Report of Findings (ROF) and Root Cause Analysis (RCA) Webinar

BHS Quality Assurance

Incident Reporting Team

2026

LIVE WELL
SAN DIEGO

Objectives

Review incidents that require a CIR, ROF and RCA

Teach the Report of Findings (ROF) processes.

Understand the Root Cause Analysis (RCA) process

Accessing helpful resources and tip sheets.

Critical Incidents Review

- Death/Pending (Pending CME investigation)
- Death/Natural Causes (Confirmed) *
- Death/Overdose (Confirmed)
- Death/Suicide (Confirmed)
- Death/Homicide (Confirmed)
- Suicide Attempt
- Non-Fatal Overdose
- Medication Error
- Alleged abuse/inappropriate behavior by staff
- Injurious assault by a client resulting in hospitalization
- Critical Injury on site (MH/SUD related)
- Adverse Media/Social Media Incident (only; no leading incident)

Any incident that does not fall within these categories will be reported as a "Non-Critical Incident"

Report of Findings (ROF)

All critical incidents shall be investigated and reviewed by the program.

The program shall submit a **Report of Findings** to QA **within 30 days** of knowledge of the incident.

In the case of a client death, there is an exception to the Report of Findings report being due to QA within 30 days when the program is waiting on the CME report.

CME Report

The CME report is the County Medical Examiner's Report.

It is required for serious incidents involving death of a client because it provides the final cause of death determination.

Multiple Program Assignments

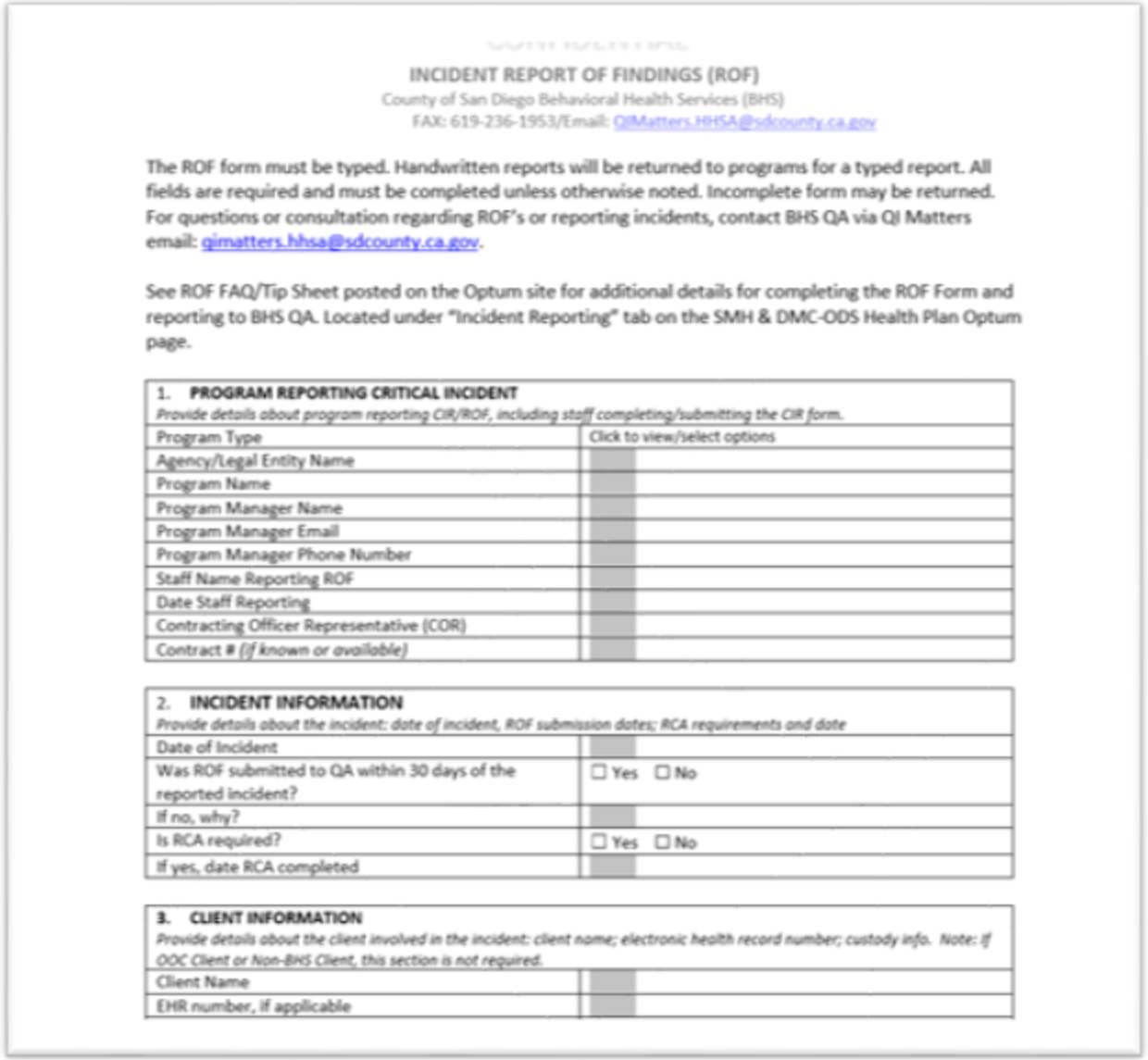
In instances where an ROF is required for a Critical Incident and there are multiple program assignments, an ROF will be required for the primary client assignment and/or the program where the critical incident took place.

Any other client program assignments submitting a CIR for the same incident may require an ROF per QA or COR request.

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*.

Completed forms are submitted via QI Matters.



INCIDENT REPORT OF FINDINGS (ROF)

County of San Diego Behavioral Health Services (BHS)

FAX: 619-236-1953/Email: QIMatters.HHSA@sdcounty.ca.gov

The ROF form must be typed. Handwritten reports will be returned to programs for a typed report. All fields are required and must be completed unless otherwise noted. Incomplete form may be returned. For questions or consultation regarding ROF's or reporting incidents, contact BHS QA via QI Matters email: qimatters.hhsa@sdcounty.ca.gov.

See ROF FAQ/Tip Sheet posted on the Optum site for additional details for completing the ROF Form and reporting to BHS QA. Located under "Incident Reporting" tab on the SMH & DMC-ODS Health Plan Optum page.

1. **PROGRAM REPORTING CRITICAL INCIDENT** *Provide details about program reporting CIR/ROF, including staff completing/submitting the CIR form.*	
Program Type	Click to view/select options
Agency/Legal Entity Name	
Program Name	
Program Manager Name	
Program Manager Email	
Program Manager Phone Number	
Staff Name Reporting ROF	
Date Staff Reporting	
Contracting Officer Representative (COR)	
Contract # *(if known or available)*	

2. **INCIDENT INFORMATION** *Provide details about the incident: date of incident, ROF submission dates; RCA requirements and date*	
Date of Incident	
Was ROF submitted to QA within 30 days of the reported incident?	☐ Yes ☐ No
If no, why?	
Is RCA required?	☐ Yes ☐ No
If yes, date RCA completed	

3. **CLIENT INFORMATION** *Provide details about the client involved in the incident: client name; electronic health record number; custody info. Note: If OOC Client or Non-BHS Client, this section is not required.*	
Client Name	
EHR number, if applicable	

Report of Findings Form

Section 1: Program Reporting the Critical Incident

1. **PROGRAM REPORTING CRITICAL INCIDENT** *Provide details about program reporting CIR/ROF, including staff completing/submitting the CIR form.*	
Program Type	Click to view/select options
Agency/Legal Entity Name	
Program Name	
Program Manager Name	
Program Manager Email	
Program Manager Phone Number	
Staff Name Reporting ROF	
Date Staff Reporting	
Contracting Officer Representative (COR)	
Contract # *(if known or available)*	

