



State of New Jersey *Department of Health*

Patient Safety Reporting System

Module 3 – Root Cause Analysis



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Governor



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Patient Safety Reporting System

Course Contents

- I. Preparing to Enter Root Cause Analysis and Action Plan**
- II. Enter Root Cause Analysis and Action Plan**
- III. PSRS review of RCA**
- IV. Other Communications about the RCA**

I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

- 1. Log into the system**
- 2. Access the “Resources” tab from the Main Menu**
- 3. “Resources” Tab Menu**
 - Information Consulted
 - Report Questions
 - User Guide
- 4. Select Event Type**
- 5. View Initial RCA Questions**
- 6. Information needed will be displayed**

I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

7. Locate Comments from the Event Reviewer

- **Locate Event for which an RCA is required**
 - Home Page: enter Event/RCA number
 - View Events: all Events and RCAs listed
 - Click on 'Detail'

8. Comments from Event Reviewer can be accessed by:

- **A comment link in the Initial Event**
 - Only visible in sections of the Event with PSRS comments
 - Click on 'Comments' link
- **A link to the comment through the Communication Log**
 - 'View All Comments'

I. Preparing to Enter Root Cause Analysis and Action Plan

RCA Questions

- 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 web interface with two tabs: 'Initial Event' and 'RCA'. The 'RCA' tab is selected and circled in red. Below the tabs is a dropdown menu with the following items: 'Environmental - Fall', 'RCA Specific Questions', 'Care Management - Pressure Ulcers', 'Environmental - Fall' (highlighted in blue and circled in red), 'Environmental - Restraints', 'Product/Device - Contaminated Drugs/Devices/Biologics', 'Product/Device - Malfunction', 'Patient Protection - Suicide\Attempted Suicide', 'Surgical - Other', 'Surgical - Wrong Site', 'Surgical - Wrong Patient', 'Surgical - Wrong Procedure', 'Surgical - Retained Foreign Object', and 'Surgical - Intra/Post-Op Coma or Death'. To the right of the dropdown menu is a button labeled 'View RCA Questions', which is also circled in red.

I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

NJ Health State of New Jersey
New Jersey Department of Health Department of Health Patient Safety Reporting System

Logged in as: HOME ADD EVENT VIEW EVENTS RESOURCES Admin

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:

Search for Report by Number

Search

Action Items

Initial Event Comments

Report Number	Submit Date
20180312	5/18/2018
20180219	4/11/2018
20180151	3/9/2018
20180193	4/5/2018
20180194	4/3/2018

Page 1 of 2 (8 items) < < Prev 11 2 Next > >

I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

State of New Jersey
Department of Health Patient Safety Reporting System

Logged in as: HOME ADD EVENT VIEW EVENTS RESOURCES Admin

Welcome to the NJ Patient Safety Reporting

Search for Report by number

Search

Action Items

Initial Event Comments

Report Number	Submit Date
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20180194	4/3/2018

Page 1 of 2 (8 items) < < Prev 11 2 Next > >

I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

View Events (includes RCAs)

NJ Health State of New Jersey
New Jersey Department of Health Department of Health Patient Safety Reporting System

Logged in as: HOME ADD EVENT VIEW EVENTS RESOURCES 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

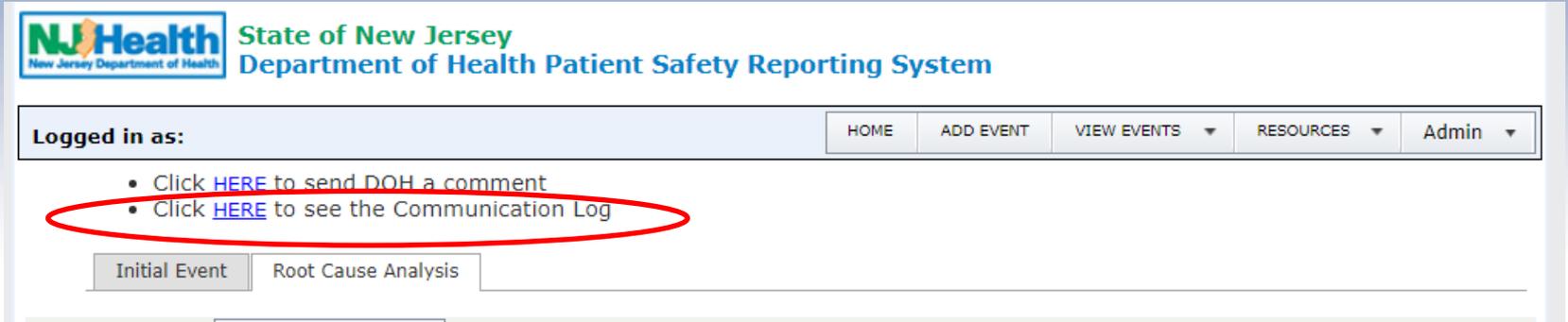
Show Customization Dialog

Drag a column header here to group by that column

View	Report Year	Event Type	Admit Date	Admission Through	Report Number	Event Status	Reportable Event	Facility
Detail	2018	Environmental - Fall	11/19/2018	Direct Admission	20180356	RCA-Facility Edit	Reportable RCA Required	TEST FACIL FORT

I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

Locate Comments



The screenshot shows the top navigation bar of the reporting system. It includes the NJ Health logo, the text "State of New Jersey Department of Health Patient Safety Reporting System", and a "Logged in as:" section with navigation links: HOME, ADD EVENT, VIEW EVENTS (dropdown), RESOURCES (dropdown), and Admin (dropdown). Below the navigation bar, there is a list of instructions: "Click [HERE](#) to send DOH a comment" and "Click [HERE](#) to see the Communication Log". The second instruction is circled in red. At the bottom of the screenshot, there are two tabs: "Initial Event" and "Root Cause Analysis".

