University of Michigan Hospitals and Health Centers
Root Cause Analysis
Sample Questions

General
What happened; what are the details of the event?
What was different this time than other times?
Why did it happen? Repeat why? Why? (I.e. pain in leg, why? Broken bone, why? Cancer of the bone)
What was the missing or weak link in the process?
Are there any other factors that directly influenced the occurrence?
What steps in the patient care process contributed to this event?
What other area/services are impacted by the process?
Did factors outside the control of the organization contribute to the occurrence?
If so, how can the organization protect against the influence of these factors?

Behavioral Assessment – (refers to psychiatric assessment)
Was the behavioral assessment complete?
Was the behavioral assessment documented?

Physical Assessment
Was the physical assessment complete?
Was the physical assessment documented?
Does the standard for physical assessment meet current requirements for necessary patient information?

Patient Identification
Was the patient properly identified before medication given?
Did patient have armband identification?
Was the patient identified verbally by name?
Was the patient properly identified before procedure or test performed?

Patient Observation Procedures
Are there guidelines for observing the patient that pertain to this event?
Were the guidelines followed?
Are the guidelines adequate?

Care Planning Process
Was the procedure/guideline not used?

- Is there no procedure/guideline?
- Is the procedure/guideline not available or inconvenient to use?
- Is the procedure/guideline difficult to use?
- Is the use of procedure not required, but should it be?

Was the procedure/guideline followed incorrectly/?

- Is the procedure/format confusing?
- Is the procedure/guideline too detailed?
- Is the procedure/guideline not detailed enough?
- Does the procedure/guideline contain ambiguous statements or instructions?

Was the wrong procedure/guideline followed?
Was an outdated procedure/guideline used?
Did caregivers misinterpret the situation that caused the wrong procedure/guidelines to be used?

Staffing Levels

Are staffing levels appropriate to the patient number, acuity and care process?
How did actual staffing compare with ideal levels?
Are there contingency plans to adjust staffing when necessary?
Are staff frequently expected to work more hours than they are scheduled?
Are staff provided sufficient time for shift change activity, adequate breaks?

Orientation and Training of Staff

Did inadequate staff orientation and/or training contribute to the occurrence?
Is there adequate supervision of new staff?

Competency Assessment/Credentialing

Are staff properly qualified and currently competent?
Is staff performance relevant to the process periodically evaluated?
Did the involved staff receive the necessary training?

- Is training offered for these activities /tasks?
- Did caregivers/staff participate in training if it was offered?
- Was training offered at a convenient time/place?

Did the involved staff understand the training they received?

- Was the training less than adequate?
- Was sufficient time allowed for practicing skills?
- Were competency/proficiency tested after training?

Is continuing education available on this topic and if so, do staff participate?

Supervision of Staff

Are there standard policies and other managerial controls in place?
Is there sufficient managerial oversight of employees? Medical Staff oversight of licensed independent practitioners? Licensed oversight of non-licensed caregivers?

- Are performance evaluations infrequent?
- Do evaluations lack depth/detail?
- Are evaluations performed by individuals without self-serving interests?

Are there good relations between management and staff? Between medical leaders and practitioners?

- Is top down/bottom up communication less than adequate?
- Is morale less than adequate?

Does management take corrective action when problems are identified? Are actions effective?
Is there adequate supervision of staff in high-risk areas?

Communication among Staff Members

Were verbal communications misunderstood?

- Was non-standard terminology used?
- Was the environment too noisy?
- Was the message too long?
- Were “repeat backs” used?

Was there no communication or untimely communication?

- Was there no communication method available?
- Was communication late?
- Was communication during patient hand-offs between caregivers less than adequate?

Communication with Patients and Families

Did poor or lack of communication with families or patient contribute to this event?

Availability of Information
Did inadequate information and/or information flow contribute to the occurrence?
Was information available to staff when needed?
Did inaccurate information contribute to the occurrence?
Did incomplete information contribute to the occurrence?
Did information ambiguity contribute to the occurrence?

Adequacy of Technical Support
Did lack of technical support lead to this event?

Equipment Maintenance/ Management
What equipment broke, if any?
How did the equipment performance affect the outcome?
Was there adequate instructions in the use of the equipment? (Operational manual)
If applicable, was the equipment on a preventative maintenance schedule?

Physical Environment
Did the physical environment contribute to the occurrence?

- Is housekeeping poor?
- Is it too hot, cold, humid?
- Is lighting adequate?
- Is it too noisy?
- Is the working space cramped?
- Are staff exposed to contamination/infection risks?

Was the environment appropriate for the processes being carried out?
Are systems in place to identify all possible environmental risks?
Did the lack of adequately planned and tested emergency procedures contribute towards the occurrence?

Security Systems and Processes
Were adequate security systems in place at the time of this event?
Were adequate security systems present in the location of this event?

Control of Medications: Storage and Access
Are medications stored in a location away from visitors and other staff?
Are staff able to access medications when needed with enough ease?

Labeling of Medications
Are there guidelines for labeling medications?
Were medications labeled according to guidelines?
Are the standards for labeling adequate?

Sources:
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