Department of Health
Patient Safety Surveillance and Improvement System

Causal Analysis and Corrective Action Plan Report

Submit no later than (60) sixty calendar days from initial report of event

Please complete all sections of this form by printing or typing the required information. The form and accompanying documentation may be submitted to the Patient Safety Surveillance & Improvement System via secure fax or mail. See last page of form for contact information. If you have questions about the form, please call 802- 951-1216

1. Facility identification:

Facility name: ____

Facility address: ____
(Street) (City) (State) (Zip)

2. Contact information:

Name and title of person submitting report: _____________________________________

Telephone Number: _______________ Email address: _______________________________

3. Event identification number: _____________ *(previously provided to you by the Patient Safety System)*

4. Causal Analysis Team *(Please list team members by title and department. If you prefer, you may attach a document containing this information.)*

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5. Final Understanding of Severity of event: *(Check only one)*

☐ Category C – Event/error reached the patient but caused no harm.
☐ Category D – Event/error increased the need for monitoring/intervention but caused no harm.
☐ Category E – Event/error increased the need for treatment/intervention and caused temporary harm.
☐ Category F – Event/error that contributed to or resulted in temporary harm and required initial or prolonged hospitalization.

(More options on next page)

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☐ Category G – Event/error that contributed to or resulted in permanent harm and required initial or prolonged hospitalization.
☐ Category H – Event/error that required intervention necessary to sustain life.
☐ Category I – Event/error that contributed to or resulted in death (unexpected death).

6. Final understanding of why this event occurred: *(Check all that apply)*

☐ **Communication** – Communication; flow of information; availability of information.

☐ **Training** - Routine job training; special training; continuing education; timing of training.

☐ **Fatigue/Scheduling** - Influence of stress and fatigue that may result from change, scheduling and staffing issues, sleep deprivation, or environmental distractions such as noise.

☐ **Environment/Equipment** - Use and location of equipment; fire protection and disaster drills; codes, specifications and regulations; the general suitability of the environment.

☐ **Rules/Policies/Procedures**: Existence and ready accessibility of directives including technical information for assessing risk, mechanisms for feedback on key processes, effective interventions developed after previous events, compliance with national policies, the usefulness of and incentives for compliance with codes, standards, and regulations.

☐ **Barriers** - Barriers protect people and property from adverse events. Example: A negative pressure room for an infectious patient is a barrier to the spread of the disease. If the ventilation in the room stops working, a critical barrier has been compromised.

7. Date of patient discharge: ____________________

8. ICD-9-CM diagnoses codes: *(Please list up to 20 diagnosis codes. If you prefer, you may attach a document containing this information.)*

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9. ICD-9-CM procedure codes: *(Please list up to 20 procedure codes. If you prefer, you may attach a document containing this information.)*

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10. Please attach the following documentation:

- ☐ Causal Analysis team - *if not included on page 1*
- ☐ ICD-9-CM diagnoses codes - *if not included on page 2*
- ☐ ICD-9-CM procedure codes - *if not included on page 3*
- ☐ Causal Analysis Summary
- ☐ Event Timeline
- ☐ Cause and Effect diagram (fishbone/Ishikawa) - *if completed for this Causal Analysis*
- ☐ Bibliography - *if completed for this Causal Analysis*
- ☐ Corrective Action Plan - *see specifications on page 4*

(See next page for submission instructions.)

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A Corrective Action Plan will include:

1. *Specific actions to correct the identified causes of the event to prevent a similar event occurring in the future;*

2. *Identified and measurable outcome(s);*

3. *A designated person(s) responsible for implementation and evaluation; and*

4. *A specific implementation plan with the following:*
   A. Completion dates;
   B. Provisions for education of and communication with appropriate hospital staff; and
   C. A description of how the hospital's performance will be assessed and evaluated following full implementation.

You may fax or mail the completed information to the Patient Safety System.

Fax form to :
Vermont Department of Health
802-651-1787
Attention: Patient Safety

Mail form to:
Vermont Department of Health
Attention: Patient Safety
108 Cherry Street, P.O. Box 70
Burlington, VT 05402-0070

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