Can Slide Number	Slide Heading	Slide Narration Text
1	Title	• Hello and welcome to the County of San Diego's Quality Assurance Incident Reporting training series. • This is a two-part training that will outline the Incident Reporting process for treatment and non-treatment programs for our System of Care. • Listeners should have at least a basic understanding of the CIR / Non- CIR process covered in part one. • This training will specifically cover the Report of Findings and the Root Cause Analysis process.
2	Objectives	• By the end of today's training, you will know the following: • A brief review of incidents that require a CIR • The Report of Findings (ROF) process • The Root Cause Analysis (RCA) process • How to access resources and tip sheets
3	Critical Incidents Review	• Critical Incidents are classified by the following categories: o Death/Homicide (Confirmed) o Suicide Attempt o Non-Fatal Overdose o Medication Error o Alleged abuse/inappropriate behavior by staff o Injurious assault by a client resulting in hospitalization o Critical Injury on site (MH/SUD related) o Adverse Media/Social Media Incident (only; no leading incident) • Please note that currently only SUD programs require confirmed natural death reporting and tracking as a part of SUD residential licensing requirement for DHCS. MH programs require a natural death CIR only if it occurs on program premises. • If you have any questions whether an Incident qualifies as a CIR please reach out to QIMatters.hhsa@sdcounty.ca.gov for consultation.

		• Important timelines: All providers are required to report all critical incidents within 24 hours of program knowledge and involving clients in active treatment or whose discharge from services has been 30 calendar days or less.
4	Report of Findings (ROF)	• All critical incidents shall be investigated and reviewed by the program. • The Report of Findings (ROF) is the report of the review and investigation with relevant findings, interventions, and recommendations. • The program shall submit a complete Report of Findings to QA within 30 calendar days of knowledge of the incident. • Exception: In the case of a client death, there is an exception to the 30 calendar day due date if the program is waiting on the County Medical Examiner (CME) report. Extensions are granted in 6 month intervals by QA. Programs are responsible for requesting an extension as needed by emailing QIMATTERS@HHSA.SDCOUNTY.CA.GOV. If the CME report has not been received when the first extension request has expired, the program is to email QIMatters to request an additional extension. • Programs may continue to send this request every 6 months until the CME report has been received. Once the CME report is received, the program is expected to complete the ROF ASAP and submit it to QA.. • Programs have the option of submitting the ROF by the 30-calendar day timeline without the CME report or requesting an extension for the ROF if it is preferred to wait for the CME report.
5	CME Report	• CME stands for the County Medical Examiner’s Report. • This report is required for serious incidents involving death of a client because it provides the final cause of death determination. • CME report is not required before submitting the ROF for incidents involving the death of a client. • ROF’s can be submitted while the CME report is pending, or programs can request an extension to submit the ROF if they prefer to have the CME report first. • In certain situations, the CME may be waived by the medical examiner’s office or not performed.

6	Multiple Program Assignments	• In many instances, a client involved in a Critical Incident will be enrolled in more than one program. • In these situations, an ROF will be required for the primary client assignment and/or the Program where the critical incident took place although an ROF may be requested by QA or the COR for any of the client's programs.
7	Report of Findings Form	• The *Report of Findings Form* & *Report of Findings FAQ & Tip Sheet* are both found on the Optum Website> Incident Reporting Tab> *Critical Incidents*. • Much of the information in the next few slides can be found on the ROF FAQ & Tip Sheet • Completed forms are submitted on a Word document via QI Matters.
8	Report of Findings Form	• Section 1 is about the program reporting the CIR • Provide details about the program, including: a. Program Type - only select one; see the prompt that states "Click to view/select options" to initiate the drop-down menu b. Name of Agency/Legal Entity and Program Name c. Program Manager info (Name, email, phone) d. Name of staff completing ROF and date completed e. COR name f. Contract #, if known or available
9	Report of Findings Form	• Section 2 is about the Incident information • Provide details about the incident including: a. Date of incident b. Was the ROF was submitted within 30 calendar days of reported incident – yes/no c. If no, explain why it was not sent to QA within calendar 30 days.

		d. If RCA is required and date completed if required. • Section 3 is about Client Information –If the client is Non-BHS or an OOC Client, this section is not required. • Provide details about the client involved in the incident, including: a. Client Name b. Client's EHR number, if applicable c. Custody status in the last 30 calendar days • We will explain more about the RCA soon in order to provide more clarity on the RCA focused sections of this form.
10	Report of Findings Form	• Section 4 pertains to incidents involving an overdose. If the critical incident is not related to an overdose, select N/A. • Provide details for critical incidents related to an overdose, including: a. Substance involved. b. If opioid was involved, was the client receiving MAT services c. where the client was referred to or receiving MAT services. d. If client was not referred to MAT or declined a referral, provide details to explain the reason why the client was not referred or is not currently receiving MAT. e. If Naloxone/Narcan administered and by whom. f. If fentanyl specific testing included in all client urine screens; include details such as date and results of most recent fentanyl specific test. g. If client given health education about Naloxone/Narcan for overdose prevention as part of treatment prior to the incident, such as during intake. h. If a Naloxone/Narcan kit was prescribed or given to client for overdose prevention prior to the incident (not including staff administration of naloxone).
11	Report of Findings Form	• Section 5 focuses on Critical Incident of Summary Findings and Recommendations/Planned Improvements

		• NOTE: If an RCA was complete, this section is not required; select N/A instead. • Please do not simply copy/paste CIR information • Describe the results of the investigation and recommendations as a result of the incident, including: a. Results of investigation i. Briefly describe the incident, including information from the Critical Incident Report and any additional information gathered during the investigation. ii. Document your investigation into the events leading up to the incident (i.e., review of chart and any relevant Policy and Procedures, interviews of staff and/or client, etc.) iii. Document your analysis of the investigation (i.e., identify any precipitating factors, follow up services, response to treatment). b. Recommendations or planned improvements i. Changes in Policies and Procedures-Identify any new policies and procedures which will be implemented in order to reduce risk to the clients and the program. ii. Quality improvement practices-Identify ongoing strategies which the program will implement in order measure the effectiveness of the policies and procedures. iii. Clinical supervision/oversight iv. Trainings, etc. • Section 6 focuses on the information obtained during the Root Cause Analysis • If an RCA has not been completed or is not required, select N/A. • If the Incident requires the program to complete this section, provide details after an RCA has been completed, including: a. If a root cause was identified – yes or no

		b. RCA Summary findings – Describe the incident, the results of the investigation and analysis of the incident. Describe the root cause if one was identified. c. RCA Summary of action items - Create a plan of action items the program will implement which will reduce the risk to the clients and program. Identify the measures that will be used to determine the effectiveness of the plan.
12	Report of Findings Form	• Section 7 is the Program Manager Attestation • This same section was on the initial Critical Incident Report • Staff completing the form is required to attest to one of the following options: a. I am the Program Manager and am attesting that the information provided is accurate. b. I am submitting on behalf of the Program Manager and am attesting that the information provided is accurate and has been reviewed with the Program Manager
13	What is a "Root Cause"?	• A "root cause" is a fundamental issue or primary reason. It is the identified earliest point at which action could have been taken to greatly reduce the chance of the incident happening. • These are underlying reasons that may be less obvious when first considering the incident. They require deeper analysis and often **systemic, long-term changes** on a program or organizational level. • The RCA is a way to prevent similar incidents from occurring in the future.
14	Root Cause Analysis (RCA)	• A Root Cause Analysis is required for any death by suicide, alleged homicide committed by client, or as requested by County QA for any other critical incident. • The goal of the RCA is to identify systemic breakdowns in processes and to discuss ways to bridge any gaps in workplace well-being and client quality of care.
15	Preparation for RCA	• To prepare for the RCA, identify the Lead, Facilitator, and participants by position and title. do not identify them by name

