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HealthEast Root Cause Analysis Summary

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
What happened:	*What departments were involved?*	
	What are the details of the event?	
Why did it happen: (Proximate cause)	*What was the missing or weak step in the process?*	
Why did that happen?	*What caused the missing or weak step in the process?*	
Why did that happen?	*What is currently done to prevent failure at this step?*	
Why did it happen: (Proximate cause)	*What was the human error?*	
Why did that happen?	*Was staff performance in the process addressed?* *Was staff properly qualified?* *Was staffing adequate?*	
Why did that happen?	*Can orientation and inservice training be improved?*	
Why did it happen: (Proximate cause)	*Was all necessary information available:* *-when needed?* *-accurate?* *-complete?*	
Why did that happen?	*Is communication among participants adequate?*	
Why did that happen?	*Are there barriers to communication?* *Is prevention of adverse outcomes considered a high priority?*	

Level of Analysis	Questions/Factors involved	Findings and Opportunities to Improve
Why did it happen: (Proximate cause)	*How did the equipment fail? What broke?*	
Why did that happen?	*What is currently being done to prevent and equipment failure?*	
Why did that happen?	*What is currently being done to protect against a bad outcome if an equipment failure does occur?*	
Why did it happen: (Proximate cause)	*What environmental factors directly affected the outcome?*	
Why did that happen?	*Was the physical environment appropriate for the process to be carried out?*	
Why did that happen?	*Are systems in place to identify environmental risks? Are responses to environmental risks planned and tested?*	
Why did it happen: (Proximate cause)	*Were there any uncontrollable external factors?*	
Why did that happen?	*Are they truly beyond the organization's control?*	
Why did that happen?	*How can we protect against them?*	
Why did it happen: (Proximate cause)	*Were there any other factors that directly influenced the outcome?*	

Type of Event:

- ❑ Patient suicide
- ❑ Op/post-op or procedure complication
- ❑ Medication error
- ❑ Wrong-site surgery
- ❑ Delay in treatment
- ❑ Patient death/injury in restraints
- ❑ Patient fall
- ❑ Assault/rape/homicide
- ❑ Patient elopement
- ❑ Perinatal death/loss of function
- ❑ Transfusion error
- ❑ Fire
- ❑ Skin Integrity breakdown
- ❑ Infant abduction/wrong family
- ❑ Medical equipment – related
- ❑ Ventilator death/injury
- ❑ Maternal death
- ❑ Death associated with transfer
- ❑ Utility system failure
- ❑ Anesthesia – related
- ❑ Infection – related
- ❑ Dialysis – related
- ❑ In-patient drug overdose
- ❑ Self-inflicted injury
- ❑ Other (less frequent)

Root Cause(s) Identified by the RCA Team:

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Check categories that apply:

- ❑ Behavioral assessment process
- ❑ Physical assessment process
- ❑ Patient identification process
- ❑ Patient observation procedures
- ❑ Care planning process/coordination of care
- ❑ Staffing levels
- ❑ Orientation and training of staff
- ❑ Competency assessment/credentialing
- ❑ Supervision of staff
- ❑ Access to care

Skin Integrity

- ❑ Communication with patient/family
- ❑ Communication among care team members
- ❑ Availability of information
- ❑ Adequacy of technological support
- ❑ Equipment maintenance/management
- ❑ Physical environment
- ❑ Security systems and processes
- ❑ Control of medications: storage/access
- ❑ Labeling of medications

Patient Name/Number:

Where incident occurred:

Date of incident:

Discovery date:

Date Root Cause Analysis Completed:

Participants in Root Cause Analysis:

Rosie Emmons, QM

Conclusions/Recommendations:

Please list references of literature search:
(articles can be found in the central library)
See attached bibliography.

Please attach the associated policies:
(including any newly revised policies)