TOOL/GUIDE TO ASSIST BEHAVIORAL HEALTH CARE IN THE COMPLETION OF A ROOT CAUSE ANALYSIS (RCA)

I. Brief description of event

Briefly summarize the circumstances surrounding the occurrence including the outcome (e.g., death, loss of function).

Example (1): A new consumer to a specialized residential home was given medication that was not his. This medication caused a severe allergic reaction and he was taken to ER by ambulance. He was admitted to the hospital for treatment and observation.

Example (2): Consumer committed suicide by shooting self in her apartment

II. Background Information

Include diagnosis, any medical issues, current medications prescribed, services receiving and for how long

Example (1): Developmental Disabled, Schizophrenia, CHF, Hypertension, Diabetes; List current medications, residential care, OT, PT, Nursing, Psychiatric; New transfer from Detroit

Example (2): Diagnosis of major depression, recurrent with severe psychotic features, alcohol abuse, HTN, Diabetes, and obesity. She was receiving therapy and psychiatric services for 2 years

III. When did the event occur?

Include the date and time the event took place.

Example (1): June 25, 2007 at 5:00 pm

Example (2): August 25, 2007 at 5 pm

IV. Who participated in the analysis

Please include a list of all team members that participated in the analysis by position and title. Please DO NOT include any names!

Example (1): Staff involved with incident, Home Manager, Case Manager, Medical Director, Nursing Staff, and Medical Staff Coordinator

Example (2): Program Director, Medical Director, Medical Practice Coordinator, Therapist**,** OP clinic nurse and prescribing physician

V. What events lead up to the situation (A Flow Diagram(s)

List the key steps involved in the specific processes relating to the event. Flow-chart the process as it was done when the sentinel event occurred.

Example (1):

- Consumer A arrives new to Residential Home at 3:45pm.

- Short staffed because of a staff calling in sick.
- Consumer B due to have Penicillin at 5pm.
- Door bell was ringing with commotion happening in the kitchen when staff was setting the penicillin up.
- The penicillin was ultimately given to Consumer A. so staff could answer the door.
- Consumer A has an allergy to Penicillin and immediately had a reaction.
- 911 called and the ambulance arrived within minutes.
- Consumer A admitted to hospital for treatment.

Example (2):

- Consumer initially being seen and treated after attempted suicide in March of 2007 and May of 2007
- Very depressed and impulsive
- Many stressors at home (32 and 35 year old living with mother and are still dependent for food and clothes, etc.)
- Continues to be very agitated
- Continues to "binge" drink on a weekly basis
- Consumer had been being seen every 2 weeks by staff or psychiatrist and then for the last 6 months has not kept scheduled appointments (inconsistent) and has not been seen for 2 months now
- Non-compliant with taking medications
- Working with MI Works to look for work opportunities
- Was seen and heard arguing with one son on the day of the incident
- Called clinic and wanted to be seen/evaluated
- Found by other son around 8 pm in apartment when he returned home

VI. Risk factors relevant to the situation

Include housing and family dynamics, substance abuse issues, consistency with treatment, age, etc.

Example (1): Residential Home understaffed. New consumer arrival at busy time of day.

Example (2): Living with 2 elderly children in apartment, no other support system. abuses alcohol, 51 years of age and not consistent with following recommended treatment

VII. Human factors that were relevant to the event

Evaluating the role of human performance factors that may have contributed to an error.
Fatigue of staff involved, personal problems where staff were not focused on job tasks, complex critical thinking requiring knowledge based decisions, not following documented policy and procedure, substance abuse, stress, boredom or staff rushing to complete the task.

Example (1): Fatigue of staff involved due to working overtime, personal problems with staff and were not focused on job tasks, and staff were rushing to complete the task.

Example (2): Staff did not feel consumer was at risk, denied suicidal ideations. Staff did not communicate to psychiatrist of missed appointments. No room on schedules to see consumer on an emergent basis (therapist or psychiatrist) and consumer refuses crisis interventions

VIII. Did equipment performance affect the outcome

List the various equipment utilized for that consumer. To assist in evaluating these processes consider the following:
Were bio-med checks done and up-to-date? Was the equipment where it was supposed to be? Why or why not? Was staff in-serviced on equipment? How long ago? How frequently is the equipment used? Were alarms, displays, and controls identifiable and/or operating properly? Is the equipment set-up and performing in accordance with the manufacturer's recommendations? Were their equipment recalls that were not addressed? Was equipment designed to accomplish its intended purpose? Were equipment parts defective? Was there a report to another agency regarding equipment defect (FDA, etc)?

