The Patient Safety Act Reporting and RCA Requirements

Patient Safety Initiative

Health Care Quality Assessment

NJ Department of Health and Senior Services

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Goals for Workshop Today

- Review legislation and rules
- Review implementation of reporting system
- Review reportable events/reporting process
- Review RCA development requirements
- Review Example of a falls RCA

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Goals for Legislation

- Strengthen patient safety
- Promote a systematic analysis
- Emphasize confidentiality
- Sets up reporting system

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Legislative Requirements

- Patient Safety Plans
- Patient Safety Committee
- Inform patient
- Mandatory reporting of serious preventable events
- Anonymous voluntary reporting less serious events

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Implementation: Mandatory Reporting

- Acute care hospitals in February 2005
- Other types of hospitals in April 2008
- Phase in for all licensed facilities

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New Approach to Reporting

- An error viewed as a systems issue
- Facility examines system and corrects
- Not restricted to enforcing regulations
- Submit RCA including monitoring plan

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Confidentiality

- Major component of system
- Protections for facility deliberations under Patient Safety Committee
- Protection of reports to DHSS
- Different from earlier reporting system
- Different from DHSS response for complaints

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How Will Information be Used?

- Facility review of events & RCA
- DHSS review of events & RCA
- Summary of reports
- Newsletters and Alerts
- Work with facilities

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Event Reporting

- Definition of a reportable event
- Types of events to report
- Time frame: 5 business days
- Continuation of other reporting

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Process for Reviewing Event Reports/RCAs

- Using forms and fax to report
- Review each form submitted
- May ask for additional information
- Confirm receipt of event form
- RCA due in 45 calendar days
- Also confirm receipt of RCA
- Review RCA-may ask questions
- Confirm that RCA is accepted

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Reporting Form Issues

- Download forms:

  www.NJ.gov/health/ps
- “Brief Event Description” (question 2)
- “Incident Date and Date Discovered” (question 2)
- “How was event discovered” (question 3)
- The patient safety liaison

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NQF Reporting Categories

- Care Management
- Environmental
- Product or Device
- Surgery-Related
- Patient Protection

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The RCA Process

RCA 101

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Culture of Safety

An organization's commitment
to patient safety
as a top-level priority.

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Culture of Safety

- Acknowledgment of high-risk, error-prone nature of organization's activities
- Blame-free environment
- Expectation of collaboration across ranks
- Willingness to direct resources to address safety concerns

AHRQ

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Culture of Safety
RCA Process

Emphasis on improving and redesigning systems and processes

Emphasis is *not* on individual performance

VA NCPS

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Root Cause Analysis (RCA)

- A process to identify the basic or contributing causal factors that underlie variations in performance associated with Adverse Events
- A specific type of focused review
- A tool for identifying prevention strategies

VA NCPS

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RCA Goals

- Identify ***what*** happened
- Identify ***why*** it happened
- Identify ***how*** to prevent recurrence

VA NCPS

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RCA Team

- Ad hoc under Patient Safety Committee
- Interdisciplinary & diverse
  - Staff knowledgeable about processes involved in the event
  - Front line staff
  - Staff involved in event (?)
- Commitment to RCA process

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RCA Components

1. Facts of Event
2. Causality Statements
3. Action Plan
4. Monitoring

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Component 1: Facts of Event

- Patient history *related to event*
- Chronological order
- Specific details of event
  - date, time, location
- Effect on patient
- Identify staff by title
- Similar event in the past 3 years

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Case Example Narrative

68 y.o. obese female, recently widowed, hard of hearing, history of TBI, HTN, asthma, fall with S/P ORIF, depression with suicide attempt

Admitted for follow-up care on 5/25/08. Verbal Admitting orders. Nurse transcribed incorrect allergy (Biaxin in place of Bactrim).

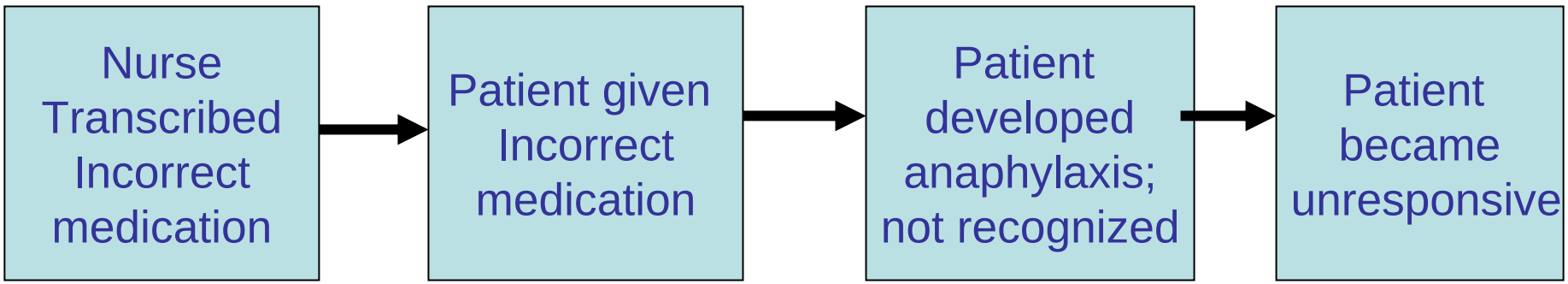
On 5/28/08, patient diagnosed with UTI. At 2 PM. Patient received dose of Bactrim. At 4 PM, patient complained of flushing, pruritis and chest tightness. During Nursing assessment, patient became severely SOB and then unresponsive.

BLS was instituted. Patient was emergently transferred to acute care hospital ED. Patient expired.

Narrative Timeline

- Patient admitted on 5/25/08 at 1800
- Physician phoned verbal orders without read back
- Nurse transcribed incorrect allergy information (Biaxin in place of Bactrim)
- Patient diagnosed with UTI on 5/28/08
- Patient received Bactrim at 1400
- At 1600, patient c/o chest tightness, flushing; became SOB and unresponsive
- BLS initiated and patient was transferred to ED; patient expired

Event Flow Diagram



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Component 2: Causality Statements

Most often, a root cause is a known or unknown system vulnerability

Human weakness is almost never a root cause

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Identify Root Causes

- Broad review: Areas of Causality
- Narrow analysis to relevant areas
- Focus on most significant areas

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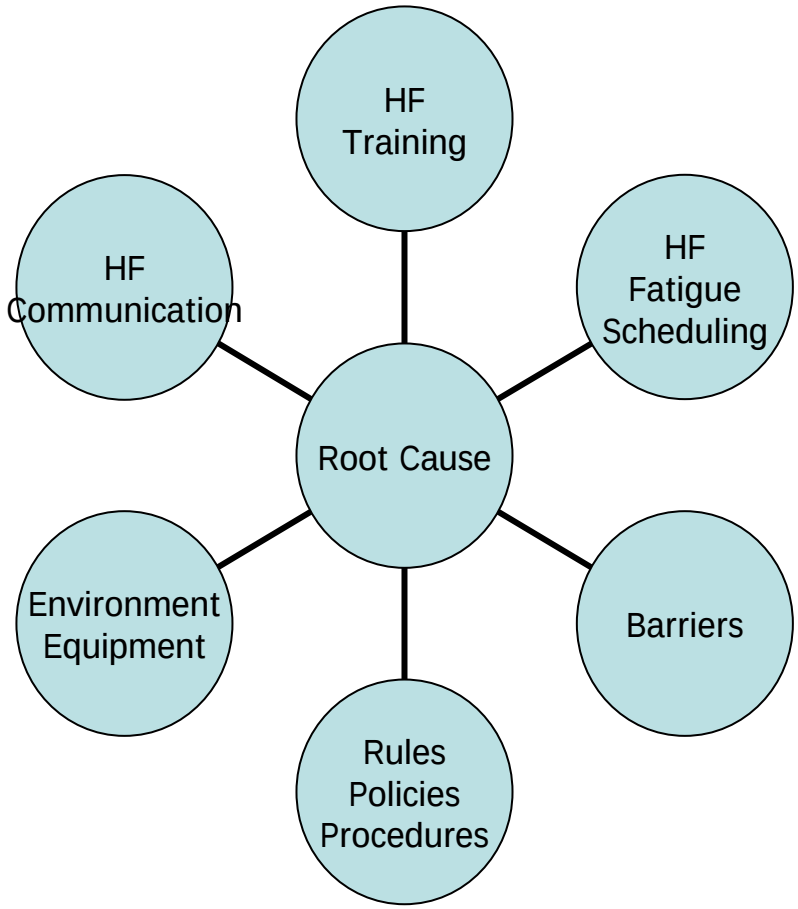
Areas of Causality



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Human Factors Communication

Patient identification

- Shared information
  - Assessments, documentation
- Co-worker to co-worker
- Management to front line staff
  - Policies/procedures, technical information
- Staff to patient/family

(Beige paper)

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Human Factors Training

- Training program
- Training provided
- Monitored
- Adequate
- Procedures/Equipment
  - Related to staff need, experience, work space

(Pink paper)

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Human Factors
Fatigue/Scheduling

- Environmental conditions
- Environmental stressors
- Adequate sleep
  - Scheduling issues
- Staff to workload ratio
- Level of automation

(Yellow paper)

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Environment Equipment

- Environment appropriate to function
- Environmental risk assessment
- Environment stress levels
- Equipment design
- Equipment maintenance program
- Safely evaluations/reviews
- Codes/specifications/regulations

(Green paper)

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Rules/Policies/Procedures

- Risk management plan
- Quality control system
- Prior audit, results & interventions
- Facility's mission, expertise & services
- Qualifications/training/orientation
- Up-to-date policies & procedures
  - Functional
  - Obstacles

(Purple paper)

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Barriers

- Design of barriers
  - Patients, staff, equipment, environment
  - Patient risk
- Were barriers in place
  - Prevention of event
- Maintenance
- Pre-implementation testing

(Blue paper)

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Identify Root Causes

- Ask *why, why, why* event occurred
- Use answers to focus on areas of causality
- *Beware of hindsight bias*

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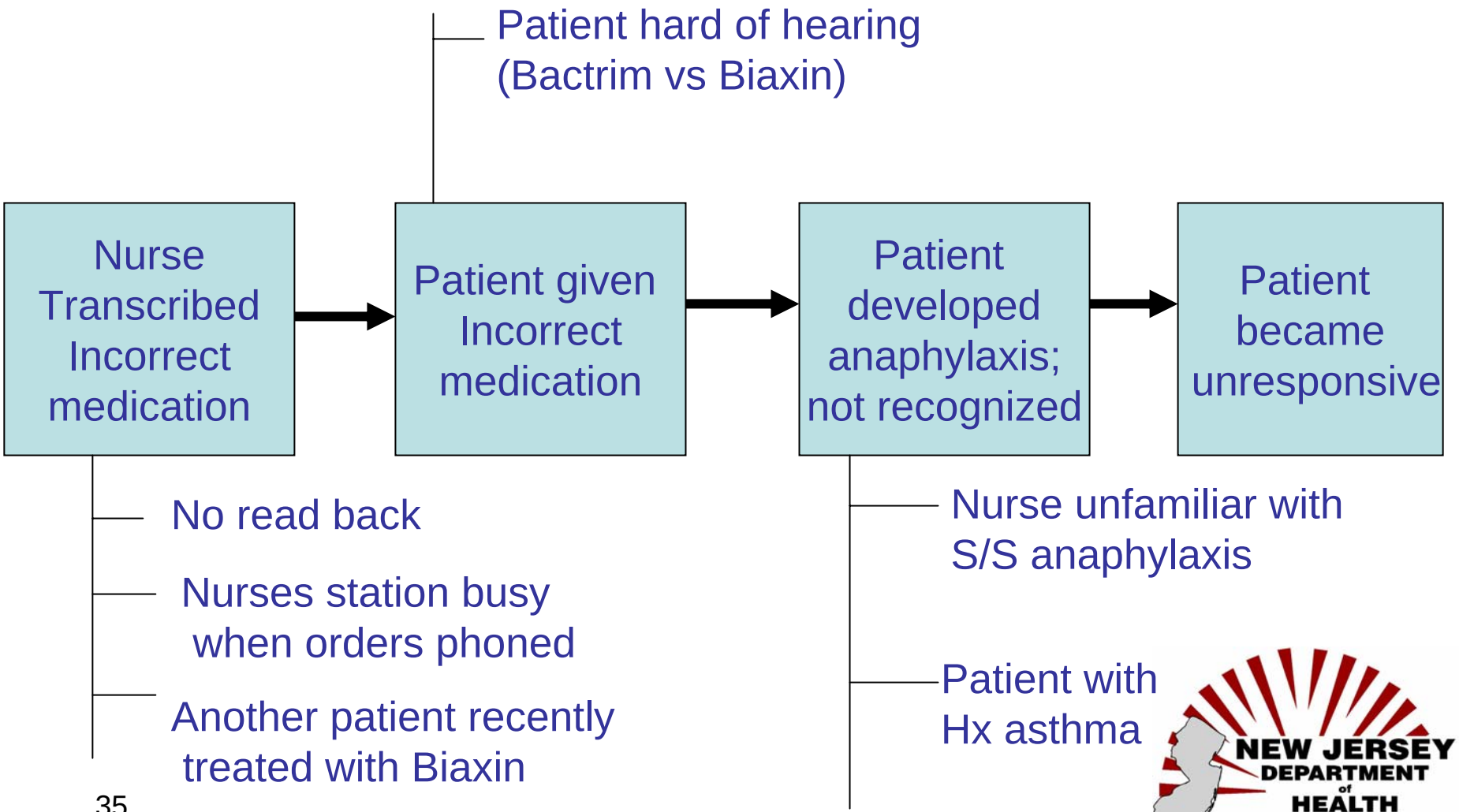
Event Flow Diagram Revisited



