State of New Jersey

Department of Health and Senior Services

Patient Safety Reporting System

Module 3 – Root Cause Analysis

Patient Safety Reporting System

Course Contents:

I. Root Cause Analysis and Action Plan

II. RCA Review by Patient Safety

III. Communications about the RCA

Patient Safety Reporting System

I. Root Cause Analysis (RCA) and Action Plan

Determination Made by Patient Safety -

RCA Required

Events can be accessed by:

- View Events – All Events

RCA Not Required

- E-mail notification will indicate that internal analysis is recommended, but an RCA does not need to be submitted to Patient Safety. If you would still like to submit an RCA for review, contact Patient Safety.

Patient Safety Reporting System

I. Root Cause Analysis (RCA) and Action Plan – Cont.

System Navigation

"Main Menu" Bar

- View Events – event listing, may create custom reports

"Report Menu" Bar

- Moves you through each report section with red arrow to indicate next step
- RCA Summary page builds as information is entered

Instructions

Provides instructions and options for each screen

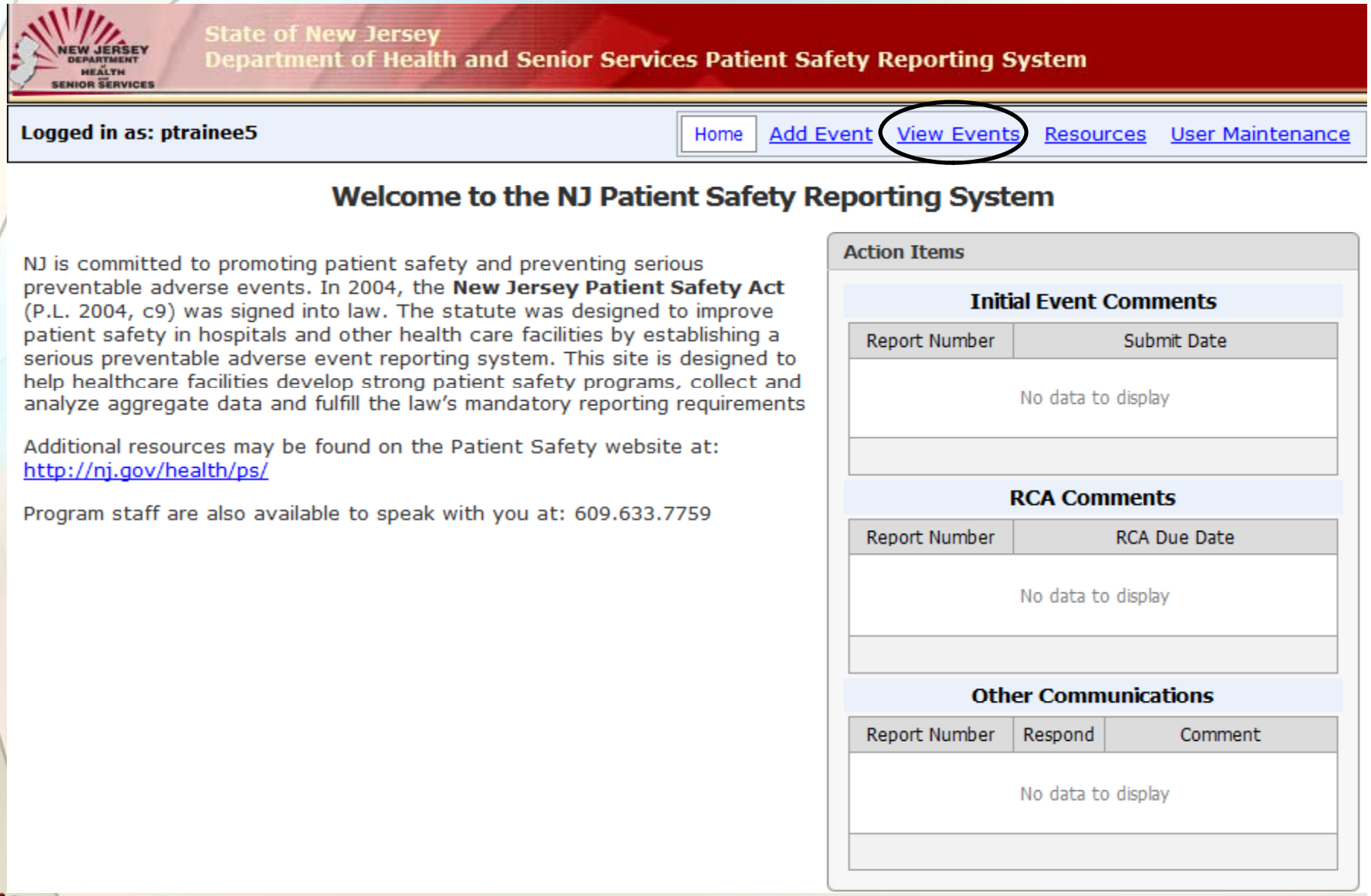
Information Consulted

- Under "Resources", information used for RCAs

"Save/Next" Button

- Move to next screen

I. Root Cause Analysis (RCA) and Action Plan – Continued



I. Root Cause Analysis (RCA) and Action Plan – Continued

View Events with Event Type “RCA- Facility Edit”

Logged in as: facilityWriterA

Home | Resources | Add Event | View Events | User Maintenance

- You can sort the data by clicking on the column headers
- Show Customization Window- Use the 'Customization Window' to add/remove fields from the grid.
- Saved Reports - Click to view your saved reports.
- Save a Report - Click to save the report.

Export to Excel

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type
Clear	2010				
Detail	2010	TEST FACILITY	20103004	Closed	edication
Detail	2010	TEST FACILITY	20103005	Closed	rong Blood
Detail	2010	TEST FACILITY	20103006	Closed	ternal Labor
Detail	2010	TEST FACILITY	20103007	RCA-DHSS Review	Care Management - Pressure Ulcers
Detail	2010	TEST FACILITY	20103008	RCA-Facility Edit	Environmental - Electric Shock
Detail	2010	TEST FACILITY	20103009	RCA-DHSS Review	Care Management - Spinal
Detail	2010	TEST FACILITY	20103010	RCA-DHSS Review	Care Management - Other
Detail	2010	TEST FACILITY	20103011	RCA-Facility Edit	Environmental - Electric Shock

(Non blanks)
Closed
Event-Facility Edit
RCA-DHSS Review
RCA-Facility Edit

Patient Safety Reporting System

I. Root Cause Analysis and Action Plan – Continued

The "Report Menu" will guide you through the event

- A red arrow will indicate the next step in the process

Complete fields for:

- General information
- Facts of the Event
  - This screen can be saved if not completed by entering "NA" for questions that do not apply
- RCA-specific questions

I. Root Cause Analysis and Action Plan – Continued

Report Menu: Return to Detail

Report Number:20110007

Event Classification: Environmental - Fall

RCA: General Information

1. List the individuals on the RCA Team:

Staff nurse, charge nurse and patient safety officer.

1947 **Characters left**

2. How many similar events has your facility had in the previous 3 years? (numbers only)

0

If your facility has similiar events, please answer the following questions

a. What changes did the organization make in response to these previous events?

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b. How are you tracking the effectiveness of these changes?

2000 **Characters left**

c. What procedures are in place to ensure that the facility knows about all the reportable events?

2000 **Characters left**

Save/Next

I. Root Cause Analysis and Action Plan – Continued

RCA: Facts of the Event

1. Facts of the Event (Answer all that apply or enter 'NA' where not applicable):

a. Patient's past medical and surgical history:

History of hyperlipidemia, right hip fracture in June 2010 and knee replacement

2000 **Characters left**

b. Clinical status of patient prior to event:

Post surgical for pacemaker placement.

1962 **Characters left**

c. Clinical status of patient after the event:

Left hip fracture after fall.

1971 **Characters left**

d. Patient's course in facility prior to event (i.e. surgery, transfer to ICU):

Surgery, transfer to med/surg.

e. Patient's course in facility after event:

Surgery for hip repair.

I. Root Cause Analysis and Action Plan – Continued

Event Classification: Environmental - Fall

RCA Specific Questions

1. Does your facility have a fall team that regularly evaluates yours falls program? (●) Yes ( ) No

2. Was a Fall Risk Screening documented at admission? (●) Yes ( ) No

3. When was a fall assessment done?

Date: 1/7/2011

Time: 0800 **Enter Time in Military (e.g 1800=6:00PM)**

☐ If assessment date is unknown, check here

4. Was a validated, reliable fall risk screening tool used? (●) Yes ( ) No

Which tool?

5. Did the screening tool indicate that the patient was at risk for a fall? (●) Yes ( ) No ( ) NA

a. Does the patient have a history of a fall prior to admission? (●) Yes ( ) No

6. If screening tool did not indicate the patient was at risk for falls:

a. Was patient still placed at risk due to clinical judgment? ( ) Yes ( ) No (●) NA

b. If yes, what were the additional factors that placed the patient at risk

c. Were universal fall precautions in place? (●) Yes ( ) No ( ) NA

d. Fall Precaution (Check at least one):

Patient Safety Reporting System

I. Root Cause Analysis and Action Plan – Continued

For each event you may have:

- More than one Root Cause
  - Each root cause will have a causality statement
- More than one Action Plan per Root Cause
  - Each Action Plan will have one Methodology
- No Root Cause (justification required)

Work through one Root Cause at a time with the corresponding Action Plan(s)

I. Root Cause Analysis and Action Plan – Continued

RCA: Root Cause/Causality Statement

1. **Use this section to enter the root cause findings**
2. **Select the first root cause below and enter the corresponding causality statement.**
3. **Click Save/Next**

Using the Five Rules of Causation

*If no Root Cause, click HERE to explain the findings

1. Root Cause Categories:

○ Behavioral assessment process	○ Patient observation procedures
○ Patient identification process	○ Staffing levels
○ Care planning process	○ Competency assessment/credentialing
○ Orientation and training of staff	○ Communication with patient/family
○ Supervision of staff	○ Availability of information
○ Communication among staff members	◉ Equipment maintenance/management
○ Adequacy of technical support	○ Security systems and processes
○ Control of medications(Storage/access)	○ Labeling of medications
○ Physical assessment process	○ Physical environment

2. Causality Statement:

A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.

1852 **Characters left**

Save/Next

I. Root Cause Analysis and Action Plan – Continued

Causality Statement:*A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.*

- Enter the Action Plan for the causality statement displayed above
- Complete all RCA: Action Plan fields
- Click 'Save/Next' when finished

RCA: Action Plan

1. Action Plan:

Environmental Services will do a safety check on bed plugs every week to make sure they are functioning properly. Staff will incorporate bed alarm safety checks as part of their safety rounds each hour.

1795 **Characters left**

2. Monitoring Strategy:

This practice will be monitored through checking for appropriate alarm functioning for all patients with alarms placed.

1881 **Characters left**

3. Methodology Observational Audits

4. Frequency Monthly

5. Sample Size all beds with bed alarms

6. Implementation Start Date 1/17/2011

7. Staff position responsible for implementation:

Nurse manager

Patient Safety Reporting System

I. Root Cause Analysis and Action Plan – Continued

When the first Root Cause and Action Plan are complete:

- Add an additional Action Plan to the Root Cause

I. Root Cause Analysis and Action Plan – Continued

Report Menu: Return to Detail

Report Number:20110007

Event Classification: Environmental - Fall

Use this section to edit/add root cause findings

- **To Edit a Root Cause** - *Edit the root cause by clicking 'Edit' on the the appropriate row in the grid below .*
- **To Add an Action Plan** - *Click on ⊞ below to expand root cause then click on 'Add Action Plan'*
- **To Add a Root Cause** - Click to enter an additional Root Cause.
- **To Continue** - *When the RCA(s) and Action Plan(s) information is complete, click the button below to answer final RCA questions.*

Continue to RCA Additional Questions (Required)

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
⊞	Edit	Delete	Equipment maintenance/management	A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.

I. Root Cause Analysis and Action Plan – Continued

Report Menu: Return to Detail

Report Number:20110007

Event Classification: Environmental - Fall

Use this section to edit/add root cause findings

- **To Edit a Root Cause** - *Edit the root cause by clicking 'Edit' on the the appropriate row in the grid below .*
- **To Add an Action Plan** - *Click on ⊞ below to expand root cause then click on 'Add Action Plan'*
- **To Add a Root Cause** - Click to enter an additional Root Cause.
- **To Continue** - *When the RCA(s) and Action Plan(s) information is complete, click the button below to answer final RCA questions.*

Continue to RCA Additional Questions (Required)

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
⊟	Edit	Delete	Equipment maintenance/management	A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.

RCA: Action Plan

Edit	Add	Delete	Action Plan
Edit	Add Action Plan	Delete	Environmental Services will do a safety check on bed plugs every week to make sure they are functioning properly. Staff will incorporate bed alarm safety checks as part of their safety rounds each hour.

Patient Safety Reporting System

I. Root Cause Analysis and Action Plan – Continued

When the first Root Cause and Action Plan(s) are complete:

- Additional Root Causes can be added with Action Plan(s)

I. Root Cause Analysis and Action Plan – Continued

Report Menu: Return to Detail

Report Number:20110007

Event Classification: Environmental - Fall

Use this section to edit/add root cause findings

- **To Edit a Root Cause** - *Edit the root cause by clicking 'Edit' on the the appropriate row in the grid below .*
- **To Add an Action Plan** - *Click on ⊞ below to expand root cause then click on 'Add Action Plan'*
- **To Add a Root Cause** - Click to enter an additional Root Cause.
- **To Continue** - *When the RCA(s) and Action Plan(s) information is complete, click the button below to answer final RCA questions.*

Continue to RCA Additional Questions (Required)

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
⊞	Edit	Delete	Equipment maintenance/management	A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.

Patient Safety Reporting System

I. Root Cause Analysis and Action Plan – Continued

When all Root Causes and Action Plans are complete:

- Complete final RCA questions
- Submit to Patient Safety for review
- Receive error message if any required information is not completed

I. Root Cause Analysis and Action Plan – Continued

Report Menu: Return to Detail

Report Number:20110007

Event Classification: Environmental - Fall

Use this section to edit/add root cause findings

- **To Edit a Root Cause** - *Edit the root cause by clicking 'Edit' on the the appropriate row in the grid below .*
- **To Add an Action Plan** - *Click on ⊞ below to expand root cause then click on 'Add Action Plan'*
- **To Add a Root Cause** - Click to enter an additional Root Cause.
- **To Continue** - *When the RCA(s) and Action Plan(s) information is complete, click the button below to answer final RCA questions.*

Continue to RCA Additional Questions (Required)

RCA: Root Cause/Causality Statement

	Edit	Delete	RCA Category Text	Causality Statement
⊞	Edit	Delete	Equipment maintenance/management	A process was not in place to ensure that the bed alarm was functioning properly resulting in the patient getting out of bed undetected and falling.

I. Root Cause Analysis and Action Plan – Continued

RCA Additional Questions

1. What were the contributing factors to the event? (Select all that apply):

☐ Team factors	☐ Work environment
☐ Task factors	☐ Staff factors
☐ Patient characteristics	☐ Organization/management
☐ Medical devices	☐ Medications
☑ Procedures	☐ Transportation
☑ Equipment	☐ Home care
☐ Patient record documentation	☐ Imaging and X-ray
☐ Laboratory and diagnostics	☐ Other

Other:

