








# ROOT CAUSE ANALYSIS PROCESS

## St. Cloud Hospital

STEP #	DESCRIPTION	RESPONSIBLE	TIME REQUIRED (approx)
1	<b>Sentinel Event is determined to require an RCA</b>	Care Ctr. Director, Dir. Q/PS and VP, Med. Affairs	.5 hours
2	<b>RCA Notification</b> A. Administration – notify the President, VP Operations, and VP Medical Staff Affairs B. Physician (primary MD involved in the case) <ol style="list-style-type: none"> <li>a. Notify the involved physician if an RCA is being conducted</li> <li>b. Notify the involved physician if an event is reportable to the MN Patient Safety Registry as a “27 Never Event”</li> </ol>	Dir. Q/PS	
3	<b>Determine RCA Team and Meeting:</b> <b>Team:</b> The size of the team will vary depending on the event. Ideally no more than 10 members on the team; can call others ad hoc. Should be an inter-disciplinary team with the department/unit leadership included. Include VP, Medical Staff Affairs. The involved physician is to be involved in the RCA analysis team and meeting unless there is an approved reason for exclusion. Record names on RCA Analysis Team Member form – <b>Attachment A.</b>  <b>Meeting:</b> When setting up the meeting, <u>allow two hours</u> for the actual meeting. Goal of the meeting: review the event, analyze causes, and determine action plans to prevent the event from happening again. Note: RCA’s need to be completed per policy within 45 days of the discovery of the event. If this is a MN Registry Eligible case, the initial report of the event is due within 15 days of discovery and full RCA entry within 60 days of the event.	Director, Dept. or Unit of area involved          Dept/Unit Admin. Assistant	1 hour
4	<b>Data Collection (gather before the meeting):</b> <ol style="list-style-type: none"> <li>1. Brief summary – what happened, when (day, date, time) and outcome.</li> <li>2. Detailed sequence of events leading up to event – the story. Prepare ahead of time with copies for the team. <b>Attachment B.</b></li> <li>3. Describe current process or process as it is supposed to work. Bullet points of key parts of the process.</li> <li>4. Medical Records – information from the chart that reflects the event and interventions should be available. Access to CDR is helpful during the meeting in case additional information is needed.</li> <li>5. Equipment/device/photos/foreign body/etc. – having samples/actual equipment/device involved in the event available at the meeting to help team understand/visualize.</li> <li>6. Review and have available Policies and Procedures pertinent to the event, Standards of Practice, etc.</li> </ol> <p style="text-align: center;">(CONT’D)</p>	Directors/designee(s) 	8-10 hours 

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	7. Staffing – census at time of the event, staffing pattern core and actual at time of the event, specific training/education specific to the care provided. <b>Attachment C.</b> 8. Any safety/preventative maintenance logs as pertinent if equipment involved. 9. Any unrelated/unusual circumstances happening concurrently in the department/unit at the time of event. 10. Literature Search – search any literature for similar events, recommended practice, safety issues, sentinel alerts, etc. The Literature Search findings are to be documented in the Root Cause Analysis (RCA) Worksheet. <b>Attachment D.</b>	Directors/designee(s) 	
5	<b>The Meeting:</b> Team Roles: <ul style="list-style-type: none"> <li>◆ Leader – generally leadership rep of the unit/department where the event occurred. The one who tells the “story” or delegates to another member. Keeps the meeting on track.</li> <li>◆ Facilitator – assures components of RCA analysis are considered and action plans identified with responsible persons, measures, and follow up</li> <li>◆ Recorder – takes attendance (<b>Attachment A</b>), notes of discussion, and provides basis for RCA report (<b>Attachment D</b>)</li> <li>◆ Team –               <ul style="list-style-type: none"> <li>- analyzes event, asks why something happened and looks for causes</li> <li>- assigns root cause</li> <li>- develops action plans</li> </ul> </li> </ul>	Director Dept/Unit or designee(s)  PI Analyst  Dept/Unit Administrative Assistant	2 hours 
6	<b>Post Meeting:</b> <ol style="list-style-type: none"> <li>1. Write up report <b>Attachment D.</b></li> <li>2. Facilitator reviews the RCA report – checks for thoroughness and completeness.</li> <li>3. Facilitator summarizes event and analysis and presents to MCRC</li> <li>4. Assigned individuals carry out the Action Plans (occurs over time)</li> <li>5. Facilitator conducts follow up with leader over time.</li> </ol>	Recorder/Leader/Facilitator  PI Analyst  Per Action Plans  PI Analyst	8-16 hours  Dependent on Action Plans  .5 hours