	TEST FACILITY	20103008	RCA-Facility Edit	Care Management - Pressure Ulcers
Detail	2010	TEST FACILITY	20103009	RCA-DHSS Review	Environmental - Electric Shock
Detail	2010	TEST FACILITY	20103010	RCA-DHSS Review	Care Management - Spinal
Detail	2010	TEST FACILITY	20103011	RCA-Facility Edit	Care Management - Other
Detail	2010	TEST FACILITY	20103011	RCA-Facility Edit	Environmental - Electric Shock

- Click on “Detail” for the event to begin the RCA entry process.
- Screen displayed below is shown:

Logged in as: **facAdminUser** [Home](#) [Add Event](#) [View Events](#) [Report](#)

- Click on comments link(s) below to read DHSS comments if there is a comment for that section.
- Click on “edit” as appropriate to make changes in response to comments.
- When all comments have been addressed click on “submit” to re-submit to DHSS.

Initial Event [Root Cause Analysis](#)

Report Menu: [General Info](#)

Report Number:2010-0061

Event Classification:Surgical - Wrong Site

- Click on “General Info” to begin the RCA entry process. This first section of the RCA entry process may also be accessed from the Report Menu.
- The Report Menu can be used to select the specific section of the RCA to be completed at a later time. The Report Menu is shown below.

Patient Safety Reporting Facility User Guide

Report Menu

1. RCA: General Information

- Complete all fields in this section – all fields are required.
- Click on “Save/Next” to save the completed information and move to the next section.

The screenshot shows a web form titled "RCA: General Information". At the top, there is a "Report Menu" section with a "Return to Detail" button. Below this, the "Report Number" is 2010-0035 and the "Event Classification" is "Care Management - Pressure Ulcers". The main form area contains the following questions and input fields:

- 1. List the titles only of the individuals on the RCA Team (500 Char Limit): [Text area]
- 2. How many similar events has your facility had in the previous 3 years? (numbers only): [Number input field with "0" and up/down arrows]
- a. What changes did the organization make in response to these previous events? (500 Char Limit): [Text area]
- b. How are you tracking the effectiveness of these changes? (500 Char Limit): [Text area]
- c. What procedures are in place to ensure that the facility knows about all the reportable events? (500 Char Limit): [Text area]

At the bottom right of the form, there is a note: "*All Fields are Required" and a "Save/Next" button.

2. RCA: Facts of the Event

- Complete all fields in this section or enter “NA” if not applicable – all fields are required.
- The RCA Facts of the Event screen can be saved when partially completed. However, all fields must be completed prior to submitting the event to DOH for review.
- Click on “Save/Next” at the bottom of the screen to save the completed information and move to the next section.

Patient Safety Reporting Facility User Guide

RCA: Facts of the Event	
1. Facts of the Event (Answer all that apply or enter 'NA' where not applicable):	
a. Patient's past medical history (500 Char Limit):	<input type="text"/>
b. Clinical status of patient prior to event (500 Char Limit):	<input type="text"/>
c. Clinical status of patient after the event (500 Char Limit):	<input type="text"/>
d. Patient's course in facility prior to event (i.e. surgery, transfer to ICU) (500 Char Limit):	<input type="text"/>
e. Patient's course in facility after event (500 Char Limit):	<input type="text"/>
f. Medication at home (500 Char Limit):	<input type="text"/>
g. Medication at facility (500 Char Limit):	<input type="text"/>
h. Other factors contributing to the event (500 Char Limit):	<input type="text"/>

If all fields are not completed and the RCA is submitted, an error message will be displayed as shown below. Return to the Facts of the Event screen to complete all entries.

Invalid Submission

- Please return to the RCA:Facts of the Event and complete all fields
- Enter 'NA' where not applicable
- Click [HERE](#) to return to the RCA: Facts of the Event

3. RCA: Specific Questions

- Complete all fields in this section — all fields are required.
- This screen contains questions based on the type of event being reported.
- Click on “Save/Next” to save the completed information and move to the next section.

Patient Safety Reporting Facility User Guide

RCA Specific Questions		
1. Pressure ulcer risk assessment (Braden) documented on admission and daily?	<input type="radio"/> Yes <input type="radio"/> No	
2. Skin inspection was documented on admission and daily?	<input type="radio"/> Yes <input type="radio"/> No	
3. Removal of devices such as stockings and splints were documented each shift?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA	
4. Did staff use the documented care plan to assess risk and plan appropriate interventions?	<input type="radio"/> Yes <input type="radio"/> No	
5. Patient Characteristics (check at least one):		
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Smoker	<input type="checkbox"/> Sepsis
<input type="checkbox"/> Morbid obesity (BMI =>40)	<input type="checkbox"/> Kidney failure	<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Clinically malnourished	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Receiving palliative or comfort care
<input type="checkbox"/> Incontinent	<input type="checkbox"/> Respiratory failure	<input type="checkbox"/> History of previous pressure ulcer
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Neurological/Neuromuscular condition	
6. Patients with impaired sensory perception, mobility, and activity as defined by the Braden scale had the following interventions documented:		
• Repositioning q 2hrs	<input type="radio"/> Yes <input type="radio"/> No	
• Heels off of bed	<input type="radio"/> Yes <input type="radio"/> No	
• Appropriate support surfaces (mattresses, chair cushions) for pressure redistribution	<input type="radio"/> Yes <input type="radio"/> No	
7. Patients with friction/shear risk as defined by the Braden scale had HOB 30 degrees or less documented (if medically contraindicated, there was an MD order and an alternative plan was documented to prevent shear injury)?	<input type="radio"/> Yes <input type="radio"/> No	
8. Did patient refuse repositioning?	<input type="radio"/> Yes <input type="radio"/> No	

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4. RCA: Root Cause/Causality Statement

- Select a single root cause and enter the corresponding causality statement.
 - More than one root cause can be associated with an RCA. Additional root causes can be added after completion of the first root cause and associated action plan(s) and monitoring.
- When the entry for this screen is complete, click the “Save/Next” button to continue to the action plan for this root cause.

Report Menu: [Return to RCA Summary](#) [Return to Detail](#)

Report Number: 20120055

Event Classification: Environmental - Fall

RCA: Root Cause/Causality Statement

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

[Using the Five Rules of Causation](#)

1. Root Cause Categories:

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

If 'Other', please identify Root Cause

2. Causality Statement:

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5. RCA: Action Plan

Multiple action plans can be entered for each root cause. How to enter additional action plans will be described in the next [section](#). An action plan can only have one methodology specified. If an action plan involves more than one methodology (i.e. chart review and observational audits), each methodology should be entered as a separate action plan. This will allow for entry of multiple methodologies with corresponding goals and thresholds.

- The causality statement is displayed for reference.
- Click on the question mark “?” button for additional information.
- Complete all entries on the screen for the action plan.
- If more than one methodology is to be used, a separate action plan is required for each methodology.
 - See the next [section](#) for instructions on adding a new action plan.
- Click “Save/Next” at the bottom of the screen

Report Number:20103008

Event Classification:Environmental - Electric Shock

Causality Statement:*The lack of a consistent process for medical order transcription has the potential for medical transcription error and allows for barriers.*

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

RCA: Action Plan

1. Action Plan:
2000 Characters left

2. Monitoring Strategy:
2000 Characters left

3. Methodology

6. Edit/Add Root Cause Findings

- To add an action plan for the root cause:
 - Click on the plus (+) symbol next to the root cause to display the action plan.
 - Select “Add Action Plan”.
 - Complete action plan fields for the new action plan.
 - Click “Save/Next”.
- To add an additional root cause finding:
 - Click on the “Add Root Cause” button.
 - Complete the steps for entering a root cause.
 - Complete the steps for entering an action plan(s) for the root cause. Each root cause must have a least one action plan associated with it.

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- Select “Add Action Plan.”
- Complete action plan fields for the new action plan.

Report Menu: [Return to Detail](#)

Report Number: 20110007


Event Classification: Environmental - Fall

Use this section to edit/add root cause findings

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

[Continue to RCA Additional Questions \(Required\)](#)

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
	Edit	Delete	Equipment maintenance/management	A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.

7. RCA Additional Questions

- When the root cause and action plan entries are complete:
 - Click “Continue to RCA Additional Questions” to complete the RCA entry process.
 - Complete all fields in this section – all fields are required.
 - Click on “Save/Next” to save the completed information.

RCA Additional Questions

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

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

Other:

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

<input type="checkbox"/> Loss of limb(s)	<input type="checkbox"/> Visit to Emergency Department
<input type="checkbox"/> Loss of digit(s)	<input type="checkbox"/> Hospital admission
<input checked="" type="checkbox"/> Loss of body part(s)	<input type="checkbox"/> Transfer to more intensive level of care
<input type="checkbox"/> Loss of organ(s)	<input type="checkbox"/> Increased length of stay

8. Submitting RCA to DOH for Review

Patient Safety Reporting Facility User Guide

- Prior to submission, any section of the RCA can be accessed by using the Report Menu options. Click on “Edit” to update that section of the RCA. Click “Save/Next” to save changes. This process is described in this [section](#).
- To submit the RCA, click on the “Submit RCA” option as shown on the following screen.
- DOH will be notified that the RCA was submitted and ready for review.

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

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

Initial Event Root Cause Analysis

Report Menu: [General Info](#) [Facts of the Event](#) [RCA Questions](#) [Root Cause\Action Plan](#) [Additional Questions](#) [→ Submit RCA](#)

Report Number:2010-0061

Event Classification:Surgical - Wrong Site

RCA: General Information

[Edit](#)

D. Step IV: RCA Review by DOH

DOH will review the RCA information and determine the next action of the RCA process. The Facility Admin will be notified via email of the decision and next steps. There may be more than one cycle for the RCA review process if DOH needs additional information to accept the RCA as complete.

Options for next steps include:

- RCA Comments – additional information needed.
- Event Complete – No additional action needed.

If additional information is needed:

- When entering the reporting system, under Action Items on home page :
 - Click on the link under “Report Number” to display the event.

Action Items	
Initial Event Comments	
Report Number	Submit Date
No data to display	
RCA Comments	
Report Number	RCA Due Date
2010-0061	10/29/2010
Status Report	
Status Report	

Under each section there will be an indicator if comments were made for that section.

