Leamington Mennonite Home
Long Term Care

QUALITY & RISK MANAGEMENT POLICY AND PROCEDURE

CATEGORY:	SUBJECT:	SECTION:
Incident Reporting	**Root Cause Analysis**	**D**
		POLICY:
		8
DATE:	**Administrator's Signature:** _____	
July 12, 2022		

ROOT CAUSE ANALYSIS

POLICY:

Root Cause Analysis can be used to systematically analyze critical incidents with the goal of generating system improvements.

An interprofessional, comprehensive, system-based review may be conducted on critical incidents, sentinel events, and serious adverse events to determine root and contributory factors, risk reduction strategies, and development of action plans along with measurement strategies to evaluate the effectiveness of the plans. Blame will not be assigned in the process.

A Root Cause Analysis may be applied to incidents of a less serious nature that potentially require system improvements.

The following four types of incidents are excluded from the Root Cause Analysis method and will be dealt with through the performance management and disciplinary process:

1) Events thought to be the result of a criminal act.
2) Purposefully unsafe acts (an act where care providers intend to cause harm by their actions).
3) Acts related to substance abuse by provider/staff.
4) Events involving suspected resident abuse of any kind.

These four types of incidents will be dealt with through the performance management system as insights gained from them will relate to human resource processes and security systems.

PROCEDURE:

The QRM Lead, together with Home Leadership Team, will:

1) Lead the Root Cause Analysis process using the Canadian Root Cause Analysis Framework: A Tool for Identifying & Addressing the Root Cares of Critical Incidents.
2) Document the Root Cause Analysis using the Canadian Root Cause Analysis tools.
3) Report the results of the Root Cause Analysis to the Regional Vice President, LTC Operations.