Patient Safety Analyst - RCA References

Review Timeline/Event

- Is this accurate?
- Any questions?
- What is the intended process flow?
- Were there any steps in the process that did not occur as intended?

Discuss Probable/Root Cause(s)

- Failure to act is only causal when there was a pre-existing duty to act
- Physical Assessment factors?
- Care planning factors?
- Communication among staff members?
- Human factors?
- Equipment factors?
- Controllable environmental factors?
- Uncontrollable environmental factors?
- Do we have process vulnerabilities?
- Clinical context and patient contributing factors:
    - Examples of care management problems:
        - Failure to monitor, observe, or act
        - Delay in diagnosis
        - Incorrect risk assessment
        - Inadequate handoff
        - Failure to note faulty equipment
        - Failure to carry out pre-operative checks
        - Failure to follow protocol (without clinical justification)
        - Not seeking help when necessary
    - Each human error must have a preceding cause: *What prevented a staff member from doing it right?*
    - Each procedural deviation must have a preceding cause: *What caused the procedure to go wrong?*

Corrective Action Plan

- Do the actions address the root cause and contributing factors?
- Are they specific?
- Are they easily understood and implemented?
- Measurable?

Measurement Strategy

- How will we know we have been successful? Measurement plan should confirm that what we wanted to accomplish did in fact occur.
- Measures effectiveness of action, not the completion of the action.
- Should have a defined numerator and denominator
- Defined sampling plan and time frame