Report of Findings Form

Section 2: Incident Information

2. **INCIDENT INFORMATION** *Provide details about the incident: date of incident, ROF submission dates; RCA requirements and date*	
Date of Incident	
Was ROF submitted to QA within 30 days of the reported incident?	☐ Yes ☐ No
If no, why?	
Is RCA required?	☐ Yes ☐ No
If yes, date RCA completed	

Section 3: Client Information

3. **CLIENT INFORMATION** *Provide details about the client involved in the incident: client name; electronic health record number; custody info. Note: If OOC Client or Non-BHS Client, this section is not required.*	
Client Name	
EHR number, if applicable	
Was the person in custody within the last 30 days?	☐ Yes ☐ No

Report of Findings Form

Section 4: Overdose Information

4. OVERDOSE INFORMATION *Complete the following for critical incidents related to an overdose.* *If incident not related to overdose, indicate here:* ☐ N/A	
a) Substance involved in the overdose	Click to view/select options Other:
b) If Opioid was involved, was the client receiving Medication Assisted Treatment (MAT) services	☐ Yes ☐ No
c) If yes, was the client referred to MAT?	☐ Yes ☐ No Referred to:
d) If client was not referred to MAT or declined a referral to MAT, please explain:	
e) Was Naloxone/Narcan administered?	☐ Yes ☐ No
	By whom:
f) Was fentanyl specific testing included in all client urine drug screens?	☐ Yes ☐ No Date of most recent fentanyl specific test:
g) If yes, result of most recent fentanyl specific test	Click to review/select options
h) Was the client given health education about Naloxone/Narcan for overdose prevention as part of treatment prior to the incident (i.e., intake)?	☐ Yes ☐ No
i) Was Naloxone/Narcan kit prescribed or given to the patient for overdose prevention prior to the incident (not including any staff administration of naloxone)?	☐ Yes ☐ No

Report of Findings Form

Section 5: Critical Incident of Summary Findings Results & Recommendations

5. CRITICAL INCIDENT OF SUMMARY FINDINGS RESULTS AND RECOMMENDATIONS

Describe the results of your investigation and recommendations as a result of the critical incident.

NOTE: Section not required if RCA was complete; indicate N/A ☐ for this section and complete section 6 below.

a)	Describe the results of your investigation and analysis of the serious incidence
b)	Describe recommendations or planned improvements including a summary of quality/system improvements as a result of the analysis of the critical incident.

6. ROOT CAUSE ANALYSIS (RCA)

If required, provide details for RCA if an RCA has been completed: if root cause was identified, findings and action items.

If RCA has not been completed, indicate N/A ☐

a)	Was a root cause identified?	☐ Yes ☐ No
b)	RCA Summary of Findings	
c)	RCA Summary of Action Items	

Section 6: Root Cause Analysis (RCA)

Report of Findings Form

Section 7: Program Manager Attestation

7. PROGRAM MANAGER ATTESTATION

This section shall only be completed by Program Manager or Designee Only; select only one option.

☐ I am the Program Manager and am attesting that the information provided is accurate.

☐ 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.

What is a “Root Cause”?

A fundamental issue or a primary reason- often underlying and less obvious- that contributed to an incident.

The root cause is usually identified at the earliest point in time at which, if action had been taken, the chances of an incident would be greatly reduced.

Identifying a Root Cause can reveal system issues and help in the prevention of similar incidents occurring in the future.

Root Cause Analysis (RCA)

RCA is required for:

- Client death by suicide
- An alleged homicide committed by client
- If requested by County QA

GOALS:

-identify systemic gaps or breakdowns in systems and processes

-discuss ways to bridge the gaps, strengthen client quality of care for improved outcomes

-develop measurable action plans

Preparation for RCA

Identify the Lead, Facilitator, and participants for the RCA by position and title (no names)

Lead- typically a program manager or QI staff. The lead has knowledge of the event.

Facilitator- an objective third party who conducts the review, guides the discussion and the findings.

Participants - Multidisciplinary staff members from all relevant departments.

