

Root-Cause Analysis and Safety Improvement Plan

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Department: NURS4035: Improving Quality of Care and Patient Safety

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This template is provided as a guide to organizing the steps in a root-cause analysis. Not all possibilities and questions will apply in every case, and there may be others that will emerge in the course of the study. However, all possibilities and questions should be fully considered in your quest for the “root cause” and risk reduction.

A sentinel event is a patient safety event that occurs unexpectedly and is not primarily related to the natural course of the patient’s illness or underlying condition.

These events are debilitating not only for patients but also for the health care providers involved. The goal is to learn from these incidents, improve systems, and prevent further harm to patients.

Remember, a thorough root-cause analysis aims to uncover both immediate causes and underlying systemic issues to prevent similar events in the future.