Confidential Quality Assurance Material

Root Cause Analysis in Response to Patient Event

Review Case #	Event Date/Time:	Reported to RM Date		Final Risk Committee Date:
	RMPSC Date:	Sentinel Event: no		Never Event:
ISDOH Case #	Age:	Sex:	Location:	Risk Analyst:
	Diagnosis:			
Attendees by Role	Expert Meeting:			
Details of Event				
Areas of Service Affected:				

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Process As Designed

Circumstances Beyond Our Control that Contribute to the Event Occurrence

Uncontrollable Contributory Factors

Human Contributing Factors

Staffing Effectiveness

Proper Qualifications and Competency for Role

Staff Performance

Communication

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Information Management Factors

Information Management Factors

Environmental Factors

Equipment Factors

Work Environment Factors

Environmental Factors (Emergency and Failure Mode in Place)

Code Blue Procedures

Rapid Response Teams

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Environmental Factors (What systems are in place to Identify Risks)

TJC Mandated Safety Regulations

Organizational, departmental, and unit policies/procedures

Organizational Risk Culture

Corporate Culture (How is IU Health culture conducive to risk identification and reduction)

Work environment that encourages disclosure of issues which may facilitate patient risk

Unit representation and participation in the IU Health Safe Passage Program

Communication Encouragement (Are there barriers to communicate risk factors)

Risk Reduction Priorities (How are the risk reduction priorities communicated?)

Patient safety is an organizational priority and is supported by IU Health Leadership

Root Cause

Patient Outcome & Disposition

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Resources (Evidence-Based References)
Policies and Procures Impacted