**Framework for Root Cause Analysis and Corrective Actions\***

The following template has borrowed very heavily from the Joint Commission on Accreditation of Healthcare Organizations, now known as the Joint Commission. It has been scaled down and reworded to more closely reflect the work done in a variety of residential settings for children in Indiana Department for Child Services care. Please feel free to use or not use it or adapt it further so that it better fits your organizations unique needs and systems.

**Event Description**

**When did the event occur?**

|  |  |  |
| --- | --- | --- |
| Date: | Day of the week: | Time: |

**Detailed Event Description Including Timeline: (Who, What, Where, When and How-include what was happening just before the incident and how event ended/action taken)**

**Diagnosis:**

**Medications: (any new or recently discontinued medications?)**

**Past Medical/Psychiatric History:**

**Root Cause Analysis - Questions**

| **#** | **Analysis Questions** | **Prompts** | **Analysis Findings** | **Causal Factors/Root Cause Details** |
| --- | --- | --- | --- | --- |
| 1 | What was the intended process flow? | List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes.  Examples of defined process steps may include, but are not limited to:   * Residential program’s protocol * Behavior management procedures * Interventions * Assessment (pain, suicide risk, medical, and psychological) procedures * Safety guidelines/Special Precautions   ***Note****:* The process steps *as they occurred in the event* will be entered in the next question*.* |  |  |
| 2 | Were there any steps in the process that did not occur as intended? | Explain in detail any deviation from the intended processes listed in Analysis Question #1 above. |  |  |
| 3 | What human factors were relevant to the outcome? | Discuss staff-related human performance factors that contributed to the event.  Examples may include, but are not limited to:   * Failure to follow established policies/procedures * Fatigue * Inability to focus on task/distraction * Inattentional blindness/confirmation bias * Personal problems * Lack of complex critical thinking skills * Rushing to complete task * Boundary issues * Emotional reaction to youth behavior * Lack of buy-in to residential program values and mission |  |  |
| 5 | What controllable environmental factors affected the outcome? | What environmental factors within the residential program’s control affected the outcome? Examples may include, but are not limited to:   * Safety or security risks in the EOC * Lighting or space issues * Potentially harmful items not removed from youth environment   The response to this question may be addressed more globally in Question #17. This response should be specific to this event. |  |  |
| 6 | What uncontrollable external factors influenced the outcome? | Identify any factors the residential program cannot change that contributed to a breakdown in the internal process, for example natural disasters, power outage, pandemic protocols |  |  |
| 7 | Were there any other factors that directly influenced this outcome? | List any other factors not yet discussed. |  |  |
| 8 | What are the other areas in the agency where this could happen? | List all other areas in which the potential exists for similar circumstances. For example:   * Other units/programs * Different physical areas of the building(s) * Identification of other areas within the residential program that have the potential to impact youth safety in a similar manner. This information will help drive the scope of your action plan. |  |  |
| 9 | Was staff properly qualified and currently competent for their responsibilities? | Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified. Examples may include but are not limited to:   * Orientation/training * Competency assessment (What competencies do the staff have and how do you evaluate them?) * Provider and/or staff scope of practice concerns (trained/qualified to do assessments) * Provider and/or staff performance issues |  |  |
| 10 | How did actual staffing compare with ideal level? | Include ideal staffing ratios and actual staffing ratios along with unit census at the time of the event.   * Note any unusual circumstance that occurred at this time. * What process is used to provide extra assistance for youth in a crisis situation? * Adequate supervisory oversight of staff to ensure protocols were followed? |  |  |
| 11 | What is the plan for dealing with staffing contingencies? | Include information on what the health care organization does during a staffing crisis, such as call-ins, bad weather, quarantine, or increased patient acuity. Describe the health care organization’s use of alternative staffing. Examples may include, but are not limited to:   * PRN staff * Mandatory overtime * Supervisors working the unit * Administrative staff working the unit * Nursing staff working the unit |  |  |
| 12 | Were such contingencies a factor in this event? | If alternative staff were used, describe their orientation to the area, verification of competency, and environmental familiarity. |  |  |
| 13 | Did staff performance during the event meet expectations? | Describe whether staff performed as expected within or outside of the processes.   * To what extent was leadership aware of any performance deviations at the time? * What proactive surveillance processes are in place for leadership to identify deviations from expected processes? * Are there in person pop-ins from administrative staff to assess compliance with agency protocols? Random video surveillance? * Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol, and guidelines in effect at the time. |  |  |
| 14 | To what degree was all the necessary information available when needed?  Accurate? Complete? Unambiguous?  Were current policies and procedures sufficient to provide guidance during this event? | * Discuss whether youth assessments were completed, shared, and accessed by members of the treatment team, to include therapists, according to the organizational processes. * Identify the communication processes used to disseminate information. * Discuss to what extent the available youth information (special precautions status and protocols, level of observation required, room safety sweep) was clear and sufficient to provide an adequate summary of the youth’s condition, treatment, and response to treatment. * Describe staff utilization and adequacy of policy, procedure, protocol, and guidelines specific to the youth care provided. * Review current policies and established procedures to determine if they provided guidance specific enough to help prevent this type of incident. |  |  |
|  |  |  |  |  |
| 15 | To what degree is communication among participants adequate? | Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof. Consider the following in your response, as appropriate:   * The timing of communication of key information * Misunderstandings related to language/cultural barriers, abbreviations, terminology, incomplete documentation, etc. * Proper completion of internal and external hand-off communication between shifts * Involvement of youth, family, and/or significant others * Supervisory involvement in communication with direct care staff * Administrative staff communication with direct care staff |  |  |
| 16 | Was this the appropriate physical environment for the processes being carried out? | Consider processes that proactively manage the youth care environment. This response may correlate to the response in Question #6 on a more global scale.   * What evaluation tool or method is in place to evaluate process needs and mitigate physical environment and youth care environmental risks? * How are these process needs addressed organization-wide? Examples may include, but are not limited to: * Assessment of EOC risks * Evaluation of egress points * Did youth’s assessed precautions level indicate this was an appropriate environment for the youth? * Rechecking youth room after initial safety sweep for potentially harmful items * Are bathrooms and other areas besides the youth’s room swept for potentially harmful items before youth accesses those environments? * How does agency handle youth re-entry to milieu from school or other areas off the living unit to ensure no items that compromise safety are brought into the environment? |  |  |
| 17 | What systems are in place to identify environmental risks? | * Identify environmental risk assessments. * \* Does the current environment meet codes, specifications, regulations? * \* Does staff know how to report environmental risks? * \* Was there an environmental risk involved in the event that was not previously identified? |  |  |
| 18 | What emergency responses have been planned and tested? | Describe variances in expected process due to an actual emergency or failure mode response in connection to the event.   * Related to this event, what safety evaluations and drills have been conducted and at what frequency (e.g. practice de-escalating techniques, behavioral emergency drills, patient abduction or patient elopement)? Emergency responses may include, but are not limited to: * Fire drills * Medical emergency drills * Suicide attempt response * Special precautions implementation   Failure mode responses may include, but are not limited to:   * Computer down time * Power loss * Insufficient staff to handle multiple concurrent behavior issues |  |  |
| 19 | How does the residential program’s culture support risk reduction? | How does the overall culture encourage change, suggestions, and warnings from staff regarding risky situations or problematic areas?   * How does leadership demonstrate the residential program’s culture and safety values? * How does the residential program assess culture and safety? * How does leadership address disruptive behavior? * How does leadership establish methods to identify areas of risk or access employee suggestions for change? * How are changes implemented? |  |  |
| 20 | How does leadership address the continuum of patient safety events, including close calls, adverse events, and unsafe, hazardous conditions? | * Does leadership independently initiate Root Cause Analyses when close calls occur? * Has leadership provided for required resources or training? * Does leadership communicate corrective actions to all staff stemming from any analysis following reported risks? * How quickly and effectively does leadership address identified risks in the environment? |  |  |
| 22 | How can orientation and in-service training be improved? | Describe how orientation and ongoing education needs of the staff are evaluated and discuss its relevance to event.   * How are competencies assessed after training? * Are critical thinking skills taught? * Does agency utilize scenarios from previous close calls to train staff in best response options? * Are all staff trained in evidence based practices? |  |  |
| 23 | Was available technology used as intended?  (examples include Electronic medical records, internal communication systems, etc.) | Describe variances in the expected process due to education, training, competency, impact of human factors, functionality of equipment, and so on:   * Were phones and/or walkie talkies available and working? * Were all staff emails or communication logs shared as intended to update staff on relevant issues per shift?   Was technology designed to minimize user errors or easy-to-catch mistakes? (will the EMR (Electronic Medical Record) flag an entry that is incomplete, lacking essential information such as interval for observation of special precautions, or signature of relevant persons notified?)  Did technology provide flags to signal staff attention to special precautions/elevated risk?  Did the technology work well with the workflow and environment?  Was the technology used outside of its specifications? |  |  |
| 24 | How might technology be introduced or redesigned to reduce risks in the future? | Describe any future plans for implementation or redesign. Describe the ideal technology system that can help mitigate potential adverse events in the future. |  |  |

