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
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

![Dropdown with options](image-url)
I. Preparing to Enter Root Cause Analysis and Action Plan – continued
I. Preparing to Enter Root Cause Analysis and Action Plan – continued

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

View Events (includes RCAs)

![Event View](image)

- 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.

<table>
<thead>
<tr>
<th>View</th>
<th>Report Year</th>
<th>Event Type</th>
<th>Admit Date</th>
<th>Admission Through</th>
<th>Report Number</th>
<th>Event Status</th>
<th>Reportable Event</th>
<th>Test Facility</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2018</td>
<td>Environmental - Fall</td>
<td>11/19/2018</td>
<td>Direct Admission</td>
<td>20180356</td>
<td>RCA-Facility Edit</td>
<td>Reportable RCA Required</td>
<td>TEST FACILITY</td>
</tr>
</tbody>
</table>

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

Locate Comments

- Click HERE to send DOH a comment
- Click HERE to see the Communication Log
I. Preparing to Enter Root Cause Analysis and Action Plan – continued

Communications Log

Click HERE to view all comments
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
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)

2

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.

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

RCA: Facts of the Event

Event Classification: Environmental - Fall

1. Facts of the Event (Answer all that apply or enter ‘NA’ where not applicable):
   - 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)

2. 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: 134/74, P: 81, R: 20
     
   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-syncpe. 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 if risk, non-slip 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 11/15/2018 at 2330, the patient was assisted to the bathroom. She fell asleep just after returning to bed. At 0630 on 11/19/2018, she was noted to be asleep with the bed alarm on.

257 Characters left
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 85, 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.

Characters left:

1603

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

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

9. 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

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

RCA: Facts of the Event

*All fields will need to be completed before the RCA can be submitted*
II. Enter Root Cause Analysis and Action Plan – continued

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: 11/19/2018
   - Time: 1900
   - 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? Morse
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?
   b. Upon transfer between units?
   c. Upon change in status?
   d. Post-fall?

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

9. Was a fall prevention intervention plan documented?

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

11. Was patient/family education completed?

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

13. Was the following equipment used to reduce falls for this patient at the time of the event:
   a. Side rails in proper position?
   b. Were restraints used?
   c. If no, were restraints considered?
   d. Was the pt wearing non-skid foot wear?
   e. Did foot wear fit properly?
   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
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

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

*If no Root Cause, click HERE to explain the findings

1. Root Cause Categories:
   - Behavioral assessment process
   - Patient identification process
   - Care planning process
   - Orientation and training of staff
   - Supervision of staff
   - Communication among staff members
   - Adequacy of technical support
   - Control of medications (Storage/access)
   - Physical assessment process
   - 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.

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Using the Five Rules of Causation

NJHealth
New Jersey Department of Health
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. Otherwise, the root cause analysis is worthless. The bottom line: the reader needs to understand who or what caused the event to occur.

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

  As humans, we try to make each job we have as easy as possible. Unfortunately, this human tendency works it way into RCA. We may shorten our findings by saying “he was poorly written” when we really have a much more serious error in mind. To force clear cause and effect (descriptive vs. inflammatory statements), we recommend against using a descriptor that is merely the placeholder for a more complete and clear description. Even words like “carelessness” and “inadequate” are poor choices because they are broad, negative judgments that do not describe the actual conditions or behaviors that led to the outcome.

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

  Most of our mishaps involve at least one human error. In order to determine a human has errored does little to aid your analysis. 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 technologist 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

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.
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.

3. Methodology

4. Frequency

Weekly

5. Sample Size

30

6. Implementation Start Date

12/3/2018

7. Staff position responsible for implementation:

Nurse Manager/Desigee

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II. Enter Root Cause Analysis and Action Plan – continued

RCA: Action Plan

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

9. Goal

10. Threshold

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.

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.

*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.

<table>
<thead>
<tr>
<th>Report Menu:</th>
<th>Return to Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Number: 20180356</td>
<td></td>
</tr>
<tr>
<td>Event Classification: Environmental - Fall</td>
<td></td>
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</table>

Use this section to edit/add root cause findings

- To Edit a Root Cause - Click on 'Edit' on the appropriate row in the grid below.
- To Add an Action Plan - Click on 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

<table>
<thead>
<tr>
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<td>Care planning process</td>
<td>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.</td>
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II. Enter Root Cause Analysis and Action Plan – continued

Edit/Add Root Cause Findings

Use this section to edit/add root cause findings

- **To Edit a Root Cause** - Edit the root cause by clicking 'Edit' on the appropriate row in the grid below.
- **To Add an Action Plan** - Click on **Add Action Plan** below to expand root cause then click on 'Add Action Plan'.
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**RCA: Action Plan**

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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 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.

