Department of Defense
Patient Safety Analysis Center

DoD Patient Suicide
RCA Process

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DoD Patient Safety Analysis Center
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- Root Cause Analysis depository
- Data analysis of adverse events
- Generation of reports, reviews, alerts and advisories
Basic Patient Safety Manager Training

- Overview of the Patient Safety Program
- Root Cause Analysis
  - TapRooT®
- Failure Mode and Effects Analysis
Root Cause Analysis (RCA)

- In depth retrospective analysis
- Decision based on severity of event or potential thereof (The Joint Commission, DoD and Service Regulations and Policy)
- Formally chartered by organization leadership
- Multidisciplinary team
- Typically 50-100 hours of staff time
- Selectively submitted to Joint Commission (accredited facilities for reviewable sentinel events) and higher headquarters
• Root Cause Analysis mandated by The Joint Commission since 1997 for all accredited facilities for:

Sentinel Events
An unexpected occurrence or variation involving death or serious physical or psychological injury, or risk thereof.

DOD Instruction 6025.13
5.2.1: All sentinel events defined by JCAHO [The Joint Commission], as reportable to JCAHO, shall be reported. The completed RCA and action plan, consistent with JCAHO policy and time limits, shall be made available to JCAHO.
Reviewable Sentinel Event for Suicide*

“Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge.”

(TJC 2009)

* Excludes most suicides occurring in the ambulatory environment.
The Joint Commission Minimum Scope of Root Cause Analysis

- Behavioral Assessment Process
- Physical Assessment Process
- Patient Observation Procedures
- Care Planning Process
- Continuum of Care
- Staffing Levels
- Orientation & Training of Staff
- Competency Assessment/Credentialing
- Supervision of Staff
- Communication with Patient/Family
- Communication Among Staff Members
- Availability of Information
- Physical Environment
- Security Systems and Processes
Where the RCA Process Begins

Event at MTF
Suicide/Attempt

Event Notification
Service Headquarters
TMA
DoD PSC

RCAT Chartered

RCA Distribution
The Joint Commission
Service Headquarters
DoD PSAC
Credible Root Cause Analysis

• Summary of the event
• Causal Factors
• Actions
• Measures
• Flow Chart – “SnapChart”
Causal Factors

• TapRooT®
• TJC Framework

• Leading Causal Factors/Contributing Factors:
  • Ineffective Communications
  • Policy Lacking
  • No Root Cause Identifiable
Using the Data

- Annual and Mid-Year Summaries
- Patient Safety Program Newsletter
- Focused Reviews
- Joint DoD/VA Collaboration