ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

The Joint Commission Root Cause Analysis and Action Plan tool has 24 analysis questions. The following framework is intended to provide a template for answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking "root cause(s)" and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. Be sure however to enter a response in the "Root Cause Analysis Findings" field for each question #. For each finding continue to ask "Why?" and drill down further to uncover why parts of the process occurred or didn't occur when they should have. Significant findings that are not identified as root causes themselves have "roots".

As an aid to avoid "loose ends," the two columns on the right are provided to be checked off for later reference:

- "Root cause" should be answered "Yes" or "No" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a "Why?" question such as "Why did it contribute to the likelihood of the event" or "Why did it contribute to the severity of the event?" Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- "Plan of action" should be answered "Yes" for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.

When did the event occur?

Date: May 23, 2017	Day of the week: Tuesday	Time: 8:10am

Detailed Event Description Including Timeline:

Ms. Lucille Jones was a 56 year old female residing at the Valley View Transitional Residence (TLR), a residence located on the grounds of and affiliated with the Main Street Psychiatric Center. On May 10, 2017 at approximately 12:00pm, patient Lucille Jones collected her lunch tray in the dining room of the TLR from the food service worker. On Ms. Jones tray was a ham & cheese sandwich, potato chips, a fruit cup and a cup of water. Ms. Jones sat down to eat her lunch. In the dining room, there was one MHTA and one LPN. Within minutes, the MHTA observed the patient slumped over and not eating. When MHTA staff member tried to communicate with the patient, she was responsive to verbal commands and appeared to be breathing. The MHTA staff said that patient Lucille Jones was not coughing and did not indicate that she was choking. The MHTA staff member called for the LPN who came over to assess. The LPN asked the patient to turn her head to the side and to spit out any food that she may have had in her mouth. She spit out a small piece of the sandwich bread. The food service worker observed that several bites had been taken from the sandwich and the other food appeared untouched.

Patient Lucille Jones then began to make quick, shaking movements and was not verbally responding to questions. The MHTA and the food service worker began to try and get the other patients out of the dining area. There were a lot of patients eating that day and some needed assistance to leave. The LPN remained with the patient and assessed her as unresponsive, with a faint pulse and shallow breathing. With this assessment, the LPN started CPR and indicated that 911 should be called. The LPN also requested the emergency bag with AED. A Rehab staff member who was also in the residence on the upper bedroom level, was able to place the call to 911. The MHTA staff member went to collect the emergency bag, which also was stored on the upper bedroom level. The 911 call was placed at approximately 12:06pm. The LPN ceased performing CPR to assist the MHTA in assembling the AED machine and connecting it to Ms. Jones. The AED incidated that a shock was advised and the 1st shock was delivered at 12:10pm. The AED indicated that CPR should be resumed. The LPN resumed CPR and a chest rise was visible, which indicated to the LPN that the airway was not obstructed.

The Rehab staff member had been placed on hold by the 911 operator, who returned to the call indicating that an ambulance had already been dispatched. The Rehab staff member indicated that no ambulance was at the residence and this was the initial 911 call for this incident. The total call time to 911 was 10 minutes resulting in a delay obtaining emergency services to the residence.

While waiting for the ambulance to arrive at the residence, the LPN continued with CPR. The Rehab staff member as well as the MHTA were trying to both manage the incident as well as monitor for the arrival of the ambulance, as well as the care of the remaining patients. EMS arrived to the residence at 12:30pm where the EMS personnel used their AED to see if an additional shock was needed, and when it was not, EMS resumed CPR. The EMS personnel used forceps to check the patients mouth and throat and then intubated the patient.

They administered medication to her via IV push. At 12:50pm, they were able to confirm that there was adequate circulation and moved the patient to the stretcher to bring to the ambulance. The patient left the Valley View Transitional Living Residence at 12:58pm for transport by ambulance to the Main Street Hospital Center Emergency Department.

On May 11, 2017, a Social Worker from Main Street Hospital Center (MSHC) ICU contacted the TLR to incidate that the patient was intubated and sedated in the ICU.

On May 12, 2017, a Physician from MSHC indicated that the patient's family had signed a Do Not Resuscitate Order. Procedures were conducted to see if there was a foreign body in the lower respiratory tract. A lodged piece of food was found to be there along with an excessive amount of purulent secretions that were aspirated. The patient required Mechanical Ventilation and developed several secondary complications including fever. She subsequently suffered from a myocardial infarction.

The patient expired on May 23, 2017 at 8:10am with the cause of death listed as Cardiac Arrest with Severe Ischemic Brain Damage, Aspiration Pnemonia and Hypoxic Respiratory Failure requiring Mechanical Ventilation.

Diagnosis:

F20.9 Schizophrenia
J44.9 Chronic Obstructive Pulmonary Disease
E78.2 Mixed Hyperlipidemia
I10 Hypertension

Medications:

Depakote ER 500mg qam
Haldol 4mg IM BID
Cogentin 0.5mg BID
ASA 81 mg Daily
Colace 200mg HS
Ventolin inhaler 2 puffs QID

Autopsy Results:

At the request of Ms. Jones family, no autopsy was conducted.

Past Medical/Psychiatric History:

Ms. Lucille Jones was a 56 year old, divorced Caucasian female with a long history of Schizophrenia, paranoid type. Ms. Jones reports that she was hospitalized multiple times starting in her early 20's. When Ms. Jones first attended George Washington Community College she began to experience symptoms that she attributed to the stress of college life. She was able to manage her symptoms through her PCP who prescribed her anti-anxiety medication. She went on to hold a job as a receptionist at a hotel chain near her home, was married and had 2 children. However, her paranoid symptoms did not improve, she was unable to complete her schooling. Her husband called the police when she did not return home one evening, leaving the 2 young children unattended at home. She was found wandering in a local grocery store, inspecting food items for contaminents and brought from there to the local emergency room where she was subsequently admitted and diagnosed with paranoid schizophrenia. This was her first inpatient psychiatric admission.

Ms. Jones was only intermittently cooperative with her medication and treatment, leading to periods of stability and then sharp declines. The stress of caretaking for her illness proved to be too much for her husband, who divorced her, taking custody of both children. This life event lead to a second inpatient admission for Ms. Jones, that resulted in a transfer to Main Street Psychiatric Center, her first State Psychiatric inpatient long term stay. Ms. Jones remained with MSPC for 8 months to stabilize before being discharged to a transitional residence and finally back to her own apartment with outpatient treatment. She had intermittent, brief stays at local hospitals for stabilization over the years, but generally with the support of her daughter and the outpatient providers, she was able to remain in the community.

Ms. Jones was able to maintain stability in outpatient treatment until 2013 when she, at age 52, began to have more medical issues that she was negligent of when living on her own. Her cholesterol and COPD were uncontrolled due to her refusal to properly eat, exercise or take her medications resulting in both medical and psychiatric inpatient stays. She remained inpatient for a second long term stay at MSPC in August of 2013- February of 2014 when her daughter agreed to allow her to stay with her post discharge for monitoring. However the living arrangement was not conducive for either party as her daughter was not home during the day and could not ensure that Ms. Jones was properly taking her medications, caring for her self or attending mental health treatment. In June of 2014, Ms. Jones was arrested for causing a scene at a local bank, demanding the cameras be turned off and trying to take them down on her own. A CPL 730.40 exam was conducted and she was found unfit to proceed. She was admitted to her local hospital for a short term eval and discharged in July 2014. New housing options were being sought by her outpatient provider, but Ms. Jones decompensated too much in the interim and in October of 2014, she was readmitted to MSPC.

In February of 2015, while an inpatient at MSPC, Ms. Jones had an episode of syncope and was admitted to Main Street Hospital Center, where she was indicated to have possibly have had a seizure, though the EEG was negative. While inpatient at the hospital center, she

was noted to have difficulty swallowing, was found to be eating too rapidly, and thus upon return to the Psychiatric Center, Ms. Jones was placed on choking precautions. She was able to have a regular diet if it was cut in to small pieces and she was observed during the meal on a 1:1 observation. She was on 1:1 observation during meals with pre-cut food from dietary from March 3, 2015 to January 19, 2017. During this course of inpatient treatment she stabilized on her psychiatric medication. Her SW met with theTreatment Team to begin a referral to the Valley View TLR as she required this level of care in the community. Ms. Jones was removed from choking precautions and 1:1 observations during meal times on January 19, 2017 and moved in to the Valley View Transitional Living Residence on January 23, 2017 after only 2 full days of being off of choking observation.

In March of 2017, Ms. Jones was noted by TLR staff to require assistance with almost all activities of daily living, including ambulating and eating. LPN notes during March, April and May of 2017 indicate that Ms. Jones needed "extra supervision while consuming food" as she was noted to have rapid eating, shoving food in her mouth and episodes "close to choking, with excessive cough required to gain adequate breath." Ms. Jones went to her primary care physician on April 18, 2017, approximately one month prior to her passing, and her PCP indicated that the patient would benefit from a soft diet and choking precautions, assistance with showering and other ADL's.

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
1	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. You may need to include multiple processes. ***Note:*** The process steps *as they occurred in the event* will be entered in the next question. Examples of defined process steps may include, but are not limited to: • Site verification protocol • Instrument, sponge, sharps count procedures • Patient identification protocol • Assessment (pain, suicide risk, physical, and psychological) procedures • Fall risk/fall prevention guidelines	**A) System as designed (Residential Emergency Medical Procedures):** Per the Residential Policy 8.6, *Emergency Intervention and Crisis Response,* Residences (including the Valley View TLR) will call 911 directly and provide the information regarding the nature of the emergency and the location. When available, the LPN will conduct an initial assessment of the nature of the emergency and take any appropriate actions. The Safety Department of Main Street Psychiatric Center and the Central Nursing Office should both be notified of the call to 911 and the emergency. Transport to the hospital will be provided by EMS. Regarding Ms. Jones, review of training all residential staff receive related to responding to an emergency reveals that		

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			the following process would have been the intended process flow: When Ms. Jones was noted to have been having an incident, one designated staff person would have commenced CPR. One designated staff person would have retrieved the emergency bag. One staff member would have placed the call to 911, the Safety Department and Central Nursing at Main Street PC. One staff would have managed the remaining residents while the emergency response was occurring. The staff member with the emergency bag would have applied the AED while the other staff continues CPR as indicated. EMS has an estimated average response time of 6 minutes or less according to the city performance indicators (February 2017). The patient would have then been brought by EMS to the local emergency department. **B) System as designed (determining that the Valley View Transitional Living Residence was an appropriate placement post inpatient discharge):** For a patient to be discharged to a TLR such as Valley View, they cannot require any skilled nursing services and must be on a regular diet with no special observations during eating. Per Medical Service Organization (MSO) policy, advancing to a regular diet with no observation should only occur in consultation with the team "after close observation for several weeks with no warning signs, choking or risky food behaviors." Once the patient is referred to the TLR, a residential screening process is conducted to ensure that there are no special dietary restrictions.		
2	Were there any steps in the process that did not occur as intended?	Explain in detail any deviation from the intended processes listed in Analysis Item #1 above.	**A) The incident occurred in the dining area, however the phone and the emergency bag were located on the upper level.** WHY? When the residence was opened, it was determined that only one E-bag was needed. It was placed on the bedroom level.	**N**	**Action #1**

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			WHY? Previous risk assessments had demonstrated that is where most TLR emergency incidents occur. WHY? Residents are not usually in the home during the day, but all are in the home at night, and staffing is more limited in the night so the bag was placed where both the residents and staff might be. The telephone was placed in the staffing area where the overnight staff stay so they did not have to go downstairs when they might be alone. This is a corded desk phone, standard office telephone used throughout the MSPC. **B) Staff had difficulty assembling the AED machine, resulting in a temporary pause in CPR so the LPN could assist.** WHY? The machine had not been used in some time. WHY? The MHTA's were overdue in BLS re-certification. WHY? The program at MSPC that oversees certification had not alerted anyone that they were due or to any upcoming trainings. WHY? Tracking system was not clear for outpatient/CR staff. WHY? Limited checks/balances and supervisory staff involvement. **C) The staff member placing the 911 call spent over 10 minutes on the phone and EMS arrived 20 minutes after the medical emergency had commenced. The staff member also did not notify MSPC Safety or Central Nursing of the emergency in progress.** WHY? There was staff confusion over who should make the call and what information to relay, including that this was an initial call to 911.	**N** **N**	**Action #3** **Action #4**

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			WHY? The staff person was not a regular staff member, but a rehab staff member who was in the house. Rehab staff are not trained on medical emergency procedures. WHY? Normally there would have been a 3rd MHTA assigned to the CR. MHTA's are trained in emergency medical procedures. WHY? One MHTA was assisting the other residents, one MHTA was with the LPN, and there was not a 3rd present due to a change in staffing patterns. WHY? Staffing was short one MHTA in response to a larger, hospital wide staffing issue. **D) Ms. Jones was on 1:1 observation during meals with pre-cut food from dietary from March 3, 2015 due to rapid eating, shoving food in her mouth and episodes "close to choking, with excessive cough required to gain adequate breath." After close to 2 years on this level of observation, Ms. Jones was taken off on January 19, 2017 leaving only 2 full days without choking precautions and pre-cut foods prior to her discharge to the residence. The residential screening process failed to note that this change was so recent and that a nurse inpatient continued to write that the patient would benefit from choking observation during meal time.** WHY? A patient who needs this level of observation was accepted to the TLR despite the indications of choking precautions. WHY? Inpatient approved the discharge plan. WHY? Inpatient staff no longer felt Ms. Jones needed that level of observation during meal times and that she would be able to manage independently cutting her food in to smaller pieces and modulating her consumption rate. WHY? Inadequate policy and process for communicating actual meal time activities and treatment progress.		

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			WHY? Staff who were observing, such as nursing, continued to feel she needed to be observed. This was not communicated effectively to the team who only saw notes that there were no choking episodes. WHY? There was no system in place where interdisciplinary teams were reviewing multi-disciplinary notes. Where a note may have come back from the PCP and been filed, nursing and dietary did not see this note nor look for it. In addition, staff may have told each other informally or verbally that she required monitoring, however, there was no chart prompt or area to note this where all staff could see.	**N**	**Action #8**
3	What human factors were relevant to the outcome?	Discuss staff-related human performance factors that contributed to the event. Examples may include, but are not limited to: • Boredom • Failure to follow established policies/procedures • Fatigue • Inability to focus on task • Inattentional blindness/ confirmation bias • Personal problems • Lack of complex critical thinking skills • Rushing to complete task • Substance abuse • Trust	**A) MHTA staff was not proficient in attaching the AED and required assistance from the LPN.** WHY? See analysis question #2 (B) **B) The staff member who called 911 was not proficient in the process resulting in a delay.** WHY? See analysis question #2 (C) **C) Staff reported after the incident that they feel unsure of what to do during an emergency scenario.** WHY? Staff report not receiving enough practice on emergency procedures. WHY? Many staff are not present for emergency drills. WHY? Current emergency standards at the hospital indicate that residential drills only need to occur semi-annually and they do not need to occur across all shifts. WHY? Per regulations, residences are not required to have medical trained staff onsite.	**N**	**Action #3**

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4	How did the equipment performance affect the outcome?	Consider all medical equipment and devices used in the course of patient care, including AED devices, crash carts, suction, oxygen, instruments, monitors, infusion equipment, etc. In your discussion, provide information on the following, as applicable: • Descriptions of biomedical checks • Availability and condition of equipment • Descriptions of equipment with multiple or removable pieces • Location of equipment and its accessibility to staff and patients • Staff knowledge of or education on equipment, including applicable competencies • Correct calibration, setting, operation of alarms, displays, and controls	**A) Location of equipment and accessibility: The choking incident occurred on the first floor dining hall, however the AED and telephone were located on the second floor bedroom level.** WHY? See analysis question #2 (a) **B) Staff knowledge of or education on equipment, including applicable competencies: MHTA staff was not proficient in attaching the AED and required assistance from the LPN.** WHY? See analysis question #2 (b) and #3 (c)	**N**	**Action #3, 4**
5	What controllable environmental factors directly affected this outcome?	What environmental factors within the organization's control affected the outcome? Examples may include, but are not limited to: • Overhead paging that cannot be heard • Safety or security risks • Risks involving activities of visitors • Lighting or space issues The response to this question may be addressed more globally in Question #17.This response should be specific to this event.	While there were some controllable environmental factors noted such as the placement of the AED machine and the use of an immobile desk phone, these did not directly affect the outcome of the incident.	**N**	
6	What uncontrollable external factors influenced this outcome?	Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters.	On the campus of the Main Street Psychiatric Center, a subsequent medical emergency was also occurring and a 911 call had been placed by a staff person there. This caused a delay in the emergency response as the EMS team believed incorrectly that an ambulance had already been dispatched to the scene. It was not clear to the EMS team	**N**	**Action #4**

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			that there were in fact two medical emergencies, one on the main campus, one at the Valley View TLR. WHY? While there are several different programs related to the MSPC, they all use the same main address which can cause confusion for outside parties who are not familiar with the campus or layout. WHY? Staff who made the call to 911 did not specify the specific location of the incident. WHY? Staff may not have recalled that there is a need to make this clarification during a chaotic incident. WHY? Not enough exposure to making emergency phone calls or structured guidance as to what to say during the call.		
7	Were there any other factors that directly influenced this outcome?	List any other factors not yet discussed.	N/A		
8	What are the other areas in the organization where this could happen?	List all other areas in which the potential exists for similar circumstances. For example: • Inpatient surgery/outpatient surgery • Inpatient psychiatric care/outpatient psychiatric care Identification of other areas within the organization that have the potential to impact patient safety in a similar manner. This information will help drive the scope of your action plan.	This could occur at any TLR location.	**N**	
9	Was the staff properly qualified and currently competent for their responsibilities at the time of the event?	Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified. Examples may include but are not limited to: • Orientation/training • Competency assessment (What competencies do the staff have and how do you evaluate them?)	Staff expressed not feeling comfortable using the equipment in the medical emergency bag. WHY? As noted above, not enough exposure through training or incidents. WHY? See Analysis question #3 (c)	**N**	**Action #3**

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		• Provider and/or staff scope of practice concerns • Whether the provider was credentialed and privileged for the care and services he or she rendered • The credentialing and privileging policy and procedures • Provider and/or staff performance issues			
10	How did actual staffing compare with ideal levels?	Include ideal staffing ratios and actual staffing ratios along with unit census at the time of the event. Note any unusual circumstance that occurred at this time. What process is used to determine the care area's staffing ratio, experience level and skill mix?	Staffing levels were met only in the sense that the appropriate number of staff were present. Due to a hospital wide MHTA shortage, the combination of staff disciplines present may not have been ideal in this scenario. There was only one nursing staff member available, and the rehab staff member did not have the same level of training, experience or knowledge as another MHTA or nursing staff member would have had. The MHTA who was working had not had exposure to this type of incident due to working almost exclusively in the TLR setting. WHY? The TLR is staffed by a multidisciplinary team to assist in meeting the mission of the TLR and address the overall care of those in a transitional living setting. Beginning in July 2017, all staff who have patient contact or who will be working in a patient care setting such as a TLR will be required to show competency annually with emergency medical situations.	**N**	**Action #3**
11	What is the plan for dealing with staffing contingencies?	Include information on what the organization does during a staffing crisis, such as call-ins, bad weather or increased patient acuity. Describe the organization's use of alternative staffing. Examples may include, but are not limited to: • Agency nurses • Cross training • Float pool • Mandatory overtime	No contingent staffing plans were being used at the time. The organization does have plans should contingencies be required, such as a voluntary float pool and mandatory overtime.	**N**	

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		• PRN pool			
12	Were such contingencies a factor in this event?	If alternative staff were used, describe their orientation to the area, verification of competency and environmental familiarity.	One of the staff present was part of a contingency staffing pattern, as noted in Analysis question #10, they did not meet the needs of this particular incident. Plans will be made going forward to ensure that all staff across all disciplines who are working in a TLR have training to assist in such an incident.	**N**	**Action #3**
13	Did staff performance during the event meet expectations?	Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at the time.	Ms. Jones was not changed to a regular diet in accordance with MSO policy. Ms. Jones was removed from choking precautions and 1:1 observations during meal times on January 19, 2017 and moved in to the Valley View Transitional Living Residence on January 23, 2017 after only 2 full days of being off of choking observations. Per MSO policy, advancing to a regular diet with no observation should only occur in consultation with the team "after close observation for several weeks with no warning signs, choking or risky food behaviors." Once the patient is referred to the TLR, a residential screening process is conducted to ensure that there are no special dietary restrictions. This screening revealed choking issues that were not appropriately communicated. WHY? There were issues with oversight and communication related to her swallowing needs and the discharge plan. WHY? There was not clear process in place for noting changes or observations nor for staff to learn about the observations of other disciplines relative to choking. WHY? There is no best practice relative to advancing a diet therefore no process was established around this.	**Y**	**Action #5,#6,#7**
14	To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous?	Discuss whether patient assessments were completed, shared and accessed by members of the treatment team, to include providers, according to the organizational processes. Identify the information systems used during patient care. Discuss to what extent the available patient information (e.g. radiology studies, lab results	While staff had access to the medical record and were able to provide EMS will all relevant paperwork, there was a concern related to the person making the 911 call being on a different floor than the LPN who was with the patient, thus the information provided on the phone was not up to the minute as to the patient condition. It would have been ideal if the LPN who was with the patient was able to make	**N**	**Action #1**

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		or medical record) was clear and sufficient to provide an adequate summary of the patient's condition, treatment and response to treatment. Describe staff utilization and adequacy of policy, procedure, protocol and guidelines specific to the patient care provided.	the call or be present during the call to answer immediate questions.		
15	To what degree was the communication among participants adequate for this situation?	Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof. Consider the following in your response, as appropriate: • The timing of communication of key information • Misunderstandings related to language/cultural barriers, abbreviations, terminology, etc. • Proper completion of internal and external hand-off communication • Involvement of patient, family and/or significant other	It would have been ideal if the LPN who was with the patient was able to make the call or be present during the call to answer immediate questions. In March of 2017, Ms. Jones was noted by VVTLR staff to require assistance with almost all activities of daily living, including ambulating and eating. LPN notes during March, April and May of 2017 indicate that Ms. Jones needed "extra supervision while consuming food" as she was noted to have rapid eating, shoving food in her mouth and episodes "close to choking, with excessive cough required to gain adequate breath." Ms. Jones went to her primary care physician on April 18, 2017, approximately one month prior to her passing, and her PCP indicated that the patient would benefit from a soft diet and choking precautions, assistance with showering and other ADL's. These observations and recommendations did not get translated to her care plan or to administration as someone who required this level of care was not appropriate for the residential setting Ms. Jones was in at the time of this incident. Review of the literature revealed several clinical indicators and ways to relay those effectively and will be brought to the MSO for consideration. WHY? There was no process in place in the TLR to communicate observations or to take additional actions. WHY? Communications such as these were logged in a communication notebook and left for each shift. They were largely not read or accurately maintained. WHY? Staff did not have an established process by which to take log communications and bring them to the treatment team meetings.	**N**	**Action #8**

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			WHY? Typically, communication log entries are minor in a residential setting and do not require care plan management or changes. WHY? Staff did not normally encounter a resident who was not appropriate for the care setting.		
16	Was this the appropriate physical environment for the processes being carried out for this situation?	Consider processes that proactively manage the patient care environment. This response may correlate to the response in question 6 on a more global scale. What evaluation tool or method is in place to evaluate process needs and mitigate physical and patient care environmental risks? How are these process needs addressed organization-wide? Examples may include, but are not limited to: • alarm audibility testing • evaluation of egress points • patient acuity level and setting of care managed across the continuum, • preparation of medication outside of pharmacy	See analysis question #15. Ms. Jones may not have been appropriate for the level of care. In addition, there were noted issues with the phone and AED kit being on the bedroom level and not in the proximity of the dining room. With this in mind, the training that is offered to staff related to emergencies did not account for this so staff had no preparation for an emergency on a different floor than the equipment.	**N**	**Action #1,#2,#3**
17	What systems are in place to identify environmental risks?	Identify environmental risk assessments. • Does the current environment meet codes, specifications, regulations? • Does staff know how to report environmental risks? • Was there an environmental risk involved in the event that was not previously identified?	The Emergency Medical Services System (EMSS) Committee makes recommendations about corrective actions to the environment however, the system for review of the Transitional Living Residences should be expanded. The TLR is reviewed during environmental rounds and is up to the appropriate standards.	**N**	
18	What emergency and failure- mode responses have been planned and tested?	Describe variances in expected process due to an actual emergency or failure mode response in connection to the event. Related to this event, what safety evaluations and drills have been conducted and at what frequency (e.g. mock code blue, rapid response,	While emergency medical drills are conducted semi-annually across all three shifts, it is not a requirement per policy. Current emergency standards at the hospital indicate that residential drills only need to occur semi-annually and they do not need to occur across all shifts.	**N**	**Action #2,#3**

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause	Plan of Action
		behavioral emergencies, patient abduction or patient elopement)? Emergency responses may include, but are not limited to: • Fire • External disaster • Mass casualty • Medical emergency Failure mode responses may include, but are not limited to: • Computer down time • Diversion planning • Facility construction • Power loss • Utility issues	Based on a review of training for regular staff at the VVTLR, several of the staff have not participated in these drills. In addition, the drills do not include non-nursing staff who are assigned to the residence and may be present during an emergency. It was noted that the MHTA present (who is considered nursing staff) did not have adequate training to quickly utilize the AED machine, requiring the LPN to stop CPR briefly to assist. This is a requirement for MHTA staff, and does not reconcile with current TLR policy. This will be addressed for MHTA's who routinely work in the TLR.		
19	How does the organization's culture support risk reduction?	How does the overall culture encourage change, suggestions and warnings from staff regarding risky situations or problematic areas? • How does leadership demonstrate the organization's culture and safety values? • How does the organization measure culture and safety? • How does leadership establish methods to identify areas of risk or access employee suggestions for change? • How are changes implemented?	Staff are educated during orientation on how to report concerns and who they can talk to if they are not comfortable reporting it to their direct supervisor. Every reported event is reviewed and evaluated. Risk Management Department and administration both review and discuss and all areas of risk are considered for corrective action. Incidents are reviewed at the Incident Review Committee and evaluated for potential risk and risk reduction strategies are discussed and implemented.	**N**	**Action #8**
20	What are the barriers to communication of potential risk factors?	Describe specific barriers to effective communication among caregivers that have been identified by the organization. For example, residual intimidation or reluctance to report co-worker activity. Identify the measures being taken to break down barriers (e.g. use of SBAR). If there are	Many of the residential staff had not had the opportunity to participate in drills and the debriefings therefore did not have an opportunity to ask questions or communicate something they did not understand or an area for improvement. Staff also did not clearly communicate amongst each other the swallowing and choking related concerns raised by	**N**	**Action #2,#3,#4**

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		no barriers to communication discuss how this is known.	nursing and Ms. Jones PCP. Documentation was not shared well, staff did not approach inpatient or administration to see if a higher level of care was needed. Measures being taken: 1. Clear training and documentation alerts for concerns such as choking or any change in patient presentation that poses risk. 2. Forms for any staff to complete with suggestions, concerns, commentary, etc. that will be given to administration and cabinet members for review. 3. Town hall meetings on all shifts with members of cabinet.		
21	How is the prevention of adverse outcomes communicated as a high priority?	Describe the organization's adverse outcome procedures and how leadership plays a role within those procedures.	Staff training, signage throughout the hospital, electronic bulletin boards, staff meetings are all meant to encourage staff to work together on the prevention of adverse outcomes.	**N**	
22	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 and discuss its relevance to event. (e.g. competencies, critical thinking skills, use of simulation labs, evidence based practice, etc.)	Changes will be made to ensure that any staff working in the residential setting have access to appropriate training and drills. Facility will make changes to the discharge planning process as well as the choking/dietary guidelines to include more specific guidelines.	**N**	**Action #2,#3,#4**
23	Was available technology used as intended?	Examples may include, but are not limited to: • CT scanning equipment • Electronic charting • Medication delivery system • Tele-radiology services	No deficits noted.		
24	How might technology be introduced or redesigned to reduce risk in the future?	Describe any future plans for implementation or redesign. Describe the ideal technology system that can help mitigate potential adverse events in the future.	Having a phone available on every floor in the CR setting or a cordless phone available.	**N**	**Action #1**

Action Plan	Organization Plan of Action Risk Reduction Strategies	Position/Title Responsible Party	Method: Policy, Education, Audit, Observation & Implementation
For each of the findings identified in the analysis as needing an action, indicate the planned action expected, implementation date and associated measure of effectiveness. OR. …	Action Item #1: Telephone and AED machines will be on both levels of the CR so that in the event of an emergency, both are easily accessed.	M. Smith, Director of Residential Services and L. Miller, Deputy Director for Facility Administrative Services	Residential Services Director and Deputy Director for Facility Administrative Services to oversee the purchase and installation of the new telephone and AED machine by 10/1/17.
If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.	Action Item #2: All staff to be notified of the new locations of the AED machine.	Nancy Nurse, EMSS Coordinator and C. Williams, Director of Medicine	Notices and new education to be provided to all staff by 11/30/17.
Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.	Action Item #3: EMSS process to be revamped to include: a) One drill per quarter per shift per residence to evaluate the medical delivery and emergency notification systems. b) Medical emergency drill report form specific to the community residences which includes debriefing, deficiencies and corrective actions. c) Enhanced system for checking that staff who are assigned to the TLR setting have the appropriate trainings including the use of the AED/Basic Life Support.	Nancy Nurse, EMSS Coordinator and M. Smith, Director of Residential Services	EMSS Coordinator to amend drill schedule by 9/10/17. EMSS Coordinator to develp the drill report form by 9/10/17. EMSS Coordinator and Director of Residential Services to create a joint tracking system to avoid any training lapses or staff who have not been trained by 9/10/17. Director of Residential Services will report back on any deficiencies

			documented and assure that they are addressed. These should be in each cabinet quarterly report starting 10/2017.
Consider whether pilot testing of a planned improvement should be conducted.	Action Item #4: Residential Services Policy addressing Crisis Intervention and Emergency procedures will be revised to include notification to the MSPC safety department every time 911 is called from a community residence and to provide guidance to staff related to placing the 911 call.	M. Smith, Director of Residential Services	Director of Residential Services will revise the policy by 9/01/17. Director of Residential Services will collaborate with MSPC Safety to develop guidance related to making 911 calls by 9/01/17. Director of Residential Services will ensure that all staff have been educated related to this change in policy & guidnance by 9/21/17.
Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.	Action Item #5: Choking Response and Gag Reflex policy # 3.22 will be reviewed and revised to include a 3-4 week clinical evaluation period when a patient is transitioned from a choking/dietary modification.	J. Powers, Clinical Director and M. Porter, Director of Dietary and Nutritional Services	The Clinical Director will work with the MSO to oversee policy revision and provide documentation that all medical staff have confirmed both receiving and understanding of the updated policy by 10/30/17.
	Action Item #6: Policy revisions to 3.22 will specify that a patient who has previously been on a mechanical soft diet cannot be considered safe for discharge on a regular diet unless there has a been a period of no less than one week with the patient:	Deputy Director for Facility Administrative Services and J. Powers, Clinical Director	Documentation of training provided to new staff to be completed by 10/30/17.

	1. On a regular diet 2. Eating without observation 3. Having no incident noted The following disciplines must all agree to the transition to regular diet with no special observation: Medicine, psychiatry, Nursing and Nutrition. In the event there is no consensus, a case review will be held within 2 business days with the Director of Medicine and the Associate Clinical Director (or proxy) and a plan of action will be made.		A prompt will be added to discharge rounds forms to track the current diet/mealtime observation status and confirmation that they have been on this for 7 days prior to discharge by 9/01/17.
	Action Item #7: Residential Services Policy addressing admission criteria will be revised to list the need for a mechanical soft diet and/or special observation as exclusion criteria for admission.	M. Smith, Director of Residential Services	Director of Residential Services to revise admission criteria policy # 4.68 to emphasize that clients on a special consistency diet or who require meal time observation cannot be accepted for placement in a community residence level of care. Expected date for completion 9/01/17. Ensure that all staff are aware and understand new policy revision by 10/01/17.
	Action Item #8: Communication log entries will be reviewed by each incoming shift and initialed as read. Weekly, they will be submitted to the House Manager for review and determination if they need to be submitted to the Resident Services Director for administrative review of any clinical or other presentation changes to a particular resident. In addition, they will be brought to any care planning meetings and reviewed for content related to the Resident in care who is being reviewed.	M. Smith, Director of Residential Services	Staff will be trained on this new practice by 9/01/17. Process to begin effective 9/02/17.

Bibliography: Cite all books and journal articles that were considered in developing this root cause analysis and action plan.

Choking in Psychiatric Patients by Sally Bookwriter (pp 120-190)
Journal of Psychiatric Medicine, "A Study on Swallowing" by Dr. Sam Studywell
Treatment Needs of Patients with Anti-Psychotic Medications by Dr. Mary Medicine

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