NJ Health State of New Jersey
New Jersey Department of Health Department of Health Patient Safety Reporting System

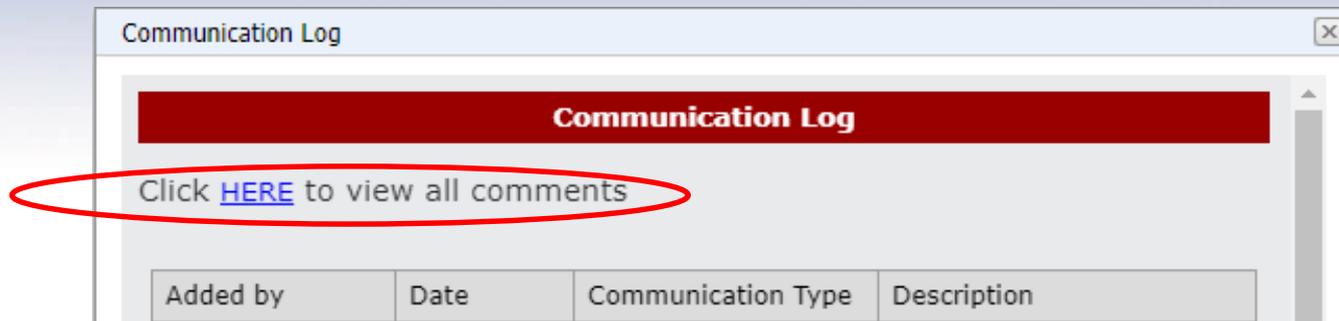
Logged in as: HOME ADD EVENT VIEW EVENTS ▼ RESOURCES ▼ Admin ▼

- Click [HERE](#) to send DOH a comment
- Click [HERE](#) to see the Communication Log

Initial Event Root Cause Analysis

I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

Communications Log



I. Preparing to Enter Root Cause Analysis and Action Plan – *continued*

System Navigation - General

“Main Menu” Bar

- View Events – Event/RCA listing, may create custom reports

“Report Menu” Bar

- Moves you through each report section with an arrow to indicate next step
- RCA Summary page builds as information is entered

“Save/Next” Button

- Move to next screen

II. Enter Root Cause Analysis and Action Plan

The “Report Menu” will guide you through the RCA

- A red arrow will indicate the next step in the process

Complete fields for:

- RCA General information
- RCA Facts of the Event
- RCA Specific Questions

Create Documents to copy information into the RCA screens

- All required fields must be completed to save screen
- *Two Hour Time Out Window*



II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: General Information

NJ Health State of New Jersey
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Logged in as: HOME ADD EVENT VIEW EVENTS RESOURCES Admin

Report Menu: Return to Detail

Report Number: 20180356

Event Classification: Environmental - Fall

RCA: General Information

1. List the individuals on the RCA Team, including their titles:

Patient Safety Committee members
Nurses
Pharmacy
Physical Therapy
Nurse Manager

Note this example is an illustration of an insufficient description of the individuals on the RCA Team. In later slides, PSRS will show you how to modify this entry to reflect best practices.

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: General Information

2. How many similar events has your facility had for this event type in the previous 3 full calendar years plus the current year? Do not include the current case in this count. (numbers only)

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

a. What changes did the organization make in response to these previous events? If this is an 'Other' event type, only include changes relevant for the specific situation. Examples include, but are not limited to, perforation, infection, delay in care).

1. Staff re-education on the Morse fall risk assessment using nursing judgment to determine if a patient is at risk for fall.
2. Fall huddles immediately after any fall on all units.

1817 Characters left

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

1. Effectiveness monitored through random observation of patients at high risk for a fall for appropriate fall prevention interventions. Conducted an audit of the Morse Score and the prevention strategies in place.
2. The effectiveness is tracked when all falls are discussed at the weekly Fall Huddle. Aggregate data is collected on falls by the Unit and/or Department on a monthly basis and analyzed for trends. All patient falls, with or without injury, are tracked.

1530 Characters left



II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: General Information

3. What procedures are in place to ensure that the facility knows about all the reportable events? This question is pertinent to all RCAs regardless of whether there have been similar events in the last 3 years.

All staff members receive education regarding reportable events. Staff are instructed to report events in the electronic event reporting system at orientation and annually. Physicians are provided education at orientation and annual education sessions. All events and RCAs are also reported at the monthly Patient Safety Committee. There is an anonymous online event reporting system for staff to report events.

1589 Characters left

Save/Next

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II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event

Event Classification: Environmental - Fall

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 and surgical history:

Medical history: Aortic stenosis, HTN, anxiety, Degenerative joint disease of the lumbar spine, hyperlipidemia, obesity
Surgical history: bilateral cataracts (2017)

1834 Characters left

b. Clinical status of patient prior to event:

Patient presented to ED with c/o dizziness and weakness, fatigue and nausea. She denied fever/chills. States she was seen in past month for weakness in ED, treated with fluids for dehydration and discharged. She was alert and oriented x 3. BP 144/76, P: 81, R: 20 100% on RA, Temp: 98.2 orally. She was noted to be weak with limited mobility.

The patient was ordered a series of diagnostic tests including labs, Chest X-ray and EKG. -all of which had negative or unremarkable results. The patient received IV normal saline fluids and was admitted to a telemetry unit with a diagnosis of near-syncope. Consultations ordered for cardiology, OT, PT.

Fall assessment was completed by receiving nurse using the Morse Scale. Patient scored high on the Morse scale putting her at a high risk for fall and the appropriate safety precautions were put in place, i.e., use of call bell, education instructing patient and family how to call for assistance, bed alarm, falling star at the door to alert staff of risk, non-skid socks, and patient was placed in a room facing the nurse's station. Staff also performed hourly rounding to be proactive. During hourly rounding, the patient is toileted, assessed for pain, positioned and the environment is assessed for clutter and cleanliness.

Later that afternoon, the patient was reassessed by the day shift RN and noted to be confused to place and safety awareness was impaired. Patient required assistance for safety with mobility, due to weakness and decreased strength. During this time her Vital signs were stable.

On 11/19/2018 at 2330, the patient was assisted to the bathroom. She fell asleep just after returning to bed. At 0030 on 11/20/2018, she was noted to be asleep with the bed alarm on.