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Area of Causality Example

- Human Factors-Communication
- Human Factors-Training
- Human Factors-Fatigue/Scheduling
- Environment/Equipment
- Rules/Policies/Procedures
- Barriers

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5 Rules of Causation

- Must clearly show “cause and effect”
- Avoid negative descriptions
- Human error must have a preceding cause
  - System cause of the error
- Violations of procedure must have a preceding cause
  - Positive & negative incentives
- Failure to act only if pre-existing duty

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Causality Statement

[***Something***] increased the likelihood of
[***something***] happening,
which led to the adverse event

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Causality Statement #1

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Causality Statement #1

The practice of providing verbal admissions orders increased the probability that ***the nurse would transcribe the incorrect allergy information***, which increased the probability that ***the patient would receive the wrong medication***.

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Component 3: Action Plan

- Addresses the root causes
- Specific and concrete
- Doable
- Consult process owners

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Levels of Action Plans

- Weaker actions
- Intermediate actions
- Stronger actions

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Action Plan

- Examine each causal statement & create action plans for each
- Specific and concrete
- Action plans should prevent or decrease the possibility of future adverse events
  - Decrease the injury if the event occurs.
- Identify stronger compared to weaker actions.
- Choose permanent over temporary actions.

Causality Statement #1

The practice of providing verbal admissions orders increased the probability that ***the nurse would transcribe the incorrect allergy information***, which increased the probability that ***the patient would receive the wrong medication***.

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Action Plan for Causal Statement #1

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Action Plan #1 Weaker

- The Nursing Managers will issue a memorandum alerting all nursing staff to this issue by 7/15/08.

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Action Plan #2
Stronger

- By 7/1/08, all Admission Orders, including allergy information, will be entered into the computer by the physician.

Action Plans

- Weaker ⇨ Memo
- Intermediate ⇨ Remove LASA meds
- Stronger ⇨ Direct order entry

Review Action Plans

- Do these actions address the cause?
- Will they prevent or reduce the probability of future events?
- Are actions doable?

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Component 4: Monitoring

- Outcome measures
  - Assess the action's effect to prevent/minimize additional events
- Specific
- Quantifiable
- Timeframe

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Monitoring for Action Plan #2

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Monitoring for Action Plan #2

- **The Performance Improvement Nurse Manager will review 15 charts per week for compliance for 3 months.**

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In Perspective

The significant problems we face cannot be solved at the same level of thinking we were at when we created them

–**Albert Einstein**, *(attributed)*
US (German-born) physicist (1879 - 1955)

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Psychological Perspective

Insanity:

Doing the same thing over and over again
And expecting different results.

–**Albert Einstein**, *(attributed)*
US (German-born) physicist (1879 - 1955)

PRACTICE SESSION

From Adverse Event Report

To

Root Cause Analysis Report

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Serious Preventable Adverse Event

SERIOUS

PREVENTABLE

ADVERSE

EVENT

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New Jersey Department of Health and Senior Services

REPORT OF SERIOUS PREVENTABLE ADVERSE EVENT IN A NEW JERSEY LICENSED HEALTH CARE FACILITY

NJDHSS INTERNAL USE ONLY
Report No.

This form must be completed for any serious preventable adverse event, which results in death or loss of a body part, or disability or loss of bodily function lasting more than seven (7) days or present at discharge. All information is protected based on the provisions of the Patient Safety Act [N.J.S.A. 26:2H-12.25(l)]

Is this a revision of an earlier report to the Patient Safety Initiative for the same event? ☐ Yes ☐ No	If yes, give DHSS Report Number:	Facility Internal Tracking Number of this incident, if known:

SECTION A - GENERAL INFORMATION

1. FACILITY IDENTIFICATION

Facility Name: _____ Facility License No.: _____

Facility Street Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Name of Person Submitting: _____ Telephone No.: _____

Title or Position: _____ Fax No.: _____

Email Address: _____

2. PLEASE SUPPLY A SIMPLE AND CLEAR DESCRIPTION OF THE EVENT OR SITUATION YOU ARE REPORTING:

Incident Information:

Incident Date: _____ Time: _____ ☐ AM ☐ PM

Date Discovered: _____ Time: _____ ☐ AM ☐ PM

3. HOW WAS EVENT DISCOVERED? *(Check only one)*

☐ 1. Report by staff/physician
☐ 2. Report by family/visitor
☐ 3. Report by patient/resident
☐ 4. Assessment of patient/resident after event
☐ 5. Review of chart/record
☐ 6. Other: _____

4. PATIENT/RESIDENT INFORMATION

☐ Inpatient or ☐ Outpatient

Admission through: ☐ ED ☐ Direct ☐ Transfer from Acute Care General Hospital ☐ Transfer from LTC

Patient/Resident Billing Number: _____

Patient/Resident Name: _____ Medical Record No.: _____

Street Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: _____

Admission Date or Date of Ambulatory Encounter: _____

Primary Diagnosis: _____

Race:

☐ Caucasian ☐ Amer. Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other: _____
☐ Black ☐ Asian ☐ Unable to Determine

Ethnicity: ☐ Non-Hispanic/Unable to Determine ☐ Hispanic

HCQ-1
OCT 06

Must Be Reported Within 5 Business days!

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New Jersey Department of Health and Senior Services

REPORT OF SERIOUS PREVENTABLE ADVERSE EVENT
IN A NEW JERSEY LICENSED HEALTH CARE FACILITY
Continued

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SECTION B - EVENT DETAILS

5. TYPES OF SERIOUS PREVENTABLE ADVERSE EVENTS *(Check only one)*

A. CARE MANAGEMENT EVENTS in a Health Care Facility

- ☐ 1. Patient/resident death/harm due to a medication error
- ☐ 2. Patient/resident death/harm due to a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- ☐ 3. Maternal death/harm due to labor/delivery in a low-risk pregnancy
- ☐ 4. Patient/resident death/harm due to hypoglycemia
- ☐ 5. Patient/resident death/harm due to failure to identify and treat hyperbilirubinemia in neonates
- ☐ 6. Stage 3 or 4 pressure ulcers acquired after admission
- ☐ 7. Patient/resident death/harm due to spinal manipulative therapy
- ☐ 8. Other event causing patient/resident death or harm that lasts seven days or is present at discharge

B. ENVIRONMENTAL EVENTS in a Health Care Facility

- ☐ 1. Patient/resident death/harm due to an electric shock
- ☐ 2. Any event in which a line designated for oxygen/other gas to be delivered to a patient/resident contains the wrong gas or is contaminated by toxic substances
- ☐ 3. Patient/resident death/harm due to a burn incurred from any source
- ☐ 4. Patient/resident death/harm due to a fall
- ☐ 5. Patient/resident death/harm due to the use of restraints or bedrails
- ☐ 6. Other event causing patient/resident death or harm that lasts seven days or is present at discharge

C. PRODUCT OR DEVICE EVENTS in a Health Care Facility

- ☐ 1. Patient/resident death/harm due to the use of contaminated drugs/devices/biologics
- ☐ 2. Patient/resident death/harm due to the use/function of a device in patient/resident care in which the device is used/functions other than as intended
- ☐ 3. Patient/resident death/harm due to intravascular air embolism
- ☐ 4. Patient/resident death/harm due to the use of a single-use device in which the device is used/functions other than as intended
  - ☐ new single-use device
  - ☐ reprocessed single-use device
- ☐ 5. Other event causing patient/resident death or harm that lasts seven days or is present at discharge

D. SURGERY-RELATED EVENTS

- ☐ 1. Surgery performed on the wrong body part
- ☐ 2. Surgery performed on the wrong patient
- ☐ 3. Wrong surgical procedure performed on a patient
- ☐ 4. Retention of a foreign object in a patient after surgery or other procedure
- ☐ 5. Intraoperative or immediately post-operative coma or death in an ASA Class I inpatient or any ASA Class same day surgery patient or outpatient
- ☐ 6. Other event causing patient death or harm that lasts seven days or is present at discharge