**CORRECTIVE ACTIONS**

|  |  |
| --- | --- |
| Corrective Actions Taken | Follow up to ensure risk is reduced/eliminated |
| Action Item #1: |  |
| Action Item #2: |  |
| Action Item #3: |  |
| Action Item #4: |  |
| Action Item #5: |  |
| Action Item #6: |  |
| Action Item #7: |  |
| Action Item #8: |  |

# Table A-1. Root Causes

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| --- | --- |
| **Root Cause Types** | **Causal Factors / Root Cause Details** |
| Communication factors | * Communication breakdowns between and among teams, staff, and providers * Communication during handoff, transition of care * Language or literacy * Availability of information * Misinterpretation of information * Presentation of information |
|  | |
| Environmental factors | * Noise, lighting, flooring condition, etc. * Space availability, design, locations, storage * Maintenance, housekeeping |
|  | |
| Equipment/device/supply/  healthcare IT factors | * Equipment, device, or product supplies problems or availability * Health information technology issues such as display/interface issues (including display of information), system interoperability * Availability of information * Malfunction, incorrect selection, misconnection * Labeling instructions, missing * Alarms silenced, disabled, overridden |
|  | |
| Task/process factors | * Lack of process redundancies, interruptions, or lack of decision support * Lack of error recovery * Workflow inefficient or complex |
|  | |
| Staff performance factors | * Fatigue, inattention, distraction or workload * Staff knowledge deficit or competency * Criminal or intentionally unsafe act |
|  | |
| Team factors | * Speaking up, disruptive behavior, lack of shared mental model * Lack of empowerment * Failure to engage resident |
|  | |
| Management/ supervisory/ workforce factors | * Disruptive or intimidating behaviors * Staff training * Appropriate rules/policies/procedure or lack thereof * Failure to provide appropriate staffing or correct a known problem * Failure to provide necessary information |
|  | |
| Organizational culture/leadership | * Organizational-level failure to correct a known problem and/or provide resource support including staffing * Workplace climate/institutional culture * Leadership commitment to resident safety |

# Adapted from: Department of Defense, Patient Safety Program. *PSR Contributing Factors List – Cognitive Aid, Version 2.0*. May 2013.