Preparation for the RCA

Schedule at least one meeting (min. 2 hours)

Utilize the RCA worksheet, located on the Optum Website on the *Incident Reporting* tab.

NAME	FILE/LINK	REVISED DATE
Critical Incident Training	Coming soon.	N/A
Critical Incident Form	Critical Incident Report (CIR) Form (12-16-24).docx	12/16/24
Critical Incident FAQ/Tip Sheet	Critical Incident Reporting (CIR) FAQ & Tip Sheet (12-16-24).pdf	12/16/24
Report of Findings (ROF)	Report of Findings (ROF) Form (12-16-24).docx	12/16/24
Report of Findings (ROF) FAQ/Tip Sheet	Report of Findings (ROF) FAQ & Tip Sheet (12-16-24).pdf	New
Root Cause Analysis Worksheet	COSD RCA Tool- Rev. 12.08.25.docx	12/08/25

Case Study Example

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.

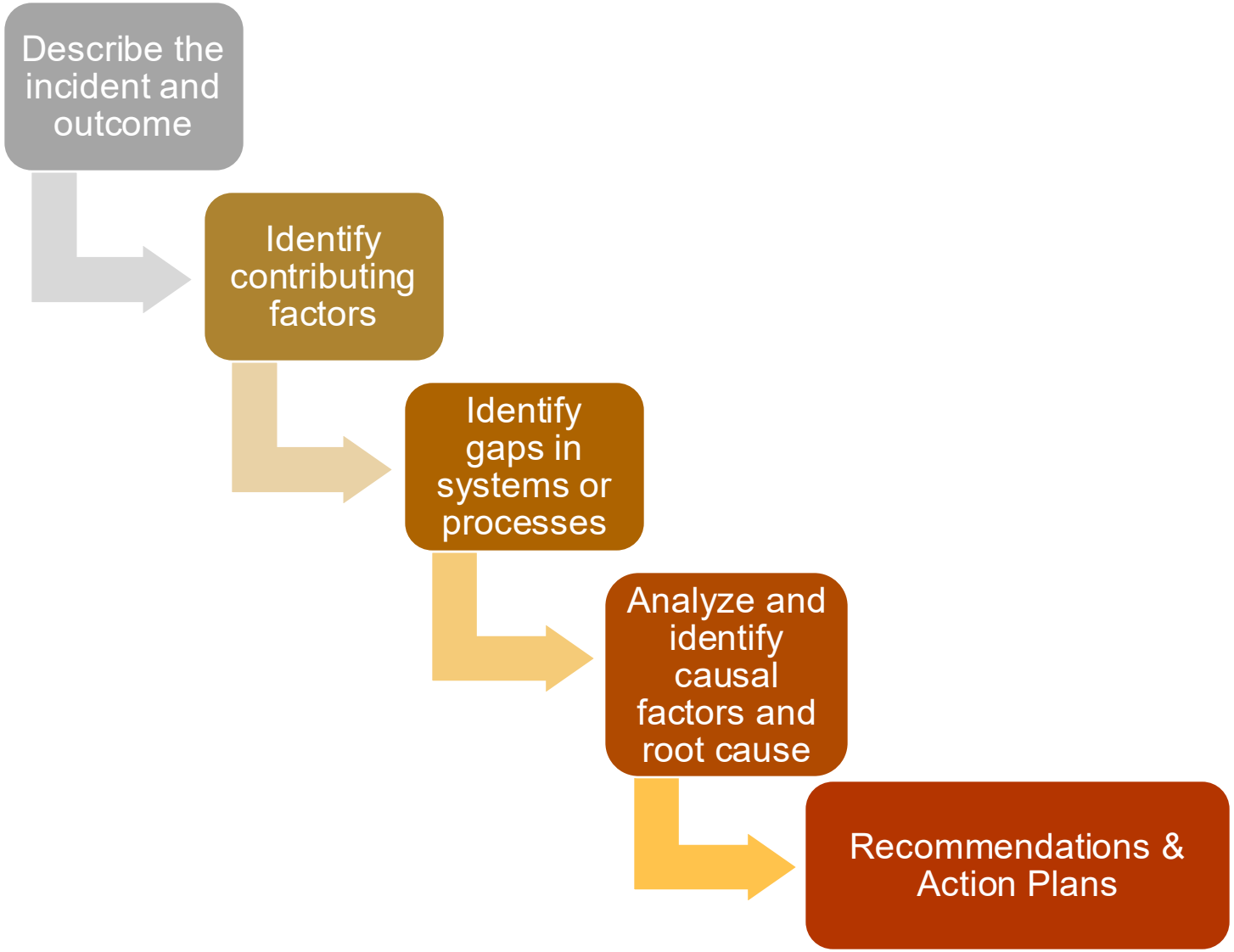
Case Study Example

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.

