

## FRAMEWORK FOR ROOT CAUSE A

**EVENT DESCRIPTION**

**When did the event occur?**

Date:	Day of the week:	Time:
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**Detailed Event Description Including Timeline:**

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**Diagnosis:**

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**Medications:**

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**Autopsy Results:**

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**Past Medical/Psychiatric History:**

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**ROOT CAUSE ANALYSIS - QUESTIONS**

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#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
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- Fatigue
- Inability to focus on task
- Inattention blindness/confirmation bias
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#	Analysis Questions	Prompts	
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#	Analysis Questions	Prompts	Analysis Findings
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#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
12	Were such contingencies a factor in this event?	<p>health care organization's use of alternative staffing. Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Agency nurses</li> <li>• Cross training</li> <li>• PRN 6ol</li> </ul> <p>If alternative staff were used, describe</p>			

#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
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#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
		<ul style="list-style-type: none"> <li>• Facility construction</li> <li>• Power loss</li> <li>• Utility issues</li> </ul>			
19	How does the organization's culture support risk reduction?	<p>How does the overall culture encourage change, suggestions, and warnings from staff regarding risky situations or problematic areas?</p> <ul style="list-style-type: none"> <li>• How does leadership demonstrate the organization's culture and safety values?</li> <li>• How does the organization measure culture and safety?</li> <li>• How does leadership address disruptive behavior?</li> <li>• How does leadership establish methods to identify areas of risk or access employee suggestions for change?</li> <li>• How are changes implemented?</li> </ul>			

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#	Analysis Questions	Prompts	Analysis Findings	Root Cause Types (Table A-1)	Causal Factors/Root Cause Details (Table A-1)
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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	<ul style="list-style-type: none"><li data-bbox="537 315 947 352">• Communication breakdowns</li></ul>

Management/ supervisory/ workforce factors	<ul style="list-style-type: none"> <li>• Disruptive or intimidating behaviors</li> <li>• Staff training</li> <li>• Appropriate rules/policies/procedure or lack thereof</li> <li>• Failure to provide appropriate staffing or correct a known problem</li> <li>• Failure to provide necessary information</li> </ul>
Organizational culture/leadership	<ul style="list-style-type: none"> <li>• Organizational-level failure to correct a known problem and/or provide resource support including staffing</li> <li>• Workplace climate/institutional culture</li> <li>• Leadership commitment to patient safety</li> </ul>

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

**TABLE A-2. ACTION STRENGTH**

<b>Action Strength</b>	<b>Action Category</b>	<b>Example</b>
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tools	medication orders. Use a standardized patient handoff format.
Enhanced documentation, communication	Highlight medication name and dose on IV bags.

**TABLE A-3. MEASURE OF SUCCESS**

<b>Fraction Part</b>	<b>Defined</b>	<b>Identified</b>	<b>Example</b>
<b>Numerator</b>	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
<b>Denominator</b>	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\***

<b>Population Size</b>	<b>Sample</b>
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.