Example (1): NA

Example (2): N/A

IX. What controllable factors directly affected the outcome

Identify factors that may have contributed to the event that the organization has the ability to change by making process improvement changes.

Example (1): Medication administration techniques assessed monthly on every med passer. Two identifiers always used no matter what the situation. Five rights checked.

Example (2): A system/process to identify those consumers who do not keep scheduled appointments. A scheduling process to incorporate areas for emergent consumers to be seen.

X. Were there uncontrollable factors

Uncontrollable factors are those factors that the organization cannot change that contribute to a breakdown in internal processes. .

Example (1): Staff shortage due to call-in. Household activities and disruptions and the arrival time of the consumer

Example (2): Not able to control impulsiveness (people and their decisions). Unable to control relationships with family members or alcohol consumption

XI. Other factors directly related

Were tools available, easily accessible and used as appropriate (e.g., lethality scale, assessment tools, communicator log)

Example (1): Communicator and/or medication administration record not updated to include allergies accordingly for new consumer.

Example (2): Lethality scale/assessment tools not used appropriately and/or communicated

XII. Human Resources

1. **Were staff properly qualified and currently competent for their responsibilities?**

Include all staff present, not just those that were determined to be involved with the event. Do not overlook physicians and other health professionals. Determine if staff was formally trained to perform the specific duties or tasks involved in the event. Was the training adequate? Were competencies documented? Had procedures and equipment been reviewed to ensure a good match between people

and tasks performed? Were there agency staff or contracted staff that may not have been familiar with procedures/equipment? Were the staff new and performing a function that they were not oriented/trained/competent in performing? Were staff oriented to the organization and department specific policies/procedures?

Example (1): GHC training completed and passed according to policy/procedures

Example (2): All staff were competent with required training completed and documented. All staff were oriented to specific processes for their job responsibilities

2. How did actual staffing compare with normal staffing levels?

Was there appropriate staffing at the time of the event to address the required workload? Keep in mind if it was a weekend, change of shift, holiday, or break time.
Document the actual staffing in area of occurrence versus planned staffing according to the usual staffing patterns. Explain any variation; higher or lower staffing.

Example (1): The normal evening staffing pattern for the residential home is two staff for six consumers; however at the time the incident occurred, one staff person did not show for their shift. Shortage of one staff person added to confusion

Example (2): Case load ratio to therapist was appropriate.

3. Was orientation and in-service training appropriate and completed?

Were all staff oriented to the job responsibilities, organization, and policies and procedures regarding safety, security, hazardous materials, emergency, equipment, life-safety, treatments, and procedures? Are policies revised/updated, evidence based, and readily available? Have policies or procedures changed without providing additional training? Was a new policy developed and staff training conducted? Do staff receive training within the areas they are assigned? Is this documented?

Example (1): Documentation on training was on file and appropriate for staffing. Orientation to the new consumer was not done due to constraints on staff and time.

Example (2): Staff oriented to their job responsibilities and clinic functions

4. Were there any common cause variations that would lead to a special cause variation?

Was there any systems or process changes that could have caused a variation to the normal activities or functions?

Example (1): Usually on-call staff are called in to cover absences. On this particular occasion on-call staff was unavailable and home manager did not respond to calls

Example (2): No common cause variation

XIII. Information Management

1. Is all information available when needed?

Was information from various consumer assessments completed, shared, and accessed by members of the treatment team as required by policy? Was the consumer correctly identified? Was the documentation clear and did it provide an adequate summary of the consumer's condition, treatment, and response to treatment? Was the level of automation appropriate? Identify what information

systems were utilized during consumer care.

Example (1): Communicator book not updated in timely manner with new consumer information, labeled prescriptions (bottles, bubble wrap)

Example (2): All medication reviews, nurse and therapist's notes were readily available and accessible due to the electronic medical record

2. Is communication among participants adequate?

Was communication of key information completed in a timely manner? Was there a misunderstanding of information shared based on a language barrier, abbreviations, terminology, etc.? Was shift-to-shift or unit-to-unit communication completed properly? Were there adequate policies and procedures in place to describe what is required? Is consumer/family/guardian involved when needed in communication of information? Was adequate information communicated when a consumer transferred from one area to another and was this communication of essential information documented? (medications, labs, etc.)

Example (1): Inadequate/incomplete information given to staff on evening shift.

