

Serious Safety Event RCA Process (Cause Map Process)



Three Step Model

RCA Required/Requested

Event Investigation Conducted

Communication with Risk Department (if needed)

Quality Referrals Sent (if needed)

Attendee List Identified

Meeting Date Identified

RCA Documentation

RCA Meeting Held

Cause Map Creation/Completion

Action Plan Development

Completed within 45 days

Present at Safety Culture Committee

Cause Mapping Step 1: Outline

What Problem(s)

When Date

Time

Differences

Where Physical Location

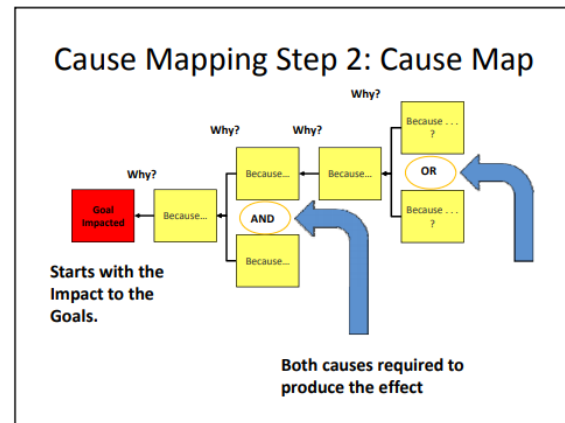
Unit/Process/Equipment

Work/Task Being Done

Impact to the Goals

Safety - Patient	
Employee Impact	
Compliance	
Environmental	
Organization	
Patient Services	
Materials, Labor	

Frequency: This incident _____ Annual Total _____



Cause Mapping Step 3: Solutions

No.	Cause	Action Item	Owner	Due Date	Status	Completed

Outline

What Problem(s) Patient death

When Date December 3, 2018

Time 12:50 PM

Where Different, unusual, unique Blood sample was left in ER room after patient was discharged

Facility, site Baylor St. Luke's Medical Center in Houston

Unit, area, equipment Emergency Room

Task being performed Patient treated with blood transfusion

Impact to each GOAL

Safety	Patient death
Customer	Negative publicity, patient trust in hospital decreased
Labor, Time	Major investigation

Frequency First patient death, but regulators identified 122 incidents of blood labeling errors during September 2018 to January 2019

