Project RedDE! Mini Root Cause Analysis Form

- Set aside a 30 minute period to perform this mini-root cause analysis two times per month with members of your core improvement team.
- Designate a team member to identify a diagnostic error that occurred recently (within the last 7 days) Note: The identified diagnostic error should be one that holds meaning for your practice and for which room for improvement can be identified.
- A team member/leader should draft an initial description of how the error occurred (Q4 below) in advance of the team meeting.
- Encourage a care team member (provider, nurse, etc) who was involved in the diagnostic error to participate in this mini-RCA meeting (this way, the factors will be best reflected below).

Patient Name: ________________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Practice Response</th>
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</table>
| 1. Type of Diagnostic Error: | □ Missed Adolescent Depression  
                              □ Missed Elevated Blood Pressure  
                              □ Delayed Actionable Laboratory Value |
| 2. Date of Error (MM/YY): | _ _ / _ _  Approximate time of day (24 hour clock): 00:00 |
| 3. Date Mini-RCA Completed (MM/DD/YY): | _ _ / _ _ |
| 4. Please describe the error and how it occurred (this meeting should be discussed briefly but the facts should not be the focus of the project): |
| 5. Where in the Process did the error occur? (Check all that apply within 1 Diagnostic Error Type) |
| A. Missed Adolescent Depression: | □ Patient Screened  
                              □ Recognize Abnormal Screen  
                              □ Notify Family of Abnormal Screen  
                              □ Refer Patient to Mental Health Resources  
                              □ Patient attends Mental Health  
                              □ Mental Health Provider Feeds Back Information to Practice  
                              □ Document Mental Health Diagnosis  
                              □ Other (Describe: __________________) |
| B. Missed Elevated Blood Pressure: | □ Measure BP  
                              □ Record BP  
                              □ Recognize Abnormal BP  
                              □ Notify Family of Abnormal BP  
                              □ Act on Abnormal BP  
                              □ Document Action on BP  
                              □ Other (Describe: __________________) |
| C. Delayed Actionable Laboratory Value: Which Lab Test? | _____________________  
                              □ Test Results Returned to Clinic  
                              □ Provider Views Test Results  
                              □ Recognize Abnormal Results  
                              □ Notify Family of Abnormal Results  
                              □ Act on Abnormal Results  
                              □ Document Action on Abnormal Results  
                              □ Other (Describe: __________________) |
| 6. At first review, why does the core improvement team believe this failure to identify and act on a diagnostic error occurred? |
The next step is to perform a Round Robin to have each core improvement team member share their perspective on the top factor/s within the (1) patient/family, (2) provider/nurse/administrative, and (3) system/practice areas that contributed to this error.

**Patient/Family Factors:**
What Patient/Family factors contributed to the error? (for example: age, gender, reason for visit, patient comorbidities, language barriers, acute illness, agitation of patient/family, social issues, etc.)

**Provider/Nurse/Administrative Factors:**
What Provider/Nurse/Administrative factors contributed to the error? (for example: type of provider, provider level of training, provider fatigue/impairment, personal stressors of providers, provider disagreements, provider knowledge, provider beliefs about the project or the patient, etc.)

**Systems/Practice Factors:**
What System/Practice factors contributed to the error? (for example: provider volume that day, nurse staffing that day, office assistant staffing that day, time of visit, clinic milieu during visit (chaotic vs. calm), day of the week, increased workload, verbal communication, written communication, computer software or hardware, non-computer equipment, etc)

Use the space below to write down the factors noted in each realm.

<table>
<thead>
<tr>
<th>7. Record Patient/Family factors that contributed to the error to the right</th>
<th>(for example: age, gender, reason for visit, patient comorbidities, language barriers, acute illness, agitation of patient/family, social issues, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Record Provider/Nurse/Administrative factors that contributed to the error to the right</td>
<td>(for example: type of provider, provider level of training, provider fatigue/impairment, personal stressors of providers, provider disagreements, provider knowledge, provider beliefs about the project or the patient, etc.)</td>
</tr>
<tr>
<td>9. Record System/Practice factors that contributed to the error to the right</td>
<td>(for example: provider volume that day, nurse staffing that day, office assistant staffing that day, time of visit, clinic milieu during visit (chaotic vs. calm), increased workload, staffing concerns, verbal communication, written communication, computer software or hardware, non-computer equipment, etc)</td>
</tr>
</tbody>
</table>

**Lessons Learned:**

1. Rank the top three factor(s) that contributed the MOST to this Diagnostic Error? (all 3 can be from the same group or different groups)

**Patient factors of:**
- gender
- age
- comorbidities
- insurance status
- reason for visit
- language barriers
- acute illness
- agitation of patient/family
- social issues
- other concerning patient factors, defined as:

**Provider/Nurse/Admin. factors of:**
- type of provider
- provider level of training
- provider fatigue/impairment
2. What Interventions can we put into place to reduce the risk of this Diagnostic Error occurring again?* (Consult strength of intervention grid below).

3. Who will lead this intervention?

4. Date we will start piloting the intervention. (MM/DD/YY):

5. How did you communicate with peers at the clinic about these lessons learned?

*Strength of Interventions

<table>
<thead>
<tr>
<th>Weaker Actions</th>
<th>Intermediate Actions</th>
<th>Stronger Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double Check</td>
<td>Checklists/ Cognitive Aid</td>
<td>Architectural/physical plant changes</td>
</tr>
<tr>
<td>Warnings and labels</td>
<td>Increased Staffing/Reduce workload</td>
<td>Tangible involvement and action by leadership in support of patient safety</td>
</tr>
<tr>
<td>New procedure, memorandum or policy</td>
<td>Redundancy</td>
<td>Simplify the process/remove unnecessary steps</td>
</tr>
<tr>
<td>Training and/or education</td>
<td>Enhance Communication (read-back, SBAR etc.)</td>
<td>Standardize equipment and/ or process of care map</td>
</tr>
<tr>
<td>Additional Study/analysis</td>
<td>Software enhancement/modifications</td>
<td>New device usability testing before purchasing</td>
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<tr>
<td></td>
<td>Eliminate look alike and sound- a-likes</td>
<td>Engineering Control of interlock (forcing functions)</td>
</tr>
<tr>
<td></td>
<td>Eliminate/reduce distractions</td>
<td></td>
</tr>
</tbody>
</table>

- Adapted from John Gosbee, MD, MS Human Factors Engineering
- Remember sometimes a weaker action is your only option.