

## ROOT CAUSE ANALYSIS

Level of Analysis	Possibilities	Questions	Findings		
<b>What happened?</b>	Sentinel Event	What are the details of the event?			
		What area/service was impacted?			
				<b>Risk Reduction Strategies</b>	<b>Measurement Strategies</b>
<b>Why did it happen?</b>	Human error	What was the error?			
<b>What was the proximate cause(s)?</b>	Process deficiency	What was the missing or weak step?			
	Equipment breakdown	What broke?			
	Controllable environmental factors	What factors directly affected the outcome?			
	Uncontrollable external factors	Are they truly beyond the organization's control?			
	Other	Are any other factors that have directly influenced this outcome?			
<b>Why did that happen?</b>	Patient care Process (es)	What are the steps in the process?	Flow chart		
<b>What processes were involved?</b>  (May involve "special cause" variation, "Common cause variation", Or both	Specify	What steps were involved in (contributed to the event)?	Cause-effect; Change analysis; failure mode & effect analysis		
		What is currently done to prevent failure at this step?	Fault tree analysis	(i.e. simplification, redundancy)	
		What is currently done to protect against a bad outcome if there is a failure at this step?	Barrier analysis	(i.e. "fail-safe" design, redundancy)	
		What other areas or services are impacted?	Failure mode and effect analysis		

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Level of Analysis	Possibilities	Questions	Findings	Risk Reduction Strategies	Measurement Strategies
Why did that happen?  What systems underlie those processes? (Common cause variation here may lead to special cause variation in dependent processes)	Human resource issues	Is staff properly qualified & currently competent for their responsibilities?			
		Is staffing adequate?			
		Does planning account for contingencies that would tend to reduce effective staffing levels?			
		Is staff performance in the operant process (es) addressed?			
		Can orientation and in-service training be improved?			
	Information systems issues	Is all necessary information available when needed? Accurate? Complete? Unambiguous?			
		Is communication among participants adequate?			
	Environment management issues	Was the physical environment appropriate for the processes being carried out?			
		Are systems in place to identify environmental risks?			
		Are emergency and failure mode responses adequately planned and tested?			
	Leadership issues; corporate culture	Is the culture conducive to risk identification and reduction?			
	Encouragement of communication	Are there barriers to communication of potential risk factors?			
	Clear communication of priorities	Is the prevention of adverse outcomes adequately communicated as a high priority?			
	Uncontrollable factors	How can we protect against these?	Barrier analysis		