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II. Enter Root Cause Analysis and Action Plan – *continued*

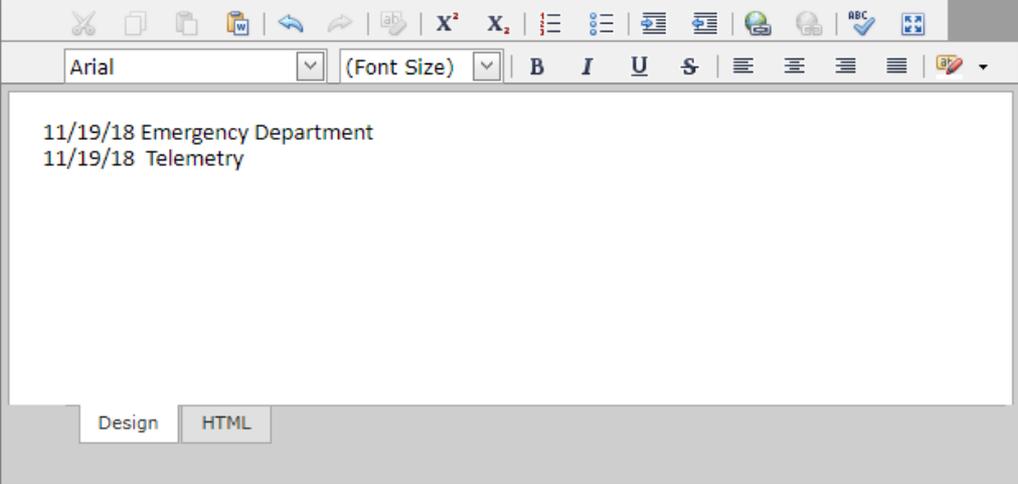
RCA: Facts of the Event

c. Clinical status of patient after the event:

Patient complained of hip pain. Alert but confused. Patient states she was trying to go to the bathroom. BP 120/62, HR 86, RR 16, T 99, pulse ox 96% on room air. Telemetry strip was reviewed and there were no changes in rhythm. Physical assessment noted external rotation of left leg. Stat X-ray of left hip showed non-displaced fracture of greater trochanter. Patient underwent ORIF the same day.

1603 Characters left

d. Patient's course in facility prior to event (i.e. surgery, transfer to ICU):



The screenshot shows a rich text editor interface. The toolbar includes icons for cut, copy, paste, undo, redo, bold, italic, underline, strikethrough, bulleted list, numbered list, link, unlink, and a color picker. The font is set to Arial. The text area contains the following text:

11/19/18 Emergency Department
11/19/18 Telemetry

At the bottom of the editor, there are two tabs: "Design" and "HTML".

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event

e. Patient's course in facility after event:

11/20/18 Telemetry
11/20/18 Operating Room for ORIF
11/20/18 PACU
11/20/18 Med-Surg

f. Medication at home:

Lansoprazole, Lorazepam, Metoprolol, Simvastatin, Iron, Centrum Silver, Aspirin.

1918 Characters left

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event

g. Medication at facility: . If this is a fall event, please include the time the last dose of any high fall risk medications were administered prior to the fall

Lansoprazole, Lisinopril, Lorazepam, Metoprolol, Simvastatin, Iron, Centrum Silver, Aspirin, percocet

1899 Characters left

h. Other factors contributing to the event. Please include detailed information about staffing. Please include appropriate lab results.

Staff factors were discussed in relationship to staffing levels, training and orientation, competency and supervision. Staffing at the time of the patient's fall was 6 RN's and 4 PCA's for 36 patients. The day shift RN assigned to the patient has been employed by the hospital for 6 years and all mandatory competencies are up to date. The RCA team determined that staff factors, including staffing levels were neither contributory nor causal to the event.

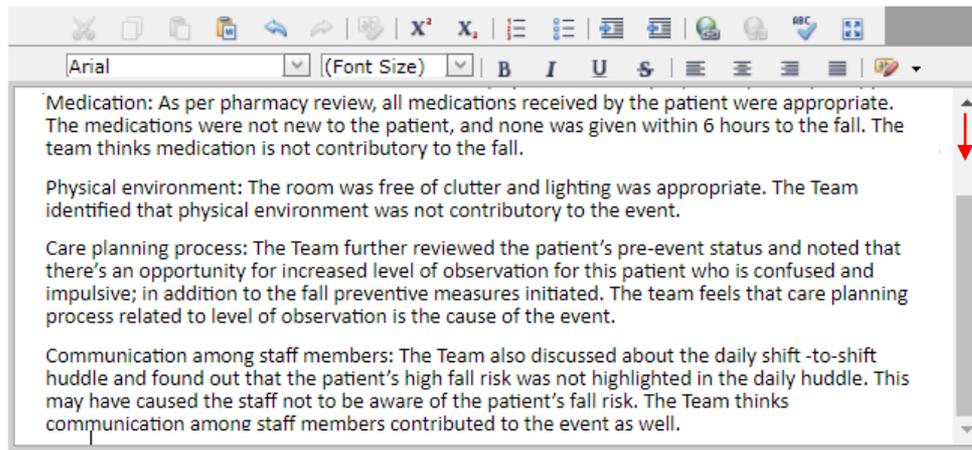
CBC and BMP obtained, results were within normal limits. Lab results not contributory.

1455 Characters left

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Facts of the Event

2. Additional event information: should be clearly stated and in chronological order: Indicate the potential areas of causality reviewed and how the facility determined certain processes did not contribute to the event. Include the Admitting ICD-code if it was not included in the initial event submission.(This is an unlimited text field.)



The screenshot shows a text editor window with a toolbar at the top. The text area contains the following paragraphs:

Medication: As per pharmacy review, all medications received by the patient were appropriate. The medications were not new to the patient, and none was given within 6 hours to the fall. The team thinks medication is not contributory to the fall.

Physical environment: The room was free of clutter and lighting was appropriate. The Team identified that physical environment was not contributory to the event.

Care planning process: The Team further reviewed the patient's pre-event status and noted that there's an opportunity for increased level of observation for this patient who is confused and impulsive; in addition to the fall preventive measures initiated. The team feels that care planning process related to level of observation is the cause of the event.

Communication among staff members: The Team also discussed about the daily shift -to-shift huddle and found out that the patient's high fall risk was not highlighted in the daily huddle. This may have caused the staff not to be aware of the patient's fall risk. The Team thinks communication among staff members contributed to the event as well.

***All fields will need to be completed before the RCA can be submitted**

Save/Next

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II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Specific Questions



State of New Jersey
Department of Health Patient Safety Reporting System

Logged in as: HOME ADD EVENT VIEW EVENTS RESOURCES Admin

Report Menu: Return to Detail

Report Number: 20180356

Event Classification: Environmental - Fall

RCA Specific Questions

1. Does your facility have a fall team that regularly evaluates your falls program? Yes No

2. Was a Fall Risk Screening documented at admission? Yes No

3. When was the most recent fall assessment done prior to the fall?
Date:
Time: Enter Time in Military (e.g 1800=6:00PM)
 If assessment date is unknown, check here

4. Was a validated, reliable fall risk screening tool used? Yes No
Which tool?

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Specific Questions

5. Did the screening tool indicate that the patient was at risk for a fall? Yes No NA

a. Does the patient have a history of a fall prior to admission? Yes No

6. Please respond to the following questions related to the patient's risk for falls:

a. Was patient placed at risk due to clinical judgment? Yes No NA

b. If yes, what were the additional factors that placed the patient at risk

c. Were the facility's universal fall precautions in place for this patient at the time of the fall? Yes No NA

d. Fall Precaution (Check all that apply):

- 1:1 observation
- Bed alarms on and functioning
- Fall alert arm band
- Floor conditions were dry and free of clutter
- Items placed within patient's reach
- Lighting was adequate
- Patient room close to nurse's station
- Personal alarms on and functioning
- Room clear of clutter

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Specific Questions

7. Was patient re-evaluated:

a. During each nursing shift?

Yes No NA

b. Upon transfer between units?

Yes No NA

c. Upon change in status?

Yes No NA

d. Post-fall?

Yes No NA

8. Was there a visual indication alerting staff to patient's at-risk status?

Yes No

9. Was a fall prevention intervention plan documented?

Yes No

10. Did the intervention plan focus on the patient's specific risk factors?

Yes No

11. Was patient/family education completed?

Yes No

12. When was patient rounding last conducted for this patient to check for pain, positioning and toileting?

<=30 minutes prior to fall ▼

13. Was the following equipment used to reduce falls for this patient at the time of the event :

a. Side rails in proper position?

Yes No NA

b. Were restraints used?

Yes No

c. If no, were restraints considered?

Yes No

d. Was the pt wearing non-skid foot wear?

Yes No

e. Did foot wear fit properly?

Yes No NA

f. Other

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Specific Questions

14. Was the patient on culprit medication within 6 hours of the fall? If yes, please address this issue in the Facts of the Event Section question #2.

Yes No

15. Patient Characteristics (check all that apply):

- Uses a hearing aid or hard of hearing
- Uses eye glasses or visually impaired
- Requires mechanical lift
- Requires an assistive device (i.e., wheelchair, walker, cane)
- Has an artificial limb
- Patient has a problem with incontinence
- Not Applicable

16. Communication concerns (check all that apply):

- Between staff and patient, including, but not limited to language barriers and confusion
- Between staff and family, including, but not limited to language barriers
- Between one staff member and another
- Not Applicable

17. Location of fall in the patient's room

Between bed and bathroom ▼

*All Fields are Required

Save/Next

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II. Enter Root Cause Analysis and Action Plan – *continued*

Root Cause/Causality Statement

- 1. For each RCA you may have:**
 - More than one Root Cause
 - *Each root cause will have a causality statement*
 - More than one Action Plan per Root Cause
 - *Each Action Plan will have one Methodology*
- 2. Work through one Root Cause at a time with the corresponding Action Plan(s)**

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Root Cause/Causality Statement

RCA: Root Cause/Causality Statement

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

[Using the Five Rules of Causation](#)

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

1. Root Cause Categories:

<input type="radio"/> Behavioral assessment process	<input type="radio"/> Staffing levels
<input type="radio"/> Patient identification process	<input type="radio"/> Competency assessment/credentialing
<input checked="" 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:

The lack of a patient-specific care plan addressing the patient's impulsivity and intermittent confusion increased the likelihood that the patient would attempt to ambulate to the bathroom unassisted and fall. Patient specific plan of care did not specifically address the patient's escalating periods of impulsivity along with confusion and the need for a higher level of observation.

1852 **Characters left**

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Five Rules of Causation

Using the Five Rules of Causation*

*Adapted for patient safety from David Marx.

The five rules of causation are designed to improve the RCA process by creating minimum standards for where an investigation and the results should be documented. The rules are created in response to the very real biases we all bring to the investigation process.

- Rule 1 - Causal Statements must clearly show the "cause and effect" relationship.

This is the simplest of the rules. When describing why an event has occurred, you should show the link between your root cause and the outcome, and each link should be clear to the RCA team. Focus on showing the link from your root cause to the unanticipated outcome you are investigating. Even a statement like "the technician was fatigued" is deficient without your description of how the fatigue led to the slip or mistake. The bottom line: the reader needs to see the link in linking your causes to the outcome.

- Rule 2 - Negative descriptors (e.g., poorly, inadequate) are not causal statements.

As humans, we try to make each job we have as easy as possible. Unfortunately, this human tendency works its way into the RCA process. We may shorten our findings by saying "the technician was poorly written" when we really have a much more detailed description of our mind. To force clear cause and effect descriptions (and avoid inflammatory statements), we recommend against using negative descriptors that are merely the placeholder for a more detailed description. Even words like "carelessness" and "poor judgment" are choices because they are broad, negative judgments that do not describe the actual conditions or behaviors that led to the error.

- Rule 3 - Each human error must have a preceding cause.

Most of our mishaps involve at least one human error. The discovery that a human has erred does little to aid in preventing a similar error. You must investigate to determine WHY the human error occurred: it can be a system-induced error (e.g., step not included in medical procedure) or an at-risk behavior (doing task by memory, instead of a checklist). For every human error in your causal chain, you must have a corresponding cause. It is the cause of the error, not the error itself, which leads us to productive prevention strategies.

- Rule 4 - Each procedural deviation must have a preceding cause.

Procedural violations are like errors in that they are not directly manageable. Instead, it is the cause of the procedural violation that we can manage. If a clinician is violating a procedure because it is the local norm, we will have to address the incentives that created the norm. If a technician is missing steps in a procedure because he is not aware of the formal checklist, work on education.

- Rule 5 - Failure to act is only causal when there was a pre-existing duty to act.

We can all find ways in which our investigated mishap would not have occurred - but this is not the purpose of causal investigation. Instead, we need to find out why this mishap occurred in our system as it is designed today. A doctor's failure to prescribe a medication can only be causal if he was required to prescribe the medication in the first place. The duty to perform may arise from standards and guidelines for practice; or other duties to provide patient care.

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Action Plan

Report Number: 20180356

Event Classification: Environmental - Fall

Causality Statement:The lack of a patient-specific care plan addressing the patient's impulsivity and intermittent confusion increased the likelihood that the patient would attempt to ambulate to the bathroom unassisted and fall. Patient specific plan of care did not specifically address the patient's escalating periods of impulsivity along with confusion and the need for a higher level of observation.

- Enter the Action Plan for the causality statement displayed above
- Complete all RCA: Action Plan fields
- If more than one methodology is required (i.e. chart review and observational audits) a separate Action Plan is required for each.
 - See next screen for instructions on adding a new action plan.
- Click 'Save/Next' when finished

RCA: Action Plan

1. Action Plan:

Re-education of Fall Prevention Program including reassessment of fall risk when there is a change in patient behavior specifically focusing on clinical triggers with implementation of additional prevention measures such as 1:1 observation. Correlate clinical picture with falls risk.

1715 Characters left

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Action Plan

2. Monitoring Strategy: ?

Nurse managers/designees will review a designated number of fall risk assessments weekly and conduct validation to determine the accuracy of the assessments and the appropriateness of the measures selected for the identified risk category (low, moderate or high risk). Data will be reported monthly at unit council meetings, Nursing Quality/Outcomes/Peer Review Council meetings, and aggregated for quarterly reporting at Hospital Performance Improvement Committee meetings.

1524 Characters left

3. Methodology ?

Chart Audit

4. Frequency ?

Weekly

5. Sample Size ?

30

6. Implementation Start Date ?

12/3/2018

7. Staff position responsible for implementation:

Nurse Manager/Designee

1978 Characters left

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA: Action Plan

8. Duration: ? 6 months sustained 100% compliance and

9. Goal ? 100% ▼

10. Threshold ? 100% ▼

11. How will effectiveness be monitored over time? ?

Effectiveness will be monitored by the robust review processes at the weekly Quality Huddles, the hospital's Patient Safety Committee, and the hospital's Performance Improvement Committee.

1811 Characters left

12. How will the Action Plan be communicated within and across departments? ?

The plan will be communicated to staff by staff meetings, small group departmental discussions, Nursing PI Committee, and the hospital's Performance Improvement Committee.

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***All fields are Required**

Save/Next

II. Enter Root Cause Analysis and Action Plan – *continued*

Edit/Add Root Cause Findings

When the first Root Cause and Action Plan are complete, you can add an additional Action Plan to the Root Cause or edit the first Root Cause.

Report Menu:

Report Number: 20180356

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.

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
	Edit	Delete	Care planning process	The lack of a patient-specific care plan addressing the patient's impulsivity and intermittent confusion increased the likelihood that the patient would attempt to ambulate to the bathroom unassisted and fall. Patient specific plan of care did not specifically address the patient's escalating periods of impulsivity along with confusion and the need for a higher level of observation.

II. Enter Root Cause Analysis and Action Plan – *continued*

Edit/Add Root Cause Findings

Report Menu:

Report Number: 20180356

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.

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
<input type="checkbox"/>	Edit	Delete	Care planning process	The lack of a patient-specific care plan addressing the patient's impulsivity and intermittent confusion increased the likelihood that the patient would attempt to ambulate to the bathroom unassisted and fall. Patient specific plan of care did not specifically address the patient's escalating periods of impulsivity along with confusion and the need for a higher level of observation.

RCA: Action Plan

Edit	Add	Delete	Action Plan
Edit	Add Action Plan	Delete	Re-education of Fall Prevention Program including reassessment of fall risk when there is a change in patient behavior specifically focusing on clinical triggers with implementation of additional prevention measures such as 1:1 observation. Correlate clinical picture with falls risk.

II. Enter Root Cause Analysis and Action Plan – *continued*

Add an Additional Root Cause

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	Care planning process	The lack of a patient-specific care plan addressing the patient's impulsivity and intermittent confusion increased the likelihood that the patient would attempt to ambulate to the bathroom unassisted and fall. Patient specific plan of care did not specifically address the patient's escalating periods of impulsivity along with confusion and the need for a higher level of observation.

RCA: Action Plan

Edit	Add	Delete	Action Plan
Edit	Add Action Plan	Delete	Re-education of Fall Prevention Program including reassessment of fall risk when there is a change in patient behavior specifically focusing on clinical triggers with implementation of additional prevention measures such as 1:1 observation. Correlate clinical picture with falls risk.

II. Enter Root Cause Analysis and Action Plan – *continued*

When all Root Causes and Action Plans are complete:

- Complete RCA Additional Questions
- Submit to PSRS for review
- You will receive an error message if any required information is not completed

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Additional Questions

Report Menu:

Report Number: 20180356

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.

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
<input type="checkbox"/>	Edit	Delete	Care planning process	The lack of a patient-specific care plan addressing the patient's impulsivity and intermittent confusion increased the likelihood that the patient would attempt to ambulate to the bathroom unassisted and fall. Patient specific plan of care did not specifically address the patient's escalating periods of impulsivity along with confusion and the need for a higher level of observation.

RCA: Action Plan

Edit	Add	Delete	Action Plan
Edit	Add Action Plan	Delete	Re-education of Fall Prevention Program including reassessment of fall risk when there is a change in patient behavior specifically focusing on clinical triggers with implementation of

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Additional Questions



State of New Jersey
Department of Health Patient Safety Reporting System

Logged in as HOME ADD EVENT VIEW EVENTS RESOURCES Admin

Report Menu: Return to Detail

Report Number: 20180356

Event Classification: Environmental - Fall

RCA Additional Questions

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

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

Other:

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

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

Other:

II. Enter Root Cause Analysis and Action Plan – *continued*

RCA Additional Questions

3. ICDCodes resulting from event:

820.8

995 Characters left

4. Diagnosis resulting from event:

Closed fracture of the left hip.

968 Characters left

5. Information consulted such as clinical literature/other published guidelines (please provide specific citations otherwise leave blank): This information is automatically entered into the 'Information Consulted' document in the Resources tab and is accessible to all facilities.

Preventing Patient Falls: A Systematic Approach from the Joint Commission Center for Transforming Healthcare Project. NJ Fall TIPS Collaborative

Preventing Falls in Hospitals: A toolkit for improving Quality of Care (<http://www.ahrq.gov/research/ltc/fallpxtoolkit/fallpxtoolkit.pdf>) (AHRQ - Agency for Healthcare Research and Quality).

