MedOnc Safety Program
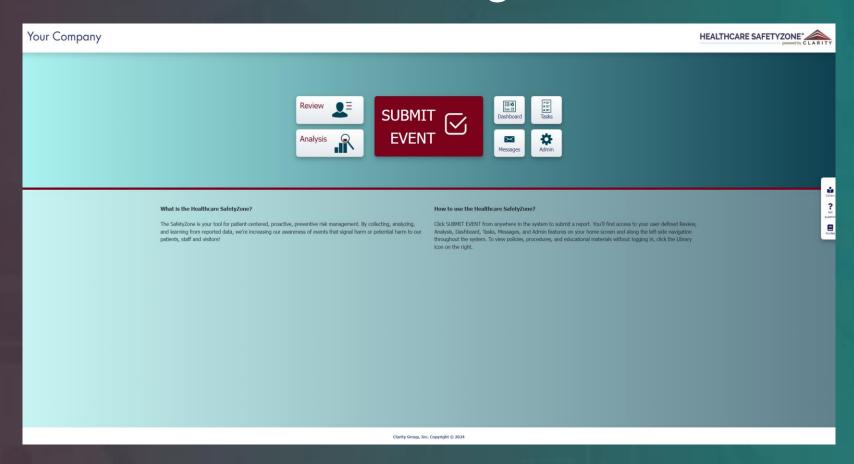# SYSTEM VIEWS
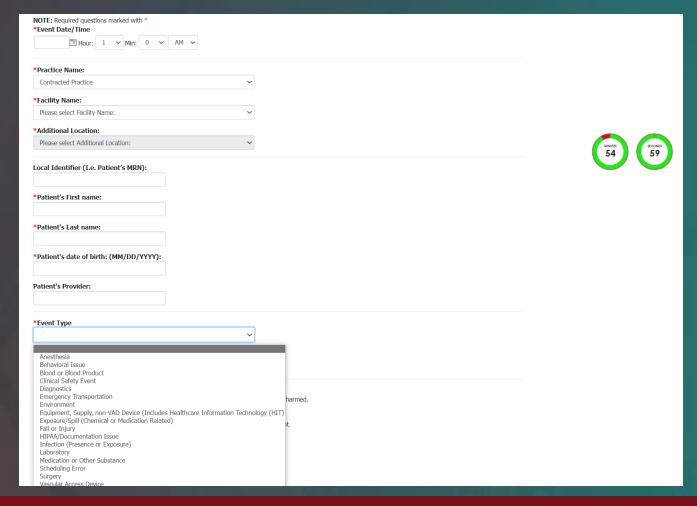
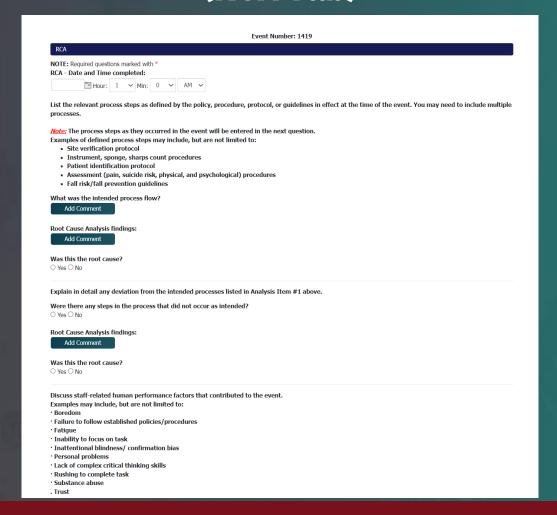# Home Page

Event Data Collection (Submission Tab)

Event Data Collection
(RCA Tab)

Event Number: 1419

RCA

NOTE: Required questions marked with *
RCA - Date and Time completed:

📅 Hour: [1 ▾] Min: [0 ▾] [AM ▾]

List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes.

Note: The process steps as they occurred in the event will be entered in the next question.
Examples of defined process steps may include, but are not limited to:
- Site verification protocol
- Instrument, sponge, sharps count procedures
- Patient identification protocol
- Assessment (pain, suicide risk, physical, and psychological) procedures
- Fall risk/fall prevention guidelines

What was the intended process flow?
[Add Comment]

Root Cause Analysis findings:
[Add Comment]

Was this the root cause?
○ Yes ○ No

Explain in detail any deviation from the intended processes listed in Analysis Item #1 above.
Were there any steps in the process that did not occur as intended?
○ Yes ○ No

Root Cause Analysis findings:
[Add Comment]

Was this the root cause?
○ Yes ○ No

Discuss staff-related human performance factors that contributed to the event.
Examples may include, but are not limited to:
· Boredom
· Failure to follow established policies/procedures
· Fatigue
· Inability to focus on task
· Inattentional blindness/ confirmation bias
· Personal problems
· Lack of complex critical thinking skills
· Rushing to complete task
· Substance abuse
. Trust

AdHoc and PSO Reports