- Click on the “Comments” link to view the reviewer’s comments.
- Click the “Edit” link to make changes to address the reviewer’s comments for that section.
- Save the changes and click on the “Submit Event” option to resend the RCA to DOH.

Patient Safety Reporting Facility User Guide

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

Initial Event	Root Cause Analysis
Report Menu:	General Info Facts of Event Root Cause Action Plan Additional Questions → Submit RCA
Report Number:	20103023
Event Classification:	Care Management - Medication Error Print Screen
RCA: General Information	

[Edit](#)

[Comments](#)

1. List the titles only of the individuals on the RCA Team:	<i>Risk Manager, Quality Management Specialist, Quality Manager for Nursing, Associate Program Director of Internal Medicine Residency Program, Attending Physician, Consulting Endocrinologist, Diabetes Educator, Diabetes Advanced Practice Nurse, Nursing Director of Critical Care, Nurse Manager of Critical Care and Internal Medicine Resident and nurses involved in the care of the patient.</i>
2. How many similar events has your facility had in the previous 3 years? (numbers only)	1
a. What changes did the organization make in response to these previous events?	<i>The action plan included revision of current hypoglycemic standing order and multidisciplinary education plan for management of the diabetic patient.</i>
b. How are you tracking the effectiveness of these changes?	<i>We stopped monitoring because we had achieved 100% compliance.</i>
c. What procedures are in place to ensure that the facility knows about all the reportable events?	<i>We monitor everything.</i>

E. Providing Additional Documentation for Event and/or RCA

At any time during the event reporting process, additional documentation can be attached to the event/RCA. Documents must be attached to the event report based on the report number. The use of attachments applies to a single event/RCA. DOH must be contacted for each event/RCA that requires attachments.

- Contact DOH and provide the report number and request to add attachments.
- When DOH confirms that attachments can be made through an email or phone call then enter the Patient Safety System.
- Use the "View Events" menu option to access the event report.
- Enter the report number in the box under the Report Number heading.
- Click on "Detail" to access the event report.

Patient Safety Reporting Facility User Guide

Logged in as: Ptrainee3 [Home](#) [Resources](#) [Add Event](#) [View Events](#) [User Maintenance](#)

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

[Export to Excel](#)

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type	Event Description
Clear	2010	test				
Detail	2010	TEST FACILITY	2010-0090	RCA-DHSS Review	Environmental - Fall	Description
Detail	2010	TEST FACILITY	2010-0091	Closed	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0092	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0093	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0094	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0095	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0100	Event-Facility Edit	Surgical - Retained Foreign Object	Description

An attachment option is available for the event/RCA as shown below.

- Click on “Upload Supporting Documentation” to attach documents to the event.

Logged in as: sfacility [Home](#) [Add Event](#) [View Events](#) [Resources](#) [User Maintenance](#)

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

- [Upload Supporting Documentation](#)

Initial Event [Root Cause Analysis](#)

Report Menu: [Patient Info](#) → [Event Info](#)

Report Number:20103029

The next screen provides the ability to browse to the document.

- Click on the “Upload” button once the document is found.
- Multiple documents can be attached.

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Report Menu: [Return to Detail](#)

Report Number: 2010-0066

Event Classification: Care Management - Medication Error

Upload File

[Upload](#)

Current Files

Delete	View Doc	Date Uploaded	File Name	Uploaded By:
No data to display				

Patient Safety Reporting Facility User Guide

VIII. Event Tracking

In addition to the Action Items listed on the Home Screen, the progress of all event reports can be viewed by using the “View Events” option.

- Click on the “View Events” option from the main menu on the top of the screen.
- To access an event or RCA, click on the link in the View column for that event.
- To limit the list enter a report number in the box under the Report Number column.
- Use the drop down arrows to select Event Status or Event Type

Logged in as: dhssadmin [Home](#) [Resources](#) [Add Event](#) [View Events](#) [Report](#) [Admin](#)

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

[Export to Excel](#)

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type	Event Description
Clear	2010					
Detail	2010	ACUITY SPECIALTY HOSPITAL OF NEW JERSEY	2010-0080	Event-Facility Edit	Care Management - Wrong Blood Product	Description
Detail	2010	ADVANCED SURGERY CENTER, LLC	2010-0076	Event-Facility Edit	Surgical - Retained Foreign Object	Description
Detail	2010	OUR LADY OF LOURDES MEDICAL CENTER	2010-0066	RCA-DHSS Review	Care Management - Medication Error	Description
Detail	2010	TEST FACILITY	2010-0067	Event-DHSS Review	Surgical - Intra/Post-Op Coma or Death	Description
Detail	2010	HACKETTSTOWN REGIONAL MEDICAL CENTER	2010-0068	RCA-Facility Edit	Environmental - Fall	Description
Detail	2010	HOLY NAME MEDICAL CENTER	2010-0069	Event-DHSS Review	Care Management - Pressure Ulcers	Description

IX. Completed Events

When an event report and RCA has been determined to be complete, DOH will send an email notification that no further action is required. This completes the process for the event report and RCA.

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X. Ad-Hoc Reports

Custom reports can be retrieved and saved in the system.

- To create custom reports use the View Events menu option.

Logged in as: dhssadmin [Home](#) [Resources](#) [Add Event](#) [View Events](#) [Report](#) [Admin](#)

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

Export to Excel

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type	Event Description
Clear	2010					
Detail	2010	ACUITY SPECIALTY HOSPITAL OF NEW JERSEY	2010-0080	Event-Facility Edit	Care Management - Wrong Blood Product	Description

This will display a default report which can be changed and saved for future use.

- To filter the information provided on the reports, use the entry box or drop-down for each column of data.
 - For example, the report below is limited to 2010 data.

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

• [Show Customization Window](#) - Use the 'Customization Window' to add/remove fields from the grid.

• [Saved Reports](#) - Click to view your saved reports.

• [Save a Report](#) - Click to save the report.

Export to Excel

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type	Event Description
Clear	2010					
Detail	2010	MEDICAL CENTER	2010-0066	Event-Facility Edit	Care Management - Medication Error	Description
Detail	2010	TEST FACILITY	2010-0067	Event-DHSS Review	Surgical - Intra/Post-Op Coma or Death	Description

[Report Year] Equals '2010' [Clear](#)

Patient Safety Reporting Facility User Guide

- To further define the filter, click on the key symbol to select the operation (equal to, greater than) for the filter

Export to Excel

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type
Clear	2010				
Detail	2010		3004	Closed	Care Management - Medication Error
Detail	2010		3005	Closed	Care Management - Wrong Blood Product
Detail	2010		3006	Closed	Care Management - Maternal Labor
Detail	2010		3007	RCA-DHSS Review	Care Management - Pressure Ulcers
Detail	2010		3008	RCA-Facility Edit	Environmental - Electric Shock
Detail	2010		3009	RCA-DHSS Review	Care Management - Spinal
Detail	2010	TEST FACILITY	20103010	RCA-DHSS Review	Care Management - Other
Detail	2010	TEST FACILITY	20103011	RCA-Facility Edit	Environmental - Electric Shock
Detail	2010	TEST FACILITY	20103012	RCA-Facility Edit	Environmental - Wrong Gas
Detail	2010	TEST FACILITY	20103013	Event-DHSS Review	Care Management - Hypoglycemia

- To remove or add columns, click on the “Show Customization Window” option to display a list of fields available to add to the report.

Logged in as: **facAdminUser** [Home](#) [Add Event](#) [View Events](#) [Report](#) [User Maintenance](#)
[Logout](#)

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

Export to Excel

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Date Discover	Event
Clear		TEST FACILITY			
Detail	2010	TEST FACILITY	2010-0067	9/10/2010	Surgic or De

[Facility Name] Equals 'TEST FACILITY'

Field Chooser

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

1. To add a column:

- Click on the field desired and while holding down the mouse button, drag the field into the report.
 - The Admission Through field is being added to this report.

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Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Admission Through	Event Status	Event Type	Event Description
Clear	2010						
Detail	2010	MEDICAL CENTER	2010-0066		Event-Facility Edit	Care Management Medication Error	
Detail	2010	TEST FACILITY	2010-0067		Event-DHSS Review	Surgical - Intra/Post-Op Coma or Death	
Detail	2010	CENTER MEDICAL	2010-0068		Event-Facility Edit	Environmental -	

[Report Year] Equals '2010'

Field Chooser
Admission Through
Admit Date
Ethnicity
Event Date
Event Date Discover

2. To remove a column:

- Click on the column name and drag it to the field chooser list.
 - The Facility Name column was removed from this report and now appears in the field chooser list.

Drag a column header here to group by that column

View	Report Year	Report Number	Admission Through	Event Status	Event Type	Event Description
Clear	2010					
Detail	2010	2010-0066	Direct Admission		Event-Facility Edit	Care Management Medication Error
Detail	2010	2010-0067			Event-DHSS Review	Surgical - Intra/Post-Op Coma or Death
Detail	2010	2010-0068	Transfer from LTC or Assisted Living		Event-Facility Edit	Environmental -

[Report Year] Equals '2010'

Field Chooser
Event Time
Facility Name
How Event Discover
How Event Discovered
ICD9

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3. To Save a Report:

- Click on the “Save a Report” option.
- Enter a name for the report and click “Save Report.”

• You can sort the data by clicking on the column headers
• [Show Customization Window](#)- Use the 'Customization Window' to add/remove fields from the grid.
• [Saved Reports](#)
• [Save a Report](#)

Export to Excel

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Date Discover	Event Type
Clear	<input type="text"/>	TEST FACILITY	<input type="text"/>	<input type="text"/>	<input type="text"/>
Detail	2010	TEST FACILITY	2010-0067	9/10/2010	Surgical - Intra/Post-Op Coma or Death

4. Accessing Saved Reports

- To access the report at a later time, click on the “Saved Reports” option.
- A list of saved reports will be shown; click on the desired report to access.

Logged in as: sfacility [Home](#) [Add Event](#) [View Events](#) [Resources](#) [User Maintenance](#)

• You can sort the data by clicking on the column headers
• [Show Customization Window](#)- Use the 'Customization Window' to add/remove fields from the grid.
• [Saved Reports](#)
• [Save a Report](#)

Export to Excel

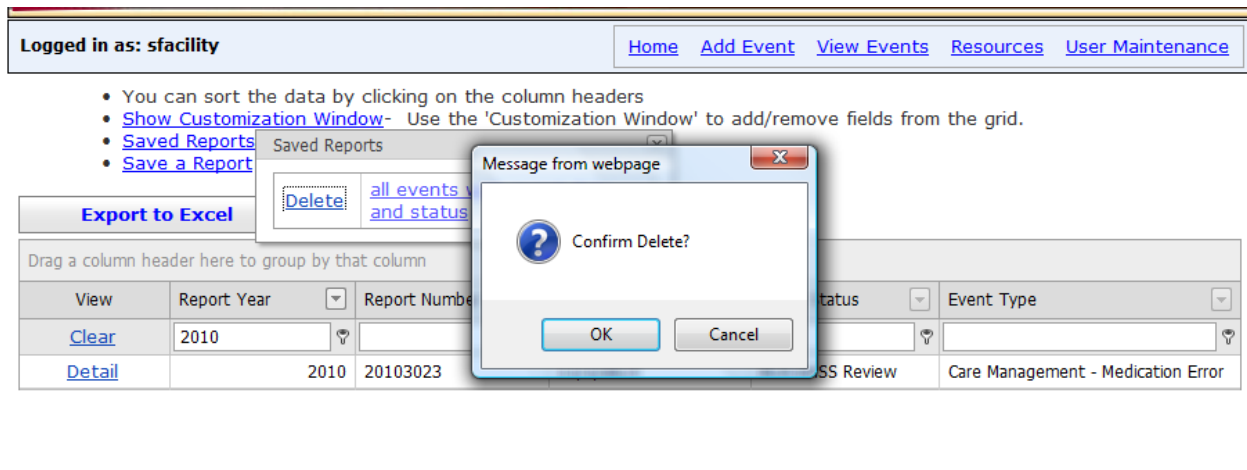
Drag a column header here to group by that column

View	Report Year	Report Number	Event Date	Event Status	Event Type
Clear	2010	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Detail	2010	20103023	11/1/2010	RCA-DHSS Review	Care Management - Medication Error

5. Deleting Saved Reports

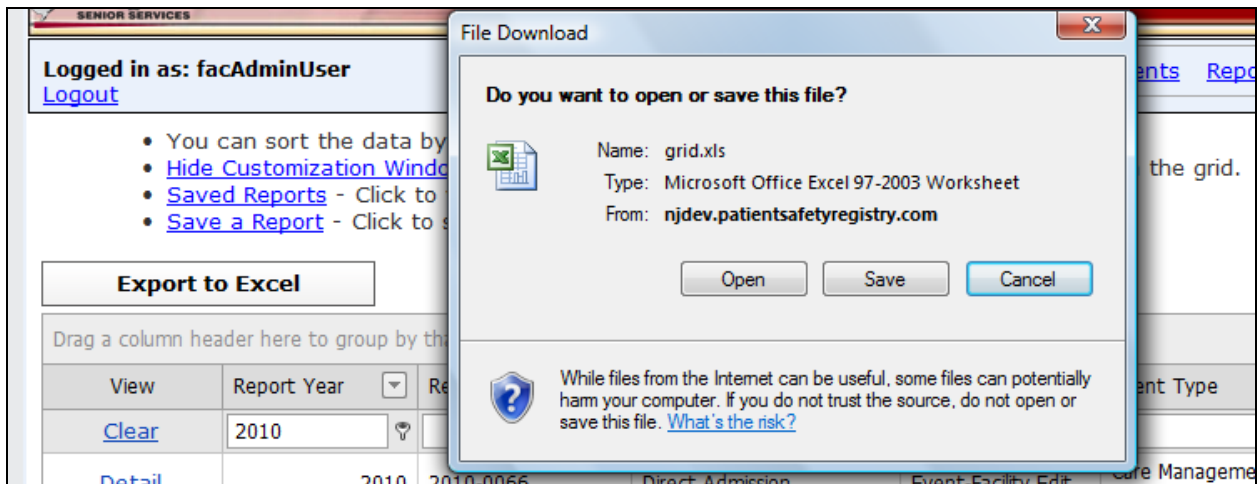
- Use the delete button to remove the report from the saved reports.
- Confirmation of the delete will be displayed

Patient Safety Reporting Facility User Guide



6. To Export Report Information

- To save the information in the report, use the "Export to Excel" option.
 - This will open a Windows download dialog box.
- Click on "Save" and specify where to save the information.



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XI. Frequently Asked Questions

General Questions

- 🔗 [What to Report?](#)
- 🔗 [What is a preventable event?](#)
- 🔗 [The event did not cause actual harm to the patient. Do I still need to report?](#)
- 🔗 [Does this event need a report?](#)
- 🔗 [What if our facility thinks the event is not-preventable?](#)
- 🔗 [What if the event is rare and unusual?](#)
- 🔗 [What types of events should be reported as Less Serious or Near Misses?](#)
- 🔗 [How do I report events?](#)
- 🔗 [When should I report?](#)
- 🔗 [Where do I report suspected criminal activity?](#)
- 🔗 [Where should I report interruption of services?](#)
- 🔗 [Where do I report communicable and infectious diseases?](#)

Specific Event Type Questions

- 🔗 [What if we discover a retained object left at another facility?](#)
- 🔗 [What types of injury from falls should be reported?](#)
- 🔗 [What types of pressure ulcers should be reported?](#)
- 🔗 [What should I report under the Care Management Event “Other” category?](#)
- 🔗 [What is considered “surgery”?](#)
- 🔗 [What if the event is considered a complication of surgery or treatment?](#)

Event Form Definition Questions

- 🔗 [How detailed should the Description of the Event be?](#)
- 🔗 [What is the Event Date?](#)
- 🔗 [What is the Event Time?](#)
- 🔗 [What is Date Event Discovered?](#)
- 🔗 [What is the Time Discovered?](#)
- 🔗 [How was Event Discovered?](#)
- 🔗 [What do the different Admission through choices mean?](#)
- 🔗 [How do I determine Race and Ethnicity?](#)
- 🔗 [What information is required for immediate clinical actions taken for the patient?](#)
- 🔗 [What information is required for immediate corrective actions to prevent future similar events?](#)

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Responses to Questions

What to Report?

According to the Patient Safety Act (N.J.P.L. 2004, c.9) every health care facility licensed by the New Jersey Department of Health and Senior Services (Department) must report every serious preventable adverse event. 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 (7) days or is still present at discharge. Some events do not need to meet a threshold of injury due to the potential serious nature of the event.

What is a preventable event?

A preventable event means an event that could have been anticipated and prepared against, but occurs because of an error or other system failure.

The event did not cause actual harm to the patient. Do I still need to report?

The following adverse events must be reported even if there is **no harm** to the patient:

- Intravascular air embolism
- Surgery/procedure/anesthesia performed on the wrong body part
- Surgery/procedure/anesthesia performed on the wrong patient
- Surgery/procedure/anesthesia performed on a patient
-
- Catheter placement in the wrong vessel
- Retention of a foreign object
- Discharge of an infant to the wrong person
- Attempted suicide

Does this event need a report?

- If the 5 day reporting deadline is approaching and you are uncertain whether an event meets the 7 day criteria for loss of bodily function or you are not sure if the disability will resolve before 7 days, report the event.
- If the issue resolves within 7 days, submit a revised report.

[Click HERE to return to questions](#)

Patient Safety Reporting Facility User Guide

What if our facility thinks the event is not-preventable?

In this situation, it is best to submit the initial event with justification of it not being preventable to the Patient Safety Reporting System and the Patient Safety staff will make the determination if it is not-preventable.

What if the event is rare and unusual?

A rare and unusual event is one that is so uncommon that complicated changes in policies and procedures may cause more problems for the health care system compared to the benefits. The event should be discussed with one of the clinical staff in the Patient Safety Reporting System and an RCA may be required.

What types of events should be reported as Less Serious Events or Near Misses?

In general, less serious events are adverse events which result in less serious injuries and can include:

- Minor lacerations and bruises.
- Less serious fractures such as:
 - single fractures of fingers, toes or ribs, that do not extend the patient's length of stay, do not significantly impact function and do not require major intervention.
 - single compression fracture that requires only pain management for therapy, does not extend the length of stay, does not significantly impact function, and does not require major intervention.
- Near Misses

are occurrences that could have resulted in an adverse event but was prevented such as, medication errors which are identified before the wrong medication is given to the patient.

○

If the facility is uncertain regarding the need to report, contact the Patient Safety Reporting System.

How do I report events?

Go to the "myNewJersey" network located at: <http://nj.gov/> and log in. Then click on the Patient Safety Reporting System link located under Applications.

[Click HERE to return to questions](#)

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When should I report?

- Event reports of **all** serious preventable adverse events are due within **five (5) business** days after the facility discovers the event.
- The Root Cause Analysis (RCA) is due within **forty-five (45) calendar** days after the facility sends the initial report of the event.

Where do I report suspected criminal activity?

A health facility should immediately report to the appropriate police authorities all criminal acts or potentially criminal acts that occur within a facility and pose a danger to the life or safety of patients or residents, employees, medical staff or members of the public present in the facility. These acts should also be reported to the Department's Acute Care Survey Unit at 1-800-792-9770.

Do not report these acts to the Patient Safety Reporting System.

Where should I report interruption of services?

Unexpected physical plant and operational interruptions should be reported within three hours to the Department's Acute Care Survey Unit at 1-800-792-9770.

Do not report these acts to the Patient Safety Reporting System.

Where do I report communicable and infectious diseases?

Communicable diseases should be reported in accordance with the requirements of N.J.A.C. 8:57-1 et seq.

Report these to the Department's Communicable Disease Service at 609-826-5964 (regular business hours) or 609-392-2020 (holidays/off hours)

These events may also be reportable to the Patient Safety Reporting System. *If the facility is uncertain regarding the need to report, contact the Patient Safety Reporting System.*

[Click HERE to return to questions](#)

Specific Event Type Questions

What if we discover a retained object left at another facility?

- If a facility discovers a retained object as a result of a surgical or diagnostic procedure that occurred at its own facility, then **the facility must report the event within 5 days and perform the RCA.**
- If a facility discovers a retained object as a result of a surgical or diagnostic procedure that occurred at another facility, then **the discovering facility must report the event within 5 days.**
 - If the identity of the original facility is ascertainable:
 - The discovering facility must inform PSRS where the prior surgery occurred.
 - The discovering facility should advise the original facility regarding the retained object if consistent with facility policy.
 - **The discovering facility is not responsible to perform an RCA.**
 - The original facility (where the object was retained) must perform the RCA.

What types of injury from falls should be reported?

Any serious injury from a fall must be reported. Serious injuries *may include but are not limited to* the following:

- Intracranial bleed/injury of any severity.
- Fracture of the hip or other joints.
- Fractures of the leg or arm.
- Injuries which require prolonged hospitalization.
- Injuries which require significant physical therapy or rehabilitation.
- Injuries which significantly impact the patient's ability to function.

If the facility is unsure if the injury meets severity criteria, they should contact the Patient Safety Reporting System for guidance.

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What types of pressure ulcers should be reported?

Stage III and IV pressure ulcers acquired after the admission of the patient/resident are reportable events.

- This excludes progression from Stage II to Stage III, if Stage II was recognized and documented upon admission.
- Any Stage II pressure ulcer that progresses to a Stage IV ulcer must also be reported.
- Unstageable pressure ulcers are not required to be reported under the current regulations but the Department strongly recommends that facilities voluntarily report these pressure ulcers and perform an RCA, as they represent full thickness tissue injuries.
- Deep tissue injuries (DTIs) are not required to be reported under the current regulations.
- This does not include skin ulcers that develop as a result of an underlying vascular etiology, including arterial insufficiency, venous insufficiency and/or venous hypertension; or develop as a result of an underlying neuropathy, such as a diabetic neuropathy.

What should I report under the Care Management Event “Other” category?

Report Care Management events which result in patient death, loss of a body part, disability, or loss of bodily function lasting more than seven (7) days or present at discharge, which are not specifically listed under Care Management events. Other events may include, but are not limited to:

- Delay in care.
- Delay in the availability of test results.
- Failure to order or follow-up on appropriate tests/x-rays.
- Unstageable pressure ulcers

[Click HERE to return to questions](#)

Patient Safety Reporting Facility User Guide

What is considered “surgery”?

- Surgery* is an invasive operative procedure in which skin or mucous membranes and connective tissue are resected, including minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar.
- Surgery includes a range of dermatological procedures including biopsy, excision and deep cryotherapy for malignant lesions to extensive multi-organ transplant.
- Surgery begins at point of surgical incision, tissue puncture, or insertion of an instrument into tissues, cavities or organs.
- Surgery ends after the surgical incision has been closed and operative devices, such as probes, have been removed and counts have concluded, regardless of setting (recovery room or surgical suite).

* General Licensure Procedures and Enforcement of licensure Regulations ([N.J.A.C. 8:43E-10](#))

What if the event is considered a complication of surgery or treatment?

If the event is a known complication of a procedure but causes harm to a patient, the event is generally reportable. Please call the Patient Safety Reporting System and discuss the case with one of the clinical staff. They will help determine if the event is reportable and whether or not an RCA is required.

Event Screen Definition Questions

How detailed should the Description of the Event be?

This should be about 2 to 3 sentences and should be brief. The Patient Safety Reporting System needs just enough information to determine if the event meets the statutory definition.

- Examples:
 - An 88 y/o female admitted from a LTC facility fell in her hospital room on 11/4/07 and sustained a hip fracture. She was taken to the OR for an ORIF on 11/5/07.
 - A 65 y/o female developed a Stage IV sacral pressure ulcer during her hospitalization following a lengthy, complicated clinical course.

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What is the Event Date?

The date of the actual event.

- For pressure ulcers, including eschar formation, use the date of the first documentation in the chart for a reportable ulcer.
- For medication error, the date of the error is the date of the event.
- For surgery/procedure related events, the date is usually the date of the surgery.

What is the Event Time?

This is the time of the actual event, not the time it was discovered. The time may need to be estimated in the event of pressure ulcers or when a patient who is a poor historian sustains an unobserved injury.

What is Date Event Discovered?

This usually matches the Event Date, as it refers to when the **clinical staff** caring for the patient became aware of the event. This **does not** refer to the time the facility administration, risk management, or the patient safety department in the facility became aware of the event. If the serious injury is discovered hours or days after the event, there are two possibilities:

- If the serious injury is discovered by a physical assessment or diagnostic test that was completed **within six (6)** hours after the event, use the Event Date and Time.
- If the discovery of the serious injury occurred **more than six (6)** hours after the event, use the actual date and time of discovery even though it will differ from the Event Date and Time. Record the actual date and time when the serious injury was discovered/confirmed.
 - This can include multiple ways of discovery including but not limited to:
 - evaluation of the patient
 - report by staff
 - chart review or audit

What is the Time Discovered?

Usually matches the Event Time, but may differ when there is a delay in identifying the patient's injury or with certain event types such as, retained foreign objects.

