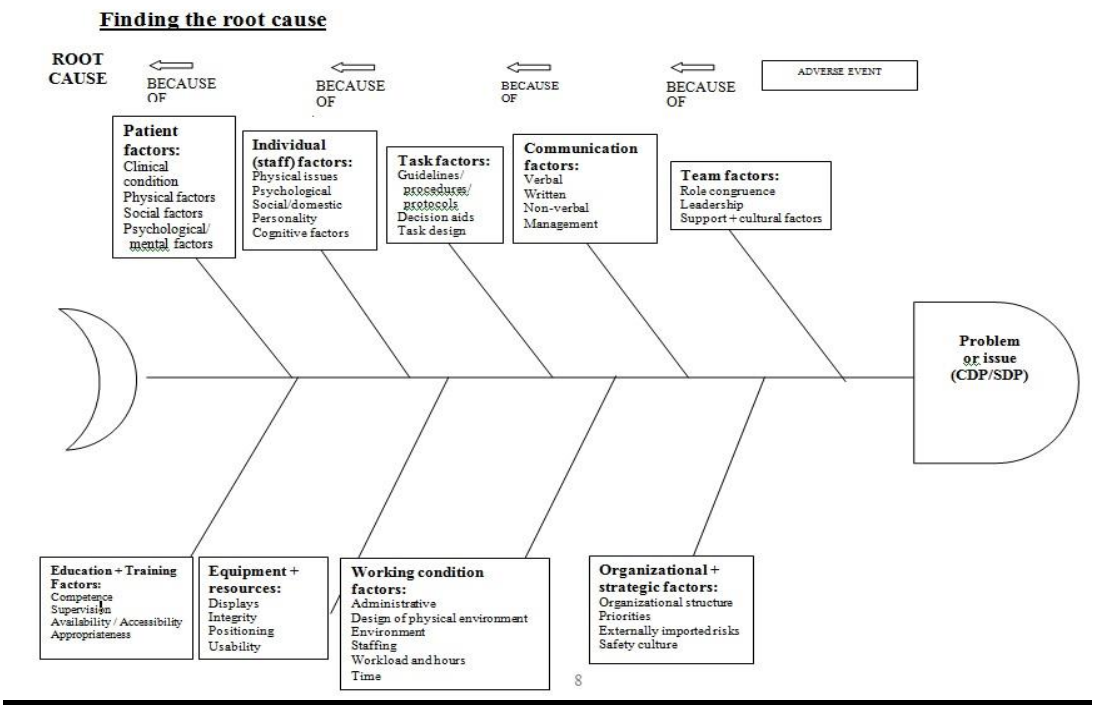


A Document for Evaluation by SE-RCA Team: SVIMS Quality Council

Contributory Factors sub classification for RCA:

GROUP-1:

Patient Factors	Components
Underlying disease status	• Complexity • Seriousness
Presenting illness	• General condition • Performance status
Personal factors	• Life style • Motivation / intelligence status • False belief
Family factors	• Financial support • Physical support • Emotional support • Intellectual support • Health status of other family members
Environmental factors	• Distant location of health care • Untrained local medical help • Transport problems/Unforeseen events (rains, floods, bandhs, road blocks)

GROUP-2:

Staff Factors	Components
Physical issues	• In adequate physical health • Physical disability • Ccontagious infection **(**Healthcare staff**)**
Psychological Issues	• Stress and lifestyle • Mental illness • Lack of interest at work
Social/Domestic	• Domestic issues • Lifestyle problems • Cultural beliefs • litigation
Personality Issues	• Low self-confidence / over confidence
Perceptional factors	• Inadequate focus • Inadequate decision/making • Attention deficit at duty • attitude towards work

GROUP-3:

Task Factors	Components
Guidelines, protocols	• Not updated • Non availability of protocol • Ambiguous and complex clauses in protocol Protocols not reviewed or monitored timely • lack of practice drills • lack of supervision
Decision making aids	• Aids not available/not working • Difficulty accessing expert advice • Difficulty accessing technical information, flow charts and diagrams
Task Design	• Disagreement in designing the procedural task • Poorly designed procedure • Poor staging of the task • Inadequate Audit, Quality control, Quality Assurance built into the task design

GROUP-4:

Communication	Components
Verbal communication	• Ambiguous/incompatible commands • Improper use of language/tone and style of expression • Communication to unsuitable/irrelevant person
Written communication	• Improper patient identification • Difficult to understand the patient record • Inaccessible record • Lack of risk assessment and management plans • Communications to the wrong people • Not providing information to patients • Lack of effective communication to staff of risks

GROUP-5:

Equipment	Components
Displays	• Incorrect information / feedback available • Inconsistent or unclear information • Illegible information • Interference/unclear equipment display
Integrity	• Poor working order • Unreliable • Ineffective safety features / not designed to fail safe • Poor maintenance program • Failure of general services (power supply, water, piped gases etc)
Positioning	• Correct equipment not available • Insufficient equipment / emergency backup equipment • Incorrectly placed for use • Incorrectly stored
Usability	• Unclear controls • Not intuitive in design • Confusing use of color or symbols • Lack of or poor quality user manual • Use of items which have similar names or packaging

GROUP-6:

Work Environment	Components
Administrative factors	• Ineffective systems e.g. Patient identification, ordering, requests, referrals, appointments) • Poor infrastructure (e.g. Phones, EPOS machines etc)
physical work space	• Poor or unsuitable office design (computer chairs, anti-glare screens, placing of filing cabinets, storage facilities, etc.) • Poor security provision • Lack of cleanliness • Temp**.** too high/low • Too high or low noise
Staffing	• Lack of trained staff • Low staff to patient ratio • No / inaccurate workload • Use of temporary/contractual staff
Working hours at duty	• Excessive working hours • Lack of breaks during work hours • Excessive of extraneous tasks • Lack of social relaxation, rest and recuperation

GROUP-7:

Organizational	Components
Organizational arrangements	• Hierarchical structure not conducive to discussion, problem sharing, etc. • Rigid constraints for accountability • Clinical versus the managerial model • Lack of strong service level agreement for contract employee
Priorities	• Not safety driven • External assessment driven e.g. Annual Health checks
External risks	• Unexpected adverse impact of national policy/guidelines of Dept of Health or other agencies**.** • Contractors related problem • Equipment loan related problem
Workplace safety	• Inappropriate safety / efficiency balance • Poor rule compliance • Lack of risk management plans • Lack of leadership example (e.g. visible evidence of commitment to safety) • Lack of learning from past experience.

GROUP-8:

Education and Training	Components
Competence	• Lack of knowledge/skills/Experience • Unfamiliar task • Lack of review and self-assessment.
Supervision	• Inadequate supervision and training • Improper target audience
Availability / accessibility	• Non availability of Hands on training • NA of Emergency training • NA of team training • NA of Continuing education programs • NA UPDATES,WORKSHOPS

GROUP-9:

Team Factors	Components
Managerial experience	• Improper role assignment • Lack of shared understanding • Responsibility not defined
Leadership	• Communication gap between leader and team members • Improper/untimely decision making • Lack of clinical and managerial knowledge and experience • lack of faith, respect and support to the leader
Support and cultural factors	• Lack of support networks for staff • Fear of adverse events and conflicts • Frequent change in rules and regulations • Lack of team sense/spirit/effort • Failure to report wrong doings.

N.B- INFORMATION IN THE ABOVE DOCUMENT ADAPTED AND MODIFIED FROM-NHS National Patient Safety Agency DOCUMENTS

1. Each contributory factor is assigned a score of minus one except patient factors
2. Non contributory factors and patient factors shall be assigned zero
3. Total contributory factors allotted are 125.
4. Patient factors being 15
5. Max contributory factors can be of minus 110 and minimum 0 (ideal)
6. Scoring will be displayed in percentage (%)

7. The percentage of total score is helpful in assessing the overall performance of the system over a period of time.

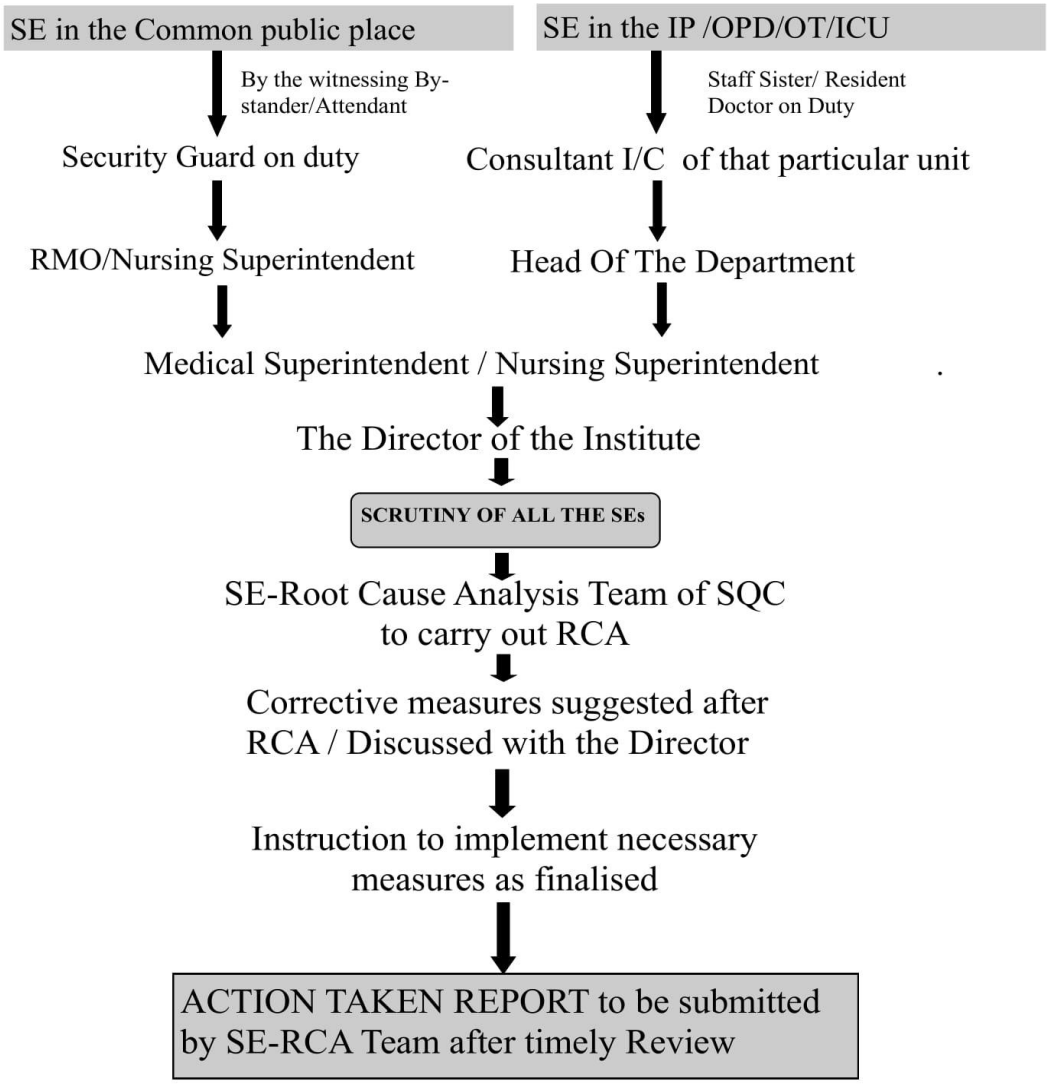
8. The percentage of individual contributory factors within a group is useful for initiating corrective action and future policy making.

D. Corrective Actions Taken by the Team

The corrective actions are initiated after the detailed analysis of the sentinel event taking in to account the individyal contributory factors that hold responsible for the occurrence of the said event.

The information regarding the corrective actions are being circulated to the concerned stakeholders as outlined by the Quality Assurance Team.

FLOW CHART FOR SENTINEL EVENT ROOT CAUSE ANALYSIS



Identified Sentinel Events by the Hospital.

- **Wrong Surgery on wrong Patient/Part.**
- **Unintended retention of foreign body**
- **Baby abducted and discharged to wrong parents.**
- **Baby charring in ICU**
- **Perinatal death of mother (pregnancy, birth,puerperium)**
- **Serious Adverse Drug Reactions.**
- Significant Medication Errors
- **Mismatched Blood Transfusion.**
- **Fall from bed or stair-case.**
- **Rape or sexual assault of a patient, attendant or staff**
- **Suicide of a patient in inpatient care**
- **Unanticipated events such as asphyxia, burns, choked on food.**
- **Occupational hazards (Needle prick injury with ELISA positivity,H1N1 infection)**
- **Significant adverse events associated with anesthesia use.**
- **Any case at the discretion of the Quality Assurance Team.**