SA Health

Guideline

How to Conduct Root Cause Analysis

Version 1.0
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Contents

List of Case Studies

1. Name of guideline

How to Conduct Root Cause Analysis.

2. Relationship to parent policy

The Clinical Incident Management Policy is the parent policy to this How to Conduct Root Cause Analysis Guideline.

3. Guideline statement

The Root Cause Analysis (RCA) Methodology is a simple way to understand and solve complex problems. This guideline provides information and resources to support staff conducting a review with the RCA methodology and aligns with the requirements of the Clinical Incident Management Policy.

4. Applicability

This guideline applies to all employees and contractors of SA Health; that is all employees and contractors of the Department for Health and Wellbeing (DHW), Local Health Networks (LHNs) including state-wide services aligned with those Networks and SA Ambulance Service (SAAS).

5. Guideline details

Staff should consider the RCA Meeting Checklist and RCA Checklist Flip Chart when conducting a review with RCA methodology.

5.1 What is a Root Cause Analysis

RCA is a method of systematic enquiry to understand and analyse a complex clinical incident. The methodology aims to:

- describe circumstances that relate to the clinical incident.
- determine the root cause of the incident.
- identify contributing factors and issues that precede the incident.
- gather information from staff, patients/family/carers.
- make recommendations to address the incident root cause, contributing factors and issues.

The benefits of RCA Methodology include:

- Comprehensive, objective analysis by experts.
- Structured process of analysis that can be replicated.
- Targeted reflection on events to identify meaningful recommendations.
- Actionable recommendations that bring about sustainable change.

5.2 When to Conduct the RCA

RCA methodology is often used when the initial review of a serious or significant incident suggests that the incident complexity requires extensive analysis. This methodology facilitates a process of objective discovery to identify a root cause of problems and appropriate solutions; elements of this methodology can be used for team-based reviews, to strengthen review integrity.

- Some incident types such as death by suicide may not have a clear cause. RCA methodologies can be used to identify system issues and failures but do not identify what could have prevented the incident. In these instances, a Restorative Just and Learning Culture (RJLC) approach can be considered rather than an RCA. Also refer to SA Chief Psychiatrist (OCP) standard Notification of Deaths of People with a Mental Health Condition into the Safety Learning System.

- RCAs can be conducted either without legal protection (unprotected RCA) or with legal protection under Part 8 of the *Health Care Act 2008* (protected Part 8 RCA). For the purposes of this guideline a Part 8 RCA investigation will be termed a protected RCA investigation.
    - Unprotected RCA reviews provide an environment for discussion and openness; full review findings are made public and are admissible in court. The learnings from unprotected RCAs can be shared across LHNs and SAAS.
    - Protected RCA investigations provide an environment for enhanced discussion; full investigation findings are not made public and are inadmissible in court.
        - Report 1 and any document or information that does not identify, either expressly or by implication, a particular person or particular persons can be shared with a court of law. *(Health Care Act 2008; Part 8 Section 73(4(a)(b)).*
        - The learnings from protected RCAs are more difficult to share across health services because of legislated protections but can be shared in a de-identified format. The de-identified format may require changes to the context of the incident to maintain the legislated protections and allow for shared learnings within or across LHNs, SAAS and state-wide services.

5.3 How to convene the RCA Team

An RCA Team (RCAT) is convened for both protected and unprotected RCAs. The following information relates to convening both protected and unprotected RCATs; those instances that relate specifically to a protected RCAs are stated.

5.3.1 Team Composition

- The RCAT requires an RCA trained team leader (TL) and suitably skilled members.
    - Members should be multi-disciplinary, clinical experts (e.g., expert in clinical, scientific or digital health aspect of the incident) and safety and quality representatives.
        - Where possible a dedicated person should be assigned for administrative tasks such as agenda preparation, minutes and general correspondence with the RCAT.
    - RCAT members cannot have a conflict of interest (e.g., be related to or have some other relationship or interest with persons or events involved in the incident) or have been directly involved in the incident or the patient's care.
    - If RCAT members are not from the same LHN, a SA Health Chief Executive authorisation is not required to share medical records with the RCAT.
    - If the incident involves a patient who is Aboriginal and/ or Torres Strait Islander an appropriate representative should be included in the RCAT.