[Click HERE to return to questions](#)

Patient Safety Reporting Facility User Guide



How Was Event Discovered?

- Report by staff/physician – Any event which was initially discovered by any staff or physician. This event may have been discovered because of a loud noise or a patient calling out or the staff actually witnessed the event.
- Report by family/visitor – Any event which was initially reported by a family member or visitor.
- Report by patient/resident – Any event which was initially reported by the patient/resident or another patient.
- Assessment of patient/resident after event – Any event which is discovered by a physical assessment or a diagnostic test (i.e., x-ray) which occurs some period of time following the event (i.e., does not occur immediately following the event). There is usually an associated delay in the date and time of discovery.
- Review of chart/record – Any event which was initially discovered by a chart audit, review of hospital Code Blue (emergency resuscitations) documentation, or other quality review. There is usually an associated delay in the date and time of discovery.
 - Do not choose this item if staff at the facility previously identified and responded to the adverse event but failed to report the event to the Patient Safety Liaison in a timely manner.
- Other – rarely used



What do the different Admission through choices mean?


This item only refers to inpatients. If the patient is an outpatient, leave this item blank.

- Emergency Department - The patient was examined and may have been treated in the Emergency Department. This category is not used when patients are transferred from another hospital or are admitted from a Long Term Care facility.
- Direct Admission - The patient was not examined in the ED but was admitted directly into the hospital.
- Transfer from General Acute Care Hospital - The patient was sent to the current facility directly from a general acute care hospital as a direct admission or an admission through the ED. In either situation, only the “Transfer from General Acute Care Hospital” item is selected.
- Transfer from LTC (Long Term Care) - The patient was sent to the current facility from a Long Term Care facility as a direct admission or an admission through the ED. In either situation, only the “Transfer from LTC” item is selected.


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How do I determine Race and Ethnicity?

Race - There are 6 categories listed which are based on the US Census Bureau 2000 specifications plus an 'Unable to Determine' category. The descriptions are located in  next to the Race field. "Other" is rarely used.

The race designation can often be found on the hospital admission form.

Ethnicity - There are 2 categories listed which are based on the US Census Bureau 2000 specifications. The descriptions are located in  next to the Ethnicity field.

What information is required for immediate clinical actions taken for the patient?

Provide the immediate clinical actions taken that involve the care of the patient.

What information is required for immediate corrective actions to prevent future similar events?

Provide the immediate corrective actions taken to prevent similar events from occurring. The following are examples, but not limited to:

- 1:1 observation for confused patients at high risk for falls.
- Ensure that toileting rounds are performed every 30 minutes for at least 3 hours after patients receive diuretics.
- Ensure that beds with weight-based alarm systems are zeroed for each new pt.
- Implement new turning and positioning system to ensure compliance with repositioning every 2 hours.

[Click HERE to return to questions](#)

XII. Additional Guidance for Ambulatory Surgery Centers

Questions

- 🔗 When should events be reported?
- 🔗 What events are reportable?
- 🔗 What events are not reportable?

Responses to Questions

- 🔗 When should events be reported?

Ambulatory Surgical Centers are mandated to report every serious preventable adverse event that results in patient death, loss of a body part, disability, or loss of bodily function lasting more than seven (7) days or present at discharge. Some events do not need to meet a threshold of injury due to the potential serious nature of the event.

- The facility must report the event within **five (5) business** days after discovery of the event.
- The facility must complete an RCA within **45 calendar days** after the submission of the initial report of the event.

- 🔗 What events are reportable?

Some of the reportable events are self-explanatory, such as wrong site surgery, wrong surgical procedure, wrong patient, or retained object and should always be reported.

The following guidance should be used when there is uncertainty regarding a potentially reportable event:

In general, ***any patient transferred to the Emergency Department and/or hospitalized with a procedure and/or anesthesia related complication which requires treatment other than observation should be reported to the Patient Safety Reporting System.***

Complications may include, but are not limited to:

- Aspiration
- Pneumothorax
- Perforation of an organ
- Cardiac and/or respiratory related problems which require intervention
- Moderate to severe bleeding which requires intervention

Patient Safety Reporting Facility User Guide

- Serious infections which require intervention
- Prolonged decrease in oxygenation and/or blood pressure which require intervention.

Treatment may include, but is not limited to:

- Fluid resuscitation
- Unscheduled blood transfusion
- Surgery
- IV Antibiotics

What events are not reportable?

The following types of events do not need to be reported to the Patient Safety Reporting System:

- Any patient who is transferred to the Emergency Department and /or hospitalized due to an unstable medical problem prior to the scheduled procedure and/or administration of anesthesia.
- Any patient who develops an expected or common complication of surgery, with the following qualifiers:
 - The complication should be identified on the consent form.
 - The patient does not require hospitalization and treatment of the complication.
 - Common complications that are not reportable may include:
 - Post-operative urinary retention.
 - The need for more intense post-operative pain control.
 - Post-operative bleeding following tonsillectomies that do not require transfusion or intervention.

If there is any question whether an event should be reported, the Department recommends that the Center err on the side of reporting in order to comply with the Patient Safety Act. The facility can always call the Patient Safety Reporting System to discuss the event.