RCA Form Definitions

	Definition	Examples*
ROOT CAUSE (Select all that apply)		
Behavioral assessment process	Failure to evaluate any patient's behavior or failure to act upon that assessment	
Patient Identification process	Failure to identify properly a patient using at least 2 pieces of information	
Care planning process	Failure to formulate or implement properly a standard plan of care from any discipline for the specific needs of the patient.	May include nursing, PT, OT, any physician, Dietary, etc.
Orientation and training of staff	Failure to orient and train any staff member in his/her job requirement and facility policies.	May include house staff, students, nurses, housekeeping, security, unit secretaries among others
Supervision of staff	Failure to oversee properly any facility staff member in any discipline to insure that he/she is doing their job	May include new attending staff or house staff, nurses, support staff, dietary among others
Communication among staff members	Failure to share information in an appropriate and timely manner between all levels of staff.	May include any type of communication (written, oral or implied)

RCA Form Definitions

	Definition	Examples*
Adequacy of technical support	Inadequate support from any support service.	May include laboratories, Information Technology,OR, Pharmacy, monitoring technicians, Central Supply among others.
Physical environment	Failure to maintain a safe area around the patient.	Wet floors, cluttered rooms, unstored cables or other devices that might be used in a suicide attempt, lockable bathrooms in patient rooms
Control of medications	Failure to supervise adequately access to all types of medication whether supplied by the facility or brought in by the patient or vendors. Failure to maintain sterility of the medications, thereby supplying contaminated medications to a patient.	Failure to remove medications brought from home. Failure to keep narcotics in a secure place.
Physical assessment process	Failure by any caregiver to evaluate any patient in an appropriate and timely manner. The evaluation must be consistent with standards of care of the respective discipline.	Failure to evaluate a patient as a fall or suicide risk.
Patient observation procedures	Failure by any caregiver to monitor adequately any patient.	May include rounding, 1:1 interactions, video monitoring, EKG monitoring, neurologic checks

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	Definition	Examples*
Staffing levels	Lack of an appropriate staff to patient ratio which takes into account patient census and acuity as well as staff training and experience. Staffing levels should meet industry standards of care.	May include RNs, LPNs, aides, respiratory therapists among others.
Competency assessment/credentialing	Failure to perform at a minimum an annual re-evaluation of the training and capabilities of all staff at all levels in the organization to ensure that the individuals are capable of performing the tasks in their respective job descriptions. Failure to adequately monitor licensing and credentialing for each licensed practitioner.	
Communication with patient/family	Failure to obtain all pertinent information from the patient and the family about the patient's status at home, recent changes, and the current presentation of symptoms and medical condition. Failure of the staff to communicate with the patient and family pertinent aspects of care.	May include medications and herbal preparations taken at home, activities of daily living at home, use of a walker, cane, hearing aids at home. May also include patient and family education on the Fall Prevention Program and pressure ulcer prevention.

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	Definition	Examples*
Availability of information	Failure of the staff to obtain and share with other caretakers all pertinent information related to the comprehensive care of the patient in a timely manner.	May include communicating results of tests (particularly panic values), significant changes in the patient's status, and pertinent information learned from the patient and/or family that might affect the patient's care. It may also include important information from prior hospital admissions.
Equipment maintenance/management	Failure of equipment involved in the event to function properly.	May include improper use, inexperience with the device, malfunctioning or breakage.
Security systems and processes	Usually involves issues related to a patient's elopement or to a baby stolen from the Nursery. Can also involve issues regarding inadequate collaboration with security personnel involved in the event including facility and nonfacility security.	May include outside security involved in the care of a patient or facility security called to help subdue or observe a patient.
Labeling of medications	Problems related to mislabeled medications, similarly labeled containers, or Look-Alike, Sound-Alike drugs that contribute to patient harm.	
Other	This category is generally not used, unless the event clearly does not fall into one of the above categories.	

RCA Form Definitions

	Definition	Examples*
What were the Contributing Factors to Event		
Team Factors	Failure of the members of the care team to work together and to communciate appropriately.	Failure of the OR staff to "speak-up" to the surgeon prior to/during wrong site surgery. Inadequate communication between an anesthesiologist and CRNA which led to the insertion of 2 oral airways. Lack of communication in the ED regarding findings & medications ordered/given which led to a medication error.
Task Factors	Tasks performed by <u>any</u> member of the care team that contribute to the event. These factors include <u>all</u> disciplines following policies and procedures established in the facility.	May include RNs not following the fall prevention strategies for a high risk patient, Nursing Managers not implementing procedures for 1:1 observation, and surgeons who do not call a "time-out" prior to surgery.
Patient Characteristics	Physical, mental, emotional and behavioral aspects of the patient that contributed to the event.	May include DTs, hallucinations, sleep walking, obesity, senility, the patient's response to therapy, and any co-morbidity. Includes the patient's choice to ignore instructions.
Medical Device	A diagnostic or therapeutic instrument, apparatus, implement, machine, etc. that malfunctions or causes harm to the patient.	May include IV pumps, ventilators, orthopedic drill bits, catheters, radiologic equipment.
Procedures	Diagnostic or therapeutic intervention that contributes to the event. The adverse event may be a known consequence or complication of the procedure.	May include chest tube insertion, CVP insertion, cardiac catheterization, catheterization of any vein, artery or of the urinary bladder.

RCA Form Definitions

	Definition	Examples*
Equipment	Any malfunction of equipment other than a medical device that causes harm to the patient. The adverse event may be due directly to malfunction of equipment, to use of the equipment for an unapproved purpose, or improperly used equipment.	May include stretchers, wheelchairs, bed alarms among others.
Patient record documentation	Missing or inaccurate information in the paper or electronic medical record. The medical record information is unavailable for any reason when it is needed and contributes to the event.	
Laboratory and diagnostics	Any problem related to diagnostic testing.	May include failure to order apprpriate tests, wrong patient results, delayed results, misleading results, failure to obtain results, or direct harm to the patient from equipment in labs or the effects of phlebotomy.
Work environment	Failure to maintain a physical environment conducive to the proper care of the patient.	May include inappropriate lighting, inappropriate noise level, inadequate space, clutter, alarms that sound alike, or unfamiliar sounds to the staff.
Staff factors	Inadequate staffing that takes into account patient census and acuity as well as staff training and experience which adversely affects patient care.	May include understaffing, untrained or inadequately oriented staff

RCA Form Definitions

	Definition	Examples*
Organizational / management	Failure of the organization to facilitate a Culture of Safety in the facility.	May include lack of or unclear policies, protocols, lack of support from facility administration, medical or nursing leadership, especially a lack of support for the Speak-up Program.
Medications	Any problem related to a medication, blood or blood product, chemotherapy, isotope, or radiation dose.	
Transportation	The event occurrs during or immediately after transportation (wheel chair, stretcher, etc.) within the facility or during, before or immediately after transportation to another facility.	
Home Care	The event is related to care provided at home by facility sponsored staff.	
Imaging and x-rays	The event occurs during an imaging procedure or is related to medication or an imaging agent used during the procedure or to equipment used in the imaging suite.	May include an allergic reaction to contrast material, or injury in Nuclear Medicine, Radiology, MRI, or CT Scan
Other	This category is generally not used, unless the event clearly does not fall into one of the above categories.	

RCA Form Definitions

	Definition	Examples*
Evaluate Impact of Event for Patient/Resident		
Loss of limb(s)		
Loss of digit(s)		
Loss of body part(s)		
Loss of organ(s)		
Loss of sensory function(s)	Loss of any of the five senses, either temporarily or permanently.	
Loss of bodily function(s)		
Disability - physical or mental impairment	Any temporary or permanent disability resulting from the event.	Includes pressure ulcers, cast or splint, paraplegia or hemiplegia.
Additional laboratory testing or diagnostic imaging	Any test/study/imaging procedure performed as a follow-up of the event.	May include x-rays, CT, MRI, blood tests during codes, Nuclear Medicine studies.
Other additional diagnostic testing	Any testing performed as a follow-up of the event exclusive of the above category.	Biopsy

RCA Form Definitions

	Definition	Examples*
Other (specify):	This category is generally not used, unless the event clearly does not fall into one of the above categories.	
Additional patient monitoring in current location	Any increased observation of the patient or his/her condition resulting from the event.	May include increased frequency of vital signs, neurology checks, 1:1 observation.
Visit to Emergency Department	Any visit to the ED as a follow-up to the event that may or may not result in a hospital admission.	
Hospital admission	Any hospital admission which occurs as a follow-up to the event.	
Transfer to more intensive level of care	Transfer to an increased level of care as a follow-up to the event.	Includes transfer to any ICU, step down unit or telemetry. Includes Behavioral Health patients who are transferred to a medical-surgical unit.
Increased length of stay	A patient's transfer or discharge is delayed for a few hours or days related to the event. This includes patients who may be transferred to other facilities but remained classified as inpatients.	Patients who are transferred from an acute care facility to an acute rehab facility to a subacute rehab facility.

RCA Form Definitions

	Definition	Examples*
Minor surgery	Any procedure in which conscious sedation or local anesthesia is given, regardless of location of the proceddure.	May include closed reductions, debridement of wounds or pressure ulcers, suturing.
Major surgery	Any trip to the OR where general anesthesia is used.	
System or process delay care to a patient	Delay in obtaining or responding to a request for a procedure, consult, or other intervention that is associated with the event and is related to systems issues.	May include delayed Wound Care Nurse consult which results from an inadequate EMR notification process.
To be determined	To be used when the final outcome of the adverse event is unknown at the time of the RCA submission.	
Death	Any death directly related to the event or to the consequences of the event.	

***Examples:** These are suggestions. The definitions are not limited to the suggestions included here.