Directions for Root Cause Analysis (RCA)

The goal of the RCA is to identify systemic gaps or failures in systems and processes, not to point fingers or lay blame on individuals. The RCA is not the same as the investigation into the incident, which should be completed prior to the RCA.

Instructions for conducting the RCA:
A Root Cause Analysis (RCA) may be completed for any serious incidents, but must be completed for any incidents of suicide and any major loss of confidential client information.

The RCA worksheet that is attached will provide a structure for completing the RCA.

After identifying the Lead, Facilitator and the Participants of the RCA, schedule at least one meeting for the RCA group to complete the following tasks:

1) The first step in completing the worksheet for the RCA is describing the serious incident. Include who was involved, services that were effected, and other details of the incident. It is recommended that the incident being reviewed be written up a flow diagram as part of the process of describing the incident. A flow diagram is very useful in identifying gaps in systems and processes. Ask participants to come to the RCA meeting with a basic description of the incident from their perspective that includes dates and processes involved.

2) Next step is to note the participants in the RCA. Participants in the RCA may include those involved in the incident but must include those staff who are knowledgeable about the systems and processes that will be analyzed.

3) Next identify the systems and processes that will be analyzed. In general, systems and processes will be those programmatic issues that are defined by policy and procedures. Examples of systems and processes are noted in the worksheet. Not all systems and processes will apply in every case, and there may be others that are not listed on the worksheet that arise in the course of analysis.

4) The next step is to break down each system or process into the steps involved – it is helpful to have a workflow diagram for each system or process as this can assist in uncovering gaps.

5) Identify findings of gaps found in system or process design, how design of system or process compared to the real event, human factors, equipment factors, controllable environmental factors, and uncontrollable external factors. It can help to think about what the system or process would “ideally” look like even if the ideal does not seem possible.

6) Identify if the finding is a “root cause” (yes or no). For each finding of root cause an analysis is to be completed. Many findings that are not a root cause themselves have “roots” that may need to be addressed. Using a “fishbone” or Ishakawa diagram can assist in identifying these “hidden roots”.

7)The next step is to note if actions will be taken to address the issues that are identified as a root cause

8) The final element of the RCA is to note Action Plans that will be taken to address any issues that are identified as a root cause. This portion of the RCA delineates the items that are being addressed, the strategies that will be implemented, and the measures that will be used to determine the effectiveness of the plan.

QUALITY IMPROVEMENT ACTIVITY

SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

Date and Time of Serious Incident: _____

(1) Summary of incident:	(List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury)
(2) Participants:	(List all the participants by position and title {no names} involved in the root cause analysis and action plan. Note the Lead of the RCA and the facilitator.)
(3) Systems and Processes:	(Note systems and processes that were analyzed to determine proximate causes) List of possible systems and processes for review: __ Assessment Process __ Physical Assessment Process __ Medication Protocols __ Staffing resources __Security __Facility __Care Coordination __Availability of information __ Risk Assessment Process __ Reception protocols __ Control of medications, storage, access __ Staff training __ Policies and Procedures __ Communications with client or family __ Communications among staff Other: _____

(3) Note each Process to be considered for review and definition	(4) What are the steps in the process as designed? (A flow diagram is recommended)	(5) Findings	(6) Root Cause?		(7) Take Action?
			Yes	No	

QUALITY IMPROVEMENT ACTIVITY

(8) Action Plan		
(a) List of Action Items	(b) Risk reduction strategies	(c) Measures of Effectiveness
Action item 1:		
Action Item 2:		
Action item 3:		
Action item 4:		
Etc…as needed		