| | |
|---|---|
| | **HOSPITAL SULTAN ABDUL AZIZ SHAH**<br>**UNIVERSITI PUTRA MALAYSIA**<br>**Document Code: HSAAS/UKPR/BR69** |
| | **ROOT CAUSE ANALYSIS AND ACTION REPORT – RCA2 FORM** |

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

1. **HOSPITAL NAME** : _____
2. **PATIENT'S MRN/ 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:

**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 |
|---|---|---|---|---|---|
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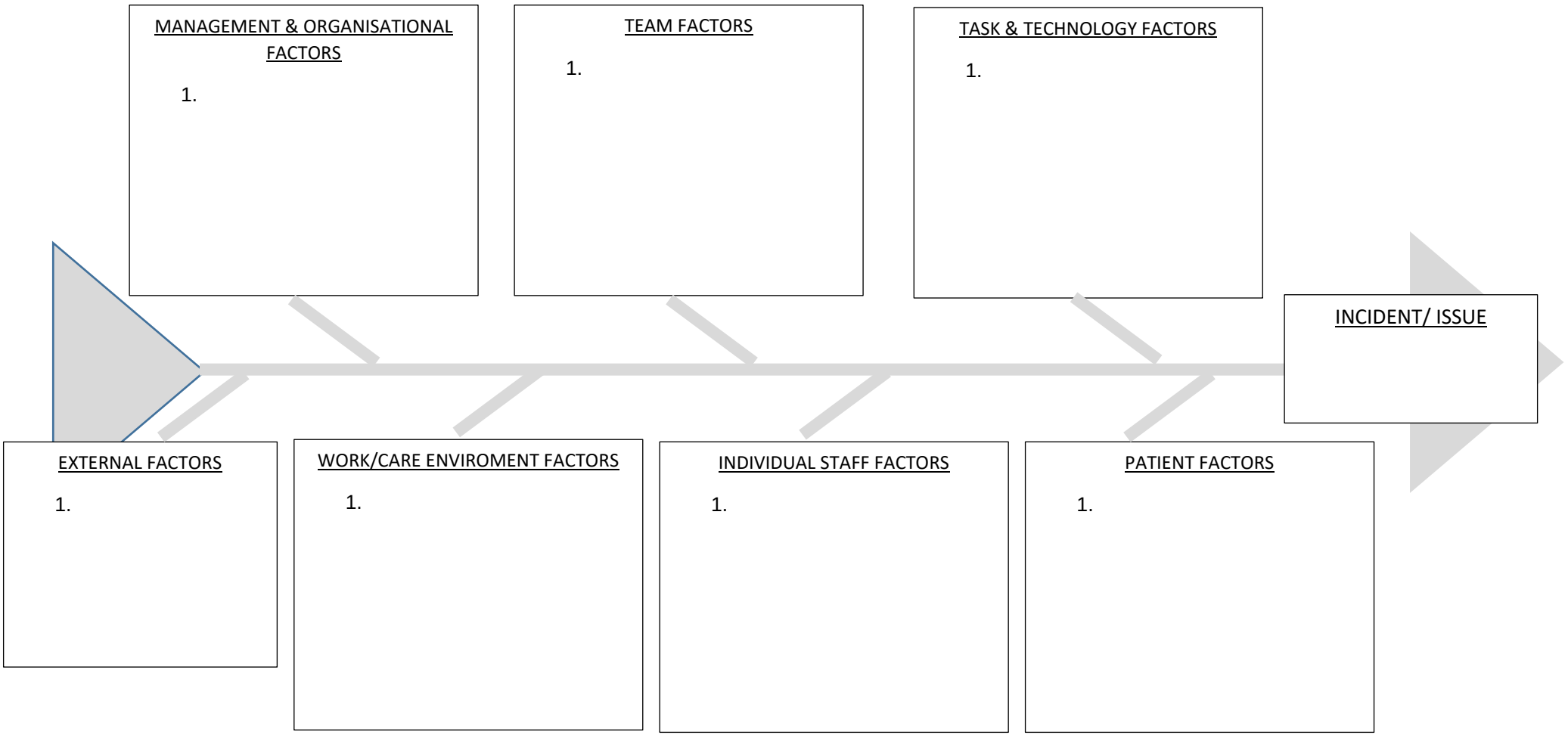
## 7. FISH BONE DIAGRAM (REFER TO LONDON PROTOCOL FOR CATEGORISATION)



## 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 LEAD 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 comorbid</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.**

| 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 |
|---|---|---|---|---|---|---|
| E.g. 1 | Slippery floor in the toilet– lead to patient fall | To use non slippery floor on every toilet | Strong | Dr. Abdullah<br>(Hospital Deputy Director) | Project completed | 1.6.18 |
| E.g. 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<br>(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 |
| E.g. 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<br>(Head of Matron) | Name list of designated staff | 1.3.18 |
| E.g. 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<br>(Operation Theatre Matron) | -Training module<br>-Attendance list of participants | 1.2.18 (General OT staff)<br>15.2.18 (Maternity OT staff)<br>1.3.18 (Trauma & emergency OT staff) |