Example (2): Lack of communication with support system of consumer (children would not be involved). Lack of communication between disciplines regarding missed appointments

XIV. Was the physical environment appropriate for the processes being carried out

Look closely at the environment the consumer was in or was transferred to/from. Spaces, privacy, safety, and ease of access are a few items to consider. Was work performed under adverse conditions (hot, humid, improper lighting, cramped, noise, construction projects)? Had there been environmental risk assessments conducted? Did the work environment meet current codes, specifications, and regulations? Was the work environment appropriate to support the function it was being used for?

Example (1): Adverse conditions due to noise/activity during the 5 pm time frame
Example (2): N/A

XV. What can be done to protect against the effects of uncontrollable factors

When looking at uncontrollable factors review the system the consumer went through.

Example (1): Have backup plan for staffing and emergencies.
Home manager on site for initial transfer of new consumers to follow through with medication communicator and employee orientation of new consumers.

Example (2): Consumer denies alcohol abuse
Consumer very impulsive
Consumer not keeping appointments
Consumer attempted suicide in the past

After listing examples, drill down further on each one and determine what action could be put in place to prevent the event or offer other alternative for action.
Was there a literature search done?

List all sources of literature accessed to complete the analysis and action plan. Literature may be accessed to assist in analyzing the event to determine process breakdowns and/or when developing

actions once the root causes have been identified to assist in developing best practice recommendations for changing current practice.

NOTE: Getting to the root cause of a sentinel event involves asking "Why?" and then exploring the ramifications of the response.

XVI. Action Plan(s)

A detailed risk reduction strategy must be stated for each root cause identified. If a risk reduction is not warranted for the identified cause, an explanation is required. A risk reduction plan may also be developed for all other areas identified as opportunities for improvement that were identified in the analysis but may not be considered root causes. The following components must be addressed:

Risk reduction strategy, person responsible for implementation, date of implementation, measures of effectiveness with committee oversight. The measures of effectiveness are the same as a performance indicator. They should include anticipated outcome and measure whether or not the action taken was effective.

ACTION PLAN

(KEEP THIS AS A SEPARATE PAGE TO UTILIZE AT COMMITTEE MEETINGS UNTIL COMPLETED)

Example: The action plan can be set up into columns to assure covering all components:

Root Cause(s)/Opportunity for Improvement(s)	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy	Committee Oversight

- **Root Cause(s)/Opportunity for Improvement(s):**

Highlight and summarize the root cause(s)/ Opportunity for Improvement(s) Issue identified during the root cause analysis.

- **Risk Reduction Strategy:**

Outline in detail the action plan steps taken to promote change. Be specific. If you change a policy and procedure, summarize the change that you are making. Outline how you are going to implement the policy and procedure (e.g., educate staff, perform post test for staff, etc.).

- **Person(s) Responsible for Implementation:**

Identify by title the individual responsible for implementing the particular risk reduction step.

- **Date of implementation:**

Outline the anticipated date of completion of each identified step. Outline the actual completion date for steps already completed.

- **Measurement Strategies/Measures of Effectiveness:**

Outline the plan for measuring the effectiveness of each risk reduction strategy:

  - Indicators must be objective, measurable, and quantifiable. (Use outcome based measurements whenever possible)
  - Measures of effectiveness need to have the data collection methodology outlined.

- Give sample size and method of collecting.
- Are you determining effectiveness by observation? Pre-test/post-test? Pilot test? Audit tool? Explain.
- Set a target range that reflects the desired range of performance for each indicator

(Examples of Measurement Strategies):

- Following a policy and procedure change, all staff will demonstrate competency by passing post test with score of 90% or higher and complete a return demonstration, if appropriate
- All medication passers will complete a return demonstration of the appropriate process to administer medications to the assigned personnel (Home Manager or Nurse, etc.)
- Case Managers/Therapists will demonstrate the appropriate way to complete a lethality scale to the assigned personnel (Supervisor, Psychiatrist, etc.)
- Staff will demonstrate the appropriate way to utilize equipment to the appropriate personnel (Home Manager, Nurse, etc.)

External comparisons may be used to develop indicator data and target measures. Sources for external comparison data are performance measurement systems, professional organizations or societies and research articles.

- **Committee Oversight:**

All risk reduction measurement strategies will be evaluated and reported to the appropriate committee (MMPRC, PI, RMC, etc.) with a required written progress report following the approval of the RCA and action plan.

XVII: Approval Process:

The RCA will be discussed and the action plan approved at the Medical Management/Peer Review Committee with oversight by the Medical Director (the PIHP Medical Director will review and approve those RCA that involve the Medical Director).