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Guide to perform the Root Cause Analysis and prepare the action plan

First part

Work planning: RCA team

Basic information about the event to be analysed	Detailed description of the event	
	Area or service involved	

	Role	Name	Position
Members of the working group	Facilitator or coordinator		
	Clinical leader		
	Management representative		
	Other team members involved in the event		

Preparation of the questions

Topic	Who will we interview?	What questions will we ask?	Responsible for follow-up (depends on how the workload will be distributed)

Second part

Event description (an explanatory diagram can be added)

Guide to perform the root cause analysis for sentinel events

These tables aim to facilitate the group discussion and the gathering of information regarding the causal factors of the event. To do this, questions are asked about the 7 sections contemplated by the Veterans Administration to perform a causal analysis (human factor / communication, human factor / knowledge, human factor / work environment / fatigue, equipment, rules / procedures, safety mechanisms and factors of the patient).

Not all sections are applicable in each case. For this reason, two types of tables are included:

1. In order to identify which of these 7 categories the RCA team should analyse, the first table provides a series of filter questions that help to select the topics to be analysed.

2. The following tables include the questions to consider for each of the topics. Once the need for a section has been identified, all suggested questions should be considered for a full investigation. The last question in each section always consists of an open question, so that the group considers other aspects that could have influenced the event and have not been asked.

Indications:

- **"Facts, immediate cause":** This involves documenting the most immediate or proximate cause, easy to identify, that is more directly related to the incident. It is recommended to briefly describe the cause and leave blank if the question asked did not influence the event being analysed.

- **"Root cause or contributing factors":** These are those causes or factors that, by eliminating them, the probability of recurrence of an incident related to patient safety could be reduced or prevented. For each identified immediate cause, the possible root causes or contributing factors, which facilitated or allowed the immediate cause to occur, will be explored. Each immediate cause can have several root causes.

- **"Implement strategy?":** Answer with YES / NO. YES should be indicated for any identified root cause that is susceptible to improvement and, therefore, for which a risk reduction strategy can be developed.

- **"No.":** Assign a number to each root cause that has been considered capable of implementing a risk reduction strategy. This number will facilitate the identification of the causal factor to which the strategy is related in the subsequent action plan.

Event description

Guide for causal analysis (1)

Filter questions	Yes/No	Facts (immediate cause)
Were fatigue or stress of the professionals related to this incident?		If so, go to the environment / schedule section.
Were issues related to patient assessment a factor in this situation?		If so, go to the communication section.
Were issues related to staff training and/or staff competency a factor in this event?		If so, go to the knowledge, skills, and competence section.
Was equipment (both its use and its lack of use) involved in the occurrence of the incident?		If so, go to the equipment section and the knowledge, skills, and competence section.
Was a lack of information (or its misinterpretation) a factor related to the occurrence of this event?		If so, go to the communication section
Were appropriate rules, procedures, and protocols – or the lack thereof – a factor involved in the occurrence of this event?		If so, go to the section on rules, procedures, protocols.
Have there been any failures of safety mechanisms or barriers (designed to protect the patient, staff, and the work environment) related to this incident?		If so, go to the section on safety mechanisms, barriers.
Have patient-specific factors been related to this incident?		If so, go to the patient factors section

Guide for causal analysis (2)

HUMAN FACTORS	Questions	Facts, immediate cause	Root cause or contributing factors	Implement strategy?	No.
Communication	- Did the clinical documentation have all the information of the assessment, treatment, etc.? - Was patient information transmitted 24 hours a day to staff who needed it? - Were policies and procedures communicated adequately? - Other aspects related to communication				
Knowledge **Competence**	- Was orientation provided to employees prior to the start of the work process? - To what degree was staff qualified to carry out their responsibilities? - Was there an assessment done to identify what staff training was actually needed? - Was the knowledge of the staff monitored over time? - Other aspects related to knowledge, skills, and competence				

Environment **Schedule**	- Was there sufficient staff on-hand for the workload at the time? - Did personnel have adequate sleep? - Were environmental conditions appropriate? (temperature, space, noise, etc.) - Other aspects related to the work environment, schedule, and fatigue.				

Guide for causal analysis (3)

EQUIPMENT AND REGULATIONS	Questions	Facts, immediate cause	Root cause or contributing factors	Implement strategy?	No.
Equipment	- Did the equipment involved meet current codes, specifications, and regulations? - Was there a maintenance program in place to maintain the equipment involved? - Was the equipment involved used correctly? - Were the equipment controls working properly and were they easy to use? - Other aspects related to equipment.				

Rules **Procedures** **Protocols**	- Did the organization have procedures or policies that addressed the work processes related to the adverse event? - Were rules and procedures clear and up to date? - Were the relevant standards, procedures and protocols followed? - If they were not used, what was the reason why they were not used? - Other aspects related to standards, procedures, and protocols.				

Guide for causal analysis (4)

SAFETY AND PATIENT	Questions	Facts, immediate cause	Root cause or contributing factors	Implement strategy?	No.
Safety mechanisms, barriers	- Which safety mechanisms or barriers were involved in this event? - Were they evaluated before being implemented? - Would the incident have been prevented if the existing safety mechanisms had worked properly? - Other aspects related to safety mechanisms.				
Patient factors	- Did the patient's condition (complexity or severity) had an impact on the event? - Was the patient / family cooperative? - Were treatments applied to the patient with known associated risks? - Other aspects related to patient factors.				

Guide for the preparation of the action plan for risk reduction

This table aims to facilitate the preparation of the action plan, indicating the minimum aspects to be defined for each of the actions. The group may add other columns to collect additional information that they consider to be relevant.

Instructions:

- "No.": Copy the number assigned to the root cause for which a risk reduction strategy is to be developed (see guide for causal analysis).
- "Risk reduction actions": Operatively define the strategy to be implemented.
- "Responsible": Person in charge of managing the implementation of the action (you can have a working group for this).
- "Implementation date": Date on which the implementation phase of the risk reduction action is expected to end.
- "Evaluation measure": Indicator (s) that will be used to assess the effectiveness of the action to reduce risk.
- "Evaluation dates": Indicate the dates on which the indicator will be evaluated to verify the effectiveness of the action. Several dates can be indicated for those actions that require long-term monitoring to assess their impact.

No.	Corrective Actions	Responsible	Implementation date	Evaluation measure	Evaluation dates
	Action Item #1:				
	Action Item #2:				
	Action Item #3:				
	Action Item #4:				
	Action Item #5:				
	Action Item #6:				
	Action Item #7:				
	Action Item #8:				

Guide for the preparation of the results dissemination plan

The main RCA results must be disseminated among professionals. And we must ask ourselves: Who needs to know the findings and recommendations proposed by the RCA team? (This may include a small number of professionals or it may be relevant to all professionals and the whole centre).

What have we learned?	Who should know it?	How to share it?