*University of Phoenix Material*

Medication Mishap Root Cause Analysis Worksheet

**Complete** the table below to analyze the Week 4 case study. The analysis questions in the table have been adapted from The Joint Commission’s Root Cause Analysis and Action Plan Framework you reviewed in this week’s learning activity.

| Analysis Questions | Considerations | Root Cause Analysis Findings | Root Cause (Y/N) |
| --- | --- | --- | --- |
| What was the intended process flow? | List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. |  |  |
| Were there any steps in the process that did not occur as intended? | Explain in detail any deviation from the intended processes. |  |  |
| What human factors were relevant to the outcome?  | Staff-related human performance factors such as fatigue, distraction, etc. |  |  |
| How did the equipment performance affect the outcome? | Consider all medical equipment and devices. |  |  |
| What controllable environmental factors directly affected this outcome? | Consider things such as overhead paging that cannot be heard or safety or security risks. |  |  |
| What uncontrollable external factors influenced this outcome? | Factors the organization cannot change |  |  |
| Were there any other factors that directly influenced this outcome? | Internal factors |  |  |
| What are the other areas in the organization where this could happen? | List where the potential exists for similar circumstances. |  |  |
| Was the staff properly qualified and currently competent for their responsibilities at the time of the event? | Evaluate processes in place to ensure staff is competent and qualified. | N/A | N/A |
| How did actual staffing compare with ideal levels? | Include ideal staffing ratios and actual staffing ratios along with unit census. | N/A | N/A |
| What is the plan for dealing with staffing contingencies? | What the organization does during a staffing crisis | N/A | N/A |
| Were such contingencies a factor in this event? | If alternative staff used, verify competency and environmental familiarity. | N/A | N/A |
| Did staff performance during the event meet expectations? | To what extent did staff perform as expected within or outside of the processes? |  |  |
| To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous? | Patient assessments were complete, shared and accessed by members of the treatment team |  |  |
| To what degree was the communication among participants adequate for this situation? | Analysis of factors related to team communication and communication methods |  |  |
| Was this the appropriate physical environment for the processes being carried out for this situation? | Proactively manage the patient care environment. |  |  |
| What systems are in place to identify environmental risks? | Were environmental risk assessments in place? |  |  |
| What emergency and failure-mode responses have been planned and tested? | What safety evaluations and drills have been conducted? |  |  |
| How does the organization’s culture support risk reduction? | Does the overall culture encourage change, suggestions, and warnings from staff regarding risky situations or problematic areas? | N/A | N/A |
| What are the barriers to communication of potential risk factors? | Describe specific barriers to effective communication among caregivers. |  |  |
| How is the prevention of adverse outcomes communicated as a high priority? | Describe the organization’s adverse outcome procedures. | N/A | N/A |
| How can orientation and in-service training be revised to reduce the risk of such events in the future? | Describe how orientation and ongoing education needs of the staff are evaluated. |  |  |
| Was available technology used as intended? | Such as: CT scanning equipment, electronic charting, medication delivery system, tele-radiology services |  |  |
| How might technology be introduced or redesigned to reduce risk in the future? | Describe any future plans for implementation or redesign.  |  |  |