Completing the RCA- Overview



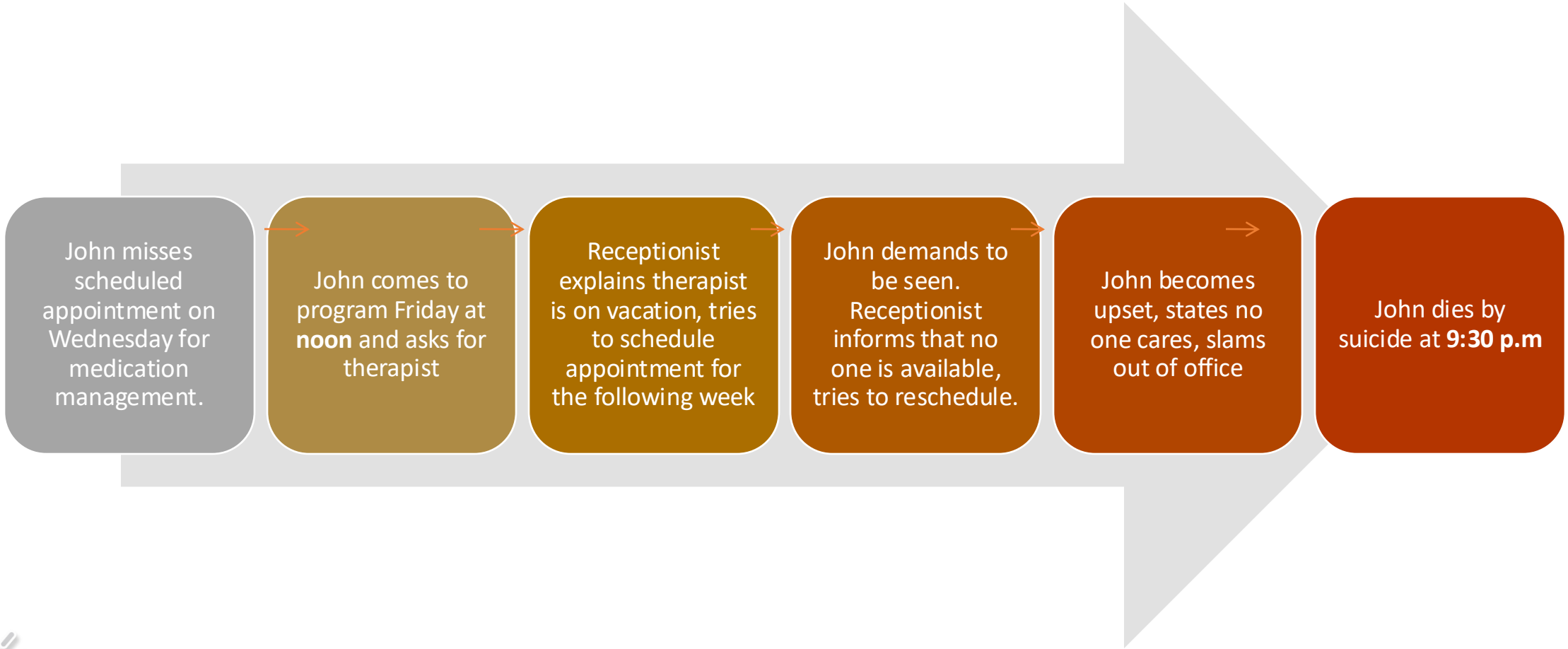
RCA Analysis Worksheet

Section 1: Summary of the Incident

Section 2: Participants

Root Cause Analysis Tool			
Date of RCA Meeting: Date	Date of Critical Incident: Date		Time of Critical Incident: Time.
1. Summary of Incident: List type of Critical Incident and explain what happened. Include who was involved, services impacted, any outside parties or witnesses, details of the incident, and the outcome/injury	Summary of Incident		
2. Participants: List all the participants by position and title (no names)		Position	Title
	Lead	Position	Title
	Facilitator	Position	Title
	Members	Position	Title
		Position	Title
		Position	Title
		Position	Title
		Position	Title

Case Study- Flowchart Example



RCA Analysis Worksheet

Section 3: Systems & Processes

