



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"

*QUALITY MANAGER NEEDS TO WRITE DOWN HOSPITAL REFERENCE NUMBER FOR EACH OF RCA² REPORT BASED ON HOSPITAL REFERENCE NUMBER IN E-IR

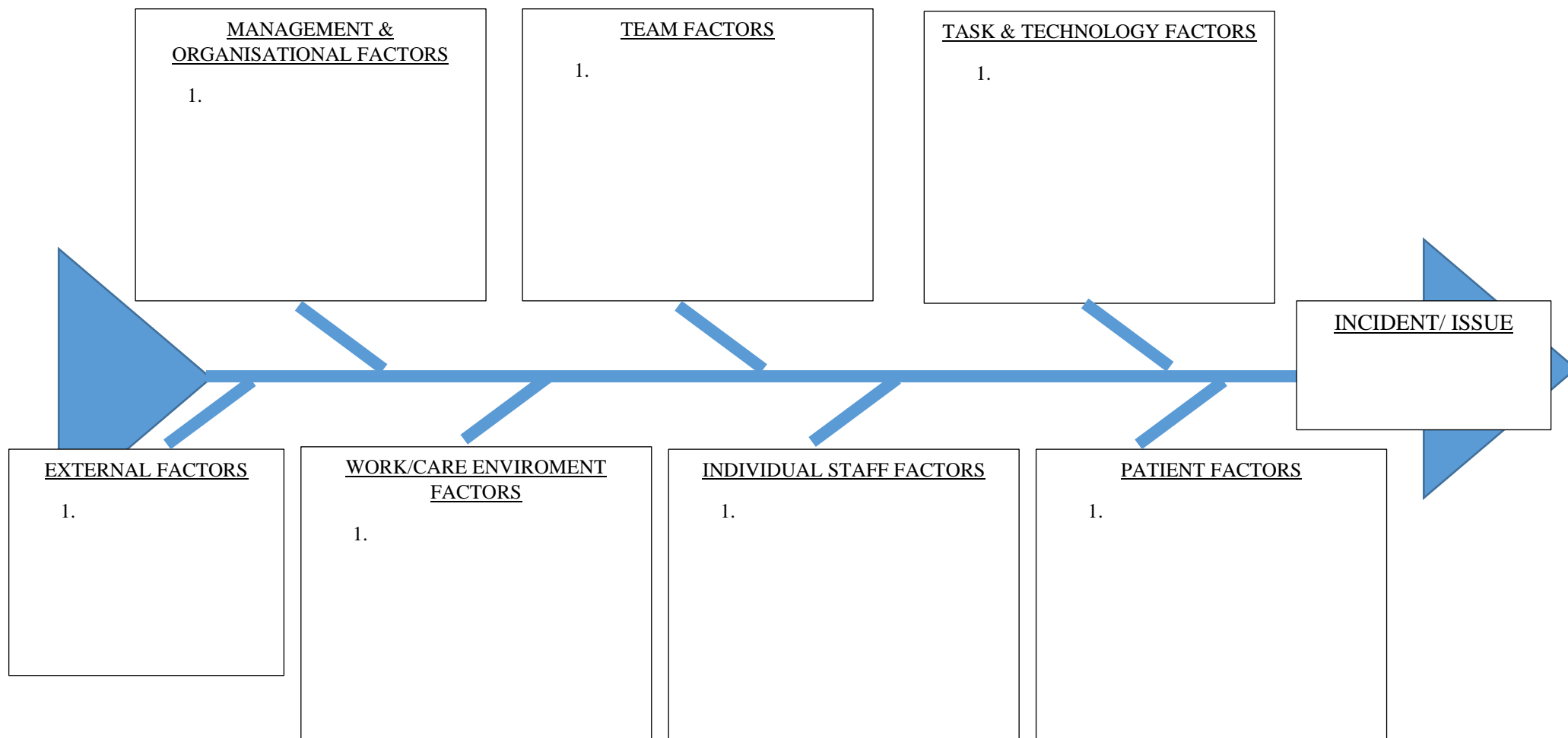
5. SUMMARY OF THE INCIDENT:

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)

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

4	TASK & TECHNOLOGY FACTOR	<table border="1"> <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> <p>Description:</p>		Availability and use of protocols/ S.O.P/ guidelines		Availability and accuracy of health information		Task design issue		Information technology (e.g malfunction, system design)		Decision making aids		Medication related issue (e.g wrong prescription, similar packaging/ sounding names, complicated dosage design)		Radiotherapy related issue (e.g miscalculation of dose)		Others (specify):				
	Availability and use of protocols/ S.O.P/ guidelines																					
	Availability and accuracy of health information																					
	Task design issue																					
	Information technology (e.g malfunction, system design)																					
	Decision making aids																					
	Medication related issue (e.g wrong prescription, similar packaging/ sounding names, complicated dosage design)																					
	Radiotherapy related issue (e.g miscalculation of dose)																					
	Others (specify):																					
5	MANAGEMENT & ORGANIZATIONAL FACTOR	<table border="1"> <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> <p>Description:</p>		Leadership and governance issue		Organizational structure issue		Objectives, policies and standard issue		Resources constraints (human/ financial)		Inadequate safety culture/ lack priorities in safety		Others (specify):								
	Leadership and governance issue																					
	Organizational structure issue																					
	Objectives, policies and standard issue																					
	Resources constraints (human/ financial)																					
	Inadequate safety culture/ lack priorities in safety																					
	Others (specify):																					
6	WORK & ENVIRONMENTAL FACTOR	<table border="1"> <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> <p>Description:</p>		Building & design related issues		Physical environment issue(temperature, lighting, wet floor, holes, storage, housekeeping)		Noisy, busy surrounding		Malfunction/ failure of equipment/ maintenance of equipment, functionality, design		Cluttered surrounding		Unsafe surrounding		Inappropriate allocation of staff (i.e not according to workload/ specialty)		Heavy workload, inadequate break		Service delivery- delay, missed, inappropriate		Others (specify):
	Building & design related issues																					
	Physical environment issue(temperature, lighting, wet floor, holes, storage, housekeeping)																					
	Noisy, busy surrounding																					
	Malfunction/ failure of equipment/ maintenance of equipment, functionality, design																					
	Cluttered surrounding																					
	Unsafe surrounding																					
	Inappropriate allocation of staff (i.e not according to workload/ specialty)																					
	Heavy workload, inadequate break																					
	Service delivery- delay, missed, inappropriate																					
	Others (specify):																					
7	EXTERNAL FACTOR	Please specify:																				

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). The leftmost column lists the root cause(s) of the incident.

All table rows must adhere to the 5 Rules of Causation (Refer to Appendix 3 of the Guideline on Implementation of Incident Reporting & Learning System 2.0). Each row must demonstrate a clear cause-and-effect relationship [1], avoiding vague wording [2], not attributing the cause to human error or procedural violations [3 & 4] and failure to act is only causal when there was a pre-existing duty to act [5].



Cause(s)/ Root Cause(s) Sebab / Punca Utama	Causing Menyebabkan	Effect Kesan	Leading to Mengakibatkan	Event / Incident Kejadian / Insiden

(Optional) Fill in the boxes below (additional boxes may be added) if not using the table above.

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

*Hospital Reference No: