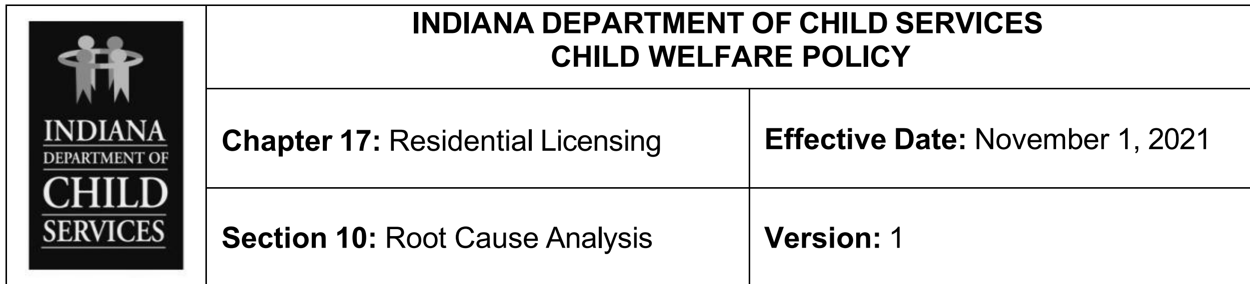

| | INDIANA DEPARTMENT OF CHILD SERVICES<br>CHILD WELFARE POLICY | |
|---|---|---|
| | **Chapter 17:** Residential Licensing | **Effective Date:** November 1, 2021 |
| | **Section 10:** Root Cause Analysis | **Version:** 1 |

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## POLICY OVERVIEW

When a sentinel event or near miss occurs in a licensed residential facility, it is imperative the facility is able to gain a clear understanding of what occurred and why. To improve child safety and outcomes, the facility must develop, implement, and adjust systems, programs, policies, and practices to address identified issues and prevent reoccurrence.

## PROCEDURE

The Indiana Department of Child Services (DCS) requires the completion of a Root Cause Analysis by a licensed residential facility following any sentinel event or near miss. The root cause analysis may be conducted using the Framework for Root Cause Analysis and Corrective Actions or the facility may choose other tools or methods. However, the Root Cause Analysis must include documentation of the analysis, findings, and actions taken to prevent reoccurrence.

The Residential Licensing Specialist (RLS) will:

1. Notify the RLS Supervisor upon learning about the possible occurrence of a sentinel event or near miss;
2. Participate in discussions with the RLS Supervisor and the Clinical Specialist to determine whether a Root Cause Analysis will be required;
3. Contact the facility to discuss the required Root Cause Analysis and provide a date for completion following a decision to require a Root Cause Analysis;
4. Provide guidance to the facility, as needed, throughout the Root Cause Analysis process;
5. Provide the completed Root Cause Analysis to the RLS Supervisor and Residential Clinical Specialist upon receipt from the facility;
6. Collaborate with the RLS Supervisor and Residential Clinical Specialist to:
   a. Review details of the sentinel event or near miss, the facility's analysis, findings, and follow-up actions to determine if additional action may be needed;
   b. Provide feedback to the facility; and
   c. Follow-up with the facility regarding the completion and/or continuation of any follow-up actions implemented and/or additional actions required by DCS.

7. Ensure all decisions and actions taken are documented appropriately; and
8. Review the Root Cause Analysis and follow-up actions taken again during the annual licensing review to ensure actions are adequate and continuing, as appropriate. See policy 17.11 Annual Licensing Review for additional information.

The Residential Clinical Specialist will:

1. Participate in discussions with the RLS and RLS Supervisor regarding the sentinel event or near miss, and make a recommendation regarding whether requirement of a Root Cause Analysis is appropriate;

2. Review the completed Root Cause Analysis and communicate with the facility to:
   a. Clarify information included in the Root Cause Analysis, as needed,
   b. Request additional information, as needed,
   c. Request documentation of actions taken, and
   d. Make recommendations regarding additional actions to prevent reoccurrence.

3. Collaborate with the RLS and RLS Supervisor to provide feedback to the facility regarding the finalized Root Cause Analysis and arrange for follow-up review of the facility's ongoing implementation of the plan.

The RLS Supervisor will:

1. Facilitate discussions with the RLS and Clinical Specialist to determine whether a Root Cause Analysis will be required;
2. Assist and provide guidance to the RLS and Clinical Specialist, as needed, with the completion of all requirements; and
3. Ensure all decisions and actions taken, including any deviation from best practice, are documented appropriately.

## LEGAL REFERENCES

N/A

## RELEVANT INFORMATION

**Definitions**

Near Miss

A near miss is an occurrence that would have resulted in a sentinel event, but for timely intervention (e.g., attempted suicide or attempted rape).

Root Cause

The root cause is a factor, which by removal, would prevent the occurrence of the adverse event.

Root Cause Analysis

Root Cause Analysis is a collaborative process undertaken to understand the underlying factors that led to a sentinel event or near miss and the development of strategies to help avoid similar occurrences in the future.

Sentinel Event

A sentinel event is any occurrence resulting in the death or serious injury of a child. The injury may be physical or psychological.

**Forms and Tools**

- Framework for Root Cause Analysis and Corrective Actions

**Related Policies**

- 17.11 Annual Review for Licensed and/or Contracted Agencies

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