# County of San Bernardino
# Department of Behavioral Health

## Root Cause Analysis Policy

**Effective Date** 03/23/09
**Approval Date** 03/23/09

Allan Rawland, Director

**Policy**

It is the policy of the Department of Behavioral Health (DBH) to establish a root cause analysis protocol, which consists of an analysis committee responsible for evaluating critical incidents for quality of care purposes, to ensure services are provided in accordance with requirements established by the State under Welfare and Institutions Code (WIC) Section 4070 and 5614.

**Purpose**

To evaluate the root cause of critical incidents within the Department for improved quality of care.

**Critical Incident**

A critical incident is any significant occurrence that a potential lawsuit may allege was caused by an action or omission of a Department employee, or resulted from a Department policy or procedure.

Circumstances that *may* be considered critical incidents include, but are not limited to:

- Death (of an unnatural cause)
- Serious physical injury and/or abuse
- Other possible quality of care issues

***Note:*** Incidents may be identified through multiple quality of care protocols. (See Related Policies.)

**Psychological Autopsy**

A psychological autopsy is a mental state examination of a deceased person. In this context a psychological autopsy is employed as a data collection tool to identify the mental state of a client prior to the person's death. Data obtained and analyzed during a psychological autopsy may include medical records and any other history obtained prior to death.

**Root Cause Analysis Initiation**

A root cause analysis may be initiated when a referral is made by the Director or Chief Deputy Director to the Medical Director. The implementation of a root cause analysis, and the type(s) of analyses required, will be the discretion of the Medical Director.

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# Root Cause Analysis Policy, Continued

**Root Cause Analysis Committee**

The Root Cause Analysis Committee is composed of the Medical Director, Compliance Officer, the Deputy Director from the related program, subject matter experts (such as a Psychiatrist(s) and other clinical staff), and Quality Management. The Committee will be assembled on a case-by-case basis. A thorough analysis and investigation may require the Committee to meet on multiple occasions depending on the severity of the incident and involvement required. It is important that all departmental resources be brought together during the process of conducting the root cause analysis to obtain all available information, knowledge and expertise.

During meetings and on-going collaboration, the Root Cause Analysis Committee will:

- Identify and investigate any actions that violated or may have violated State quality assurance requirements
- Conduct an *informed* and objective case review
- Objectively research and analyze critical incidents and significant trends
- Analyze Department policies, procedures and general practices
- Verify and assess compliance with established policies
- Incorporate the guidance of County Counsel and other subject matter experts
- Identify Departmental practices that may be vulnerable to critical incidents
- Identify trends and evaluate specific programs or practices that are consistently areas of deficiency

After the analysis has concluded, the Committee will:

- Recommend policies and procedures designed to prevent similar incidents
- Recommend operational and organizational changes to ensure best practices and eliminate exposure to liability issues
- Submit a comprehensive critical incident report to the Director

**Compliance Officer Responsibility**

It is the responsibility of the Compliance Officer to:

- Ensure coordination of intradepartmental resources when conducting a root cause analysis containing compliance related matters
- Analyze critical incident information and seek legal advise from County Counsel

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# Root Cause Analysis Policy, Continued

**Compliance Officer Responsibility** (continued)

- Communicate with County Counsel and disseminate information to Root Cause Analysis Team
- Influence areas of risk management and policy to ensure best practices and quality of care

**Trend Analysis**

A trend analysis refers to the concept of collecting information and attempting to identify a pattern or trend. Trend analysis will be a significant part of the root cause analysis; it particularly includes identifying trends of specific incident types, and/or reoccurring circumstances that may have contributed to the incident being evaluated. Such reoccurring circumstances, or states of nature, are considered adverse to the Department.

A trend analysis will assist in strategically formulating the plan of action to correct problem areas. Identifying trends and analyzing causal factors empower the Root Cause Analysis Committee to make recommendations and improve the decision making process.

**Priority Level**

Critical incidents for review will be analyzed by priority. Priority levels are listed as follows:

| Level | Description/Example |
|---|---|
| 1 | • Death<br>• Physical harm<br>• A grievance or lawsuit has been filed<br>• Designation by the Medical Director, Chief Deputy Director or Director<br>• Civil rights complaint filed in court<br>• Violent or high profile case in court<br>• Department error(s) and/or omissions identified |
| 2 | • Claim status only<br>• An identifiable or permanent injury without evidence of Department involvement<br>• Preliminary review (by the Office of Compliance) establishes low exposure to departmental error or omission |

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# Root Cause Analysis Policy, Continued

**Root Cause Analysis Process**

The following illustrates the root cause analysis process:

| Stage | Description |
|---|---|
| 1 | Preliminary review of Unusual Occurrence/Incident Report or other reporting mechanism |
| 2 | Advisement to Department Director and County Counsel of investigation/analysis |
| 3 | Planning and coordination of the analysis and investigation, including determination of participants for the Root Cause Analysis Committee |
| 4 | Committee meetings and collaboration, which may include:<br>• Research of applicable practices, policies, regulations and laws<br>• Consultation with County Counsel regarding liability concerns, legal guidelines and case precedence<br>• Utilization of various resources, including, but not limited to:<br>-Fraud investigators<br>-Human Resource Officer<br>-Risk Management<br>-Civil Rights Investigators<br>-Department Supervisors, Managers and direct service providers<br>-Outside experts (without divulging any information that may jeopardize the integrity of the Department)<br>• Organizing and implementing a psychological autopsy |
| 5 | Follow-up Team meeting and collaboration, which may include:<br>• Analysis and discussion of information gathered<br>• Identifying and analyzing trends in researched data<br>• Outlining recommendations to prevent future critical incident occurrences and improve program effectiveness (i.e. policies, procedures, and operational and/or organizational changes) |
| 6 | Prepare a comprehensive critical incident report and present to the Department Director<br><br>***Note:*** The comprehensive critical incident report that is presented to the Director is generally submitted forty-five (45) days from the time the initial incident report was received by the Office of Compliance. However, completion time may vary depending on the complexity of the analysis and investigation. |

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# Root Cause Analysis Policy, Continued

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| **Related Policies** | • Investigating and Reporting Death of Consumer<br>• Quality of Care Referral Policy<br>• Special Incident Reporting Procedure – Client Related |
| **References** | Welfare and Institutions Code, Sections 4070, 5614 and 5328 |