

HICPAC Sample Root Cause Analysis Template: Reprocessing Flexible Endoscopes

Purpose: Facilities can use this sample Root Cause Analysis as a template to develop their own tool to pinpoint and understand process breakdowns that resulted in a flexible endoscope reprocessing event with undesired outcomes. A thorough Root Cause Analysis of these events is an important part of improving practices and ensuring patient safety. Facilities are encouraged to modify the “Possible Cause” and “Sample Questions” columns to fit the reprocessing event in need of analysis. Refer to “Essential Elements of a Reprocessing Program for Flexible Endoscopes – Recommendations of the Healthcare Infection Control Practices Advisory Committee” for additional detail on reprocessing practices.

Attending: _____

Date: _____

1. Identify the event:
2. What are the details of the event?
3. What areas of service were impacted by the event?
4. Why did the event occur? (There may be more than one cause.)

Possible Proximate Cause (<i>may vary by event</i>)	Evaluation Questions (<i>adjust as necessary</i>)	Findings	Risk Reduction Strategies	Measurement Strategies
Human Error	What was the error?			
Process Deficiency	What was the missing or deficient step?			
Equipment Breakdown or Malfunction	What broke?			
Controllable Environmental Factors	What factors directly affected the outcome?			
Uncontrollable External Factors	Are they truly beyond the organization's control?			
Other	Did any other factors directly influence this outcome?			

5. Why did the proximate cause occur? What processes were involved? (There may be more than one contributing issue.)

Possible Root Cause (may vary by event)	Evaluation Questions (adjust as necessary)	Findings	Risk Reduction Strategies	Measurement Strategies
Patient Care Process Issues	- What are the steps in the process? - Which of these steps were involved in (contributed to) the event? - What processes are currently in place to prevent failure at this step? - What processes are currently in place to protect against a bad outcome if there is failure at this step? - What other areas or services are impacted by a failure or bad outcome?			
Human Resources Issues	- Are staff properly qualified and competent for their responsibilities? - Is staffing adequate? - Does planning account for contingencies that could lead to reductions in effective staffing levels? - Is staff performance in the operant process(es) addressed? - Can orientation and in-service training be improved?			
Information Management Issues	- Is all necessary information available when needed? - Is the information accurate? Complete? Unambiguous?			

Possible Root Cause (may vary by event)	Evaluation Questions (adjust as necessary)	Findings	Risk Reduction Strategies	Measurement Strategies
Environment Management Issues	• Was the physical environment appropriate for the processes being carried out? • Are systems in place to identify environmental risks? • Are emergency and failure mode responses adequately planned and tested?			
Leadership Issues: Corporate Culture	• Is the organizational culture conducive to risk identification and reduction? • Are there adequate resources?			
Communication Issues	• Are there barriers to communication of potential risk factors? • Is communication among participants adequate? • Is the prevention of adverse outcomes adequately communicated as a high priority?			
Uncontrollable Factors	• How can the organization identify these factors? • How can the organization protect against these factors? • Are they really uncontrollable?			

Available from: <https://www.cdc.gov/hicpac/recommendations/flexible-endoscope-reprocessing.html>