5.3.2 Legal Protection

- Protected RCA are conducted in line with the *Health Care Act 2008: part 8, section 74 (the Act), Health Care Regulations 2008:part 2, sections 12-14 (the Regulations)* and the Clinical Incident Management Policy.

5.3.3 Protected RCA Team Appointment

- A designated authority endorses the appointment of a protected RCA investigation.
    - In SA Health a designated authority can be:
        - the LHN or SAAS Chief Executive Officer (CEO) or CEO delegate.
        - the General Manager of a hospital.
        - the Chief Psychiatrist if the incident involves a mental health consumer.
        - a quality improvement with Part 7 authority such as a Part 7 Committee.
    - The protected RCA investigation team is appointed as outlined in the Clinical Incident Management Policy.

- A detailed description of legislative requirements for protected RCAT appointment is found in the *Health Care Regulations 2008 Part 12*.

- Protected RCA investigations should use the RCA Appointment Letter Template as per *Appendix 1: RCA Investigation Team Appointment Letter Template.*
- Records of protected RCAT members and accepted appointed letters are stored in a secure location with restricted user access. These records are not for public viewing.

5.3.4 Team Preparation

- The RCAT TL should draft a RCAT Terms of Reference (TOR) to provide a structure for review meetings. The TOR should outline the obligations and role of the RCAT as detailed in *Appendix 2: Protected RCA Team Terms of Reference*.
- All RCA Meetings should have an agenda and be minuted, with an associated action plan.
- The protected RCA investigation team documentation is stored in a secure safety and quality drive with restricted user access.
- Retention and destruction of all documentation is outlined in the Clinical Incident Management Policy; General Disposal Schedule No 30.
- Unprotected RCA reviews that are subsequently used in litigation, are disposed of in accordance with the Insurance Services Records Disposal requirements. Schedules such as, disposal schedules 28, and 30 are applicable in this instance.
  - Senior managers should also consider the Health Records Disposal Freeze Requirements - Fact Sheet.

5.4 How to lead the RCA Team

The following is recommended to support comprehensive planning and timely completion of RCA reviews and investigations. Four meetings are recommended; however it is acknowledged that more than four meetings may be required. The timing of meeting tasks below is discretionary.

5.4.1 Team Culture

- The RCA review or investigation should be conducted in line with the principles of the Clinical Incident Management Policy. A Safe and Just Culture should be reflected in all team meetings with a focus on system, process and resource improvements, not individual staff actions.
- If a prescribed act is identified, refer to the Clinical Incident Management Policy and the *Act Part 8 Section 70(3)* for more detailed information.

5.4.2 Team Success

The TL is responsible for ensuring documents are prepared before the meeting, meeting conduct, and support of the RCAT throughout the RCA process. The TL should monitor the team progress using the RCA Meeting Checklist. RCAT success is measured by the following deliverables:

- A multidisciplinary review or investigation of an incident, within a safe and just environment.
- Active engagement of staff and consumers about the incident.
- A problem statement that describes the incident problem.
- Development of a causation statement (if determined).
- Identification of the contributing factors and issues.
- Recommendations and associated owners to address 3-5.
- Completion of the protected RCA investigation in accordance with the Act.

5.4.3 Meeting One - the What

Meeting one aims to establish the incident facts, identify additional information required to understand what happened, and prepare a problem statement.

Before the meeting:

- The RCAT meeting series is distributed to members.
    - Protected RCA investigations have specific timelines outlined in the Clinical Incident Management Policy; Appendix 4 of the policy.
- All reports or available documents that relate to the incident are collated and stored in a secure drive with restricted user access and provided securely to the RCAT.
- Local, state, national or international standards that relate to the incident are considered and collated.
- A timeline of events is prepared as outlined in the Timeline of Events Template.
- The DHW S&Q Team are informed that the protected RCA is commencing, and the start date is documented in the structured review tab of the Safety Learning System (SLS) incident notification.

At the meeting:

- Confirm the TOR with the membership.
- Provide a brief overview of the patient incident and impact.
- Present the timeline of events and confirm the detail with members.
- Decide on a draft problem statement.
- Establish if additional documentation or facts are required.
- Identify patient/family/carers and staff to be interviewed.
    - Patient/family/carers and staff should be approached to add their perspective to the incident facts if they are agreeable; this involves active listening and fact finding by staff.

