|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Adverse Event ID No:** | **Date:** | | | **Review Team:** | |
| **Facilitator of the RCA:** | | | | **Name** | **Designation** |
|  |  |
| **Name** | | **Designation** | |  |  |
|  | |  | |  |  |
| **Phase** | | | **Description** | | **Comment** |
| **1. Sequence of event** | | |  | |  |
| The detailed record in chronological order is documented here.  Using the reverse chronological time line helps in working from the event backwards to discover any parts of the process where problems may have occurred.  (Please document in the description column)  Determining the sequence of events may flag issues associated but not directly relevant to the event.  Those issues will be noted in the comment column. | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Phase** | | **Description** | **Comment** |
| **2. Identify Causal Factors** | |  |  |
| Brainstorm this part of the RCA.  Don’t hold back any ideas.  No judgment or criticism  No discussion  Build on ideas  Don’t interpret  Do this quickly 5-15 minutes | |
| **Phase** | | **Description** | **Comment** |
| **3. Select Root Cause** | |  |  |
| The events or conditions that if eliminated or identified would reduce the possibility of the serious incident and its consequences recurring.  The casual factors will determine the root cause or causes.  root causes may include:   * Errors * Omissions * Slips * System deficiencies * Inadequate competencies * Non-adherence to policies and procedures * Poor communication or documentation * Inadequate facilities or equipment * Inadequate skill mix or availability of staff * Managerial inaction | |
| **Phase** | **Description** | | |
| **4. Develop Action Plan** | **A)** | | |
| Generate a plan to address the root causes that contributed to the sentinel event.  the action plan includes:   * The root causes * The actions to address the root causes as determined by the investigation team * Identify who is responsible for implementing the action(s) * Identify the timeframe for implementation * Identify any resource requirements * Evidence of completing including on-going monitoring * Formal sign-off of actions as they are completed * Identify the date to evaluate the effectiveness of the action plan | **B)** | | |
| **C)** | | |
| **D)** | | |
|  | | |

|  |  |
| --- | --- |
| **Phase** | **Phase** |
| **5. Report** | **6. Implementation (Use Service Improvement Request)** |
| The investigation team’s report is to convey the results of the investigation that will help to understand what happened, why it happened and what can be done to prevent a recurrence.  The roles of staff involved will be used in the report – no names.  The report includes:   * Summary * Introduction * Analysis and Findings * Recommendations * Learning Points * Residual Risk * Attachments | A quality improvement approach will be used during the implementation stage.  Consideration should include:   1. Plan implementation of the quality improvement actions  * Communicate the results * Review policies and procedures * Implement training * Establish plans for on-going monitoring |
| **Phase** | |
| **7. Evaluate Effectiveness of Actions** | |
| At the evaluating date the changes/solutions specified within the action plan should be evaluated to ascertain the level of implementation and effectiveness.  This is to ensure:   * The root cause(s) have been addressed * Recurrences have been reduced or eliminated * Lessons have been learnt and communicated * Identified barriers to change have been unfrozen * Close the loop | |