494 Characters left

***All Fields are Required**

Save/Next

II. Enter Root Cause Analysis and Action Plan – *continued*

Submit RCA to PSRS

NJ Health State of New Jersey
New Jersey Department of Health Department of Health Patient Safety Reporting System

Logged in as: HOME ADD EVENT VIEW EVENTS ▼ RESOURCES ▼ Admin ▼

- 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

- Click [HERE](#) to send DOH a comment
- Click [HERE](#) to see the Communication Log

Please click the 'Submit' tab below to notify DOH that this RCA is ready for review

Initial Event Root Cause Analysis

Report Menu: General Info Facts of Event RCA Questions Root Cause\Action Plan Additional Questions ➔ **Submit RCA**

III. RCA Review by PSRS

1. Automated e-mail sent to PSRS when RCA is submitted
2. PSRS reviews the RCA
3. Possible Review Outcomes:
 - Email: RCA Comment Process
 - Email: RCA Complete

III. RCA Review by PSRS - *continued*

Email: RCA Comment process:

1. Additional information is needed
2. PSRS makes comments to determine if the RCA contains the required components of an RCA
3. An email is sent to the FacAdmins
 - *Comments are available on this RCA. Please log into the Patient Safety Reporting System to view the details and respond accordingly.*
 - **Note: PSRS must be added as a safe sender so PSRS emails do not go to your spam folder**
4. A Facility User must log into the PSRS and open the Communication log for that RCA to view the email and read the comments



III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

5. Comments can be accessed by:

- **A comment link in the RCA**
 - Only visible in sections of the RCA with PSRS comments
 - Click on 'Comments' link
- **A link to the comment through the Communication Log**
 - Click **HERE** to see the Communication Log
 - Click **HERE** to view all comments

III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

6. Respond to all comments by editing the RCA

- Click on 'Edit' in the section(s) with the Comments
- Provide responses to the Comments/Questions
- The RCA: Facts of the Event section question #2 is an unlimited text field

7. Resubmit the RCA to PSRS

- Click on 'Save' to keep the changes
- Click on the 'Submit RCA' tab to resend the RCA to PSRS

8. There may be more than 1 cycle of responding to comments

III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

- Click [HERE](#) to send DOH a comment
- Click [HERE](#) to see the Communication Log

Communication Log

Click [HERE](#) to view all comments

Added by	Date	Communication Type	Description
	11/24/2018	Email:RCA Comment Process	Report Number: 20180356 Email Text Sent to Facility: There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly. Reviewer Comments: Thank you for the submission of this RCA. The following are the comments, questions, and recommendations made based on the information provided on the RCA submitted. Please respond to these comments in question #2 of the RCA: Facts of the Event section, which is an unlimited text field, within two weeks by 12/5/18. Thank you for your cooperation
	11/18/2018	Event Determination	Report Number: 20180356 Email Text Sent to Facility: 'A determination has been made on this event. Please log into the Patient Safety Reporting System to view the details of the event and respond accordingly.' Event Determination: Reportable RCA Required Your event has been received and accepted by the Patient Safety Reporting System. Please follow the process for submitting an RCA for this event. In accordance with N.J.A.C. 8:43F-10.6(k) "A

III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

- Click [HERE](#) to send DOH a comment
- Click [HERE](#) to see the Communication Log

Please click the 'Submit' tab below to notify DOH that this RCA is ready for review

Initial Event Root Cause Analysis

Report Menu:

General Info

Facts of Event

RCA Questions

Root Cause\Action Plan

Additional Questions

→ Submit RCA

Report Number: 20180357

Event Classification: Environmental - Fall

Print Screen

RCA: General Information

Edit

Comments

1. List the individuals on the RCA Team, including their titles:

III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

Initial Event | Root Cause Analysis

Report Menu: General Info | Facts of Event | RCA Questions | Root Cause\Action Plan | **Additional Questions** | → Submit RCA

Report Number: 20180356

Event Classification: Environmental - Fall Print Screen

RCA: General Information

Edit

1. List th

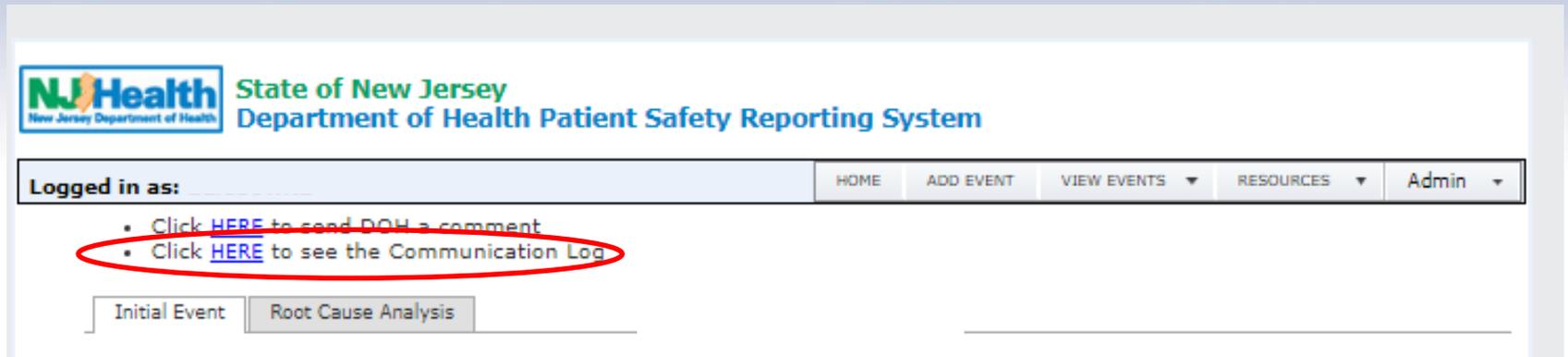
DOH Comments

[Click to Print This Page](#)

Please be more specific regarding the members of the RCA team and give their titles.

III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*



The screenshot shows the NJ Health Patient Safety Reporting System interface. At the top left is the NJ Health logo with the text "New Jersey Department of Health". To its right is the text "State of New Jersey Department of Health Patient Safety Reporting System". Below this is a navigation bar with "Logged in as:" followed by a dropdown menu. The navigation bar also includes buttons for "HOME", "ADD EVENT", "VIEW EVENTS" (with a dropdown arrow), "RESOURCES" (with a dropdown arrow), and "Admin" (with a dropdown arrow). Below the navigation bar is a list of instructions: "Click [HERE](#) to send DOH a comment" and "Click [HERE](#) to see the Communication Log". The second instruction is circled in red. Below the list are two buttons: "Initial Event" and "Root Cause Analysis".