Case Study 1: Meeting One

Understanding the problem

The RCAT considered the timeline of events and other available facts to identify the following:

Incident facts: Millie is a seven-year-old girl who while skate boarding fell and fractured her skull. She was rushed to a regional hospital where she was monitored for several hours and discharged home. Later that night Millie was rushed to hospital again with a reduced level of consciousness and intermittent seizures. Her retrieval to Adelaide was delayed. During the flight Millie lapsed into a coma and is now in the intensive care unit at the Women's and Children's Hospital.

Draft problem statement: Delayed detection and retrieval of a patient with a subdural haematoma resulted in an ICU admission and the potential for long term functional deficits.

5.4.4 Meeting Two – the Why

Meeting two aims to finalise the problem statement and identify the root cause of the problem.

Before the meeting:

- Source any policies, standards or literature relevant to the incident problem.
- Conduct patient/family/carers interviews if appropriate.
    - before the interview staff should provide consumers with the FAQ RCA Consumer Topic Guide.
    - patient/family/carers should be informed about the limited release of protected RCA investigation findings because of the Act.
- Conduct staff interviews if appropriate.
    - before the interview provide staff with the FAQ RCA Staff Topic Guide.

- Review of equipment and/ or visit to the incident location to understand the incident context.
- Collect any additional information requested by the membership.
- Update the timeline of events with meeting one information and any new information discovered.
    - a journey map can be used as a visual representation of care as in the Journey Map Templates.

At the meeting:

- Summarise the actions taken since the last meeting including interview outcomes.
- Confirm the problem statement.
- Consider the problem statement and ask the five whys of the problem statement.
    - the five whys can be used to identify the incident root cause as provided in the Five Whys Template.
- Identify the root cause of the problem and prepare a draft causation statement.
    - members should consider the five rules of causation when writing causation statements.
        - the causation statement should have three distinct parts including the cause, the event and the outcome.
- Identify actions required before the next meeting.

Case Study 2: Meeting Two

Root Cause
The RCAT considered the interview content and asked the 5 whys of the problem statement to identify the updated text below. **Updated Incident facts:** Millie is a seven-year-old girl who while skate boarding fell on a concrete path and fractured her skull. She was rushed to a regional hospital where she was monitored for several hours and discharged home. A locum general practitioner (GP) was working in the emergency department (ED) that day and was not experienced with head injuries in children. Nursing staff rostered on the same shift had limited ED experience due to ED sick leave. Millie was discharged home without a computed tomography scan and against the families wishes. Later that night Millie was rushed to hospital again with a reduced level of consciousness and intermittent seizures. Retrieval services were in high demand and the retrieval consultant could not provide immediate advice to the GP. Millie's retrieval to Adelaide was delayed because the retrieval team had limited flight hours. During the flight Millie lapsed into a coma and is now in the intensive care unit at the Women's and Children's Hospital. **Updated problem statement:** Early diagnostics, detection and retrieval of a patient with a subdural haematoma did not take place resulting in a missed diagnosis, ICU admission and the potential for long term functional deficits. **Causation statement (root cause):** A child who presented with a head injury at a regional hospital experienced a treatment delay (event) because of local procedures and a high demand for retrieval services (cause) resulting in an ICU admission and the potential for long term functional deficits (outcome).

5.4.5 Meeting Three – the How

Meeting three aims to identify contributing factors or issues that preceded the incident problem and develop recommendations to prevent the incident happening again.

Before the meeting:

- Prepare final versions of the timeline of events, problem and causation statements.
- Update the five why tool or other tools used in meeting two.
- Prepare a draft cause and effect diagram to identify contributing factors and issues, as provided in the Cause and Effect Diagram Template.
- Collate any other supporting documentation.

At the meeting:

- RCA TL presents final timeline of events, problem and causation statements.
- Introduce the cause and effect diagram to identify contributing factors and issues.
- Consider variations in care along the timeline of events to populate the cause and effect diagram template.
    - focus on systems, processes and resources using contemporary theories such as human factor science, systems thinking, and complexity theory.
- Make strong recommendations that address the root cause, contributing factors and issues, in line with Appendix 3: Hierarchy of Recommendations.
    - Recommendations are strong when they focus on system, process and resource improvements.
    - Recommendations are strong when they are specific, measurable, attainable, relevant and time limited.
        - Specific: a clear objective with defined steps to achieve its objective by a designated owner.
        - Measurable: the outcome or value of a recommendation is quantifiable through a numeric or qualitative measure. e.g., consumer, patient outcome or operational measure.
        - Attainable: can be achieved with available or additional resources.
        - Relevant: considers context and current processes in place.
        - Time limited: set time frames for completion.
- Measure any residual risk and develop controls/ treatments.
- Identify actions required before the next meeting.

