Causal Analysis and Corrective Action Plan (CAP)

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

Please complete all sections of this form and submit to the Patient Safety Surveillance & Improvement System (PSSIS) administered by Vermont Program for Quality in Health Care, Inc. via secure email at sre@vpqhc.org.

For questions regarding the Patient Safety Surveillance & Improvement System (PSSIS) contact:
Vermont Program for Quality in Health Care, Inc. (VPQHC)
132 Main Street Montpelier, VT 05602
Phone: 802-229-2152
Email: sre@vpqhc.org

Please specify the documentation included in the submission:

☐ Chronology of Events

☐ Summary of Causal Analysis

☐ Bibliography (if indicated)

☐ Corrective Action Plan

Guidelines: Corrective Action Plan (CAP) should include:

1. *Specific actions to correct the identified causes of the event to minimize (to the extent possible) the risk of a similar event from occurring in the future;*
2. *Identified and measurable outcome(s);*
3. *A person(s) responsible for implementation and evaluation;*
4. *A specific implementation plan with the following:*
   - *Anticipated completion dates;*
   - *A description of how the hospital's performance will be assessed and evaluated following full implementation.*
   - *Provisions for education of and communication with appropriate hospital staff.*

1. Facility identification

Facility name:

2. Contact information

Title of person submitting report:

Telephone number:

3. Event identification number: (*Previously provided to you by the PSSIS Program)*

4. Patient Information:

Patient sex at birth: ☐ Male ☐ Female

Patient Gender:

☐ Agender/doesn't identify with any gender
☐ Male
☐ Transitioning
☐ Unknown
☐ Female
☐ Transgender
☐ Non-Binary

Ethnicity:

☐ Not of Hispanic, Latino/a/x, or Spanish origin
☐ Yes, of Hispanic, Latino/a/x or Spanish origin

Race: Choose as many as needed

☐ American Indian or Alaskan Native
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Asian
☐ Middle Eastern
☐ Unknown

Preferred Language:

☐ English

☐ Additional: If preferred language is known please indicate _____

Disability Status: Was the patient determined to meet disability status by the Social Security Administration (defined as receiving SSI and/or SSDI benefits) at the time of admission/facility encounter?

☐ Yes ☐ No ☐ Unable to determine/Unknown

5. Causal Analysis Team (***Please list team members by title and department (no names). If you prefer, you may attach a document containing this information.)***

6. Final understanding of severity of event (check only one)

☐ **No harm evident, physical or otherwise**
Event reached patient but no harm was evident.

☐ **Emotional distress or inconvenience**
Event reached the patient; mild and transient anxiety or pain or physical discomfort, but without the need for additional treatment other than monitoring (such as by observation; physical examination; laboratory testing, including phlebotomy; and/or imaging studies). Distress/inconvenience since discovery and/or expected in future as a direct result of event.

☐ **Additional Treatment**
Injury limited to additional intervention during admission or encounter and/or increased length of stay, but not other injury. Treatment since discovery and/or expected in future as a direct result of event.

☐ **Temporary Harm**
Bodily or psychological injury, but likely not permanent. Prognosis at the time of assessment.

☐ **Permanent Harm**
Lifelong bodily or psychological injury or increased susceptibility to disease. Prognosis at the time of assessment.

☐ **Severe Permanent Harm**
Severe lifelong bodily or psychological injury or disfigurement that interferes significantly with functional ability or quality of life. Prognosis at time of assessment.

☐ **Death**
Dead at time of assessment.

7. Final understanding of factors identified that contributed to event occurrence (check all that apply)

☐ **Communication Problems or inadequate flow of information:** *Insufficient flow or availability of critical information, verbal, written or electronic, between any members of the healthcare team.*

☐ **Training/education and transfer of knowledge:**
Insufficiencies in training and/or inconsistent or inadequate education for those involved in providing care.

☐ **Environment/Equipment:**
Complications or failures in appropriate use of equipment. Environment refers to conditions in the environment that present a risk or unsafe situation.

☐ **Patient Characteristics, Medical History, and other Patient Related Issues:**
Includes patient physical assessment, comorbid medical and mental health conditions, and/or the patient's understanding and engagement in the plan of care.

☐ **Rules/Policies/Procedures:**
Failures in processes that can be traced to non-existent or inadequate protocols and procedures. Failure to follow established protocols or procedures.

☐ **Leadership:**
Refers to the safety culture principles and behaviors of the organization.

☐ **Staffing Patterns and Workflow:**
Inadequate staffing leading to situations where there is greater risk for patient safety events.

☐ **Additional Information** *(Please explain):*

8. Was the patient and/or family notified of the event?

☐ Yes **and** disclosure **v**erified through documentation

☐ No, If no disclosure, why?