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Office of Health Care Quality (OHCQ) Root Cause Analysis (RCA) and Actions Tool

CONFIDENTIAL: THIS REPORT IS MADE PURSUANT TO THE EVALUATION AND IMPROVEMENT OF QUALITY HEALTH CARE FUNCTIONS SET FORTH IN SECTION 14-501 (c) OF THE HEALTH OCCUPATIONS ARTICLE OF THE ANNOTATED CODE OF MARYLAND AND IS INTENDED AS A RECORD OF A MEDICAL REVIEW COMMITTEE AS DEFINED IN THAT STATUTE.

Hospital:

OHCQ Case Number:

Date of Event:

Elements	Guidelines	Comments
<p>Brief Description of Event</p>	<p>Include key details of the event, such as the date, day of the week, time of the event, and the area of the hospital in which the event occurred. If appropriate, include a timeline (this can be uploaded as a separate attachment)</p>	

<p>Analysis of policies and procedures COMAR 10.07.06.06C</p>	<p>If there is a policy in place for this process, please (1) describe the appropriate process steps as defined by the policy, (2) explain any deviation from the intended process, and (3) comment on whether the policy realistically supports the workflow.</p>	
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<p>Analysis of policies and procedures COMAR 10.07.06.06C</p>	<p>Was all the necessary information to comply with policies and procedures available when needed? Was it accurate, complete, and unambiguous?</p>	
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<p>Analysis of policies and procedures COMAR 10.07.06.06C</p>	<p>Were any barriers to compliance with policies and procedures identified?</p>	
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<p>Multi-disciplinary RCA team COMAR 10.07.06.06A</p>	<p>List participants by title. Some participants (but not necessarily all) should have knowledge of the processes or systems being analyzed.</p>	
<p>Patient/Family Notification</p>	<p>Was the patient and/or family informed of the event?</p>	<p> <input type="radio"/> Yes <input type="radio"/> No Unknown <input type="radio"/> N/A </p>
<p>Date of RCA Meetings</p>		

<p>Diagram or narrative analysis of cause and effect COMAR 10.07.06.06C</p>	<p>Please include a narrative analysis of cause and effect or an event process diagram. This can also be uploaded as a separate attachment.</p>	
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<p>Analysis of all available resources COMAR 10.07.06.06C</p>	<p>List all resources used to identify factors relevant to the event, including medical records, interviews, policies and procedures, maintenance logs, committee minutes, etc.</p>	
<p>Analysis of personnel factors COMAR 10.07.06.06C</p>	<p>Communication: Did communication breakdowns contribute to the event? Were there any opportunities for improved communication?</p>	

Analysis of personnel factors COMAR 10.07.06.06C	Training: Were all involved staff appropriately qualified, properly trained, and competent to execute their responsibilities?	
	Were there instances in which staff did not follow established policies/procedures? What underlying factors contributed to this?	

Analysis of personnel factors COMAR 10.07.06.06C	Scheduling: Was there sufficient staff on-hand for the workload at the time?	
	Did fatigue or difficulty focusing on tasks contribute to the event? What underlying factors may have contributed to staff fatigue or difficulty concentrating?	

Analysis of equipment and environment COMAR 10.07.06.06C 1	Was all the necessary equipment available?	
	Did issues with equipment performance and/or maintenance contribute to the event?	

Analysis of equipment and environment COMAR 10.07.06.06C 1	Was available technology used as intended?	
	Did the technology work well with the workflow and environment?	

Analysis of equipment and environment COMAR 10.07.06.06C 1	Were staff appropriately trained in the use of the relevant technology?	
	What other environmental factors may have contributed to the event?	

Clearly identified Root Cause contributing factors COMAR 10.07.06.06C 4	Did patient refusal to participate in interventions play a role in this event? If so, how?	
	Identify the primary root cause(s) of the event.	

Clearly identified Root Cause contributing factors COMAR 10.07.06.06C 4	Did unconscious bias play a possible role in this event? If so, how?	
	Identify potential barriers to identifying, reporting, and responding to risks.	

Action Plan: PS #

RCA #

Identify corrective action COMAR 10.07.06.02B
 Identify mechanisms to compensate for uncontrollable environmental factors. Stronger actions include architectural/physical plant changes, tangible involvement & action by leadership, simplifying the process, standardizing equipment or processes, and/or implementing a new device that has had usability testing performed.

Intermediate actions include checklists, cognitive aids, staffing changes, readbacks, enhanced documentation and communications, software enhancements/modifications, elimination of look- and sound-alikes, and eliminating or reducing distractions.

Weaker actions include redundancy/double checks, warnings and labels, procedures/memos/policies, training, and additional study and analysis.

Wherever possible, develop actions that do not rely on the memories of staff members.

Item #	Specific measures to correct problems of areas of concern and specific measures to address areas of system improvement.	Hierarchy of Action Category	Hierarchy of Action Level <i>Defined as strong, intermediate, or weak.</i>	Outcome Measures COMAR 10.07.06.05A 5 <i>When possible, please include quantifiable measures with defined numerators, denominators and thresholds. Set realistic and achievable thresholds for performance. Include any physical/operational changes to be implemented.</i>	Timeframes for Implementing Specific Measures COMAR 10.07.06.02B	Title of Person Responsible for Implementation COMAR 10.07.06.02B	Status
1							

Action Plan: PS #
RCA #

2							
3							

Action Plan: PS #
RCA #

4							
5							

Action Plan: PS #
RCA #

6							
7							