		• The "Lead" is usually the program manager or your legal entity's QI person**.** The lead has knowledge of the event and authority within the organization. • The "Facilitator" can be an objective third party – someone with RCA or other facilitation skills but has no real tie to the incident. • The "Participants"- should be multidisciplinary staff members from all relevant departments. It is often helpful to have people present who were not a part of the Incident and who can offer a different viewpoints.
16	Preparation for the RCA	• Schedule at least one meeting. A minimum of 2 hours is recommended • Utilize the RCA worksheet , located on the Optum Website on the *Incident Reporting* tab, Critical Incidents subtab. • The RCA worksheet is required for all county programs, but other legal entities may use their own version of this tool
17	Case Study Example	The next few slides hold a simplified case study example. We will use this information to demonstrate how to incorporate the clinical details into a timeline and identify gaps in the system that may help us pinpoint a root cause. Client John Doe died by suicide Friday night at approximately 9:30 p.m. John's last scheduled appointment at the co-occurring program was the Wednesday prior (for medication management) but John did not show. John came to the program that Friday around 12 p.m. asking to see his therapist. The receptionist informed John the therapist was on vacation and tried to set an appointment for the following week.
18	Case Study Example	John became agitated and raised his voice, demanding to be seen. The receptionist explained that no one was available and again offered appointment for the following week. John shouted that no one cared about him and left, slamming the door on his way out. There were no outside parties or witnesses to this office interaction. **John reportedly stepped in front of the Main Street trolley at around 9:30 p.m.**

19	Completing the RCA-Overview	• This is a general overview of the RCA process: 1. Describe the incident and outcome 2. Identify contributing factors 3. Identify gaps in systems or processes 4. Analyze and identify root cause 5. Action Plan • The next several slides will review the process in detail utilizing the RCA Tool. • As a reminder, County programs are required to complete the RCA tool. • Other program may choose to use it to help guide the RCA process.
20	RCA Analysis Worksheet	• The RCA worksheet can provide structure for completing the process. It will be reviewed section by section on the next few slides. • Much of the information on these slides can be found on the ROF FAQ & Tip Sheet on the Optum Website Incident Reporting tab • Section 1 asks for a summary of the Critical Incident. Explain in detail what happened to the best of the group's knowledge, including: • who was involved • services impacted (including outside parties/ witnesses) • and the outcome/injury. • Gather information by interviewing staff involved in the event, review medical records, policy and procedure manuals and any other appropriate information. • Section 2 asks for a list of participants in the meeting it is important to note that NO NAMES are to be used, only identify participants by position and title
21	Case Study-Flowchart Example	• It is highly recommend to create a step by step flow chart or timeline as the first step in your RCA. I will read out loud the example case study in timeline form: • First arrow: John misses scheduled appointment on Wednesday for medication management. • Second arrow: John comes to program Friday at **noon** and asks for therapist

		• Third arrow: Receptionist explains therapist is on vacation, tries to schedule appointment for the following week • Forth arrow: John demands to be seen. Receptionist informs that no one is available, tries to reschedule. • Fifth arrow: John becomes upset, states no one cares, slams out of office • Sixth arrow: John dies by suicide at **9:30 p.m** • This will help create a "whole picture" of the incident. Remember to identify "just the facts" of what happened without opinion or judgment to arrive at a clear/concise description • Ask participants to come to the RCA meeting with a basic description of the incident from their perspective that includes dates and processes involved.
22	RCA Analysis Worksheet	• Section 3 asks participants to identify the systems and processes that will be analyzed. Systems and processes are typically defined by policy and procedures. Once the timeline has been created, the group can examine systems and processes to determine proximate causes: • Some (but not all) examples of systems and processes are noted in the Tool. It may be helpful to go down the list and examine each example to see if it applies to the Incident. • For example: • Procedure or policy - Was there one in place? Was it followed? • Equipment - Did it function properly? • Staffing resources – What were the circumstances at the time of the incident • Communication issues?
23	RCA Analysis Worksheet	• Section 4 asks for an outline/ break down of each system or process– it is helpful to have a workflow on hand for each. This can assist in uncovering gaps, identifying processes involved and any missed opportunities for intervention. • Section 5: Findings: Identify any gaps found. How does the written workflow compare to the what actually happened during the critical incident? • It can help to think about what the process would "ideally" look like.

		• After identifying each potential contributing factor, consider: Would this event have happened if this factor had/ had not been present? • It can help to think about what the system or process would "ideally" look like.
24	Completing the RCA- Identifying Gaps	• Identify a range of contributing factors which are potential causes that could have led to the event – including any 'gaps' • **What constitutes a gap in the system?** Look at how the design of the system or process compares to the real event, human factors, equipment factors, controllable environmental factors, and uncontrollable external factors. • It can help to think about what the system or process would "ideally" look like. • Focus on identifying policies, procedures, and trainings that were may have not been followed or did not exist. • Identify if the policies and procedures were followed to help determine if any of these systems or processes are a root cause.
25	Case Study- Identified Gaps Example	This our flow with the case study example. In this flowchart, it is modified to highlight the identified "gaps" Let's go through the flow chart again highlighting the possible factors and breakdowns that may have contributed to John's suicide Read through the timeline highlighting the 3 identified gaps • Gap1 – John misses scheduled appointment on Wednesday for medication management. o The Policy is for the Program nurse to call clients to follow up after missed MD appointments. o What actually happened: The nurse didn't leave message because John's voicemail didn't work. • Gap 2 - Receptionist explains therapist is on vacation, tries to schedule appointment for the following week o The Policy is for the Duty worker to see if walk-ins or appointment can be offered with other team members.

		○ What actually happened: Several staff were out sick so no duty-worker was available to meet with John or try to figure out a short term solution. • Gap 3- John demands to be seen. Receptionist informs that no one is available, tries to reschedule. ○ In an ideal scenario all new staff would have additional support as they are learning policies and procedures associated with the clinic. ○ What actually happened: the receptionist was newly hired and not fully trained yet with policy/procedure on handling clients. ○ As a result, John becomes upset, states no one cares, slams out of office
26	Completing the RCA- Identifying the Root Cause	• As you start the analysis, you may identify contributing (causal) factors that are not necessarily a 'root cause' • It is essential for these "**causal factors**" to be examined in the process. • Causal Factors may look like: Visible or obvious, surface-layer factors contributing to a problem or incident / Things that went wrong or weren't optimal — but they stem from deeper system problems. • On the slide above are some examples of Causal factors versus Root Causes ○ **Causal (Contributing) Factor Examples:** • Client does not have a working phone or the internet in the office is faulty, resulting in unsuccessful attempts to call or communicate with the client. • Multiple clinical staff are out of the office or unavailable to provide services due to large caseloads • Staff are distracted by other clients, activity, or crisis situations. ○ **Possible Root Cause Examples:** A workplace culture that promotes speed over safety, or quantity over quality: Does the culture promote speaking out when hazards or deficits in care are noticed?

		• The office design allows easy access to potentially dangerous objects (i.e. scissors, pens, or unlocked medication) in unsecured areas where clients can gain access to them • Lack of program funding to hire and train staff or remain open during business hours.
27	RCA Worksheet	• Section 6: Identify whether each finding being analyzed is a "root cause" via "yes" or "no". • Section 7: Action Taken: Note whether or not actions will be taken to address the issues that are identified as a root cause. Many findings that are not a root cause themselves have "roots" or factors that may need to be addressed.
28	Completing the RCA-Action Plan	• Action Plan: The final element is to note plans for action to address any issues that are identified as a root cause. • This portion of the RCA delineates the items that are being addressed, the strategies that will be implemented, and the measures that will be used to determine the effectiveness of the plan. • **The goal of the action plan is to prevent similar events from occurring**. • Actions should be concrete and easily understood. • Assign responsibility for implementing each action • Develop a timeline for implementation and outline monitoring practices for evaluating their effectiveness. • These are completed in Section 8, a-c.
29	Resources for ROFs and RCAs	• There are a number of other helpful resources on the Optum Website described below: • The ROF form Word document is located on the Incident Reporting tab. • Critical Incident Reporting Information can be found within the OPOH for Mental Health providers and the SUDPOH for Substance Use Disorder providers. The OPOH and SUDPOH are located on the Optum Website under the OPOH/SUDPOH tab.

		• Other helpful resources such as the ROF FAQs and Tip Sheets, Links to trainings and the most up to date Incident Reporting Information is located on the Optum website *Incident Reporting* tab. • Lastly, you can always refer to this presentation at any time to refresh your understanding of the IR process
30	End Slide	This concludes our training for Report of Findings and Root Cause Analysis. If you have any additional questions, please contact the QA department at the email above: QIMATTERS.HHSA@SDCOUNTY.CA.GOV