QUESTIONS FOR ROOT CAUSE ANALYSIS

Participants (job titles):

Description of event:

1. What happened?

2. Where did process go wrong? What steps were involved in (contributed to) the event?

3. What are the usual steps in the process(es)?

4. Why do you think it happened?

Human Factors

1. What role did human performance play in this event?

2. What human factors were relevant to this case? I.e. fatigue, staff illness, noise, temperature, scheduling, personal problems, stress, rushing, cognitive errors?

3. Were distractions or interruptions a factor in this case?

Communication among staff / Information availability

1. Was communication adequate and timely in this event?

2. Are there obstacles to communication relating to this event?

3. Was the needed information available, accurate, and complete?

4. Was patient identification an issue in this case?

5. Does the medical record documentation adequately provide a clear picture of what happened?

6. Were there issues related to continuity of care?

Aspects of care and care planning:

1. What issues related to physical or behavioral assessment were a factor in this event?

2. What policies or procedure relate to the level and frequency of observation and monitoring?

3. Did the level and frequency of patient observation or monitoring meet standard of care?

4. What issues relating to philosophy of care or care planning had an impact on this case?

Staffing

1. How did staffing levels compare with ideal levels? (Give #s)

2. Was workload a factor in this event?

3. How are staffing contingencies handled?

Training/Competency/

1. Were issues relating to staff training or staff competency a factor in this event? Is training provided prior to the start of the work process?

2. Was an individual performing in a situation for which they were inappropriately trained or prepared?

3. How is staff performance assessed? Are competencies documented?

4. Are the results of training monitored over time?

5. Is there a program to identify what training is needed?

Supervision of Staff and Credentialing (Includes physicians in training)

1. Was supervision of staff an issue in this case?

2. Was the staff physician involved in the case in a timely way?

3. Are there issues related to credentialing?

Adequacy of Technological Support

1. Was technological support adequate?

Equipment / Equipment Maintenance/Management

1. What equipment / products were involved in this case/event?

2. Did equipment / products function properly?

3. Did alarms, monitoring systems function properly?

4. Was equipment used as designed?

5. Has staff been adequately trained in the use of the equipment / products?

6. Was equipment maintenance an issue?

7. Is there a maintenance program?

Environmental aspects

1. Was the work area or environment designed to support the function for which it was being used? (i.e space, privacy, safety, access)

2. Does the work environment provide physical stressors for staff? (i.e. temperature, noise, improper lighting)

3. Does the work environment meet current codes, specifications, and regulations?

4. What systems are in place to identify environmental risks?

5. What security systems and processes relate to this event? Were there issues related to security systems and processes?

6. What emergency and failure modes responses have been tested? (safety evaluations, disaster drills, etc?)

Control of Medications: Storage/Access

1. Was storage or access to medications an issue?

Labeling of Medication

1. Was labeling medications (manufacturer or HCMC labeling) an issue?

Leadership:

1. To what degree is the culture conducive to risk identification and reduction?

2. What are the barriers to communication of potential risk factors?

3. How is the prevention of adverse outcomes communicated as a high priority?

Other questions:

1. Are there any other factors that influenced this outcome?

2. Were there uncontrollable external factors?

3. What can be done to protect against the uncontrollable factors?

4. What other areas or services are impacted (might have a similar event)?

Communication with Patient/Family

1. Was communication with patient and family adequate?

2. Was there disclosure regarding the untoward outcome, details of the event?

Summary of Root Causes and contributing factors: