Appendix C: Mini root cause analysis tool

For Practice Use Only. Select Information **(4 non-PHI questions) to be entered in SurveyMonkey**

Suggestions on the use of this form:

- Set aside a 30 minute period to perform this mini-root cause analysis two times per month with members of your core improvement team.
- Designate a team member to identify a diagnostic error that occurred recently (within the last 7 days) **Note: The identified diagnostic error should be one that holds meaning for your practice and for which room for improvement can be identified.**
- A team member/leader should draft an initial description of how the error occurred (Q4 below) in advance of the team meeting.
- Encourage a care team member (provider, nurse, etc) who was involved in the diagnostic error to participate in this mini-RCA meeting (this way, the factors will be best reflected below).

Patient Name: _____ Medical Record Number: _____

	Question	Practice Response
1.	Type of Diagnostic Error: **SurveyMonkey Question1.**	□ Missed Adolescent Depression □ Missed Elevated Blood Pressure □ Delayed Actionable Laboratory Value
2.	Date of Error (MM//YY):	_ _ / _ _ Approximate time of day (24 hour clock): 00:00
3.	Date Mini-RCA Completed (MM/DD/YY):	_ _ / _ _ / _ _
4.	Please describe the error and how it occurred (this meeting should be discussed briefly but the facts should not be the focus of the project) :	
5.	Where in the Process did the error occur? (Check all that apply within 1 Diagnostic Error Type) **SurveyMonkey Question2. [logic included for above mentioned Q1]**	
	A. Missed Adolescent Depression: □ Patient Screened □ Recognize Abnormal Screen □ Notify Family of Abnormal Screen □ Refer Patient to Mental Health Resources □ Patient attends Mental Health □ Mental Health Provider Feeds Back Information to Practice □ Document Mental Health Diagnosis □ Other (Describe: _____)	
	B. Missed Elevated Blood Pressure: □ Measure BP □ Record BP □ Recognize Abnormal BP □ Notify Family of Abnormal BP □ Act on Abnormal BP □ Document Action on BP □ Other (Describe: _____)	
	C. Delayed Actionable Laboratory Value: Which Lab Test? _____ □ Test Results Returned to Clinic □ Provider Views Test Results □ Recognize Abnormal Results □ Notify Family of Abnormal Results □ Act on Abnormal Results □ Document Action on Abnormal Results □ Other (Describe: _____)	

6.	At first review, **<u>why</u>** does the core improvement team believe this failure to identify and act on a diagnostic error occurred?	
	The next step is to perform a *Round Robin* to have each core improvement team member share their perspective on the top factor/s within the (1) patient/family, (2) provider/nurse/administrative, and (3) system/practice areas that contributed to this error. **Patient/Family Factors**: What Patient/Family factors contributed to the error? (for example: age, gender, reason for visit, patient comorbidities, language barriers, acute illness, agitation of patient/family, social issues, etc.) **Provider/Nurse/Administrative Factors**: What Provider/Nurse/Administrative factors contributed to the error? (for example: type of provider, provider level of training, provider fatigue/impairment, personal stressors of providers, provider disagreements, provider knowledge, provider beliefs about the project or the patient, etc.) **Systems/Practice Factors**: What System/Practice factors contributed to the error? (for example: *provider volume that day, nurse staffing that day, office assistant staffing that day,* time of visit, clinic milieu during visit (chaotic vs. calm), day of the week, increased workload, verbal communication, written communication, computer software or hardware, non-computer equipment, etc.)	**Use the space below to write down the factors noted in each realm.**
7.	Record <u>Patient/Family</u> factors that contributed to the error **to the right →** *(for example: age, gender, reason for visit, patient comorbidities, language barriers, acute illness, agitation of patient/family, social issues, etc.)*	
8.	Record <u>Provider/Nurse/Administrative</u> factors that contributed to the error **to the right →** *(for example: type of provider, provider level of training, provider fatigue/impairment, personal stressors of providers, provider disagreements, provider knowledge, provider beliefs about the project or the patient, etc.)*	
9.	Record <u>System/Practice</u> factors **that contributed to the error to the right →** *(for example: provider volume that day, nurse staffing that day, office assistant staffing that day, time of visit, clinic milieu during visit (chaotic vs. calm), increased workload, staffing concerns, verbal communication, written communication, computer software or hardware, non-computer equipment, etc)*	

	Lessons Learned:	
1.	Rank the top three factor(s) that contributed the MOST to this Diagnostic Error? (all 3 can be from the same group or different groups) **SurveyMonkey Question3.**	**Patient factors of**: □ gender □ age □ comorbidities, □ insurance status □ reason for visit, □ language barriers, □acute illness, □agitation of patient/family, □social issues, □ other concerning patient factors, defined as: _____, **Provider/Nurse/Admin. factors of**: □ type of provider, □provider level of training □ provider fatigue/impairment □ personal stressors of providers □ provider disagreements □ provider knowledge □ provider beliefs about the project or the patient, □ other provider/nurse/administrative factors defined as: _____ **Systems factors of:** □ patient volume that day □ nurse staffing that day □ office assistant staffing that day □ time of day of visit, □ clinic milieu, □verbal communication, □ written communication, □computer software, □computer hardware, □non-computer equipment, □other concerning systematic factors, defined as: _____
2.	What Interventions can we put into place to reduce the risk of this Diagnostic Error occurring again?* (*Consult strength of intervention grid below).* **SurveyMonkey Question4.**	
3.	Who will lead this intervention?	
4.	Date we will start piloting the intervention. (MM/DD/YY):	_ _ / _ _ / _ _
5.	How did you communicate with peers at the clinic about these lessons learned?	

***Strength of Interventions**

Weaker Actions	Intermediate Actions	Stronger Actions
Double Check	Checklists/ Cognitive Aid	Architectural/physical plant changes
Warnings and labels	Increased Staffing/Reduce workload	Tangible involvement and action by leadership in support of patient safety
New procedure, memorandum or policy	Redundancy	Simplify the process / remove unnecessary steps
Training and/or education	Enhance Communication (read-back, SBAR etc.)	Standardize equipment and/ or process of care map
Additional Study/analysis	Software enhancement/modifications	New device usability testing before purchasing
	Eliminate look alike and sound- a-likes	Engineering Control of interlock (forcing functions)
	Eliminate/reduce distractions	

- Adapted from John Gosbee, MD, MS Human Factors Engineering
- Remember, sometimes a weaker action is your only option.