E. PATIENT/RESIDENT PROTECTION EVENTS in a Health Care Facility

- ☐ 1. Infant discharged to the wrong person
- ☐ 2. Patient/resident death/harm due to patient elopement
- ☐ 3. Patient/resident suicide/attempted suicide
- ☐ 4. Other event causing patient/resident death or harm that lasts seven days or is present at discharge

Adopted from The National Quality Forum

NEVER EVENTS

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New Jersey Department of Health and Senior Services

REPORT OF SERIOUS PREVENTABLE ADVERSE EVENT
IN A NEW JERSEY LICENSED HEALTH CARE FACILITY
Continued

NJDHSS INTERNAL USE ONLY
Report No.

6. IF S.A.1 WAS SELECTED, COMPLETE THIS SECTION:

What type of medication error occurred? *(Check all that apply)*

- ☐ Wrong Patient
- ☐ Wrong Drug
- ☐ Wrong Dose
- ☐ Wrong Route
- ☐ Wrong Frequency
- ☐ Wrong Time
- ☐ Omission
- ☐ Administration After Order Discontinued/Expired
- ☐ Wrong Diluent/Concentration/Dosage Form
- ☐ Monitoring Error
- ☐ Other: _____

Brand/Product Name (If Applicable): _____

Generic Name: _____

7. WHERE WAS THE PATIENT/RESIDENT WHEN THE EVENT OCCURRED? *(Check only one)*

- ☐ Patient/Resident Room
- ☐ Emergency Department
- ☐ Radiology
- ☐ Laboratory
- ☐ Operating Room
- ☐ Cardiac Catheterization Laboratory
- ☐ Labor and Delivery
- ☐ Nursery
- ☐ Recovery Room
- ☐ Rehabilitation Areas
- ☐ In Transit
- ☐ ICU / CCU / TCU
- ☐ Step Down Unit
- ☐ Telemetry Unit
- ☐ NICU
- ☐ Hallway or Other Common Area
- ☐ Other:

_____

DIATE CORRECTIVE ACTION(S) TAKEN:

ACTIONS FOR THE PATIENT

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NJDHSS Reporting Initiative

- **Reports of Preventable Adverse Events began in February, 2005**
- **Falls with Serious Injury and Pressure Ulcers are the most reported event types for the last two years**

YEAR	ADVERSE EVENTS	FALLS	PRESSURE ULCERS
2005	376	125	77
2006	450	165	129

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Root Cause Analysis

Purpose:

To identify the factor or factors that led to and caused the serious preventable adverse event

Conducting and writing an RCA is an opportunity to examine how the systems for providing care function.

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RCA Components

The RCA must have four components:

1) **Facts of the Event**

2) **Causality Statements**

3) **Prevention Strategies or Actions**

4) **Monitoring**

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Component One

FACTS OF THE EVENT

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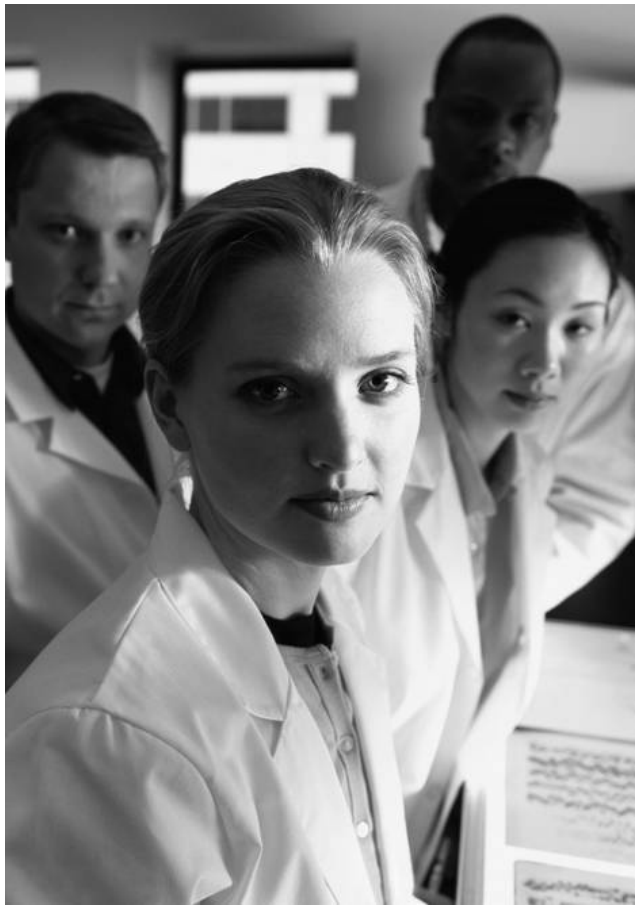
The RCA Team



- **Multidisciplinary**
- **Ad Hoc Members**
- **Subject Matter Experts**

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Potential Team Members

- Medical Director
- Director of Psychiatric Medicine
- Director of Nursing
- Performance Improvement
- Risk Management
- Patient Safety Liaison
- Clinical Pharmacist

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Potential Team Members

- Nurse Manager of Behavioral Health Unit
- Patient Caregivers (RN, LPN, PCA, Tech)

Other Examples:

- Engineering
- Dietary
- Housekeeping
- Occupational Health and Safety
- Physical Therapy
- Transportation
- Respiratory Therapy

Component Two

CAUSALITY STATEMENT

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Causality Statement

[***Something***] increased the likelihood of
[***something***] happening,
which led to the adverse event

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Searching for Root Causes

The **Facts of the Event** are reviewed by the entire RCA Team

Tools such as the NCPS Triage Questio for RCA, a detailed timeline, or a flow diagram/chart may be used to explore potential root causes.

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Areas of Causality

- Human Factors – Communication
- Human Factors – Training
- Human Factors – Fatigue/Scheduling
- Environment/Equipment
- Rules/Policies/Procedures
- Barriers

Other Tools

DETAILED TIMELINE

Facts of the Event with specific dates and times

DIAGRAMS

Event Flow Diagram

Intermediate Event Flow Diagram

Final Flow Diagram

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Methodologies

Different assessment methodologies may be used for determining root causes but they always involve repeatedly asking **“Why”.**

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Areas of Causality

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Causality Statement

Definition

The Causality Statement is a brief, succinct sentence that connects an identified factor with the adverse event.

The **Facts of the Event** information is used to examine the processes involved in the event in order to identify WHY the event occurred.

WHY the adverse event occurred, the underlying reason(s), is the **root cause**.

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Rules of Causation

- Five Rules
- Designed to improve the RCA Process by minimizing the very real biases we all bring to an investigation
- Create minimum standards for how an RCA investigation and its results should be documented

5 Rules of Causation

Rule 1: Root Cause Statements must clearly show the "cause and effect" relationship.

Rule 2: Negative descriptors are not used in causal statements.

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

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

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

-NCPS

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Causality Statements

"**The lack of** (insert the process or system) **related to** (insert the reason it happened, the root cause) **may have led to** (name the type of adverse event)"

Examples

"**The lack of** proper implementation of the Falls Prevention strategies for high risk fall patients, **related to** the absence of a cross training program for float staff, **may have led to** the fall with serious injury."

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Causality Statements

Causality Statement	**Action or Prevention Strategy**	**Monitoring**
•Cause and Effect Relationship •No negative descriptions •Human Errors/Policy Violations- must have a preceding cause •Procedures deviations •Failure to Act only Causal if there is pre-existing Duty to Act	•Specific, measurable actions, implemented within 45 days of incident, or are currently being implemented •Include time frames, responsible staff	•Includes specific time frames and responsible staff •Need to Confirm actions have taken place

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Component three

Actions/Prevention Strategies

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Actions/Prevention Strategies

Prevention strategies or actions describe what will be done to address an identified root cause.

- Root cause may have more than one action in the action plan
- Action(s) should be clearly defined, measurable, and relate to a specific root cause
- Specified time frames for implementation and a designated person responsible for implementation should be stated

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Actions/Prevention Strategies

- Actions should prevent or decrease the possibility of future adverse events
- Implement stronger actions, if possible, as compared to weaker actions
- Implement permanent actions over temporary actions, if possible

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Actions/Prevention Strategies

Causality Statement	**Action or Prevention Strategy**	**Monitoring**
• Cause and Effect Relationship • No negative descriptions • Human Errors/Policy Violations- must have a preceding cause • Procedures deviations • Failure to Act only Causal if there is pre-existing Duty to Act	• Specific, measurable actions, implemented within 45 days of incident, or are currently being implemented • Include time frames, responsible staff	• Includes specific time frames and responsible staff • Need to Confirm actions have taken place