2. Evaluate the impact of event for Patient (Select all that apply):

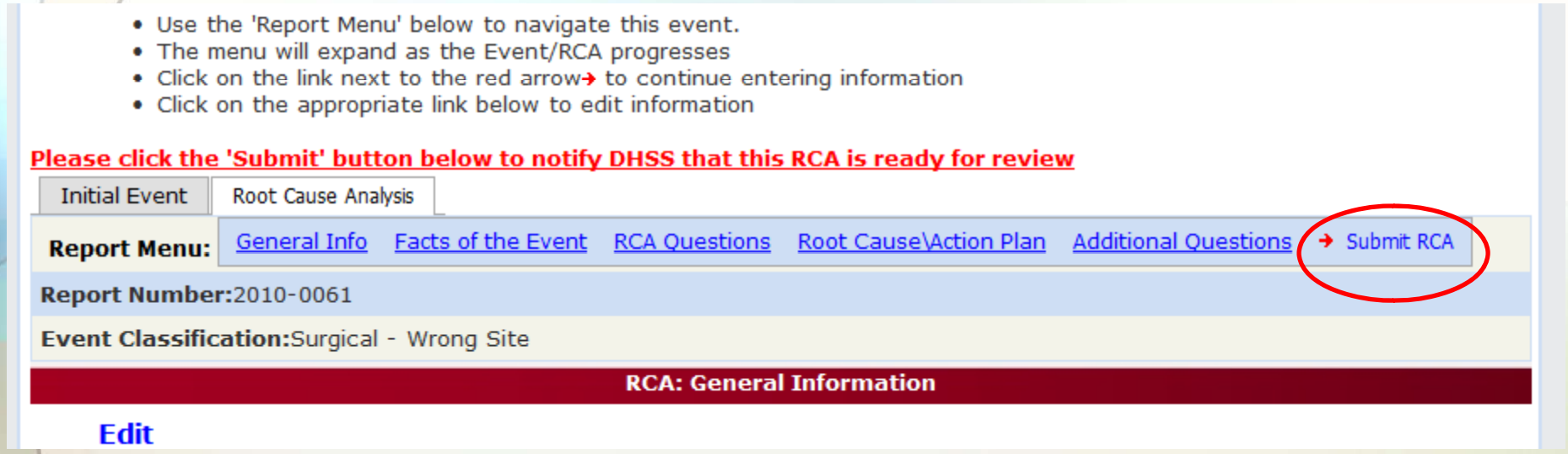
☐ Loss of limb(s)	☐ Visit to Emergency Department
☐ Loss of digit(s)	☐ Hospital admission
☐ Loss of body part(s)	☐ Transfer to more intensive level of care
☐ Loss of organ(s)	☑ Increased length of stay
☐ Loss of sensory function(s)	☐ Minor surgery
☐ Loss of bodily function(s)	☑ Major surgery
☐ Disability-physical or mental impairment	☐ System or processes delay care to patient
☐ Additional laboratory testing or diagnostic imaging	☐ To be determined
☐ Other additional diagnostic testing	☐ Death
☐ Additional patient monitoring in current location	☐ Other

I. Root Cause Analysis and Action Plan – Continued

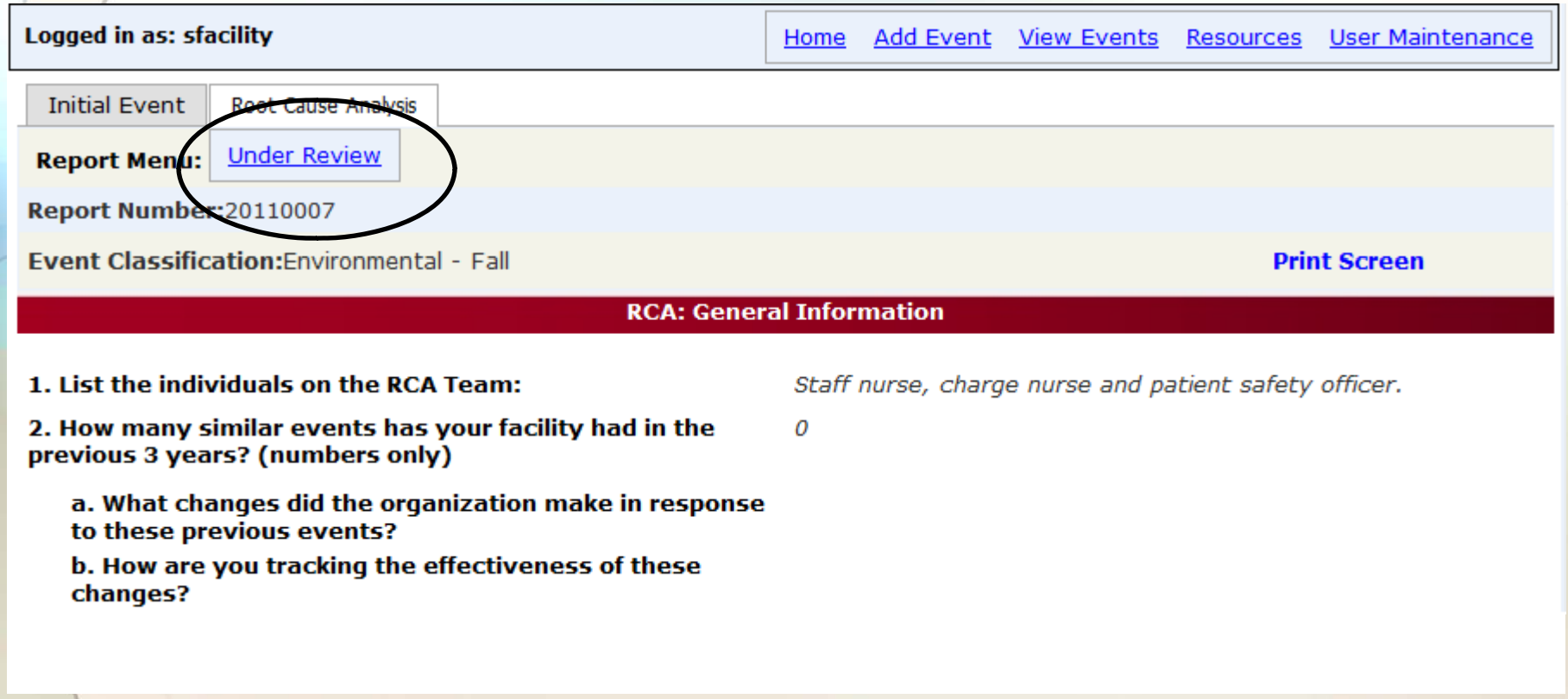
RCA additional questions:

- Information Consulted
- Gathered and can be viewed under "Resources"

I. Root Cause Analysis and Action Plan – Continued



I. Root Cause Analysis and Action Plan – Continued



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II. RCA Review by Patient Safety

1. Automated e-mail sent to Patient Safety
2. Patient Safety completes review
3. Review Outcomes:
   - RCA Comments
     - Additional information is needed and must be completed in 2 weeks
   - RCA Complete
     - RCA is complete; no further action needed
4. Patient Safety generates e-mail notification of outcome of review

Patient Safety Reporting System

II. RCA Review by Patient Safety - Continued

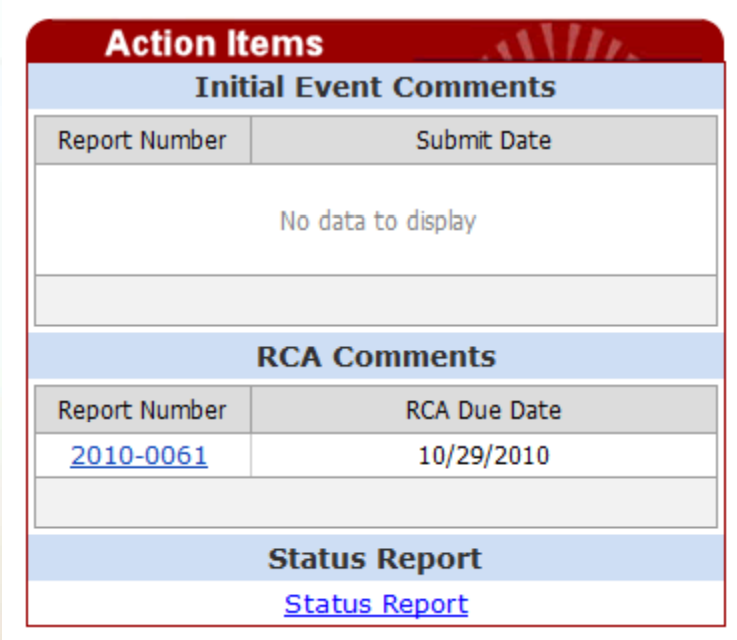
- RCA Comments can be accessed by:
  - Action Items – Listed under “RCA Comments”
  - View Event – By Status
- A comment link will only be visible in the sections of the RCA that have Patient Safety comments

Patient Safety Reporting System

II. RCA Review by Patient Safety - Continued

- Edit the field(s) necessary to respond to comments
- When edits are completed RCA must be re-submitted to Patient Safety for further review
- Cycle continues until RCA process is determined complete by Patient Safety

III. Communications about the RCA



Action Items

Initial Event Comments

Report Number	Submit Date
No data to display	

RCA Comments

Report Number	RCA Due Date
2010-0061	10/29/2010

Status Report

Status Report

III. Communications about the RCA

Logged in as: Ptrainee3

Home | Resources | Add Event | View Events | User Maintenance

- You can sort the data by clicking on the column headers
- Show Customization Window- Use the 'Customization Window' to add/remove fields from the grid.
- Saved Reports - Click to view your saved reports.
- Save a Report - Click to save the report.

Export to Excel

Drag a column header here to group by that column

View	Report Year	Facility Name	Report Number	Event Status	Event Type	Event Description
Clear	2010	test				
Detail	2010	TEST FACILITY	2010-0090	RCA-DHSS Review	Environmental - Fall	Description
Detail	2010	TEST FACILITY	2010-0091	Closed	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0092	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0093	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0094	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0095	Event-DHSS Review	Surgical - Retained Foreign Object	Description
Detail	2010	TEST FACILITY	2010-0100	Event-Facility Edit	Surgical - Retained Foreign Object	Description

III. Communications about the RCA - Continued

Please click the 'Submit' button below to notify DHSS that this RCA is ready for review

Initial Event | Root Cause Analysis

Report Menu: General Info | Facts of Event | Root Cause\Action Plan | Additional Questions | → Submit RCA

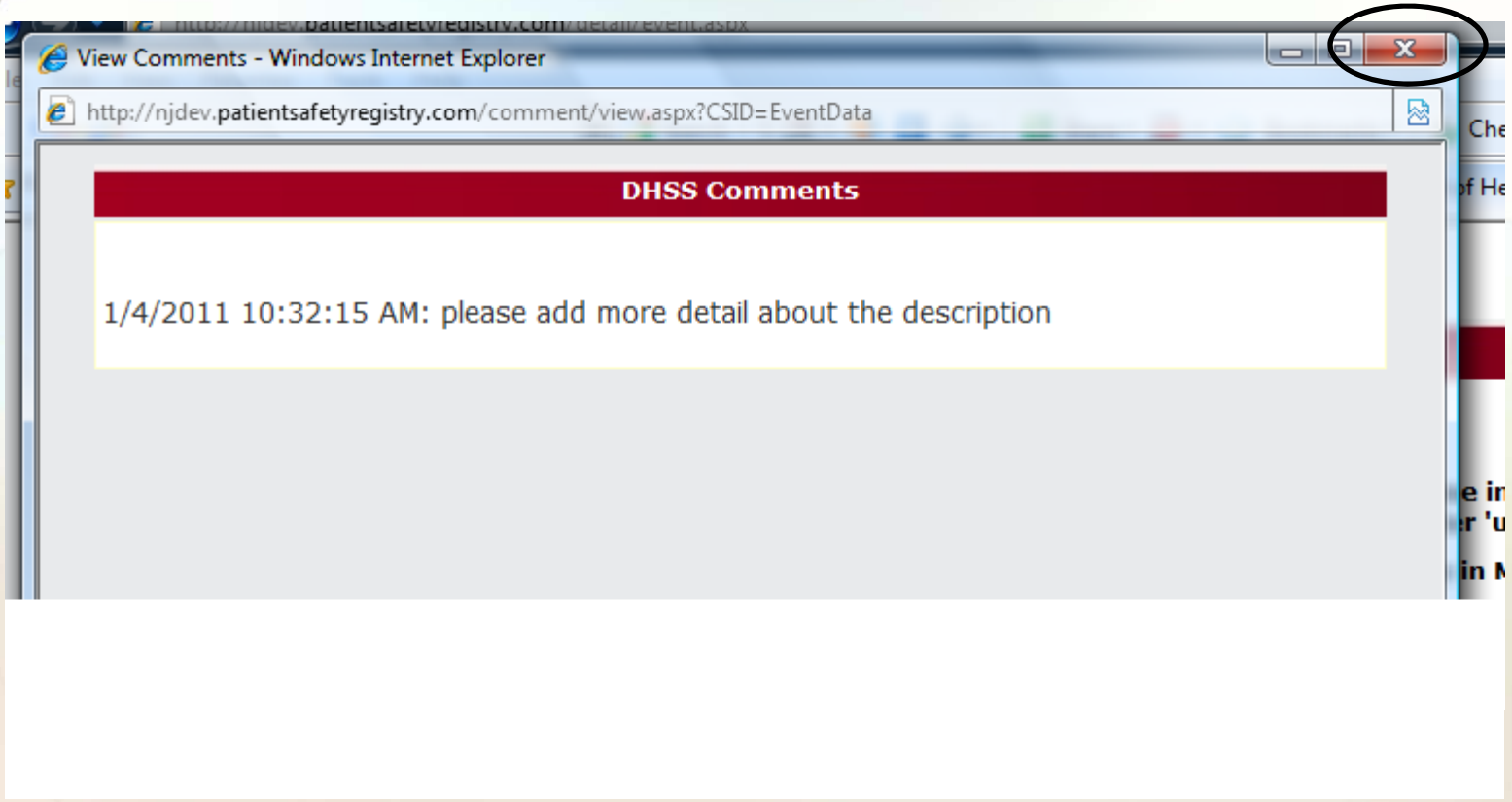
Report Number:20103023

Event Classification: Care Management - Medication Error **Print Screen**

RCA: General Information

Edit	Comments
1. List the titles only of the individuals on the RCA Team:	*Risk Manager, Quality Management Specialist, Quality Manager for Nursing, Associate Program Director of Internal Medicine Residency Program, Attending Physician, Consulting Endocrinologist, Diabetes Educator, Diabetes Advanced Practice Nurse, Nursing Director of Critical Care, Nurse Manager of Critical Care adn Internal Medicine Resident and nurses involved in the care of the patient.*
2. How many similar events has your facility had in the previous 3 years? (numbers only)	*1*
a. What changes did the organization make in response to these previous events?	*The action plan included revision of current hypoglycemic standing order and multidisciplinary education plan for management of the diabetic patient.*
b. How are you tracking the effectiveness of these changes?	*We stopped monitoring because we had achieved 100% compliance.*
c. What procedures are in place to ensure that the facility knows about all the reportable events?	*We monitor everything.*

III. Communications about the RCA - Continued



III. Communications about the RCA - Continued

Report Menu: Return to Detail

Report Number:20110007

Event Classification: Environmental - Fall

RCA: General Information

1. List the individuals on the RCA Team:

Staff nurse, charge nurse and patient safety officer.

1947 **Characters left**

2. How many similar events has your facility had in the previous 3 years? (numbers only)

0

If your facility has similiar events, please answer the following questions

a. What changes did the organization make in response to these previous events?

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b. How are you tracking the effectiveness of these changes?

2000 **Characters left**

c. What procedures are in place to ensure that the facility knows about all the reportable events?

2000 **Characters left**

Save/Next

III. Communications about the RCA - Continued

Please click the 'Submit' button below to notify DHSS that this RCA is ready for review

Initial Event | Root Cause Analysis

Report Menu: General Info | Facts of Event | Root Cause\Action Plan | Additional Questions | Submit RCA

Report Number:20103023

Event Classification: Care Management - Medication Error **Print Screen**

RCA: General Information

Edit	Comments
1. List the titles only of the individuals on the RCA Team:	*Risk Manager, Quality Management Specialist, Quality Manager for Nursing, Associate Program Director of Internal Medicine Residency Program, Attending Physician, Consulting Endocrinologist, Diabetes Educator, Diabetes Advanced Practice Nurse, Nursing Director of Critical Care, Nurse Manager of Critical Care adn Internal Medicine Resident and nurses involved in the care of the patient.*
2. How many similar events has your facility had in the previous 3 years? (numbers only)	*1*
a. What changes did the organization make in response to these previous events?	*The action plan included revision of current hypoglycemic standing order and multidisciplinary education plan for management of the diabetic patient.*
b. How are you tracking the effectiveness of these changes?	*We stopped monitoring because we had achieved 100% compliance.*
c. What procedures are in place to ensure that the facility knows about all the reportable events?	*We monitor everything.*

Patient Safety Reporting System

Review

1. Use “View Events” menu to find Event requiring RCA
2. Enter Root Cause and Action Plan
3. Multiple Root Causes and Action Plans can be entered
4. Patient Safety reviews RCA and responds with next step
5. Review Patient Safety comments and edit event
6. Re-submit event to Patient Safety

Patient Safety Reporting System

Next Module

1. Creating Reports
2. Review of Resources
3. Support