

**WASHINGTON DEPARTMENT OF HEALTH
PATIENT SAFETY-ADVERSE EVENT PROGRAM**

Root Cause Analysis Evaluation Criteria

Thank you for submitting the RCA to the adverse event identified above to the Patient Safety Adverse Event Program. All elements are scored as Met/Not Met. The evaluation of the your RCA is intended to provide guidance on completeness, to provide feedback, and offer cues in areas where it appears closer attention to the detail of the event could provide more useful information. The comments and scores provided are intended to assist health care facilities in evaluating and improving their RCA processes.

Element (All elements are required)	Guidelines	Met or Not Met	Comments
Facility Information	Facility Name: Institution Type Adverse Event # Adverse Event Type:		Event Description:
1. Determine that an adverse event occurred	a. Brief description of event, date, day of week and time event occurred, and area/service involved. Include timeline if appropriate. How discovered? What is facility system for reporting?		
	b. Has a similar event occurred in your facility in the past? Were previous actions taken effective?		
	c. Has the organization included past events that are similar in nature?		
	d. Has the organization developed a flow chart of the event?		
2. Composition of RCA	a. Interdisciplinary, non-biased members		

Team	identified. Involvement of those knowledgeable about the processes are listed by title.		
	b. The organization includes description of how the RCA team was endorsed by Facility Leaders.		
3. Conduct an RCA	a. Thorough fact finding. Did the RCA team look at all medical records, policies, and procedures, maintenance logs, committee minutes, etc. necessary to identify relevant factors? Have all pertinent staff been interviewed?		
	b. Description of processes involved in event.		
	c. Process/procedure involved in event. Written policy available? How usually performed? What happened this time? Identify any barriers to compliance with policies and procedures.		
	d. Each step in flow chart analyzed for possible root cause(s). "What" and "Why" asked repeatedly		
	e. Analyze human factors which include communication, training, competencies, staffing, and fatigue/scheduling.		
	f. Analyze availability of necessary equipment, equipment performance and maintenance, and identification of any environmental factors.		
	g. Identify possible barriers to identifying, reporting, and responding to risks and possible contributing factors.		
	h. Identify if risks or possible contributing factors may affect other areas/processes in the hospital.		

	i. Identify the root cause contributing factors. List all that apply. Demonstrate cause and effect.		
4. Develop an Action Plan	a. Each finding is addressed in detail and includes a corrective action.		
	b. Analysis identifies changes that could be made in systems and processes through either redesign or development of new processes/procedures identified.		
	b. Each correction specifies a date for completion		
	c. Responsibility assigned to an actual person		
	d. Prevention plan clear		
	e. Monitoring schedule to assess effectiveness is specified and responsibility assigned.		
5. Outcome Measures; Measuring Effectiveness of Plan	a. Strategy developed for change in practices which will impact culture has been identified. Must measure impact on the root cause or adverse event. Measures effectiveness of actions, not steps in process to implement actions.		
	b. Plan for providing feedback to staff including changes in policies or procedures resulting from the RCA to employees and staff involved in the event.		
	b. Audits or reviews are occur when procedures or policies are being followed or implemented.		
	c. Leadership concurrence for corrective actions identified by job title/date. List all involved		

	committees.		
6. Relevant Literature Considered	a. List relevant literature.		
7. Copy received by PSAE Program	a. Within appropriate timeframe		
	b. All identifiers redacted?		

Comments: