Causal Analysis and Corrective Action Plan (CAP)

Submit no later than (60) sixty calendar days from initial report of event

Please complete all sections of this form and submit to the Patient Safety Surveillance & Improvement System (PSSIS) administered by Vermont Program for Quality in Health Care, Inc. via secure email at sre@vpqhc.org.

For questions regarding the Patient Safety Surveillance & Improvement System (PSSIS) contact**:** Vermont Program for Quality in Health Care, Inc. (VPQHC)
132 Main Street Montpelier, VT 05602
Phone: 802-229-2449
Email: sre@vpqhc.org

Please specify the documentation included in the submission:

- ☐ Event Timeline
- ☐ Summary of Analysis
- ☐ Bibliography (if indicated)
- ☐ Corrective Action Plan

Guidelines: Corrective Action Plan (CAP) should include:

1. *Specific actions to correct the identified causes of the event to minimize (to the extent possible) the risk of a similar event from occurring in the future*
2. *Identified and measurable outcome(s);*
3. *A person(s) responsible for implementation and evaluation;*
4. *A specific implementation plan with the following:*
   - *Anticipated completion dates;*
   - *A description of how the hospital's performance will be assessed and evaluated following full implementation.*

Facility Identification

Facility Name:

2. Contact Information

Title of person submitting report:

Telephone number:

3. Event identification number: *(Previously provided to you by the PSSIS Program*

4. Patient Information

Patient Sex at Birth ◯ Male ◯ Female

Race & Ethnicity: *Please choose all that apply*

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latino/a/x
- ☐ Multi Racial/Multi Ethnicity
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Unknown

Preferred Language:

- ◯ English
- ◯ Other:

5. Causal Analysis Team: Please list team members by title and department (no names) If you prefer you may attach a document containing this information.

6. Event occurred during a patient encounter? A patient encounter is defined as an interaction between an individual and a healthcare setting, for the purposes of providing healthcare services or assessing the health status of an individual.

- ◯ Yes
- ◯ No

7. Does the event involve healthcare worker harm? (see SRE 5, 11, and 16 for details)

- ◯ Yes
- ◯ No

8. Is the event serious? Resulting in death or contributing to patient harm that includes physical, emotional, or psychological harm(s) that require major intervention (i.e. surgery, higher level of care, or treatment post discharge, or impairs a patient's ability to perform ADLs.) *(check all that apply)*

- ☐ Physical harm
- ☐ Emotional or psychological harm
- ☐ Major intervention or higher level of care required
- ☐ Impairs patient's ability to preform ADL's

9. Is the event largely preventable? Avoidable by means currently available within the generally accepted performance standards of care.

- ◯ Yes
- ◯ No

10. Final understanding of severity of patient harm at the time of this report
(check all that apply)

- ☐ Near Miss
- ☐ No Harm
- ☐ Minimal Harm
- ☐ Moderate Harm
- ☐ Impairs the Patients Ability to Perform ADL's
- ☐ Emotional or Psychological Harm (EHI)
- ☐ Permanent Harm
- ☐ Major Intervention
- ☐ Severe Harm
- ☐ Death

11. Final understanding of factors identified that contributed to event occurrence óÖKŜŎ] l·ff űKl·ű l·LJLJfèú

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☐ **Training/education and transfer of knowledge:** Insufficiencies in training and/or inconsistent or inadequate education for those involved in providing care.

☐ **Environment/equipment:** Complications or failures in appropriate use of equipment. Environment refers to conditions in the environment that present a risk or unsafe situation.

☐ **Patient characteristics, medical history, and other patient related issues:** Includes patient physical assessment, co-morbid medical and mental health conditions, emotional status and/or the patient's understanding and engagement in the plan of care.

☐ **Rules/Policies/Procedures:** Failures in processes that can be traced to non-existent or inadequate protocols and procedures. Failure to follow established protocols or procedures.

☐ **Leadership:** Refers to the safety culture, principles and behaviors of the organization.

☐ **Staffing patterns and workflow:** Inadequate staffing leading to situations where there is greater risk for patient safety events.

☐ **Bias or inequities:** May include but not limited to stereotyping, social, cognitive or cultural bias or other influence of providers' decision making or staff/patient interactions.

☐ **Additional Information:** Please explain

12. Was the patient and/or family notified of the event?

○ Yes, and disclosure verified through documentation

○ No, if disclosure not done please explain why