III. RCA Review by PSRS - *continued*

Email: RCA Comment Process *continued*

• Click [HERE](#) to send DOH a comment

Communication Log

Communication Log

Click [HERE](#) to view all comments

Added by	Date	Communication Type	Description
			Report Number: 20180356 Email Text Sent to Facility: There is a new comment available from the Patient Safety Reporting System. Please log into the web based

III. RCA Review by PSRS - *continued*

Review All Comments Link

Comments

Comment Section: General Comment
Added by: |
Report Number:20180356
Email Text Sent to Facility:There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly.

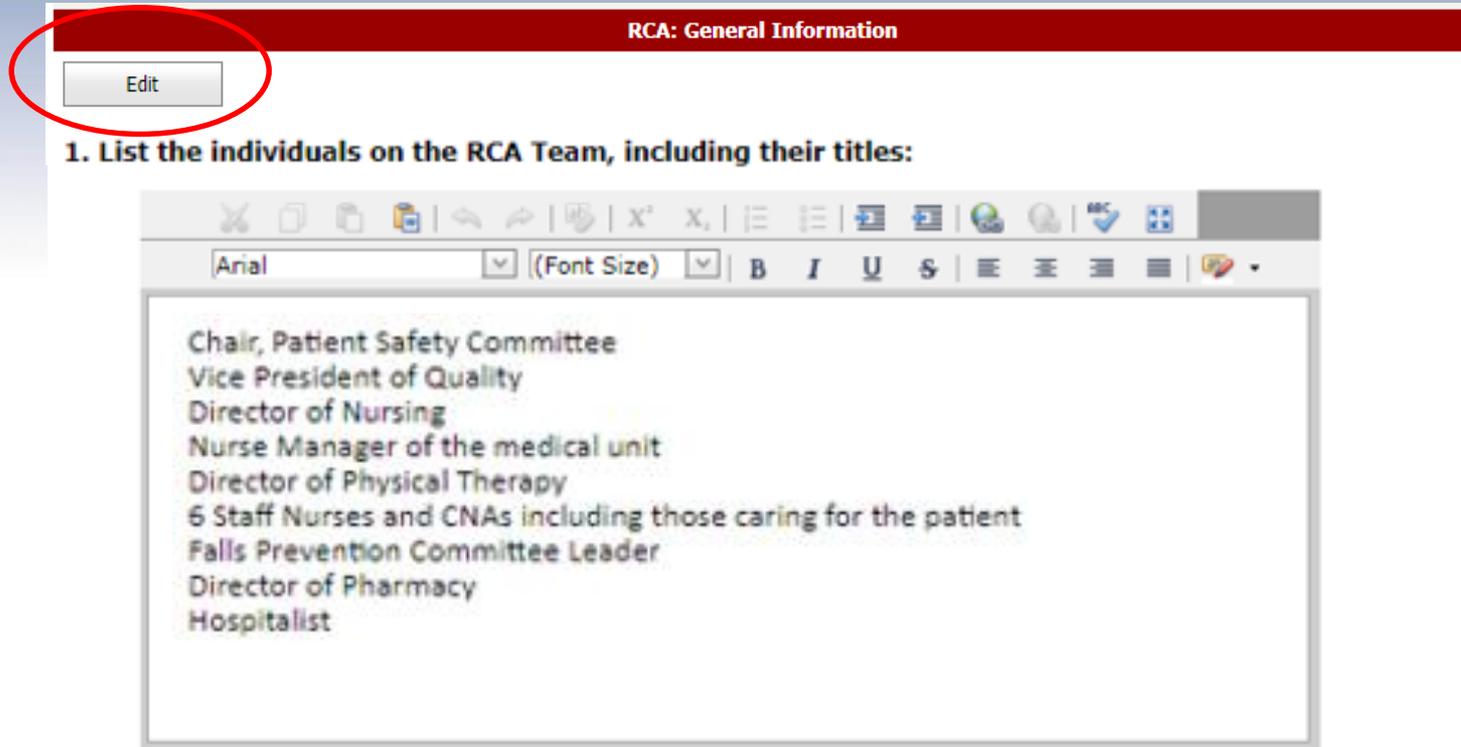
Reviewer Comments:'PSRS has received your additional information and will review and respond. Thank you for your submission.'

Comment Section: RCA: General Information
Added by: |
Reviewer Comments:Please be more specific regarding the members of the RCA team and give their titles.

The comment above was added:11/21/2018 7:04:03 PM by BLiebowitzAdmin

III. RCA Review by PSRS - *continued*

Edit RCA



The screenshot displays a web interface for editing RCA information. At the top, a dark red header bar contains the text "RCA: General Information". Below this header, a button labeled "Edit" is circled in red. Underneath the button, a bold instruction reads: "1. List the individuals on the RCA Team, including their titles:". Below the instruction is a text editor window with a standard toolbar. The text editor contains the following list of roles:

- Chair, Patient Safety Committee
- Vice President of Quality
- Director of Nursing
- Nurse Manager of the medical unit
- Director of Physical Therapy
- 6 Staff Nurses and CNAs including those caring for the patient
- Falls Prevention Committee Leader
- Director of Pharmacy
- Hospitalist

III. RCA Review by PSRS - *continued*

Re-Submit Edited RCA

NJ Health State of New Jersey
New Jersey Department of Health Department of Health Patient Safety Reporting System

Logged in as: | HOME ADD EVENT VIEW EVENTS ▾ RESOURCES ▾ Admin ▾

- Click on comments link(s) below to read DOH 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.
- Click [HERE](#) to send DOH a comment
- Click [HERE](#) to see the Communication Log
- [Upload Supporting Documentation](#)

Please click the 'Submit' tab below to notify DOH that this RCA is ready for review

Initial Event Root Cause Analysis

Report Menu: General Info Facts of Event RCA Questions Root Cause/Action Plan Additional Questions **Submit RCA**

III. RCA Review by PSRS - *continued*

Email: RCA Complete:

1. The RCA is closed
2. Additional information or clarification may be requested to complete the RCA Review
3. An email is sent to the FacAdmins
 - *The status of this RCA has changed. Please log into the Patient Safety Reporting System to view the details and respond accordingly.*
 - **Note: PSRS must be added as a safe sender so PSRS emails do not go to your spam folder**

III. RCA Review by PSRS - *continued*

Email: RCA Complete *continued*:

