FRAMEWORK FOR ROOT CAUSE A

EVENT DESCRIPTION

When did the event occur?

Date:	Day of the week:	Time:

Detailed Event Description Including Timeline:

Diagnosis:

Medications:

Autopsy Results:

Past Medical/Psychiatric History:

ROOT CAUSE ANALYSIS - QUESTIONS

#	

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors / Root Cause Details (Table A-1)
		• Fatigue • Inability to focus on task • Inattentional blindness / confirmation bias •			

#	Analysis Questions	Prompts	

#	Analysis Questions	Prompts	Analysis Findings

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors / Root Cause Details (Table A-1)
		health care organization's use of alternative staffing. Examples may include, but are not limited to: • Agency nurses • Cross training • F (ab)3 4[1.00 Tw 0 -1.198 TD[44I TD[44I TD[44I le A ≮MCID I TD[44I l x MTw 0 -1.ndatory overtime • PRN 6ol			
12	Were such contingencies a factor in this event?	If alternative staff were used, describe			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors / Root Cause Details (Table A-1)

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors / Root Cause Details (Table A-1)
		but are not limited to: • Alarm audibility testing • Evaluation of egress points • Patient acuity level and setting of care managed across the continuum • Preparation of medication outside of pharmacy			
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 and failure-mode responses have been planned and tested?				

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors / Root Cause Details (Table A-1)
		• Facility construction • Power loss • Utility issues			
19	How does the organization'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 organization's culture and safety values? • How does the organization measure 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					

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors / Root Cause Details (Table A-1)
	close calls, adverse events, and unsafe, hazardous				

BIBLIOGRAPHY

Cite all books and journal articles that were considered in developing this root cause analysis and action plan.

TABLE A-1. ROOT CAUSES

Root Cause Types	Causal Factors / Root Cause Details
Communication factors	• Communication breakdowns

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 patient safety

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

TABLE A-2. ACTION STRENGTH

Action Strength	Action Category	Example

	tools	medication orders. Use a standardized patient handoff format.
	Enhanced documentation, communication	Highlight medication name and dose on IV bags.

5.54 Tm[(Pa)1.6 (ge)jETEMC /PT9019 0.481 ref319/ETEMC /PT9019 0.481 re25.54 0ETEMC /PT9019 0.481 re1 (06 1 (02 1 (02 rg39.52 949/P 65TJ 94/P <M*CID 4 >BDC 5Qq319

TABLE A-3. MEASURE OF SUCCESS

Fraction Part	Defined	Identified	Example
Numerator	The number of events being measured	Ask a specific question—what are you measuring?	Falls that resulted in hip fractures in diabetic patients over 70 years of age
Denominator	All the opportunities in which the event could have occurred	Identify the patient population from which to collect the information.	The number of diabetic patients on a unit who are older than 70 years of age

TABLE A-4. SAMPLE SIZE*

Population Size	Sample
Fewer than 30 cases	100% of cases
30 to 100 cases	30 cases

*The sampling methodology was determined using quality assurance sampling methods which determines the sample size needed to be able to say from a sample of cases that the "defect" rate is less than a specified amount (here we used 10%) with 95% confidence if no "defects" are found in the sample.