

Root Cause Analysis Matrix

Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events - June 2002

Note: Updates are highlighted in red.

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

	Suicide (24° care)	Med. Error	Proced. Cmplic.	Wrong site surg.	Treatment delay	Restraint death	Elopement death	Assault/ rape/ hom.	Transfusion death	Infant abduction
Behavioral assessment process ¹	X					X	X	X		
Physical assessment process ²	X		X	X	X	X	X			
Patient identification process		X		X					X	
Patient observation procedures	X					X	X	X	X	
Care planning process	X		X			X	X			
Continuum of care	X				X	X				
Staffing levels	X	X	X	X	X	X	X	X	X	X
Orientation & training of staff	X	X	X	X	X	X	X	X	X	X
Competency assessment / credentialing	X	X	X		X	X	X	X	X	X
Supervision of staff ³		X	X		x	X			X	
Communication with patient/family	X			X	X	X	X			X
Communication among staff members	X	X	X	X	X	X			X	X
Availability of information	X	X	X	X	X	X			X	
Adequacy of technological support		X	X							
Equipment maintenance / management		X	X			X				
Physical environment ⁴	X	X	X				X	X	X	X

Security systems and processes	X						X	X		X
Control of medications: storage/access		X							X	
Labeling of medication		X							X	

1. Includes the process for assessing patient's risk to self (and to others, in cases of assault, rape, or homicide where a patient is the assailant).
2. Includes search for contraband.
3. Includes supervision of physicians -in-training.
4. Includes furnishings; hardware (e.g., bars, hooks, rods); lighting; distractions .