3. Systems and Processes:	☐Assessment Process ☐Availability of information ☐Care Coordination ☐Communications among staff ☐Communication w/ clients or family ☐Control of meds, storage, access ☐Equipment ☐Facility ☐Medication Protocols	☐Physical Assessment Process ☐Policies and Procedures ☐Reception protocols ☐Risk Assessment Process ☐Security ☐Staffing resources ☐Staff Training/Education ☐Other: Other

RCA Analysis Worksheet

Section 4: Steps

4. **Steps**: What are the steps in the workflow for the process(es) in step 3?	Process	Workflow/ P&P steps
	Process	Workflow/ P&P steps
	Process	Workflow/ P&P steps
	Process	Workflow/ P&P steps

Section 5: Findings

5. Findings
Findings.
Findings.
Findings.
Findings.

Completing the RCA- Identifying Gaps

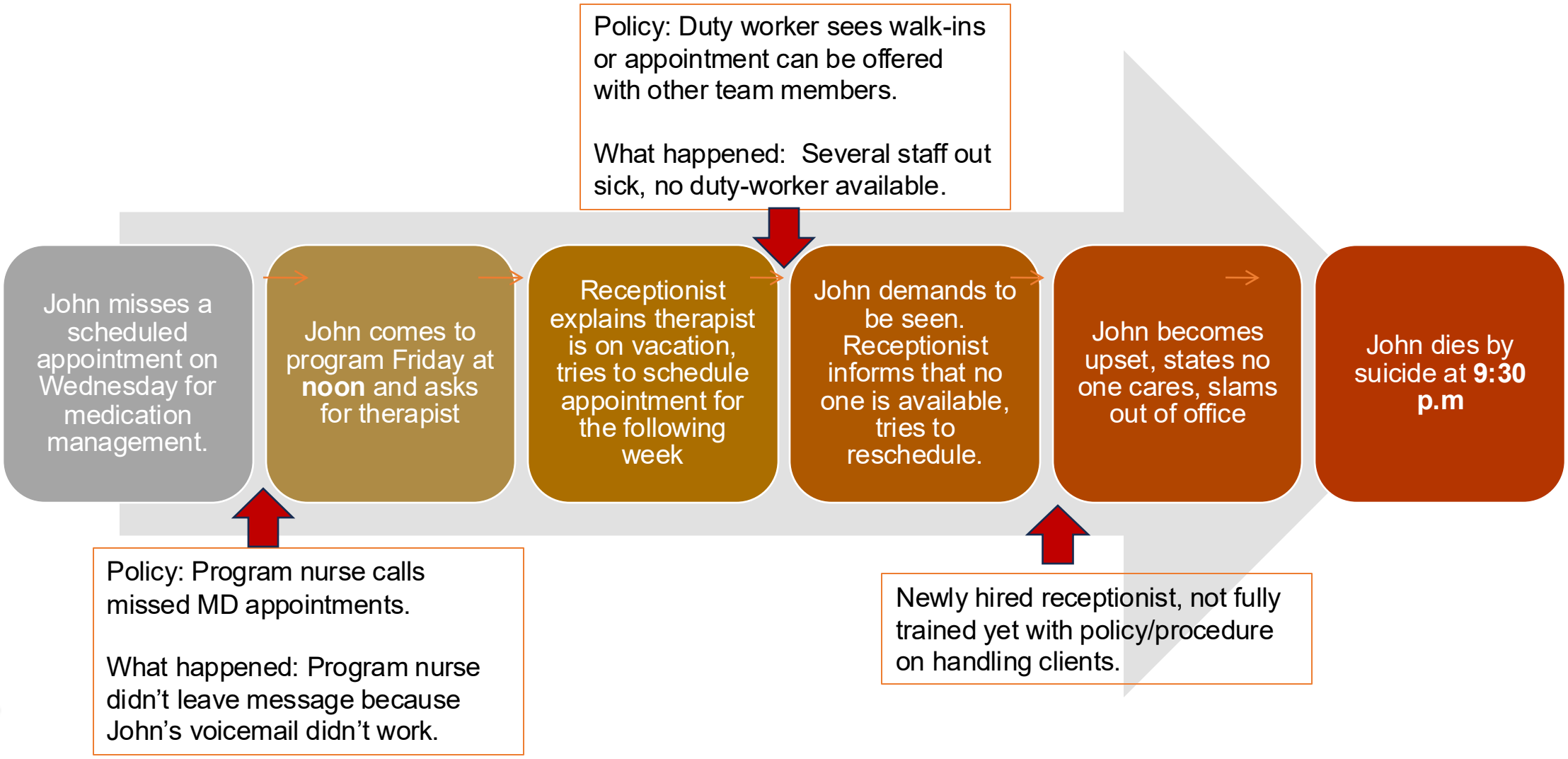
Identify a range of contributing factors that could have led to the event – including any ‘gaps’

