Root Cause Analysis (RCA) TOOL 11

RCA Quality Check List

Government of South Australia
SA Health

Health Service ……………………………………………………………………

RCA ID Number ……………………………………

Conducted under Part 8 Health Care Act ☑ Yes ☐ No

If No – Why not

Meeting 1 - Initial Flow Diagram

- ☐ Clear overview of incident from clinical notes, incident reports, IMS
- ☐ Create a simple Flow Diagram based on sequence of events – Only major key points across the time line
- ☐ Identify in each box date / time surrounding the incident as appropriate
- ☐ Identify who could provide information about what is unknown
- ☐ Identify if interviews need to occur and by whom
- ☐ Identify any other information needed: policies, equipment, photos etc…
- ☐ Brainstorm key questions or things that need further review
- ☐ Develop an action plan

Meeting 2 - Final Flow / Cause and Effect Diagram

Final Flow – What happened?

- ☐ Construct a detailed chronology of what happened - Final Flow Diagram
- ☐ Identify in each box date / time surrounding the incident
- ☐ Did the team ask 'so what' or 'what is the relevance' of each box in the incident chain?
- ☐ Identify contributing factors
- ☐ Identify where barriers would be most effective – (will this stop the problem from occurring again?)

Cause and Effect Diagram – Why it happened

- ☐ Identify the real problem (what are you trying to prevent) – Problem statement
- ☐ Identify the contributing factors – (only choose those that are most relevant to the event)
- ☐ Identify immediate factors (WHY- what caused this to occur) from contributing factors
- ☐ Identify the Root Cause
- ☐ Clear / Defined / Concise / Specific

Meeting 3 - Causal Statements

Causal Statements

- ☐ Identify Root Cause/ Contributing Factors from the Cause & Effect Diagram
- ☐ Prioritise Root Cause/Contributing Factors
- ☐ Clearly show a Cause & Effect relationship
- ☐ Specific & accurate descriptors of what occurred
- ☐ Identify preceding causes - not human error
- ☐ Identify preceding causes of procedure violations
- ☐ Link to Problem statement
- ☐ Link to Cause & Effect Diagram
- ☐ Negative descriptors not used/ Clear / Defined / Concise / Specific

continued

Meeting 4- Recommendations, Outcome measures, Draft Final Report

Recommendations

- ☐ Develop preventable actions for each causal statement
- ☐ Aim: 4 recommendations
- ☐ Clear / Defined / Concise / Specific
- ☐ Practical and achievable
- ☐ Strength of recommendation:
  - ☐ Strong ☐ High Effort
  - ☐ Intermediate ☐ Moderate Effort
  - ☐ Weak ☐ Low Effort
- ☐ Position accountable for each action
- ☐ Realistic timeframe
- ☐ Measurable

Outcome Measures

- ☐ Outcome measure - specific
- ☐ Outcome measure - quantifiable – numerators, denominators, thresholds and timeframes
- ☐ Outcome measure targets what you are trying to address
- ☐ Outcome measure designed to prevent or minimise additional adverse events or close calls
- ☐ Set realistic thresholds

Meeting 4 - Final RCA Report

- ☐ States the privilege applied to the report
- ☐ ID Number
- ☐ Date of Event
- ☐ RCA completion date
- ☐ Clear description of event
- ☐ Analysis of Findings
- ☐ Causal Statement
  - ☐ Rules of causation followed
- ☐ Recommendations
  - ☐ Preventable, measurable, achievable
  - ☐ Clear / Defined / Concise / Specific
- ☐ Action Plan
  - ☐ Outcome measures

Patient Safety Manager………………………..….. Date……..................…………

Signature ……………………..…

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