MedPro Group
a Berkshire Hathaway company

Checklist

Event Reporting and Root Cause Analysis

To mitigate the occurrence of adverse events, many healthcare organizations report them to an event (error) reporting system as well as conduct a root cause analysis (RCA). When healthcare organizations participate in event reporting, whether to internal systems (e.g., an organizational adverse event reporting system or a patient safety committee) or external systems (e.g., such as a government agency), it plays a crucial role in loss reduction.[1]

RCA involves analyzing organizational processes and systems to determine what improvements could reduce future adverse events. The analysis focuses primarily on systems and processes, not on individual performance. The goals of RCA include identifying the root of a problem, determining how to fix the underlying causes, and applying what is learned to systematically prevent similar occurrences.

Assessing the type and number of adverse events and near misses also helps healthcare organizations determine the cause of these issues and put in place strategies to reduce events that occur with high frequency or that have a high potential to result in patient harm.

Successful event reporting and RCA hinge on a healthcare organization's ability to cultivate a nonpunitive culture of safety that encourage reporting and treats errors and near misses as learning opportunities. Healthcare organizations can use the questions in this checklist to help plan and refine their event reporting and RCA procedures.[2]

	Yes	No
Leadership and Organizational Culture		
Does your organization have and enforce a code of conduct that supports a nonpunitive culture of safety?	☐	☐
Does leadership encourage reporting of adverse events, safety hazards, and near misses?	☐	☐

	Yes	No
Leadership and Organizational Culture (continued)		
Does leadership identify and address barriers to event reporting (e.g., poor process, lack of provider engagement, communication barriers, etc.)?	☐	☐
Does leadership place an emphasis on detecting system failures rather than individual errors, and do they use event reporting data to identify system flaws?	☐	☐
Does leadership provide timely and compassionate feedback when any adverse event occurs?	☐	☐
Does leadership ensure that responses to adverse event reporting are nonpunitive?	☐	☐
Does leadership create an environment in which healthcare employees can speak up about errors and adverse events without fear of punishment?	☐	☐
Does leadership define which events should be reported and identify the roles of various stakeholders (e.g., providers, patients, clinicians, staff members, etc.)?	☐	☐
Does leadership ensure that all individuals who might potentially report events understand how and why to make these reports?	☐	☐
Does leadership ensure that data are analyzed and acted upon to improve clinical and operational processes?	☐	☐
Does leadership ensure that stakeholders receive timely and complete feedback?	☐	☐
Does leadership address the continuum of patient safety events, including near misses, adverse events, and hazardous conditions?	☐	☐
Root Cause Analysis: Task/Process Factors		
Are the following task/process factors considered as part of the RCA: • The process flow of the activity in which the event occurred and whether providers/staff adhered to it?	☐	☐
• The specific, defined process steps of the activity in which the event occurred and whether any did not happen as intended?	☐	☐
• Whether items requiring improvement were addressed following the event?	☐	☐

	Yes	No
Root Cause Analysis: Environmental Factors		
Are the following factors considered as part of the RCA:		
• Whether any controllable environmental factors — such as lighting, noise, or space issues — played a role in the event?	☐	☐
• Whether any uncontrollable environmental factors — such as a natural disaster or power outage — affected the outcome of the event?	☐	☐
• Whether the physical environment was appropriate for the processes being carried out?	☐	☐
• Whether systems were in place to identify environmental risks?	☐	☐
Root Cause Analysis: Equipment/Technology Factors		
Are the following factors considered as part of the RCA:		
• Whether equipment operated properly?	☐	☐
• Whether any alarms were silenced, disabled, or overridden?	☐	☐
• Whether any health information technology issues — such as display/interface issues — occurred during the event?	☐	☐
• Whether equipment performance ultimately affected the outcome of the event?	☐	☐
• Whether technology can be implemented or redesigned to reduce future risks?	☐	☐
Root Cause Analysis: Staff Performance Factors		
Are the following factors considered as part of the RCA:		
• Whether staff members involved in this event were properly qualified, trained, and competent for their responsibilities (including proper credentialing and privileging)?	☐	☐
• Whether staff performance during the event met expectations?	☐	☐
• Whether any human factors — such as failure to follow procedure, fatigue, or inability to focus on tasks — affected the outcome of the event?	☐	☐
• Whether orientation and in-service training can be modified and improved as a result of the event?	☐	☐

	Yes	No
Root Cause Analysis: Team Factors		
Are the following factors considered as part of the RCA:		
• Whether appropriate healthcare employees were involved in conducting and reviewing the RCA?	☐	☐
• Whether any disruptive behavior occurred among staff members during the event?	☐	☐
• Whether any communication failures occurred among staff members during the event?	☐	☐
Root Cause Analysis: Workforce Factors		
Are the following factors considered as part of the RCA:		
• Whether ideal staffing ratios were in place during the event?	☐	☐
• Whether staff members who were involved in the event were properly trained on policies and procedures?	☐	☐
• Whether staff members who were involved in the event received all necessary information to perform their responsibilities?	☐	☐
• Whether a plan was in place for dealing with staffing contingencies?	☐	☐
• Whether staffing contingencies were a factor in the event?	☐	☐

Resources

- Agency for Healthcare Research and Quality: Patient Safety Primer: Reporting Patient Safety Events
- Agency for Healthcare Research and Quality: Patient Safety Primer: Root Cause Analysis
- Institute for Healthcare Improvement: RCAw2: Improving Root Cause Analyses and Actions to Prevent Harm
- Minnesota Department of Health: Root Cause Analysis Toolkit
- The Joint Commission: Framework for Root Cause Analysis and Corrective Actions
- VHA National Center for Patient Safety: Root Cause Analysis

Endnotes

[1] ECRI. (2022, June 21). Event reporting. *Health System Risk Management.* Retrieved from www.ecri.org/components/HRC/Pages/EventReporting.aspx

[2] This checklist is based on information from the following sources: ECRI, Event reporting. ECRI. (2023, April 25 [last updated]). Essentials: Culture of safety. *Health System Risk Management.* Retrieved from www.ecri.org/components/HRC/Pages/Essentials_Culture-of-Safety.aspx; The Joint Commission. (2017). *Framework for root cause analysis and corrective actions*. Retrieved from www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/rca_framework_101017.pdf