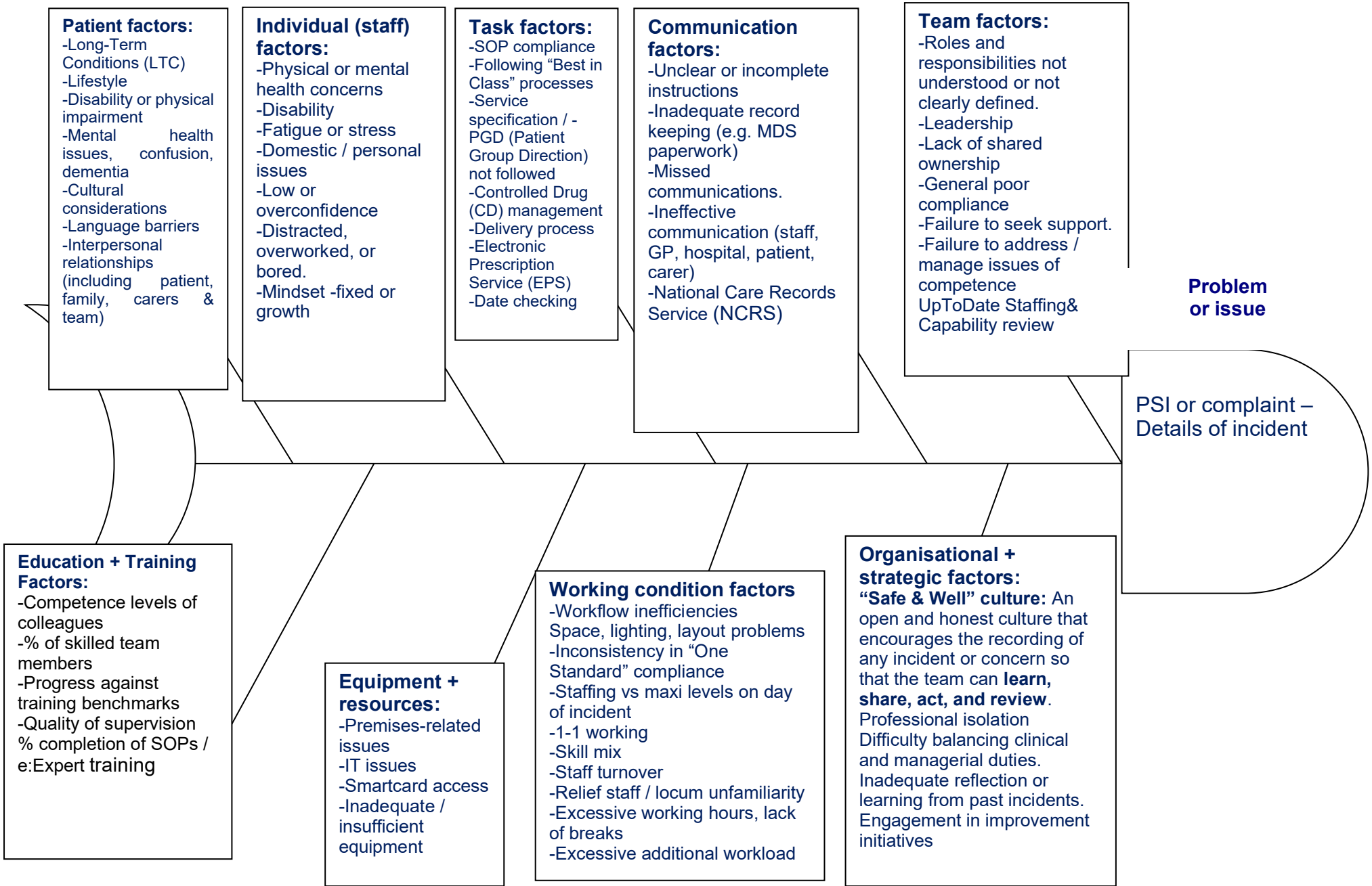
Root Cause Analysis Investigation

Fishbone Diagram - tool

Safe+well

NHS National Patient Safety Agency



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Information Gathering	Patient Safety Incident Reference Number:	Pharmacy Name/Number:
	Date of RCA Completion:	Patient Name:
	Colleagues present completing RCA:	
Incident Data Collection	Time of incident:	Date of incident:
	Pharmacist on duty:	Colleagues of duty and their role:
	Colleagues involved in the incident and their role:	
	No. Script items dispensed on the day	Ave. Script items dispensed per day
Outline of incident		

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Factors	Comment
Patient • Long Term Conditions (LTC) • Lifestyle • Disability or physical impairment • Mental health issues, confusion, dementia • Cultural considerations • Language barriers • Interpersonal relationships (including patient, family, carers & team)	
Individual colleague • Physical or mental health concerns • Disability • Fatigue or stress • Domestic / personal issues • Low or overconfidence • Distracted, overworked, or bored. • Mindset -fixed or growth	

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Task • SOP compliance • Walk-in /overridden from CF/MDS CF • CF/MDS out of stock/rejection • LASA • Following “Best in Class” processes • Service specification / PGD not followed • CD management • Delivery process • EPS • Date checking	
Communication • Unclear or incomplete instructions • Inadequate record keeping (e.g. MDS paperwork) • Missed communications. • Ineffective communication (staff, GP, hospital, patient, carer) • National Care Records Service (NCRS)	
Factors	**Comment**

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Team • Roles and responsibilities not understood or not clearly defined. • Up to date Staffing& Capability review • Leadership • Lack of shared ownership • Poor compliance • Failure to seek support/support not received when sought • Poor competence not addressed/managed	
Education & training • Competence levels of colleagues • % of skilled team members • Training on track e.g. Buttercups • Quality of supervision • % completion of SOPs / e:Expert	

Fishbone Diagram - tool

Equipment and resources • Premises-related issues • IT issues • Smartcard access • Inadequate / insufficient equipment	
Working conditions • Workflow inefficiencies • Space, lighting, layout problems • Inconsistency in “One Standard” compliance • How many services completed • Staffing vs maxi levels • 1-1 working • Skill mix • Staff turnover • Relief staff / locum unfamiliarity • Excessive working hours, lack of breaks • Excessive additional workload	

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Organisational / Strategic • **"Safe & Well" culture:** An open and honest culture that encourages the recording of any incident or concern so that the team can **learn, share, act, and review**. • Professional isolation • Difficulty balancing clinical and managerial duties. • Inadequate reflection or learning from past incidents. • Engagement in improvement initiatives	

Learnings & improvement actions

Probable Root Cause	Improvement Action(s)	By Whom	By When	How (monitor/follow-up)

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Fishbone Diagram - tool
