MedPro Group
a Berkshire Hathaway company

Checklist

PATIENT SAFETY & RISK SOLUTIONS

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) to find and examine the cause of these events and devise a plan to prevent them in the future. 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, which involves analyzing organizational processes and systems to determine what potential improvements could be made to lessen the occurrence of future adverse events, focuses primarily on systems and processes, not on individual performance. The goals of RCA include discovering the root of a problem or event, understanding how to fix the underlying causes, and applying what is learned to systematically prevent issues or repeat successes.

Assessing the type and number of adverse events and potential adverse events (i.e., near misses) they incurred also helps healthcare organizations determine the cause of system breakdowns and other factors that contribute to adverse events. This knowledge highlights the importance of preventing and reducing events that occur with high frequency or that have a high potential to result in patient harm.

Inherent in this quest to prevent adverse events is the critical need for a healthcare organization's leadership to instill a culture of safety and cultivate an atmosphere that encourages event reporting and a nonpunitive response to it. Learning from adverse events and taking action by adjusting systems and policies is paramount to a healthcare organization's ongoing commitment to maintain patient safety and reduce liability exposure.

Healthcare organizations can use the questions in this checklist to enhance their efforts in planning and refining their event reporting and RCA procedures. The root cause types in the checklist are based on The Joint Commission's Framework for Root Cause Analysis and Action Plan.[2]

	Yes	No
Leadership and Organizational Culture		
Does leadership develop and enforce a code of conduct that defines appropriate behavior that supports a culture of safety as well as unacceptable behavior that can undermine it?	☐	☐
Does leadership encourage reporting of hazardous conditions and near misses as well as adverse events that reach the patients?	☐	☐
Does leadership identify and address any organizational barriers to event reporting?	☐	☐
Does leadership place an emphasis on detecting system failures rather than individual errors?	☐	☐
Does leadership provide timely and compassionate feedback when any adverse events occur?	☐	☐
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 use the information reported on events to identify the system flaws that contribute to mistakes?	☐	☐
Does leadership select an event reporting system based on ease of use and results?	☐	☐
Does leadership define events that should be reported and identify the roles of the stakeholders?	☐	☐

	Yes	No
Leadership and Organizational Culture (continued)		
Does leadership ensure that all potential reporters understand how and why to report events?	☐	☐
Does leadership ensure that data are analyzed and respond accordingly to improve clinical and operational processes?	☐	☐
Does leadership ensure that stakeholders receive timely and comprehensive feedback?	☐	☐
Does leadership address the continuum of patient safety events, including close calls, adverse events, and unsafe, hazardous conditions?	☐	☐
Are there barriers to the communication of potential risk factors to healthcare employees?	☐	☐
Task/Process Factors With RCA		
Was there follow-through with items requiring improvement, such as policy revision, equipment repair, or training?	☐	☐
Was the process flow (including defined process steps) adhered to in the activity in which the event occurred?	☐	☐
Were there any steps in the process that did not occur as intended?	☐	☐
Environmental Factors With RCA		
Did any controllable environmental factors, such as lighting, noise, or space issues, play a role in the event?	☐	☐
Did any uncontrollable environmental factors, such as a natural disaster, affect the outcome of the event?	☐	☐
Was this the appropriate physical environment for the processes being carried out?	☐	☐
Are there systems in place to identify environmental risks?	☐	☐

	Yes	No
Equipment/Device/Supply/Healthcare Information Technology Factors With RCA		
Did equipment performance (if applicable) affect the outcome in this event? • Did the equipment or device operate properly? • Were any alarms silenced, disabled, or overridden?	☐ ☐ ☐	☐ ☐ ☐
Did any health information technology issues, such as display/interface issues (including display of information), occur during this event?	☐	☐
Can technology be introduced or redesigned to reduce risks in the future?	☐	☐
Are there other areas in the organization where this event could also happen?	☐	☐
Staff Performance Factors With RCA		
Were staff members involved in this event properly qualified, trained, and currently competent for their responsibilities, including the credentialing of the provider?	☐	☐
Did staff performance during the event meet expectations?	☐	☐
Were there any human factors, such as failure to follow procedure, fatigue, inability to focus on task, and more, that were relevant to the event's outcome?	☐	☐
Can orientation and in-service training be modified and improved as a result of the event?	☐	☐
Team Factors With RCA		
Are the appropriate healthcare employees involved in conducting and reviewing the RCA?	☐	☐
Did any disruptive behavior among staff occur during the event?	☐	☐
Did any communication failures among staff occur during the event?	☐	☐

	Yes	No
Management/Supervisory/Workforce Factors With RCA		
Did staffing compare with the organization's ideal staffing ratios during the event?	☐	☐
Were staff members who were involved in this event properly trained on policies and procedures?	☐	☐
Did staff members who were involved in this event receive all necessary information to perform their responsibilities?	☐	☐
Is there a plan in place for dealing with staffing contingencies? • Were such contingencies a factor in the adverse event?	☐ ☐	☐ ☐

Resources

- Agency for Healthcare Research and Quality: Patient Safety Primer: Root Cause Analysis
- The Joint Commission: Framework for Root Cause Analysis and Action Plan
- VHA National Center for Patient Safety: Root Cause Analysis

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[1] ECRI. (2021, May 18). Essentials: Culture of safety. *Health System Risk Management*. Retrieved from www.ecri.org/components/HRC/Pages/Essentials_Culture-of-Safety.aspx

[2] The Joint Commission. (n.d.). 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?db=web&hash=B2B439317A20C3D1982F9FBB94E1724B