Control #	Rev. Date:	Title:	Effective Date:	10/16
CRR 1.14	9/2021	Root Cause Analysis (RCA)	Next Review Date:	9/2023

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health, Clinical Services Branch to review all sentinel events, designated near misses or at the discretion of the Medical Director, Agency Manager, Patient Safety Officer or Agency QAPI (Quality Assurance and Performance Improvement) Director.

2.0 PURPOSE:

To overview the Root Cause Analysis methodology used to analyze actual or potential adverse events using a systems approach. A root cause analysis focuses primarily on systems and processes, not individual performance. The objective of an RCA must not be to assign individual blame but to determine a process or processes and the causes or potential causes of variation that can lead to error and identify process changes that would make variation less likely to recur. The goal of the root cause analysis is to produce an *action plan* that identifies the strategies the organization intends to implement to reduce the risk of similar events occurring in the future.

3.0 DEFINITIONS:

3.1 *Root Cause* is the most fundamental reason (or one of several fundamental reasons) a failure or situation in which performance does not meet expectation, has occurred.

3.2 *Cause* refers to the relationship or potential relationship between certain factors that enable an event to occur. Cause does not imply the assignment of blame.

3.3 *Sentinel Event* is an unexpected occurrence involving the death of a person or serious physical or psychological injury, or the risk thereof when he/she is on state property or in residential services with 24 hour awake staff. Serious injury specifically includes but is not limited to loss of limb or function. Events are considered "sentinel" because they signal a need for an immediate investigation and response.

3.4 *Patient Safety Officer* as used in this policy references NRS 439.815 and means a person who is designated as such by a medical facility pursuant to NRS 439.870.

3.5 *Root Cause Analysis* is a formal process for identifying causal factors that contribute to an event associated with adverse outcomes or near miss/close call situations.

3.6 *Reportable Event* is an event that occurs on state property or in residential services with 24 hour awake staff and results in:

3.6.1 Death, permanent harm or severe temporary harm
3.6.2 Suicide within 72 hours of discharge from an inpatient setting
3.6.3 Abduction of any patient receiving care, treatment and services
3.6.4 Fall related fracture, surgery, casting or traction; required consult or management or comfort care for a neurological or internal injury.
3.6.5 Loss of limb or permanent loss of function.
3.6.6 Sexual assault.
3.6.7 Paralysis, coma or other major permanent loss of function associated with a medication error or other treatment intervention.
3.6.8 Consumer death or major permanent loss of function which occurs during an elopement, i.e., unauthorized departure.
3.6.9 Any elopement of a person from a staffed around-the-clock care setting leading to death, permanent harm, or severe temporary harm to the patient.
3.6.10 Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor or vendor while onsite at the hospital.
3.6.11 Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care caused by equipment operated and used by the hospital. Equipment must be in use at the time of the event, staff do not need to be present.
3.6.12 *Sexual abuse/assault* (including rape) as a sentinel event is defined as nonconsensual sexual contact involving a patient and another patient, staff member or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal, or anal penetration or fondling of a patient's sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event:

3.6.12.1 Any staff-witnessed sexual contact, as described above that occurred on the premises
3.6.12.2 Admission by the perpetrator that sexual contact, as described above, occurred on the premises

3.6.12.3 Sufficient clinical evidence obtained by the hospital to support allegations of nonconsensual sexual contact

3.6.13 *Severe Temporary Harm* is critical, potentially life-threatening harm lasting for a limited time with no permanent residual but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

3.6.14 *Adverse outcomes* are outcomes that are directly related to the natural course of an illness or underlying condition are exempt from the reporting requirement.

4.0 PROCEDURE:

4.1 Agency Medical Director, Agency Manager or Designee shall appoint a Root Cause Analysis Facilitator.

4.1.1 The facilitator must have had training in the root cause analysis process
4.1.2 The facilitator will ensure collection of all necessary materials, i.e. medical records, police reports, policies, equipment
4.1.3 Assign team members, to include the attending physician, social worker, mental health technician, nurse.
4.1.4 Assign a member of Performance Improvement to be a consultant to the team for specific policy, procedure, external standards and PI monitoring features and the Health Information Director or appropriate designee to serve as technical consult in reviewing the clinical record for completion and adherence to agency standards regarding records.
4.1.5 Assign other representatives as needed i.e., Activity Therapy, Psychology, Dietary, Maintenance, Pharmacy and any other pertinent disciplines.
4.1.6 Assign team members to conduct any necessary interviews, data collection (monitor boards, allegation packets, equipment, policies, etc.)

4.1.6.1 The facilitator will contact staff supervisors and staffing department with meeting schedules to ensure coverage on the units.

4.1.6.2 The facilitator will provide involved staff with information on the root cause analysis process and prepare the team for process.

4.2 Use the Joint Commission RCA framework form.

4.2.1 Each element of the RCA Framework Template must be addressed. "Not applicable (NA)" may not be used.

4.3 The RCA must focus on identifying the systems and processes that may have led to the event.

4.3.1 Gather information to find out what happened.
4.3.2 Analyze why the event happened.
4.3.3 Develop what steps you need to take to prevent it from happening again.
4.3.4 Prepare RCA Action Plan.
4.3.5 Submit to the Agency Medical Director for review and approval.
4.3.6 Submit to the Agency Manager/Hospital Administrator for review and approval.
4.3.7 Submit to the Medical Executive Committee of each agency for review.
4.3.8 Upon final approval, Agency Manager/Hospital Administrator shall submit to QAPI for submission to appropriate agencies (The Joint Commission and/ or Nevada Sentinel Event Registry, or OSHA) as needed.

5.0 REFERENCES:

5.1 Root Cause Analysis in Health Care: Tools and Techniques 5th Edition Joint Commission Resources
5.2 Sentinel Events CAMBHC Update 1, July 2021
5.3 Sentinel Events CAMH Update 1, July 2021
5.4 Root Cause Analysis Basics Candace J. Hamner, RN MA and Kurt a. Patton, MS, RPh 2008
5.5 DPBH policy A 5.2 Review of Client Death for Adult Mental Health Agencies
5.6 DPBH policy CRR 014 Risk Management and Reporting Serious Incidents
5.7 DPBH policy CRR 1.13 Sentinel Event

6.0 ATTACHMENTS:

6.1 CRR 1.14 ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE Attachment A
6.2 CRR 1.14 Root Cause Analysis Sentinel Event Reporting Requirements Attachment B

7.0 Implementation of Policy

Each Division agency within the scope of this policy shall implement this policy and may develop specific written protocols as necessary to do so effectively.