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|  | **HOSPITAL PENGAJAR UNIVERSITI PUTRA MALAYSIA** |
| **LAPORAN PUNCA DAN TINDAKAN – RCA2 *(ROOT CAUSE ANAYSIS AND ACTION REPORT – RCA2)*** |

**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:

**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)**

MANAGEMENT & ORGANISATIONAL FACTORS

TEAM FACTORS

TASK & TECHNOLOGY FACTORS

INCIDENT/ ISSUE

WORK/CARE ENVIROMENT FACTORS

EXTERNAL FACTORS

PATIENT FACTORS

INDIVIDUAL STAFF FACTORS

**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)

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| --- |
| **FACTORS THAT LEADS TO THE INCIDENT**  |
| 1 | TEAM FACTOR |

|  |  |
| --- | --- |
|  | Written communication issue |
|  | Verbal communication issue |
|  | Unclear roles and responsibility |
|  | Lack of supervision/ monitoring |
|  | Ineffective leadership & responsibility |
|  | Problem in seeking help |
|  | Staff or colleague response/ support to help |
|  | Others (specify) |

 Description:  |
| 2 | INDIVIDUAL STAFF FACTOR |

|  |  |
| --- | --- |
|  | Lack of knowledge/experience/ skill |
|  | Distraction |
|  | Fatigue/ stress |
|  | Lapse of concentration |
|  | Non-compliance to protocol/ policy/ SOP |
|  | Personal issue |
|  | Unsafe behaviour – assuming, not asking clarification etc |
|  | Interpersonal issue |
|  | Others (specify): |

Description:  |
| 3 | PATIENT FACTOR |

|  |  |
| --- | --- |
|  | Miscommunication between patient and staff |
|  | Language barrier |
|  | Non-compliance patient |
|  | Social issue |
|  | Patient-staff relationship issue |
|  | Patient-patient relationship issue |
|  | Complexity of clinical condition |
|  | Pre-existing comorbid |
|  | Known risk associated with treatment |
|  | Others (specify): |

Description:  |
| 4 | TASK & TECHNOLOGY FACTOR |

|  |  |
| --- | --- |
|  | 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): |

Description: |
| 5 | MANAGEMENT & ORGANIZATIONAL FACTOR |

|  |  |
| --- | --- |
|  | 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): |

Description:  |
| 6 | WORK & ENVIRONMENTAL FACTOR |

|  |  |
| --- | --- |
|  | 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): |

Description:  |
| 7 | EXTERNAL FACTOR | Please specify: |

**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(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(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 (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(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) |