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Component four

Monitoring

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Monitoring

- Describes how the effectiveness of each action will be measured and communicated.
- States what will be monitored, by whom, and for how long.
- Specific for each action

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Monitoring

Causality Statement	**Action or Prevention Strategy**	**Monitoring**
•Cause and Effect Relationship •No negative descriptions •Human Errors/Policy Violations- must have a preceding cause •Procedures deviations •Failure to Act only Causal if there is pre-existing Duty to Act	•Specific, measurable actions, implemented within 45 days of incident, or are currently being implemented •Include time frames, responsible staff	•Includes specific time frames and responsible staff •Need to Confirm actions have taken place

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

New Jersey Department of Health and Senior Services

REPORT OF SERIOUS PREVENTABLE ADVERSE EVENT IN A NEW JERSEY LICENSED HEALTH CARE FACILITY: ROOT CAUSE ANALYSIS (RCA)

NJDHSS INTERNAL USE ONLY
Report No.

This form must be completed for any serious preventable adverse event, which results in death or loss of a body part, or disability or loss of bodily function lasting more than seven (7) days or present at discharge. All information is protected based on the provisions of the Patient Safety Act [N.J.S.A. 26:2H-12.25(f)]

SECTION A - GENERAL INFORMATION

1. FACILITY IDENTIFICATION

Facility Name: _____ Facility License No.: _____

Facility Street Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Name of Person Submitting: _____ Telephone No.: _____

Title or Position: _____ Fax No.: _____

Email Address: _____

SECTION B - INCIDENT INFORMATION

2. INCIDENT DATE: _____ Time: _____ ☐ AM ☐ PM

Date Initial Report Sent to Patient Safety Initiative: _____ DHSS Report Number (Assigned by DHSS): _____

Medical Record Number: _____ Patient/Resident Billing Number: _____

Patient/Resident Name: _____

SECTION C - ROOT CAUSE ANALYSIS

3. SELECT ROOT CAUSE (Select all that apply):

- ☐ Behavioral assessment process
- ☐ Patient identification process
- ☐ Care planning process
- ☐ Orientation & training of staff
- ☐ Supervision of staff
- ☐ Communication among staff members
- ☐ Adequacy of technical support
- ☐ Physical environment
- ☐ Control of medications (Storage/access)
- ☐ Physical assessment process
- ☐ Patient observation procedures
- ☐ Staffing levels
- ☐ Competency assessment/credentialing
- ☐ Communication with patient/family
- ☐ Availability of information
- ☐ Equipment maintenance/management
- ☐ Security systems and processes
- ☐ Labeling of medications
- ☐ Other: _____

New Jersey Department of Health and Senior Services

REPORT OF SERIOUS PREVENTABLE ADVERSE EVENT IN A NEW JERSEY LICENSED HEALTH CARE FACILITY: ROOT CAUSE ANALYSIS (RCA)
(Continued)

NJDHSS INTERNAL USE ONLY
Report No.

4. WHAT WERE THE CONTRIBUTING FACTORS TO EVENT (Select all that apply):

- ☐ Team factors
- ☐ Task factors
- ☐ Patient characteristics
- ☐ Medical Device
- ☐ Procedures
- ☐ Equipment
- ☐ Patient record documentation
- ☐ Laboratory and diagnostics
- ☐ Work environment
- ☐ Staff factors
- ☐ Organizational/management
- ☐ Medications
- ☐ Transportation
- ☐ Home Care
- ☐ Imaging and X-rays
- ☐ Other (Specify): _____

5. EVALUATE IMPACT OF EVENT FOR PATIENT/RESIDENT (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
- ☐ Other (Specify): _____
- ☐ Additional patient monitoring in current location
- ☐ Visit to Emergency Department
- ☐ Hospital admission
- ☐ Transfer to more intensive level of care
- ☐ Increased length of stay
- ☐ Minor surgery
- ☐ Major surgery
- ☐ System or processes delay care to a patient
- ☐ To be determined
- ☐ Death

6. DESCRIBE ROOT CAUSE ANALYSIS:

(Attach the RCA.)

45 Calendar Days

Contacts

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NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

Support Materials

- NJ Patient Safety web site:
  http://nj.gov/health/ps/
- Institute for HealthCare Improvement (IHI)
  http://www.ihi.org/ihi
- National Center for Patient Safety (NCPS)
  www.patientsafety.gov/tools/html
- AHRQ Patient Safety Network (PSNet)
  http://psnet.ahrq.gov/

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES