# Education Update

**Trinitas Regional Medical Center**
**Education Department**

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# Patient Safety Act

**N.J. Law Requires Mandatory Reporting of Serious Preventable Adverse**

**The New Jersey Patient Safety Act** was signed into law in October 2004. This law was designed to improve patient safety in hospitals and other health-care facilities by creating a medical error reporting system. The goal is to improve health care quality and save lives by creating a system for healthcare institutions to report and analyze serious preventable adverse events (SPAE) and to create solutions to prevent the occurrence of these errors in the future. ***Reporting of every occurrence*** of a SPAE to the New Jersey Department of Health and Senior Services is **mandatory.**

The Patient Safety Act defines the serious preventable adverse events as: **An adverse event that is a preventable event and results in death or loss of a body part or disability or loss of bodily function lasting more than seven days or still present at the time of discharge.**

**There are 5 categories of SPAEs:**

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

Examples of these Serious Preventable Adverse Events include transfusion of incompatible blood; electric shock or burns; use of contaminated drugs or devices; wrong site, wrong patient, wrong procedure surgery; and inpatient suicide or attempted suicide.

## Definitions

***Adverse Event:***
An event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

***Near Miss:***
An occurrence that **could** have resulted in an adverse event but was prevented.

***Preventable Event:***
An event that could have been anticipated and prepared against but occurs because of an error or other system failure.

## How to Report a Serious Preventable Adverse Event (SPAE)

If you are involved in a SPAE occurrence:

- Complete an Incident Report.
- Report the event to your Manager/Supervisor who will notify the Director of Risk Management.
- The Director of Risk Management will report the incident to the State Department of Health within the 5 day timeframe.
- Follow-up by the hospital will consist of submission within 45 days of a Root Cause Analysis of the reported event.