Department of Defense
Patient Safety Analysis Center

DoD Patient Suicide
RCA Process

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DoD Patient Safety Analysis Center

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- **Root Cause Analysis depository**
- **Data analysis of adverse events**
- **Generation of reports, reviews, alerts and advisories**

Basic Patient Safety Manager Training

- Overview of the Patient Safety Program
- Root Cause Analysis
  - TapRooT®
- Failure Mode and Effects Analysis

Root Cause Analysis (RCA)

- In depth retrospective analysis
- Decision based on severity of event or potential thereof (The Joint Commission, DoD and Service Regulations and Policy)
- Formally chartered by organization leadership
- Multidisciplinary team
- Typically 50-100 hours of staff time
- Selectively submitted to Joint Commission (accredited facilities for reviewable sentinel events) and higher headquarters

- **Root Cause Analysis mandated by The Joint Commission since 1997 for all accredited facilities for:**

Sentinel Events

An unexpected occurrence or variation involving death or serious physical or psychological injury, or risk thereof.

DOD Instruction 6025.13

5.2.1: All sentinel events defined by JCAHO [The Joint Commission], as reportable to JCAHO, shall be reported. The completed RCA and action plan, consistent with JCAHO policy and time limits, shall be made available to JCAHO.

Reviewable Sentinel Event for Suicide*

"Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge."

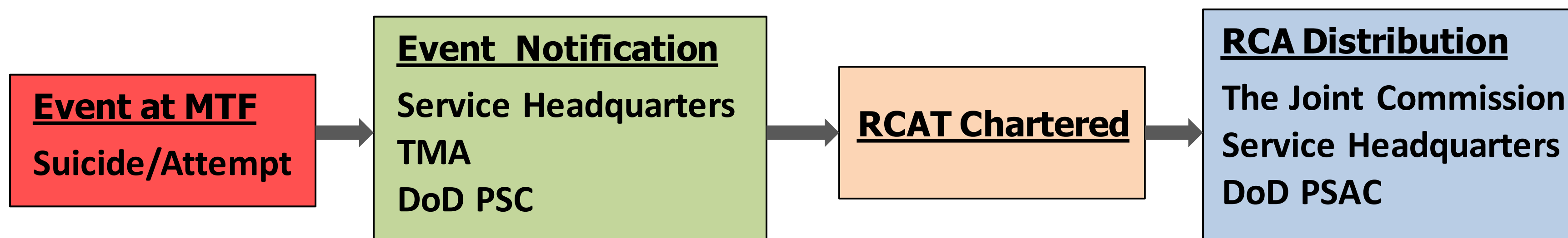
(TJC 2009)

* Excludes most suicides occurring in the ambulatory environment.

The Joint Commission Minimum Scope of Root Cause Analysis

- Behavioral Assessment Process
- Physical Assessment Process
- Patient Observation Procedures
- Care Planning Process
- Continuum of Care
- Staffing Levels
- Orientation & Training of Staff
- Competency Assessment/Credentialing
- Supervision of Staff
- Communication with Patient/Family
- Communication Among Staff Members
- Availability of Information
- Physical Environment
- Security Systems and Processes

Where the RCA Process Begins



Credible Root Cause Analysis

- Summary of the event
- Causal Factors
- Actions
- Measures
- Flow Chart – “SnapChart”

Causal Factors

- TapRooT®
- TJC Framework

- Leading Causal Factors/Contributing Factors:
  - Ineffective Communications
  - Policy Lacking
  - No Root Cause Identifiable

Using the Data

- Annual and Mid-Year Summaries
- Patient Safety Program Newsletter
- Focused Reviews
- Joint DoD/VA Collaboration