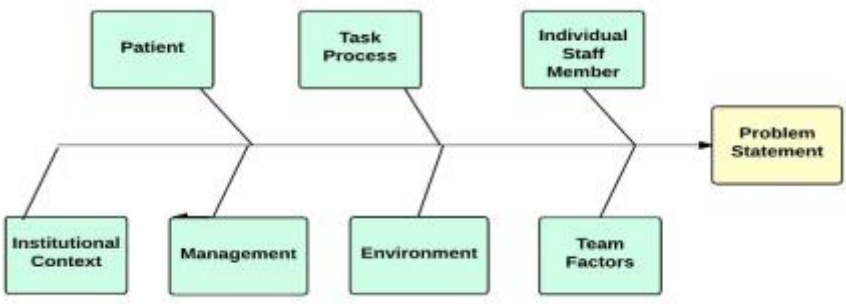
Patient Safety Root Cause Analysis (RCA)

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!**

Root cause/contributing factor statements

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:

Evaluating Effectiveness

What outcome will be measured?

Date of measurement?_____

Modified 2016 from pscurric@med.va.gov *www.patient safety.gov* Dec 04. Learn from Defects Tool. 2012. Agency for healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/toolkit/learndefects.html Gosbee, J. and Gosbee, L.L. (Eds.). (2010) Using Human Factors Engineering to Improve Patient Safety (2nd ed.), Oakbrook Terrace, IL: Joint Commission Resources.