

Root Cause Analysis Rubric (January 2023)

Purpose: The purpose of this document is to assist the Licensing Specialist with assessing each component of a provider’s Root Cause Analysis to determine compliance with regulations 160.E.1.a, 160.E.1.b and 160.E.1.c.

Definition:

- **Root Cause Analysis (RCA)** - A method of problem solving designated to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.

Please note: The logic for what is considered “higher-level” and “lower-level” regulations reflects how the Office of Licensing issues citations and is reflected in the business rules designed within CONNECT. A “lower-level” regulation includes the specific regulatory requirement which must be met by the provider; therefore, the “higher-level” regulations are not citable. The below specified regulations are subsequently identified as “higher-level” and are not editable on the screen licensing specialist utilizes to enter citations (*Inspection Data Entry Screen*).

- The following regulations are **NOT citable** in CONNECT:
 - 160.E; and
 - 160.E.1

Regulation:

- **160.E:** A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider’s premises. An RCA does not focus on the people involved. The goals of an RCA to find out what happened, why it happened, and determine if action needs to be taken. A RCA should include, at a minimum, documentation that the three elements below were considered to the extent that they are known or could be known by the provider.
- **160.E.1:** The root cause analysis shall include at least the following information:

Regulation	What the regulation specifies:	What questions to ask yourself to determine compliance:	The provider would be given a rating of Non-Compliance:
160.E.1.a, 160.E.1.b and 160.E.1.c.	A root cause analysis shall be conducted by the provider within 30 days of discovery of Level II serious incidents and any Level III serious incidents that occur during the provision of a service or on the provider’s premises.	<ul style="list-style-type: none"> • Were RCAs completed for Level II serious incidents and any Level III serious incidents that occurred during the provision of a service or on the provider’s premises? • Does the RCA include the date of the incident and the date the RCA was completed? • Was the RCA completed within 30-days from date of discovery of the incident? 	<ul style="list-style-type: none"> • If the RCA was not completed within <u>30 days</u> from the date of discovery, the RCA does not include the date the RCA was completed, or if there was a Level II or III serious incident and an RCA was not completed then the provider would be non-compliant with 160.E.1.a, 160.E.1.b and 160.E.1.c. • If the RCA is determined to be non-compliant for any of the above reasons, then each component of the regulation must be cited, and

			the RCA does not need to be reviewed further by the specialist.
160.E.1.a	A detailed description of what happened;	<ul style="list-style-type: none"> Does it include the step-by-step sequence of events leading up to the incident? Does it include the actions the provider took immediately following the incident? 	<ul style="list-style-type: none"> If the RCA does not include the sequence of events leading up to the incident and the actions taken by the provider immediately following the incident.
160.E.1.b	An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and	<ul style="list-style-type: none"> Did the provider compare what happened to what should have happened before, during and after the incident? Did the provider compare the actions taken before, during, and after the incident to the requirements in their policies and procedures, DBHDS licensing and other applicable regulations, accreditation standards, and applicable laws? Did the provider identify the underlying causes of the incident that were under the control of the provider? 	<ul style="list-style-type: none"> If the RCA does not compare what happened to what should have happened before, during, and after the incident. If the RCA does not compare the actions taken before, during, and after the incident to the requirements in the provider's policies and procedures, DBHDS licensing and other applicable regulations, accreditation standards, and applicable laws. If the RCA does not clearly identify the underlying causes of the incident that were under the control of the provider.
160.E.1.c	Identified solutions to mitigate its reoccurrence and future harm when applicable.	<ul style="list-style-type: none"> Does the RCA identify solutions, as applicable, to be taken by the provider to keep the situation from happening again? What should the provider do to prevent this type of incident in the future? Do the solutions focus on systems rather than only the individual factors? 	<ul style="list-style-type: none"> If the RCA does not identify solutions, as applicable, to be taken by the provider to keep the situation from occurring again or minimize the likelihood of its reoccurrence and future risk of harm. If the provider's solutions are not individual and systemic as indicated by the analysis of the incident.