Look at how the design of the system compares to the real event, human factors, environmental factors, and controllable versus uncontrollable factors.

Think about what the system and processes would “ideally” look like.

Identify whether policies and procedures were followed to help determine if any of these processes are a root cause.

Case Study- Identified Gaps Example



Completing the RCA- Identifying the Root Cause

Causal (Contributing) Factor Examples:

- Client does not have a working phone, or the internet access in the office is not working; resulting in unsuccessful attempts to communicate with the client
- Multiple clinical staff are out of the office or are unavailable to provide services due to large caseloads.
- Staff are distracted by other clients, activities, or crisis situations.

Possible Root Cause Examples:

- A workplace culture that promotes speed over safety or quantity over quality - does the office culture promote speaking up when hazards 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 to remain open during business hours

RCA Worksheet

Section 6: Root Cause

Section 7: Action

6. Root Cause (Y/N)		7. Take Action (Y/N)	
☐Y	☐N	☐Y	☐N
☐Y	☐N	☐Y	☐N
☐Y	☐N	☐Y	☐N
☐Y	☐N	☐Y	☐N

Completing the RCA- Action 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.

8. Action Plan	
a. Action Items	Action Item 1.
	Action Item 2.
	Action Item 3.
	Action Item 4.
	Action Item 5.
b. Risk Reduction Strategies	Risk Reduction Strategies 1
	Risk Reduction Strategies 2
	Risk Reduction Strategies 3
	Risk Reduction Strategies 4
	Risk Reduction Strategies 5
c. Measures of Effectiveness	Measures of Effectiveness 1
	Measures of Effectiveness 2
	Measures of Effectiveness 3
	Measures of Effectiveness 4
	Measures of Effectiveness 5

Resources for ROFs and RCAs

You can find Critical Incident Reporting Information within the Organizational Provider Operations Handbook (OPOH) and the Substance Use Disorder Provider Operations Handbook (SUDPOH) on the Optum Website > *OPOH/SUDPOH* tab

Forms can be found in the Optum Website > BHS Provider Resources > SMH & DMC-ODS Health Plans > *Incident Reporting* 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.

Contact Information

For Questions or Consults please contact

QA Incident Reporting Team

QIMatters Email: qimatters.hhsa@sdcounty.ca.gov