Patient Safety Root Cause Analysis (RCA)

Use this card to organize and document the Case Conference or M&M process.

What Happened?* (Flow chart or Fishbone)

Why Did it Happen? (Circle relevant questions)

**Patient Factors**
- Condition and seriousness?
- Language and communication?
- Personality and social factors?

**Task/Processes**
- Protocol available to guide therapy?
- Use of checklist or other tools?
- Standardized process, or order sets?
- Test results available and accurate?

**Individual Staff Member**
- Knowledge and skills; competence?
- Physical and mental health?
- Lack of knowledge or experience of specific staff?

**Institutional Context**
- Regulatory, inconsistent policies?
- Funding problems?
- Administrative support of units?

**Management**
- Safety culture, leadership structure?
- Standards of care?

**Environment/Equipment**
- Staffing, high workload?
- Access to equipment?
- Equipment safety mechanisms functional?
- System designed to be fault tolerant?
- Standardized equipment or different?
- Maintenance/upgrades up to date?
- Warnings/labels understandable?

**Team Factors**
- Written and verbal communication during hand off clear, accurate, clinically relevant and goal directed?
- Supervision, team structure and leadership?

*Note: This is a Quality Improvement document. Do not include patient or healthcare provider identifiers!
How to prevent it? (Strength of Interventions)

Weaker Actions
* Double Check * Warnings and labels * Training and/or education
* New procedure, memorandum or policy * Additional Study/Analysis

Intermediate Actions
* Checklists/Cognitive Aid * Increased Staffing/ Reduce workload,
* Redundancy * Enhance Communication (read-back, IPASS, SBAR etc.)
* Software enhancement/modification * Eliminate look alike and sound-a-like
* Eliminate/reduce distractions

Stronger Actions
* Architectural/physical plant change *Action by leadership in support of PS
* Simplify the process/removed unnecessary steps *Standardize equipment
* Standardize protocol and process of care * New device usability testing before purchasing. * Engineering control of interlock (forcing functions)

Your Specific Solutions:

Root cause/contributing factor statements

Evaluating Effectiveness
What outcome will be measured?

Date of measurement: __________________________