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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

Use this section to edit/add root cause findings

- **To Edit a Root Cause** - Edit the root cause by clicking 'Edit' on the appropriate row in the grid below.
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- **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

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II. Enter Root Cause Analysis and Action Plan – continued

RCA Additional Questions

1. What were the contributing factors to the event? (Select all that apply):
   - Team factors
   - Task factors
   - Patient characteristics
   - Medical devices
   - Procedures
   - Equipment
   - Patient record documentation
   - Laboratory and diagnostics

   Other:

2. Evaluate the impact of event for Patient (Select all that apply):
   - Loss of limb(s)
   - Loss of digit(s)
   - Loss of body part(s)
   - Loss of organ(s)
   - Loss of sensory function(s)
   - Loss of bodily function(s)
   - Disability-physical or mental impairment
   - Additional laboratory testing or diagnostic imaging
   - Other additional diagnostic testing
   - Additional patient monitoring in current location

   Other:
II. Enter Root Cause Analysis and Action Plan – continued

RCA Additional Questions

3. ICD Codes resulting from event:
   828.8

4. Diagnosis resulting from event:
   Closed fracture of the left hip.

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. NO 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).

   *All Fields are Required
   Save/Next
II. Enter Root Cause Analysis and Action Plan – continued

Submit RCA to PSRS
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**

- **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.

<table>
<thead>
<tr>
<th>Added by</th>
<th>Date</th>
<th>Communication Type</th>
<th>Description</th>
</tr>
</thead>
</table>
|          | 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. 8:43B-10.6(b) "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**

<table>
<thead>
<tr>
<th>Initial Event</th>
<th>Root Cause Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Menu:</strong></td>
<td>General Info Facts of Event RCA Questions Root Cause/Action Plan Additional Questions Submit RCA</td>
</tr>
<tr>
<td><strong>Report Number:</strong></td>
<td>20180357</td>
</tr>
<tr>
<td><strong>Event Classification:</strong></td>
<td>Environmental - Fall</td>
</tr>
</tbody>
</table>

1. List the individuals on the RCA Team, including their titles:
III. RCA Review by PSRS - continued

Email: RCA Comment Process continued

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
III. RCA Review by PSRS - continued

Email: RCA Comment Process *continued*
III. RCA Review by PSRS - continued

Review All Comments Link

**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

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

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
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
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

<table>
<thead>
<tr>
<th>Added by</th>
<th>Date</th>
<th>Communication Type</th>
<th>Description</th>
</tr>
</thead>
</table>
|          | 11/25/2018 | Email: RCA Complete  | **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.  
**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. |
|          | 11/25/2018 | RCA Submission       | **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. |
|          | 11/24/2018 | General Comment      | **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 12/12/18. Thank you for your

---

[Logo: NJ Health New Jersey Department of Health]
IV. Other Communications About the RCA - continued

Email: RCA Complete

<table>
<thead>
<tr>
<th>View</th>
<th>Report Year</th>
<th>Event Type</th>
<th>Admit Date</th>
<th>Admission Through</th>
<th>Report Number</th>
<th>Event Status</th>
<th>Reportable RCA Required</th>
<th>FORT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018</td>
<td>Environmental - Fall</td>
<td>11/19/2018</td>
<td>Direct Admission</td>
<td>20180356</td>
<td>Closed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
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

<table>
<thead>
<tr>
<th>Added by</th>
<th>Date</th>
<th>Communication Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11/21/2018</td>
<td>Email:Other</td>
<td></td>
</tr>
</tbody>
</table>

**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 submitting your RCA. We will review and get back to you with our determination.
IV. Other Communications About the RCA - continued

Email: General Comment

<table>
<thead>
<tr>
<th>Date</th>
<th>Type</th>
<th>Report Number</th>
<th>Email Text Sent to Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/20/2018</td>
<td>General Comment</td>
<td>20180356</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reviewer Comments: Please be more specific regarding the timeline of events. Please enter time in military format.</td>
</tr>
</tbody>
</table>
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
IV. Other Communications About the RCA - continued

Thank you for your feedback regarding our RCA. We will review your comments and make the appropriate changes.
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
IV. Other Communications About the RCA – continued

Upload Supporting Documentation

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