NCPS
Nebraska Coalition for Patient Safety

Root Cause Analysis Audit Tool

Purpose: Use this tool to determine areas in need of improvement to conduct root cause analyses that are credible, thorough, and acceptable.

Scoring: Rate the extent to which the following practices are in place using the following scale:

0 = Not in place/Don't Know, 1 = in place but ineffective, 2 = moderately effective, 3 = very effective

Practices	Score
Practices that ensure an RCA is <u>credible</u> because it is clear, complete, systematic, and considers diverse perspectives	
A trained facilitator, who was not involved in the event, leads an interdisciplinary team to conduct the RCA by setting the agenda, managing time, and staying on task.	
Facilitator is knowledgeable about patient safety and quality improvement.	
Facilitator knows the purpose and steps needed to conduct an RCA.	
Facilitator uses ground rules to manage hierarchical and dominating behaviors so that all team members are treated equally and feel free to speak up.	
Members of the interdisciplinary team construct a detailed timeline of the facts leading up to the event based on a review of the medical record and interviews with those involved in the event.	
The team asks "why?" exhaustively about each fact leading up to the event.	
The team understands/views the environment in which the event occurred.	
The team reviews all relevant policies/procedures.	
The team reviews any process map/flowcharts associated with intended processes associated with the event.	
The team integrates perspectives of front-line staff involved in event.	
The team integrates perspectives of clinical experts.	
The team integrated perspectives of managers.	
The team integrates information from all relevant disciplines.	
The team integrated perspectives of patient/family.	
Practices that ensure an RCA is <u>thorough</u> because it considers all possible systemic causes	
The team constructs a causal map or causal statements[a] to determine root causes that if prevented would have prevented the outcome to the patient.	
The team identifies all relevant root causes by considering the following:	
Communication and Team Factors (including patient)	
Culture/Organizational Factors (e.g., lack of psychological safety)	
Environment/Equipment	
Human Factors (fatigue, distractions, multitasking, human error)	
Information Management/Electronic Medical Record/Software	
Patient Factors (e.g., pre-existing conditions)	
Rules/Policies/Procedures (absence/knowledge/adherence)	
Safeguards (Presence/absence of barriers and controls)	
Staffing Factors/Scheduling	
Task Factors and Training	
Practices that ensure an RCA is acceptable because the action plan addresses root causes of the event and includes stronger/intermediate actions in addition to weaker training actions	
The action plan specifies interventions that will reduce the risk of recurrence consistent with the causal map and/or causal statements.	
The action plan includes stronger or intermediate actions in addition to weaker interventions.[b]	
The action plan specifies process and outcome measures for proposed interventions.	

a. A causal statement ensures that a potential root cause contributed to the patient's outcome. Causal statements follow five rules:
    1) Clearly show cause and effect relationship
    2) Use specific and accurate descriptions
    3) Identify the system cause of the error
    4) Identify preceding cause of policy or procedure violation
    5) Acknowledge that a failure to act is only causal when there is a preceding duty to act based on a known policy/procedure.

    Causal statements take the following general form:

    The lack of_____,
    resulted in_____,
    which increased the likelihood that (insert outcome to the patient).

    Example:

    The lack of adherence to the time-out policy, which requires all staff to cease activity and participate in the time-out, resulted in the CRNA continuing to talk to a student during the time-out, which increased the likelihood that the wrong leg was selected for a nerve block.

b. Actions that address the root causes of the event, which will vary in strength.
    - Weak actions include education/training, policy/procedure change.
    - Intermediate actions include audit/feedback, checklists, redundancy and standardization.
    - Stronger actions change the structure of care and include changes in the environment, equipment, and information technology.

References

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VHA National Center for Patient Safety. Guide to Performing a Root Cause Analysis. Available at: https://patientsafety.va.gov/PATIENTSAFETY/docs/RCA-Guidebook_02052021.pdf Accessed April 27, 2023.