4. A Facility User must log into the PSRS to read the Status of the RCA, which will be located in the Communication log for that RCA, and respond accordingly.
5. If requested, additional information may be sent to PSRS by
 - General Comment
 - Attachment (Upload Documentation)
 - Covered in 'Other Communications about the RCA'

III. RCA Review by PSRS - *continue*

Communication Log

Communication Log

Click [HERE](#) to view all comments

Added by	Date	Communication Type	Description
	11/25/2018	Email:RCA Complete	<p>Report Number:20180356 Email Text Sent to Facility:'The status of this RCA has changed. Please log into the Patient Safety Reporting System to view the details and respond accordingly.'</p> <p>Reviewer Comments:'Thank you for the timely submission of this RCA. We will be closing this RCA with the following comments/suggestions. Please respond to comment #s 11 & 12 in a General Comment within two weeks by 12/12/2018. Thank you for your cooperation. '</p>
	11/25/2018	RCA Submission	<p>Report Number:20180356 Email Text Sent to Facility:A new RCA has been entered. Please log into the Patient Safety Reporting System to view the details of the RCA.</p>
	11/24/2018	General Comment	<p>Report Number:20180356 Email Text Sent to Facility:There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly.</p> <p>Reviewer Comments:Thank you for the submission of this RCA. The following are the comments, questions, and recommendations made based on the information provided on the RCA submitted. Please respond to these comments in question #2 of the RCA: Facts of the Event section, which is an unlimited text field, within two weeks by 12/5/18. Thank you for your</p>

Click and drag to expand

IV. Other Communications About the RCA - *continued*

Email: RCA Complete

Logged in as HOME ADD EVENT VIEW EVENTS ▾ RESOURCES ▾ 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

Show Customization Dialog

Drag a column header here to group by that column

View	Report Year	Event Type ▾	Admit Date ▾	Admission Through	Report Number ▾ ▾	Event Status ▾	Reportable Ever	Facilit
Clear	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	20180356	<input type="text"/>	<input type="text"/>	<input type="text"/>
Detail	2018	Environmental - Fall	11/19/2018	Direct Admission	20180356	Closed	Reportable RCA Required	TEST FACIL FORT

Page 1 of 1 (1 items) < **[1]** >

Patient Safety Reporting System

IV. Other Communications About the RCA

Communication from PSRS

- FacAdmins receive notification via email there is a communication from PSRS

1. General Comment or Email:Other

- *There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly*

2. Access Communications using the Communication Log

IV. Other Communications About the RCA - *continued*

Email: Other

Communication Log

Communication Log

Click [HERE](#) to view all comments

Added by	Date	Communication Type	Description
	11/21/2018	Email: Other	<p>Report Number:20180356</p> <p>Email Text Sent to Facility:'There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly.'</p> <p>Reviewer Comments:'Thank you for submitting your RCA. We will review and get back to you with our determination.'</p>

IV. Other Communications About the RCA - *continued*

Email: General Comment

Communication Log			
	11/20/2018	General Comment	<p>Report Number:20180356</p> <p>Email Text Sent to Facility:There is a new comment available from the Patient Safety Reporting System. Please log into the web based system and check the Communication Log to review the comment and respond accordingly.</p> <p>Reviewer Comments:Please be more specific regarding the timeline of events. Please enter time in military format.</p>

IV. Other Communications About the RCA - *continued*

Communication to PSRS

- PSRS will receive email notification that there is a communication from the facility about a specific Event
- Be sure to send communication for the correct Event number

1. General Comment

2. Respond to PSRS Comment

3. Send Communication through the Communication Log

IV. Other Communications About the RCA - *continued*

The screenshot shows the top navigation bar of the NJ Health Patient Safety Reporting System. The header includes the NJ Health logo and the text "State of New Jersey Department of Health Patient Safety Reporting System". Below the header is a navigation menu with the following items: "HOME", "ADD EVENT", "VIEW EVENTS" (with a dropdown arrow), "RESOURCES" (with a dropdown arrow), and "Admin" (with a dropdown arrow). A "Logged in as:" label is positioned to the left of the menu. Below the menu, there are two bullet points: "Click [HERE](#) to send DOH a comment" and "Click [HERE](#) to see the Communication Log". The first bullet point is circled in red. At the bottom of the screenshot, there are two buttons: "Initial Event" and "Root Cause Analysis".

IV. Other Communications About the RCA - *continued*

Send a comment

Check Spelling ...

Thank you for your feedback regarding our RCA. We will review your comments and make the appropriate changes.

Cancel\Close **Send Comment**

Click and drag to expand

Director of Nursing

IV. Other Communications About the RCA – *continued*

Upload Supporting Documentation

- Documents can be attached to the RCAs; contact PSRS through the PSRS Communication Log to enable the attachment function
- Applies to a single Event or RCA
- Do NOT attach medical records
- Attachment titles cannot contain special characters, for example: @ ! ? *

IV. Other Communications About the RCA – *continued*

Upload Supporting Documentation

NJ Health State of New Jersey
New Jersey Department of Health Department of Health Patient Safety Reporting System

Logged in as: HOME ADD EVENT **VIEW EVENTS** RESOURCES 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

Show Customization Dialog

Drag a column header here to group by that column

View	Report Year	Admit Date	Admission Thro	Report Number	Event Status
Detail	2018	11/19/2018	Direct Admission	20180356	Event-DOH Review
Detail	2018	10/15/2018	Direct Admission	20180347	Event-Facility Edit
Detail	2018	10/15/2018		20180348	Event-DOH Review

IV. Other Communications About the RCA – *continued*

Upload Supporting Documentation

NJ Health State of New Jersey
New Jersey Department of Health Department of Health Patient Safety Reporting System

Logged in as: HOME ADD EVENT VIEW EVENTS ▾ RESOURCES

- Click [HERE](#) to send DOH a comment
- Click [HERE](#) to see the Communication Log
- [Upload Supporting Documentation](#)

Initial Event Root Cause Analysis

Note: This link is not available unless the attachment function is enabled by PSRS.

REVIEW

- 1. Use “View Events” menu to find Event requiring RCA**
- 2. Enter Root Cause and Action Plan**
- 3. Multiple Root Causes and Action Plans can be entered**
- 4. PSRS reviews RCA and responds with next step**
- 5. Review PSRS comments and respond accordingly**

Next Module

- I. System Navigation**
- II. Reports**
- III. Resources and Support**