SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY

NUMBER: BA115

NAME: ROOT CAUSE ANALYSIS

INITIAL APPROVAL DATE:	11/12/2015	BY: Administrative Committee
(LAST) REVISION DATE:	03/13/2024	BY: CIO
(LAST) REVIEW DATE:	02/20/2025	BY: Policy Committee
DISCONTINUED DATE:	NA	REPLACED BY: NA

I. PURPOSE

To establish guidelines and criteria for conducting a root cause analysis.

II. APPLICATION

Populations: **ALL**
Programs: **Direct - ALL**
Contracted - ALL

III. POLICY

It is the policy of Sanilac CMH to conduct a root cause analysis in the event of recidivism; a Recipient Rights reportable event; or by special administrative request made by the Chief Operating Officer (COO), Chief Executive Officer (CEO), or Medical Director.

IV. DEFINITIONS

Recidivism: Readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge.

Critical Incident: Pursuant to policy RR012, a critical incident has been determined to have occurred with individuals receiving services in the following situations:

- Death (Suicide or Natural Cause)
- Injuries requiring emergency room visits and/or admissions to hospitals
- Medication Errors requiring emergency room visits and/or admissions to hospitals
- Arrest.

Risk Event: Pursuant to policy RR012, a "risk thereof" event has occurred for which the reoccurrence would carry a significant chance of a serious adverse outcome and requires a review of the process.

Root Cause Analysis: The review of an event to help identify not only *what* and *how* an event occurred, but also *why* it happened to be able to specify workable corrective measures that prevent future events of the type observed.

Appropriate Staff Person: A CMH staff person; primary caseholder or other appropriate staff person with extensive knowledge of the situation.

Psychiatric Consult Group: Medical Director, Chief Operating Officer, and all appropriate Clinical Supervisors along with the primary caseholder/appropriate staff person.

V. STANDARDS

This administrative process will be facilitated by the CIO or designee. In situations when a recidivism event has occurred, the Hospital Program Coordinator will initiate the review by notifying the CIO of any outliers. The CIO or designee will initiate the review pursuant to policy RR012 as well as at the direction of the Chief Operating Officer, Chief Executive Officer, or Medical Director in special circumstances.

This process shall be completed electronically. This process shall be administrative in nature and all documentation generated from the analysis of the incident shall be maintained by the CIO and not be placed in any EHR.

The data collected from these incidents may also be used for determining trends or issues that need to be addressed by Administration and/or Quality Improvement.

The CEO will determine if any further follow up is necessary.

VI. PROCEDURE

Responsible Staff	Actions
1. Hospital Program Coordinator/Medical Director/CEO/or COO	• The Hospital Program Coordinator, in the case of a recidivism event, will notify the CIO of an outlier. • The Medical Director, in the case of a critical incident, will notify the CIO. The CEO, COO, or Medical Director, in the event of an Administrative Request, will notify the CIO.
2. Data Management	When the CIO receives notice the root cause analysis process will be initiated by completing part 1 of the Analysis. Specific staff to be involved in the review will be identified during part 1 of the Analysis. At the signing of part 1 an email will be sent to the primary caseholder/appropriate party.
3. Primary Caseholder/Appropriate Party	The primary caseholder, or appropriate party, will electronically complete and sign Part 2 of the analysis within 4 days of notice. An email will then be sent to the Clinical Supervisor (by population), the Chief Operating Officer and the Medical Director. Once Part 2 of the analysis has been signed it cannot be changed.

Responsible Staff	Actions
4. Clinical Supervisor, Chief Operating Officer and Medical Director	The Clinical Supervisor (by population), the Chief Operating Officer and the Medical Director will contribute to Part 3 of the analysis within 2 days of notice. Once the Clinical Supervisor, Chief Operating Officer and Medical Director have signed Part 3 it cannot be changed. An email will be sent to the CEO.
5. CEO	The CEO will be able to review the entire document and add any comments. Once the CEO signs the document it cannot be changed. An email will be sent to the CIO that the process is complete.
6. Data Management Department	The department will review the completed process and note any trends or issues that need to be reviewed by Administration and forward that information on.
7. Administrative Committee	The Committee shall review all critical incidents to ensure compliance in the review process and assess any system improvement opportunities. If a Root Cause Analysis is being completed pursuant to a Plan of Correction, a synopsis of the specific review shall be submitted to the Region 10 PIHP.
8. Region 10	A report shall be communicated to the PIHP Chief Clinical Officer at a minimum of every 30 days that provides the status including any updates or necessary plans of correction and final disposition of any root cause analyses when the review is for a R10 corrective action plan.

VII. ATTACHMENTS

None

VIII. REFERENCES

Critical Incidents, Sentinel Events and Risk Events, Policy RR012
Michigan's Mission Based Performance Indicators, Indicator #10