Root Cause Analysis (RCA) Report

Category 1 and Category 2 Clinical and Corporate Incidents

Service Name:		**Service Address:**		**Incident Notification Report No.:**	
Date of Incident:		**SWSPHN Notification Date:**		**RCA Report Date:**	

The RCA Report must have Contractor Senior/Executive Management sign off before being sent to SWSPHN

Senior/Exec. Management:		**Signature:**		**Date:**	
RCA Lead:		**Signature:**		**Date:**	

The information provided in this RCA Report will remain confidential. Please return this Report to SWSPHN within 45 calendar days of initial notification of the incident by email to: contracts@swsphn.com.au

Instructions to complete a RCA Report can be found in Appendix 1. Contact the SWSPHN Commissioning Team on (02) 4632 3000 if you have questions regarding this process.

Section 1: Description of the Incident that was Investigated.

Provide a concise chronological account of the Category 1 or Category 2 incident.

Section 2: Contributing Factors and Root Causes

Contributing factor and root cause statements must clearly address why something occurred, with a focus on processes and systems, not individuals. Each root cause displayed must be addressed in the action plan.

Communications

Were issues relating to communication a factor in this event? If yes, tick the appropriate boxes and provide details.

Communication between staff	☐ Yes ☐ No	Provide details:
Communication between staff and patient/family/carers	☐ Yes ☐ No	
Documentation	☐ Yes ☐ No	
Patient assessment	☐ Yes ☐ No	
Information not provided	☐ Yes ☐ No	
Misinterpretation of information	☐ Yes ☐ No	
Other (please specify)	☐ Yes ☐ No	

Knowledge/Skills/Competence

Were issues relating to knowledge/skills/competence a factor in this event? If yes, tick the appropriate boxes and provide details.

Staff training/skills	☐ Yes ☐ No	Provide details:
Staff competency	☐ Yes ☐ No	
Staff supervision	☐ Yes ☐ No	
Use/Not using/Misuse of equipment	☐ Yes ☐ No	
Other (please specify)	☐ Yes ☐ No	

Work Environment

Were issues relating to work environment a factor in this event? If yes, tick the appropriate boxes and provide details.

Workplace design	☐ Yes ☐ No	Provide details:
Suitability of work environment	☐ Yes ☐ No	
Environmental stressors	☐ Yes ☐ No	
Safety assessments/evaluations/procedures	☐ Yes ☐ No	
Resource issues	☐ Yes ☐ No	
Other (please specify)	☐ Yes ☐ No	

Patient Factors

Were issues relating to patient factors in this event? If yes, tick the appropriate boxes and provide details.

Medical history/known risks	☐ Yes ☐ No	Provide details:
Clinical condition	☐ Yes ☐ No	
Physical factors	☐ Yes ☐ No	
Social factors	☐ Yes ☐ No	
Mental/psychological factors	☐ Yes ☐ No	
Interpersonal relationships (with staff, family, etc.)	☐ Yes ☐ No	
Other (please specify)	☐ Yes ☐ No	

Equipment

Were issues relating to equipment (including the use or lack of use) a factor in this event? If yes, tick the appropriate boxes and provide details.

Suitability/availability/lack of equipment	☐ Yes ☐ No	Provide details:
Safety/maintenance	☐ Yes ☐ No	
Appropriate use of equipment	☐ Yes ☐ No	
Emergency provisions/backup systems	☐ Yes ☐ No	
Other (please specify)	☐ Yes ☐ No	

Policies, Procedures, Guidelines

Were issues relating to policies, procedures and guidelines a factor in this event? If yes, tick the appropriate boxes and provide details.

Absence of relevant, up-to-date policies, procedures or guidelines	☐ Yes ☐ No	Provide details:
Education/training	☐ Yes ☐ No	
Application of policies, procedures or guidelines	☐ Yes ☐ No	
Audit/quality control system	☐ Yes ☐ No	
Other (please specify)	☐ Yes ☐ No	

Safety Mechanisms

Were issues relating to safety a factor in this event? If yes, tick the appropriate boxes and provide details.

Lack of appropriate safety mechanisms	☐ Yes ☐ No	Provide details:
Breakdown of safety mechanisms	☐ Yes ☐ No	
No evaluation of safety mechanisms	☐ Yes ☐ No	
Application of policies, procedures or guidelines	☐ Yes ☐ No	
Other (please specify)	☐ Yes ☐ No	

Other

If there were other factors involved in the incident which do not fall into the above categories, please provide details below:

Provide details:

Section 3: RCA Risk Reduction Recommendations

Where a cause has been identified in Section 2, a corresponding action is to be identified to reduce the recurrence of the incident. Actions can be classified as eliminating, controlling or accepting the risk.

- Eliminate: strong actions to eliminate risk and simplify processes, standardise processes.
- Control: medium action to control the risk which may include, checklists, increased staffing, cognitive aids, etc.
- Accept: the risk is accepted, and risk minimisation strategies are implemented. For example, implement a new procedure, training in absence of knowledge deficit, warnings and labels.

Outcome measures should be specific and quantifiable. Use percentages, thresholds and timeframes whenever possible.

Causation	Recommendation	Action Classification	Action Owner	Outcome Measure	Completion Date

Appendix 1

Root Cause Analysis (RCA) – Report Completion Instructions

Root Cause Analysis (RCS) is a process analysis used to learn as much as possible about the causes contributing to an incident. RCA investigates what happened, why it occurred and what can be done to prevent it from happening again.

RCA is to be performed on Category 1 and Category 2 incidents only.

The RCA investigation process should be started as soon as possible after an incident has occurred and the report submitted to South Western Sydney PHN within 45 days of notification.

The following process is a suggested framework for conducting Root Cause Analysis (RCA). Please note however, that the process may vary depending on the complexity of the case.

Step 1 – Information Gathering

Create a simple flow diagram of the activities that surrounded and led to the incident. Limit the diagram to five or six boxes and include only the key events that are crucial to understanding what happened.

Use the Contributing Factors and Root Causes questions in Section 2 to assist identify what you know, what you don't know and what you need to find out as part of information gathering.

Information gathering may include interviewing people relevant to the incident, including patients and carers.

Step 2 – Construct a detailed chronology of what happened

Once all information has been gathered, a final flow diagram should be constructed to chronologically detail what happened. At each point of the flow diagram, it needs to be asked 'so what' or 'what is the relevance' of each box in the incident chain.

At each step in the flow diagram it needs to be identified if barriers might stop the incident from occurring again. Once complete, a cause and effect diagram (figure 1) can be created to assist in formulating the causal links and error chains leading to the contributing factors or root causes.

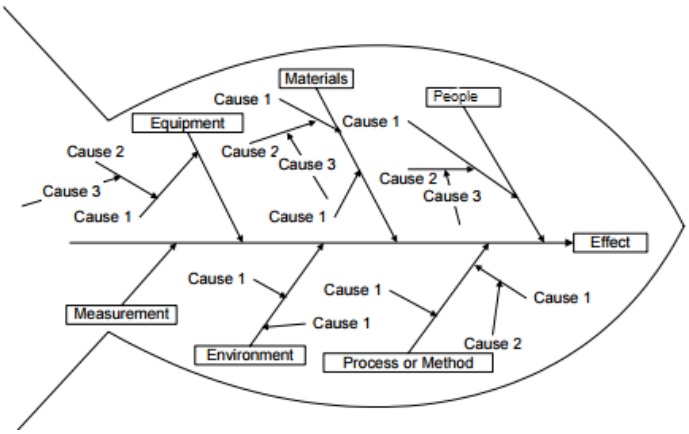

Figure 1: Example cause and effect diagram (Source: Quality Management and Training Limited)

Step 3 – Development of causation statements (Section 2)

Having collected the data, and analysed the underlying causes, causation statements can be developed. Contributing factor and causation statements must clearly address why something occurred, with a focus on process and system vulnerabilities, not individuals. The following five rules of causation assist in developing contributing factor and root cause statements.

1. Causal statements must clearly show the 'cause and effect' relationship. When describing why an event has occurred, show the link between the root cause and the undesirable outcome.
2. Negative descriptors are not used in causal statements. To force clear cause and effect descriptions (and avoid inflammatory statements) do not use negative descriptors.
3. For every human error in the causal chain, there must be a corresponding condition that combined to contribute to the undesired effect, for example doing a task by memory instead of using a checklist. It is the conditions that led to the error which provide the most valuable insight into required changes.
4. Each procedural deviation must have a preceding cause. Identify the cause of a procedural violation, not the violation itself.
5. Failure to act is only causal when there was a pre-existing duty to act. The duty to perform might arise from standards and guidelines for practice or other duties to provide patient and staff care.

Step 4 – Risk Reduction Action Plan (Section 3)

The causal statements developed in the RCA investigation need to be converted into risk statements. This should be done in conjunction with staff responsible for organisation risk management.

- The risk reduction action plan should include a description of:
- Who is accountable for the risk
- What action is to be taken
- Who is responsible for the action
- When is the action to be completed by
- A measurable performance target

The risk reduction plan should summarise what the organisation will undertake to change or monitor as a result of the incident.

Step 5 – Post RCA Responsibilities

The RCA Lead has responsibility for presenting the investigations findings to the people involved in the incident, ensuring organisational reporting requirements are met and an approved RCA Report is forwarded to South Western Sydney Primary Health Network (SWSPHN) within 45 days of the incident notification.

Contractor Senior Management/Executive is responsible for ensuring a Risk Reduction Action Plan (RRAP) is prepared and implemented, and to monitor the progress and outcomes of risk mitigation strategies. Progress on the RRAP may be monitored by SWSPHN as part of Contractor Performance Review.

Document control

Policy review every (choose most applicable) ☐ 1 year ☐ 2 years ☑ 3 years

Version	Date Commenced	Policy Owner	Change Description	Review Date	Authorising Executive

V1.0	November 2017	Commissioning Manager	New Form	November 2018	Director of Planning and Performance
V2.0	November 2018	Commissioning Manager	Form Review	November 2019	Director of Planning and Performance
V3.0	November 2019	Commissioning Manager	Form Review	November 2020	Director of Planning and Performance
V4.0	November 2020	Commissioning Manager	Form Review	November 2021	Director of Planning and Performance
V5.0	November 2021	Commissioning Manager	Form Review	November 2024	Director of Planning and Performance
V6.0	June 2025	Commissioning Manager	Form Review	June 2028	Director of Planning and Performance

This form will remain in effect until replaced.