*Hospital Reference No:

RCA² - Root Cause Analysis & Action Report

Incident Reporting & Learning System

PLEASE ATTACH THE IR 2.0 FORM THAT CORRELATES WITH THE INCIDENT AS THE FIRST PAGE.

1. HOSPITAL NAME: _____
2. PATIENT'S RN/ IDENTIFICATION NUMBER: _____
3. INCIDENT TYPE :

_____

4. INVESTIGATION TEAM:

Name	Designation
Team Leader/ Coordinator	
Team Members	

Reported By:

Name:

Designation/ Stamp:

Date:

Verified By:

Name:

Designation/ Stamp:

Date:

This template need to be used together with "Guidelines on Implementation Incident Reporting & Learning System 2.0 for Ministry of Health Malaysia Hospitals"

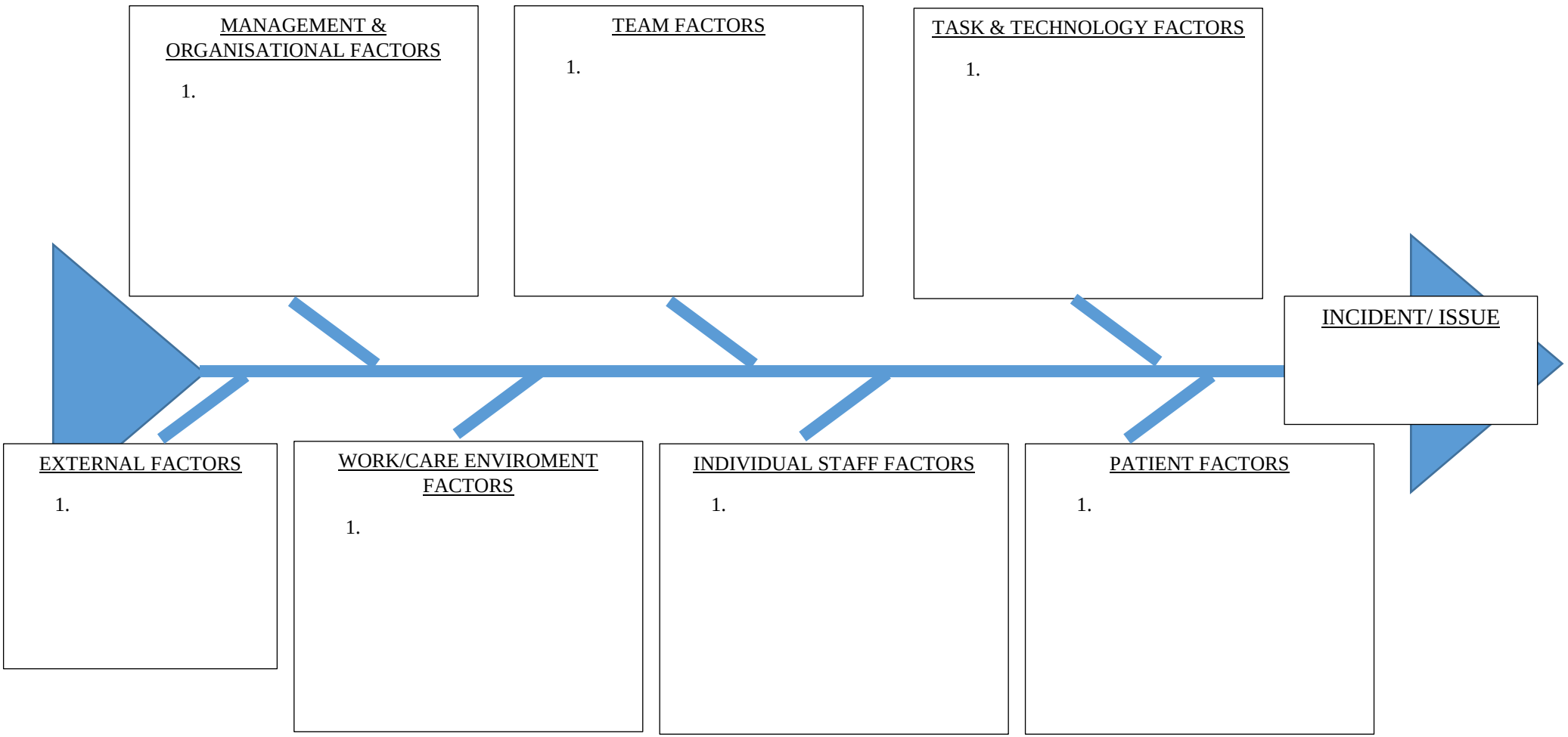
5. SUMMARY OF THE INCIDENT:

6. SEQUENCE OF EVENTS:

Please state **only the important information/events/steps** that **lead to the incident:**

Date	Time (24 h)	Location	Event description	Key person involved (initial) & designation	Comments- please add in what went wrong in every sequence

7. FISH BONE DIAGRAM (REFER TO LONDON PROTOCOL FOR CATEGORISATION)



8. CONTRIBUTING FACTORS:

Please choose and tick at the relevant box the relevant contributing factors that lead to the incident & describe the factors. (can be more than one factor)

<table>
<tr><th colspan="3">FACTORS THAT LEADS TO THE INCIDENT</th></tr>
<tr><td>1</td><td>TEAM FACTOR</td><td>
<table>
<tr><td></td><td>Written communication issue</td></tr>
<tr><td></td><td>Verbal communication issue</td></tr>
<tr><td></td><td>Unclear roles and responsibility</td></tr>
<tr><td></td><td>Lack of supervision/ monitoring</td></tr>
<tr><td></td><td>Ineffective leadership & responsibility</td></tr>
<tr><td></td><td>Problem in seeking help</td></tr>
<tr><td></td><td>Staff or colleague response/ support to help</td></tr>
<tr><td></td><td>Others (specify)</td></tr>
</table>
Description:
</td></tr>
<tr><td>2</td><td>INDIVIDUAL STAFF FACTOR</td><td>
<table>
<tr><td></td><td>Lack of knowledge/experience/ skill</td></tr>
<tr><td></td><td>Distraction</td></tr>
<tr><td></td><td>Fatigue/ stress</td></tr>
<tr><td></td><td>Lapse of concentration</td></tr>
<tr><td></td><td>Non compliance to protocol/ policy/ SOP</td></tr>
<tr><td></td><td>Personal issue</td></tr>
<tr><td></td><td>Unsafe behaviour – assuming, not asking clarification etc</td></tr>
<tr><td></td><td>Interpersonal issue</td></tr>
<tr><td></td><td>Others (specify):</td></tr>
</table>
Description:
</td></tr>
<tr><td>3</td><td>PATIENT FACTOR</td><td>
<table>
<tr><td></td><td>Miscommunication between patient and staff</td></tr>
<tr><td></td><td>Language barrier</td></tr>
<tr><td></td><td>Non-compliance patient</td></tr>
<tr><td></td><td>Social issue</td></tr>
<tr><td></td><td>Patient-staff relationship issue</td></tr>
<tr><td></td><td>Patient-patient relationship issue</td></tr>
<tr><td></td><td>Complexity of clinical condition</td></tr>
<tr><td></td><td>Pre-existing comorbids</td></tr>
<tr><td></td><td>Known risk associated with treatment</td></tr>
<tr><td></td><td>Others (specify):</td></tr>
</table>
Description:
</td></tr>
</table>

<table>
<tr><td>4</td><td>TASK & TECHNOLOGY FACTOR</td><td>
<table>
<tr><td></td><td>Availability and use of protocols/ S.O.P/ guidelines</td></tr>
<tr><td></td><td>Availability and accuracy of health information</td></tr>
<tr><td></td><td>Task design issue</td></tr>
<tr><td></td><td>Information technology (e.g malfunction, system design)</td></tr>
<tr><td></td><td>Decision making aids</td></tr>
<tr><td></td><td>Medication related issue (e.g wrong prescription, similar packaging/ sounding names, complicated dosage design)</td></tr>
<tr><td></td><td>Radiotherapy related issue (e.g miscalculation of dose)</td></tr>
<tr><td></td><td>Others (specify):</td></tr>
</table>
Description:
</td></tr>
<tr><td>5</td><td>MANAGEMENT & ORGANIZATIONAL FACTOR</td><td>
<table>
<tr><td></td><td>Leadership and governance issue</td></tr>
<tr><td></td><td>Organizational structure issue</td></tr>
<tr><td></td><td>Objectives, policies and standard issue</td></tr>
<tr><td></td><td>Resources constraints (human/ financial)</td></tr>
<tr><td></td><td>Inadequate safety culture/ lack priorities in safety</td></tr>
<tr><td></td><td>Others (specify):</td></tr>
</table>
Description:
</td></tr>
<tr><td>6</td><td>WORK & ENVIRONMENTAL FACTOR</td><td>
<table>
<tr><td></td><td>Building & design related issues</td></tr>
<tr><td></td><td>Physical environment issue(temperature, lighting, wet floor, holes, storage, housekeeping)</td></tr>
<tr><td></td><td>Noisy, busy surrounding</td></tr>
<tr><td></td><td>Malfunction/ failure of equipment/ maintenance of equipment, functionality, design</td></tr>
<tr><td></td><td>Cluttered surrounding</td></tr>
<tr><td></td><td>Unsafe surrounding</td></tr>
<tr><td></td><td>Inappropriate allocation of staff (i.e not according to workload/ specialty)</td></tr>
<tr><td></td><td>Heavy workload, inadequate break</td></tr>
<tr><td></td><td>Service delivery- delay, missed, inappropriate</td></tr>
<tr><td></td><td>Others (specify):</td></tr>
</table>
Description:
</td></tr>
<tr><td>7</td><td>EXTERNAL FACTOR</td><td>Please specify:</td></tr>
</table>

9. List out the most important contributing factors/ root cause (s) that lead to the incident .

The factors/ root cause (s) should be selected/written using 5 Rules of Causation (Please refer to Appendix 3 of Guideline on Implementation of Incident Reporting & Learning System 2.0)

Factor 1

Factor 2

Factor 3

10. *Root Cause (s):

*if the root cause(s) can be identified

11. ACTION PLAN TABLE

Based on the contributing factors/root cause (s) listed above, identify the most effective action plan. The action plan should have at least **1 strong/intermediate action plan.** "Weak" action can be implemented to support other action or while waiting for "stronger" or "intermediate" action to be implemented.

No.	Contributing Factors/ Root Causes	Description of Action Plan	Action Hierarchy (strong/ intermediate/ weak)	Person responsible (Name & designation)	Evidence of completion/ Progress	Expected Completion Date
Eg. 1	Slippery floor in the toilet– lead to patient fall	To use non slippery floor on every toilet	Strong	Dr. Abdullah (Hospital Deputy Director)	Project completed	1.6.18
Eg. 2	Similar 'look alike' ampules of atropine and adrenaline which were stored next to each other in the emergency trolley–causing the nurse to mistakenly pick up the wrong ampules	To store adrenaline and atropine ampules far from each other in the emergency trolley and to label them using TALL man lettering	Intermediate	Pn Hasnita (Head of Pharmacy Department)	Storage for adrenaline and atropine had been adjusted (far from each other and labelled them using TALL man lettering) in all emergency trolley	7.2.18
Eg. 3	The absence of designated staff to check the storage of LASA medication	To assign 1 specific staff in every wards to check proper storage of LASA medication every week	Intermediate	Matron Julia (Head of Matron)	Name list of designated staff	1.3.18
Eg. 4	Lack of knowledge among staff on proper warming methods and monitoring of hypothermia intraoperatively leads to 1% deep dermal burn over the right shoulder of the patient	To train and educate OT staff on proper warming methods and monitoring of hypothermia – via CME	weak	Matron Leong (Operation Theatre Matron)	-Training module -Attendance list of participants	1.2.18 (general OT staff) 15.2.18 (maternity OT staff) 1.3.18 (trauma & emergency OT staff)

PLEASE DELETE THE EXAMPLES OF ACTION PLAN GIVEN AND WRITE DOWN YOUR OWN ACTION PLAN IN THE TABLE PROVIDED

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