Case Study 3: Meeting Three

Contributing factors and recommendations

The RCAT considered the timeline of events and the facts to populate a cause and effect diagram. The diagram facilitated the identification of contributing factors and issues as per below.

Contributing factors (issue): **communication** (support for the GP was limited due to high demand on the retrieval team consultant), **knowledge/ skills/ competence** (the locum GP was new to the regional context and had no training prior to commencement), **work environment/ scheduling** (retrieval services had limited flight hours, back fill of ED nursing staff did not include experienced ED nursing staff), and **policies/ procedures/ guidelines** (local procedures did not stipulate that a CT was required before discharge).

Contributing factors and recommendations

Recommendations:

1. **Communication**: access to a second retrieval consultant is made available for high demand times across emergency service teams.

2**. Knowledge/ skills/ competence**: Orientation of locum GPs to regional EDs is to include specialised training and mentoring prior to commencement. An annual audit of compliance is recommended.

3. **Work environment/ scheduling**: Consideration of a flexible model for flight hours is constructed and discussed with the relevant unions. The regional hospital director of nursing (DON) surveys staff about fatigue and job satisfaction. Flexible nursing workforce models for the ED are developed based on the survey feedback and best practice guidelines.

4. **Policies/ procedures/ guidelines**: A clinical pathway for head injury from regional to metropolitan hospitals is developed and implemented with associated training.

5.4.6 Meeting Four – the RCA Report

Meeting four aims to consider and finalise the draft report prepared by the writing group.

Before the meeting:

- The RCAT determines the lead writer for the RCA report.
- A draft report is prepared by the lead writer.
    - the draft should include any visual analysis tools (e.g., timelines, cause and effect diagram) developed in the RCAT meetings.
    - the timeline of events or flow diagram findings can be summarised in the Patient Journey Map Template
    - protected RCA investigations have specific report inclusions stipulated in the Act.
- The RCAT consider the draft report and provide feedback.
- The lead writer prepares a final draft based on reviewer feedback.
- The final draft is circulated to the RCAT at least two weeks prior to the meeting.
- The RCAT provide feedback about the report before meeting four.

At the meeting:

- RCAT feedback is discussed, and agreement reached on changes.
- Develop recommendations with allocated owners to provide clarity of accountability.
    - Owners of recommendations should be notified by the RCAT TL prior to the release of the report to ensure recommendation appropriateness and feasibility.
    - If a protected RCA only, the recommendations can be shared with the owner.
    - Where the owner asks to view additional protected RCA documents to understand the reasoning for the recommendations this cannot be granted due to legal protection
- Identify designated members outside of the RCAT to receive a copy of the report.
- If an unprotected RCA review, consider media and communications input to support the release of the RCA report including open disclosure with the family as a priority.
- Identify any outstanding actions.

Case Study 4: Meeting Four

The RCA report

The RCA team met and considered the draft RCA report. The draft text was updated and distributed to the membership four weeks prior to the meeting, and members were asked to provide feedback within two weeks. The RCAT writing group convened when all feedback was available and drafted the final version for the RCAT.

At meeting four the draft report was considered and discussed with final changes agreed upon. The final report was distributed to the agreed persons.

5.5 Preparing RCA Reports

The RCA report should summarise the RCAT findings.

5.5.1 Report Templates

- Staff conducting an unprotected RCA review can use their local template to prepare the report.
- Staff conducting a protected RCA Investigation should use Report 1 Template and the Report 2 Template to prepare reports.

5.5.2 Report Endorsement

- Unprotected RCA Reports are endorsed as per local clinical governance processes.
- Protected RCA Reports are endorsed by a quality improvement body, and/ or the RCAT.

5.6 Shared Learnings

Shared learnings about the de-identified incident should take place across local, extended networks and DHW.

