

# NYPORTS ROOT CAUSE ANALYSIS EVALUATION PROTOCOL

RCA Item #	STANDARD CRITERIA REQUIRED	Intent Met	Intent Not Met	N/A	COMMENTS FOLLOW-UP		Date Intent Met
<b>1.</b>	<b>Short Form</b>						
<b>1a.</b>	Short form category code(s) accurately reflects occurrence described.						
<b>1b.</b>	Detail code (900 series code) accurately reflects occurrence described.						
<b>2.</b>	<b>RCA Narrative Description</b>						
<b>2a.</b>	Detailed description of the adverse occurrence (sentinel event) must include date, day of the week, time and area/service involved.						
<b>2b.</b>	Identify who by title, what, where and a chronology of event that includes times.						
<b>2c.</b>	When pertinent, include: co-morbid conditions, height, weight, serial lab values, surgical procedures, changes in level of care, diagnostic testing results, vital signs, consults, other clinical data, and/or non-clinical data.						
<b>2d.</b>	Fully explains the event so that a reader unfamiliar with the occurrence understands what happened and why the event happened.						
<b>3-7</b>	<b>Policy or Process in Which Event Occurred (P), Human Resource Factors and Issues (H), Environment of Care (E), Information Management/ Communication Issues (I)</b>				<b>P H E I</b>	<b>COMMENTS FOLLOW-UP</b>	
<b>3a.</b>	Root cause statement #1 is consistent with the 5 rules of causation.						
<b>3b.</b>	Root cause #1: Risk reduction strategies/actions would prevent or minimize future events or close calls.						
<b>3c.</b>	Measures of effectiveness directly apply to risk reduction strategy for root cause #1.						
<b>3d.</b>	Measures of effectiveness must have defined timeframes, numerators for audits, thresholds in percentages for compliance, and follow-up for non-compliance. They must measure impact of root cause or risk reduction strategies.						
<b>4a.</b>	Root cause statement #2 is consistent with the 5 rules of causation.						
<b>4b.</b>	Root cause #2: Risk reduction strategies/actions would prevent or minimize future events or close calls.						

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<b>4c.</b>	Measures of effectiveness directly apply to risk reduction strategy for root cause #2.						
<b>4d.</b>	Measures of effectiveness must have defined timeframes, numerators for audits, thresholds in percentages for compliance, and follow-up for non-compliance. They must measure impact of root cause or risk reduction strategies.						
<b>5a.</b>	Root cause statement #3 is consistent with the 5 rules of causation.						
<b>5b.</b>	Root cause #3: Risk reduction strategies/actions would prevent or minimize future events or close calls.						
<b>5c.</b>	Measures of effectiveness directly apply to risk reduction strategy for root cause #3.						
<b>5d.</b>	Measures of effectiveness must have defined timeframes, numerators for audits, thresholds in percentages for compliance, and follow-up for non-compliance. They must measure impact of root cause or risk reduction strategies.						
<b>6a.</b>	Root cause statement #4 is consistent with the 5 rules of causation.						
<b>6b.</b>	Root cause #4: Risk reduction strategies/actions would prevent or minimize future events or close calls.						
<b>6c.</b>	Measures of effectiveness directly apply to risk reduction strategy for root cause #4.						
<b>6d.</b>	Measures of effectiveness must have defined timeframes, numerators for audits, thresholds in percentages for compliance, and follow-up for non-compliance. They must measure impact of root cause or risk reduction strategies.						
<b>7a.</b>	Root cause statement #5 is consistent with the 5 rules of causation.						
<b>7b.</b>	Root cause #5: Risk reduction strategies/actions would prevent or minimize future events or close calls.						
<b>7c.</b>	Measures of effectiveness directly apply to risk reduction strategy for root cause #5.						
<b>7d.</b>	Measures of effectiveness must have defined timeframes, numerators for audits, thresholds in percentages for compliance, and follow-up for non-compliance. They must measure impact of root cause or risk reduction strategies.						

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8.	Hospital policies, clinical practice guidelines, critical pathways, or practice protocols related to event are followed as intended, developed, or revised after review of the occurrence.					
9.	Review identifies all root causes likely to prevent recurrence of event.					
10.	RCA and identified root causes do not leave any obvious unanswered questions.					
11.	RCA is internally consistent and does not contradict itself.					
12.	<b>Literature Search</b>					
12a.	Literature search includes at least 3 sources when available. References can include books, articles, and websites. List the name of author(s), title of article, date of publication, journal name, volume number etc.					
12b.	Focus of literature search is on issues relevant or related to the event (s) that includes established community standards of care.					
13.	<b>Leadership: Corporate Culture</b>					
13a.	Leadership is involved in the evaluation of adverse patient care occurrences. They participate in the RCA process and are identified by title.					
14.	<b>Executive Summary of the Analysis</b>					
14a.	Analysis of clinical findings of review of occurrence is thorough.					
14b.	Any external expert review findings are included if obtained.					
14c.	Relevant Q/A findings are summarized.					
14d.	Pertinent findings from literature review are included.					
14e.	All elements are tied together to justify root causes, risk reduction strategies, and measures of effectiveness.					
15.	<b>RCA Participants</b>					
15a.	Individuals in roles involved in the processes and systems under review participate in RCA and are identified by title only. (i.e., RN, Pharmacist, Radiological Technician, LPN, Attending Surgeon, Resident, PCA, etc.)					

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<b>16.</b>	<b>Quality/Standard of Care</b>				
<b>16a.</b>	RCA findings support the facility's standard of care determination.				
<b>16b.</b>	Facility's determination of standard of care is consistent with current practice.				
<b>16c.</b>	If standard of care not met and is directly linked to an individual practitioner, the full name and license number or certification number is entered.				

**RCA item            Additional root causes**

<b>17 a.</b>	Root cause statement #6 is consistent with the 5 rules of causation.
<b>17 b.</b>	Root cause #6: Risk reduction strategies/actions would prevent or minimize future events or close calls.
<b>17 c.</b>	Measures of effectiveness directly apply to risk reduction strategy for root cause #6.
<b>17 d.</b>	Measures of effectiveness must have defined timeframes, numerators for audits, thresholds in percentages for compliance, and follow-up for non-compliance. They must measure impact of root cause or risk reduction strategies.
<b>18 a.</b>	Root cause statement #7 is consistent with the 5 rules of causation.
<b>18 b.</b>	Root cause #7: Risk reduction strategies/actions would prevent or minimize future events or close calls.
<b>18 c.</b>	Measures of effectiveness directly apply to risk reduction strategy for root cause #7.
<b>18 d.</b>	Measures of effectiveness must have defined timeframes, numerators for audits, thresholds in percentages for compliance, and follow-up for non-compliance. They must measure impact of root cause or risk reduction strategies.
<b>19 a-d.</b>	Apply to root cause statement #8.
<b>20 a-d.</b>	Apply to root cause statement #9.

**Any required follow-up with a facility on RCA protocol criteria, will be documented on NYSDOH NYPORTS Review Screen.**

## ***Five Rules of Causation, Action Statements & Rating Actions***

### ***Five Rules of Causation:***

Rule #1: Root Cause statements must clearly show the “cause and effect” relationship.

Rule #2: Negative descriptions should not be used in root cause statements.

Rule #3: Each human error must have a preceding cause.

Rule #4: Violations of procedure are not root causes, they must have a preceding cause

Rule #5: Failure to act is only causal when there is a pre-existing duty to act.

### ***Action Statements:***

Actions can be defined as stronger, intermediate, or weaker actions.

Actions can be classified as controlling, eliminating, or accepting the root cause or risk.

Identify mechanisms to compensate for uncontrollable environmental factors.

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

Indicate job title of person responsible for implementing/monitoring actions.

### ***Stronger Actions:***

Architectural/physical plant change, tangible involvement and action by leadership in support of patient safety, simplify process and remove unnecessary steps, standardize equipment processes, or care maps. Perform usability testing of new devices before purchase.

### ***Intermediate Actions:***

Checklists and cognitive aids, increased staffing, decreased workload, use of read-backs, enhanced documentation and communications, software enhancements/modifications, eliminating look-alikes and sound-alikes, and eliminating or reducing distractions.

### ***Weaker Actions:***

Redundancy/double checks, warnings and labels, new procedures/policy, new memorandums, training in absence of knowledge deficit and additional study/analysis.

