

Root Cause Analysis and Action Plan

<u>Level of Analysis</u>		<u>Questions</u>	<u>Findings</u>	<u>Root Cause?</u>	<u>Take Action?</u>
What Happened?	Sentinel event	What are the details of the event? (Brief description)			
		Did the event pose an immediate danger to patients or staff?			
		When did the event occur? (Date, day of week, time)			
		What area/service was impacted?			
		What areas/services/departments are participating in the root cause analysis?			
Why did it happen? What were the most proximate factors? (typically "special cause" variations)	The process or activity in which the event occurred	What are the steps in the process, as designed? (A flow diagram may be helpful here)			
		What steps were involved in (contributed to) the event?			
	Human factors	What human factors were relevant to the outcome?			
	Organizational factors	What organizational factors are relevant to the outcome?			
	Equipment factors	How did the equipment performance affect the outcome?			
	Controllable environmental factors	What factors directly affected the outcome?			
	Uncontrollable external factors	Are they truly beyond the organization's control?			
	Other	Are there any other factors that have directly influenced this outcome?			
		What other areas or services are impacted?			

<u>Level of Analysis</u>		<u>Questions</u>	<u>Findings</u>	<u>Root Cause?</u>	<u>Take Action?</u>
<p>Why did that happen? What systems and processes underline those proximate factors?</p> <p>(Common cause variation here may lead to special cause variation in dependent processes.)</p>	Human resource issues	To what degree are staff properly qualified and currently competent for their responsibilities?			
		How did actual staffing compare with ideal levels?			
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?			
		To what degree is staff performance in the operant process(es) addressed?			
		Was there a knowing violation of policies or procedure?			
		Were any unauthorized substances in use or suspected?			
	Information management issues	To what degree is all necessary information available when needed? accurate? complete? unambiguous?			
		To what degree is communication among participants adequate?			
	Environmental management issues	To what degree was the physical environment appropriate for the processes being carried out?			
	Uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?			

	<u>Risk Reduction Strategies</u>	<u>Responsibility</u>	<u>Date</u>	<u>Measures of Effectiveness</u>
For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, and associated measures of effectiveness, OR . . .				
If, after consideration of such a finding, a decision is made not to implement an 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.				
Cite any books or journals articles that were considered in developing this analysis and action plan:				

RCA completed by:

name/title

date