- The unprotected RCA review report can be shared with relevant staff but sensitivities to impacted patient/family/carers and staff should be accommodated.
- The unprotected RCA review report is saved in the documents tab of the SLS.
- Protected RCA investigations have legislative restrictions about the distribution of RCA Reports 1 and 2. These restrictions are detailed in the *South Australian Health Care Act 2008*, and outlined in the Clinical Incident Management Policy:
    - Report 1 can be shared with the patient and any relevant staff.
        - Report 1 is saved in the SLS.
        - Recommendations from report 1 can be shared in bulletins or team meetings but the persons involved in the incident are de-identified.
    - Report 2 is only shared with the RCAT and the quality improvement body.
- The DHW Safety and Quality Adverse Events Team review RCA findings to share the identified themes with safety and quality teams across SA Health.

5.7 RCA Timelines

- Unprotected RCA Reviews are recorded in the structured review tab of the SLS and completed within 70 days from the incident date.
- Protected RCA Investigations are recorded in the structured review tab of the SLS and are completed within 70 days from the first RCAT meeting.

6. Supporting information

- Best Practice Guide to Clinical Incident Management – QLD Health, January 2023
- Cause and Effect Diagram QI Essentials Toolkit, Institute for Healthcare Improvement

- Checklist Flip Chart for Root Cause Analysis Teams, SA Health
- *Contributing Factors Topic Guide Sheet*
- Failure Modes and Effects Analysis, QI Essentials Toolkit, Institute for Healthcare Improvement
- *Health Care Act 2008*
- *Health Care Regulations 2008*
- Healthcare Variation Resources, Australian Commission on Safety and Quality in Healthcare
- Hibbert, PD, Thomas MJW, Deakin A, Runciman WB, and Braithwaite J, et al. (2018). Are root cause analyses recommendations effective and sustainable? An observation study. International Journal for Quality in Health Care, 30(2)
- Human Factors for Health and Social Care: A white paper, Chartered Institute of Ergonomics and Human Factors July 2018
- Patient Safety Education Program PEPS: Module 1 Systems Thinking
- Patient Safety Incident Response Framework Supporting Guidance: Guide to responding proportionately to patient safety incidents, NHS England
- RCA Meeting Check List
- Restorative Just and Learning Culture (RJLC) Fact Sheet
- Root cause analysis (RCA) and risk reduction action plans (RRAP), Victoria Health
- Root cause analysis (RCA) review planning template, Victoria Health
- SA Health Clinical Incident Management in the Safety Learning System
- Serious Adverse Event Review: Root cause analysis toolkit. Clinical Excellence Commission, NSW Government
- Serious Adverse Event Review: Root cause analysis workbook for teams, Clinical Excellence Commission, NSW Government
- Systems Analysis of Clinical Incidents: the London Protocol
- Systems Analysis of Clinical Incidents: the London Protocol Toolkit
- Using five whys to review a simple problem, NHS England

7. Definitions

- **Adverse incident:** means a category of serious patient incident used for commissioning a Root Cause Analysis under Part 8 of the Health Care Act 2008. The list of gazetted incidents can be found on page 2683 of the 11 July 2019 SA Government Gazette.
- **Causation statement:** means a concise description of how and why an incident problem eventuated and the impact on the consumer and/ or staff.
- **Clinical incident:** means an event or circumstance that occurs during SA Health Care that could have or did result in patient harm to a patient, client or consumer of SA health services.
- **Complexity theory:** means a theory that suggests errors, or incidents are more likely to occur and are more difficult to understand when complicated presentations, systems, resources or processes are present. It also suggests that interactions between any of these complexities may influence the other.
- **Consumers:** means a patient, family, carer, substitute decision maker or guardian.
- **Contributing factor:** means a circumstance, action or influence that is thought to have played a part in an incident.

- **Five rules of causation:** means 1. causal statements are clear, 2. use specific and accurate descriptions for what has occurred, rather than negative or vague words, 3. identify the preceding cause not the human error, 4. identify the preceding cause(s) of procedure violations and 5. failure to act is only causal when there is a pre-existing duty of care. RCA Check List Flip Chart
- **Five whys:** means a process of asking 'why' of an incident, to understand its root cause.
- **Harm:** means impairment of structure or function of the body and/ or psychological distress. Harm includes disease, injury, suffering, disability, and death.
  - Harmful incidents can occur because an unplanned or unintended variation in care has occurred, the patients or medical team's expectations of care were not met, or a complication of investigation, (e.g., colonoscopy) or treatment, (e.g., surgery) resulted in patient harm. (e.g., bowel perforation or pneumothorax).
  - Harm may also be self-inflicted or as a result of violence and aggression.
- **Human Factor Science:** means a theoretical model that suggests that health care design should consider the human users of the system.
- **Issues:** means problems that are related to a contributing factor.
- **Just culture:** means a concept related to systems thinking which suggests that incidents are usually a product of organisational culture rather than the individual practitioner. After an incident the question asked is 'What went wrong' rather than 'Who caused the problem?' A just culture helps create an environment where individuals feel free to report errors and help the organisation to learn. It supports a culture of fairness, openness and learning.
- **Legal protection:** means information gained during a protected RCA cannot be disclosed in a court of law unless it is information contained in RCA Report 1 or any information or document that does not identify, either expressly or by implication, a particular person or particular persons involved in the patient incident.
- **Patient:** means a person receiving services from a SA Health service or a service funded by SA Health. For the purpose of this document, patients, consumers, clients and residents are equivalent terms.
- **Prescribed act:** an act where a staff member is alleged or suspected to have committed a criminal offence or is under investigation for unprofessional conduct reportable to a regulatory agency. Refer to *the Act Part 8 Section 70(3)* for more detailed information.
- **Problem statement:** means a concise description of the incident facts.
- **Recommendations:** means actions required to minimise the likelihood of the root cause, contributing factors and issues happening again. They should be:
  - specific, measurable, achievable, realistic, and time limited.
  - system based and not focused on individual staff actions.
  - where appropriate allocated to a senior manager who is responsible for implementation.
  - include a feedback mechanism for ensuring recommendations are actioned or reason for not completed.
- **Restorative Just and Learning Culture:** means to avoid retributive, backward-looking accountability (which tends to blame individuals for things that went wrong) and instead focuses on the hurts, needs and obligations of all who are affected by the event. All stakeholders (staff, consumers, carers, the service and the community) should be engaged in collaboratively identifying responsibilities for changes and improvements. Processes in place for reviewing events need to facilitate this forwarding looking accountability to learn, improve and heal.
- **Root cause:** means the primary reason an incident problem eventuated.
- **Root cause analysis (RCA):** means a methodology of systematic reflection and analysis of a patient incident to understand an incident problem. It aims to create a chronological map of the sequence of events for an incident and ask a series of questions about those events to identify the root cause of the incident.

- **Safety culture:** means organisations with effective safety cultures share a constant commitment to safety as a top-level priority, which permeates the entire organisation. Components include:
  - acknowledgment of the high-risk, error-prone nature of an organisation's activities.
  - a blame-free environment where individuals are able to report errors or close calls without punishment.
  - an expectation of collaboration across ranks to seek solutions to vulnerabilities.
  - a willingness on the part of the organisation to direct resources to address safety concerns.
- **Safety Learning System:** means the SA Health Incident Management System for reporting patient incidents. It aims to support comprehensive clinical governance, embed a culture of patient safety and quality, provide opportunity for trending of patient incidents, and shared learning across SA Health to improve patient safety and quality.
- **State-wide services:** means State-wide Clinical Support Services, Prison Health, SA Dental Service, BreastScreen SA and any other state-wide services that fall under the governance of the Local Health Networks and DHW.
- **Systems thinking:** means a theory that the health system is a series of non-linear dynamic systems, often influencing the other in direct and/ or indirect ways.
- **Variations in care:** means a deviation from healthcare processes or outcomes, compared to an accepted standard, such as an evidence-based guideline.

8. Document ownership

Guideline owner: Domain Custodian for the Clinical Governance, Safety, and Quality Policy Domain.

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9. Document history

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1.0	15/04/2024	A/Chief Executive, DHW	Original Version

10. Appendices

1. RCA Investigation Team Appointment Letter Template

2. RCA Team Terms of Reference

3. Writing Strong Recommendations

Appendix 1: RCA Investigation Team Appointment Letter Template

Dear *insert RCA team members full name*

Re: Appointment to the Root Cause Analysis Investigation Team

As the designated authority for the purposes of Part 8 of the *Health Care Act 2008* (the *Act*), I am inviting you to join a Root Cause Analysis (RCA) Team, investigating SAHI - under Part 8 of the *Act*.

The purpose of the protected RCA investigation is to identify issues within the system that have contributed to the occurrence of an adverse incident and provide recommendations to prevent its reoccurrence.

In your role as the RCA team member, you are required to:

- conduct the RCA in accordance with the *Act* and the Clinical Incident Management Policy.
- commence the investigation within 14 days from the appointment date in this letter.
- maintain the confidentiality of all documents, conversations and findings in relating to the RCA review process as per the *Act.*
- assist in the completion of the RCA Report 1 and 2 within 70 calendar days of the first RCA meeting.
- disclose a conflict of interest, if you become aware that you (or your spouse, domestic partner or a relative) has or may have a direct or indirect personal or pecuniary interest in the adverse incident which is the subject of this protected RCA investigation.
- only provide the report to those persons that the *Act* allows.

After consideration of attachment 1, please confirm your acceptance of the position and team member accountabilities by completing below in the presence of a witness.

I, insert full name, insert position,

have read and understand my accountabilities under the *Act* and Clinical Incident Management Policy. I agree to participate as a member of the RCA team appointed to investigate incident number SAHI – (*insert number).*

_____

[Signed] [Date]

Witnessed by _____

[Name and Position] _____

Signed copies of this letter must be returned to the *insert generic mailbox* by / / .

The RCA Team appointment date will be:

/ /

has been appointed as the team leader for the RCA Team.

The other members of the RCA Team are:

Any questions regarding your appointment to the RCA Team can be directed to the team leader.

Yours sincerely

Designated Authority

Insert designated authority role

/ /

Attachment 1: The How to Conduct a Root Cause Analysis Guideline

(Must be read prior to signing this RCA Team invitation letter)

Appendix 2: RCA Team Terms of Reference

The following template provides a proforma for protected RCA team meetings. LHNs, SAAS and state-wide services can use the template as required. The template can be used for unprotected RCAs with removal of part 8 reference and requirements.

Terms of Refence Template

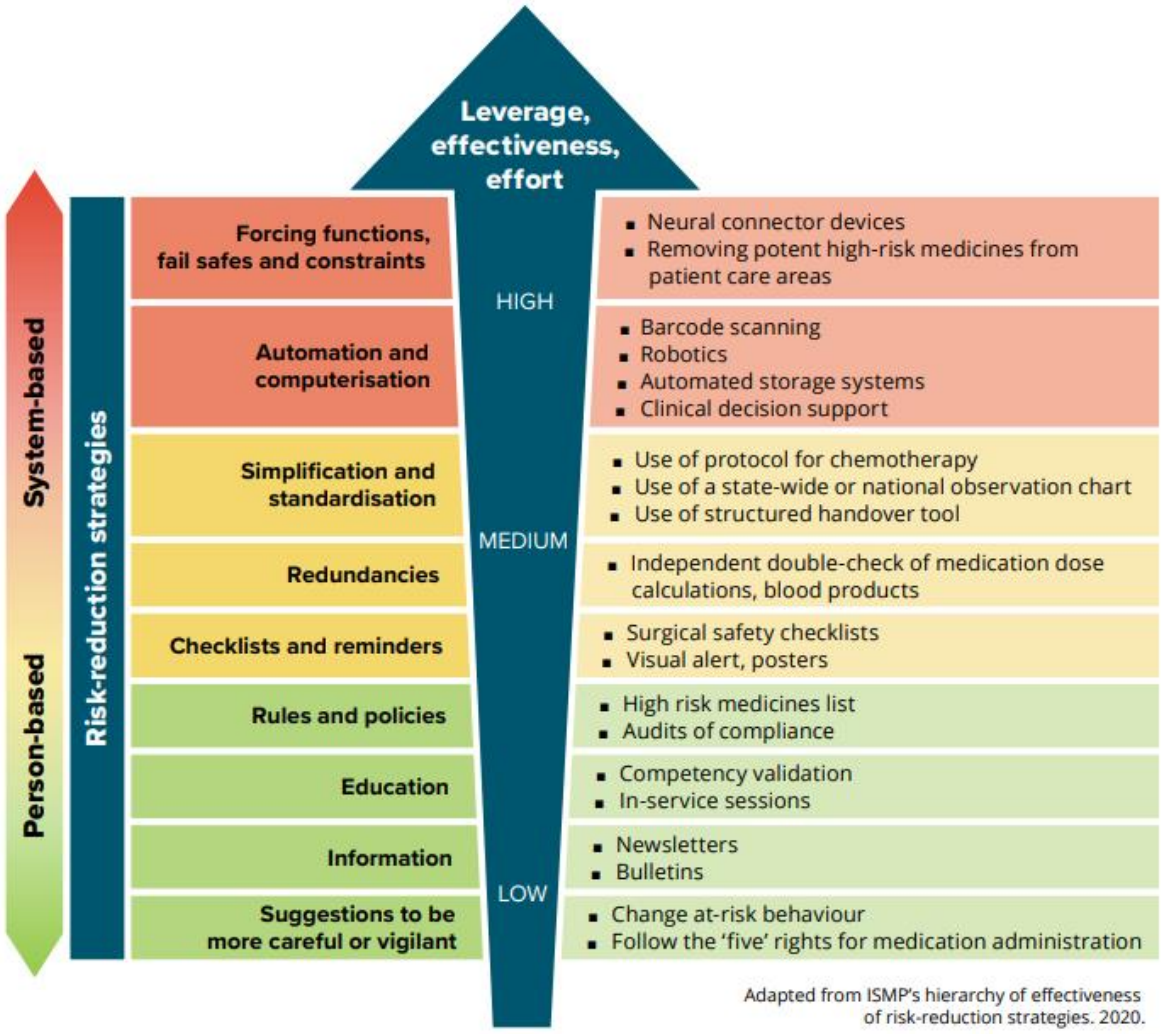
Purpose	**To reflect and learn from an adverse incident through an RCA methodology within a safe and just environment. The investigation will provide reports that describe the incident, analyse events and make recommendations to prevent the incident happening again.**
Scope	The RCA Team was appointed on the / / by insert name of designated authority. The RCA Team will investigate the events and circumstances of incident SAHI-insert number.
Responsibilities	1. The RCA Team must conduct the RCA in accordance with the *Health Care Act 2008 (the Act)* and the Clinical Incident Management Policy. 2. Commence the investigation within 14 days of appointment. 3. Store all RCA meeting documents and reports in a secure electronic location with restricted user access. 4. Maintain the confidentiality of all conversations and findings of the RCA Meetings as per the Act. 5. Complete two reports (report 1 and 2) within 70 calendar days of the first RCA meeting. 6. Disclose a conflict of interest, if a member becomes aware that they (or their spouse, domestic partner or a relative) has or may have a direct or indirect personal or pecuniary interest in the adverse incident which is the subject of this RCA. 7. Provide two reports following the investigation, report 1 and 2. 8. Provide copies of report 1 and 2 to required persons and the DHW Adverse Events Team.
Ways of working	Decisions will be made by consensus. If a consensus is not reached the Chair will negotiate with team members until an agreement is reached. Team members' behaviour is to be based on the principles of the South Australian Public Sector Code of Conduct and the relevant SA Health policies which include the following: • Respectful Behaviours • Organisational Development • Communication • Employee Relations • Supportive Working Environments • Work Health Safety Legislation

Chair/ Team Leader	• insert chair name and professional role
Membership	• list members and professional roles
Meeting Procedures	**Quorum** A quorum is required for meetings to proceed or decisions to be progressed. **Frequency of meetings** Only four meetings will be conducted and are proposed as: • / / • / / • / / • / / **Meeting papers** Prepared and distributed at least one week prior to the scheduled meeting. **Meeting record** The meetings will be minuted and distributed with the papers prior to each meeting.
Success Indicators	1. A multidisciplinary investigation of an incident, within a safe and just culture. 2. Active engagement of staff and consumers about the incident. 3. A problem statement that describes the incident problem. 4. Development of a causation statement (if determined). 5. Identification of the root cause, contributing factors and issues. 6. Recommendations and owners to address 3-5. 7. Completion of the RCA investigation in accordance with the Act.

Appendix 3: Hierarchy of Recommendations

Strategies that are system-based such as forcing functions have high leverage and are more effective in preventing errors. However, these strategies may require more planning and effort to implement. Medium leverage strategies are moderately effective but may require periodic updating and reinforcement. Strategies that are person-based are easier to implement but have low leverage and are least effective in preventing errors.

Incident Management Guide 2021, Australian Commission on Safety and Quality in Healthcare



Infographic sourced from the Incident Management Guide 2021, Australian Commission on Safety and Quality in Healthcare