Root Cause Analysis - (Insert Patient/Case Identifier)

The following documentation was undertaken pursuant to (insert referenced Policy Name) Policy. It is intended that the minutes reflecting any of these discussions, records of investigation, inquiry, proceeding or conclusion related to this health services review will be privileged to the fullest extent under Wisconsin Statute Sections 146.37 and 147.38, any amendments thereto, and all applicable federal law.

Completed by:
Date:

Level of Analysis	Questions	Findings/Facts
What happened?	When did the event occur? (Date, day of week, time)	
	What area/service was impacted or involved?	
	What are the details of the event? (Attach a brief description)	
Process or activity in which the event occurred	What are the steps in the process, as designed? (A flow diagram may be helpful)	
	What steps in the above process contributed to the event?	

Possibilities	Questions	Findings/Facts	Why? Offer explanation/rationale for facts identified.	Root Cause?	Take Action?
Patient Care Processes: **Assessment** Was this event related to patient assessment? Yes No	Was an appropriate, timely and complete physical patient assessment conducted?				
	Was an appropriate behavioral assessment done?				
	Was appropriate diagnostic testing done and were results readily available?				
	Was there agreement regarding interpretation of test results? Was there an error in the assessment?				
	Was the proper process followed for identification of the patient, procedure, and or site?				
	Was there appropriate patient observation?				
Treatment Was this event related to patient treatment? Yes No	Was the care plan adequate and appropriate?				
	Was there adequate communication between all staff and physicians?				

Possibilities	Questions	Findings/Facts	Why? Offer explanation/rationale for facts identified.	Root Cause?	Take Action?
	Was there appropriate communication with patient and family members?				
	Were appropriate consults obtained?				
	Did all staff agree who was in charge of the patient's care?				
Medication related issues Were medications involved in this event? Yes No	Was there proper control of medications including storage and access?				
	Was there proper administration of medications?				
	Were the effects of medications appropriately monitored?				
	Did labeling of medications contribute to this event?				
	Was there appropriate ordering of medications?				

Possibilities	Questions	Findings/Facts	Why? Offer explanation/rationale for facts identified.	Root Cause?	Take Action?
Contributing Patient Factors Did the patient's condition or any actions contribute to the event? Yes No	How did the patient's clinical condition or severity of illness contribute to this event?				
	Did any actions by the patient or family contribute to the event?				
Human factors Was there human error involved? Yes No	Was staff properly qualified and competent for their job responsibilities?				
	Was there human error involved?				
	Were there other unexpected events or duties that were affecting work flow during the time of the event?				
	Were staff levels appropriate?				
	What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?				

Possibilities	Questions	Findings/Facts	Why? Offer explanation/rationale for facts identified.	Root Cause?	Take Action?
	Did staff performance during the event meet expectations? Were policies and procedures following during the event?				
	Was staff being adequately supervised?				
	Are staff adequately oriented and trained in the involved processes?				
	Were any of the involved staff impaired?				
	Is it reasonable to think that other staff in the same situation would act in the same way?				
	Do any of the involved staff have a history of unsafe acts?				
Information management (Paper and electronic information) Was information management a contributing factor? Yes No	To what degree was all necessary information available when needed? Accurate? Complete? Unambiguous?				
	Was available information communicated among participants adequately?				

Possibilities	Questions	Findings/Facts	Why? Offer explanation/rationale for facts identified.	Root Cause?	Take Action?
Physical Environment Was the physical environment a contributing factor? Yes No	Was the physical environment appropriate for the processes being carried out?				
Equipment Was equipment a contributing factor? Yes No	Was the event related to an equipment failure?				
	Was the event related to incorrect use of equipment?				
	Was appropriate equipment available?				
	Was equipment adequately maintained and monitored?				
Uncontrollable external factors?	What, if any, external factors contributed to this event? Explain. Are they truly beyond the organizations control?				
Leadership: Corporate structure	Is this culture conducive to risk identification and reduction? Explain how.				
Encouragement of communication	What barriers exist in communicating potential risk factors?				

Possibilities	Questions	Findings/Facts	Why? Offer explanation/rationale for facts identified.	Root Cause?	Take Action?
Mitigation of harm	Were appropriate actions taken to mitigate real or potential harm related to this event?				
Other	Are there any other factors that have directly influenced this outcome?				
Literature Review	List any pertinent items in the literature that will support the findings~~?~~				

Was this incident found to be a sentinel event? _____Yes _____No

If yes, was event reported to JCAHO? _____Yes _____No _____Reporter _____Date

Root Cause Analysis Action Plan - _____

Recommendation #1: **Assigned to:** **Date Assigned:** **Measure:** **Frequency:** **Sample Size:**			
Detail of steps taken toward completed implementation:	**By Whom and By When:**	**Evidence of Completion:**	**Status:**
Document meetings, dates, attendees and brief summary of meetings.			

Recommendation #2: **Assigned to:** **Date Assigned:** **Measures:** **Frequency:** **Sample Size:**			
Details of steps taken toward completed implementation:	**By Whom and By When:**	**Evidence of Completion:**	**Status:**
Document meetings, dates, attendees and brief summary of meetings.			

- For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date and associated measure of effectiveness OR…..
- If, after consideration of such a finding, a decision is made not to implement as associated risk reduction strategy, indicate the rationale for not taking action at this time.
- Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.
- Consider whether pilot testing of a planned improvement should be conducted.
- Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.