Safety Event and Root Cause Analysis (RCA) Procedure

Effective Date: 08/15/2025

Approved By: Director of Medical and Clinical Services

Review Schedule: Annually or as Needed

Applies To: All Programs — Outpatient MH/SUD, IOP, PHP, and Integrated Primary Care/Behavioral Health

I. Purpose

To establish standardized procedures for identifying, reporting, investigating, and analyzing safety events that result in or have the potential to cause harm to clients, staff, or visitors. This procedure ensures timely corrective action, promotes system-wide learning, and supports a proactive culture of safety consistent with CARF, OAC, and REACH for Tomorrow risk management standards.

II. Scope

Applies to all employees, contractors, and volunteers across all REACH for Tomorrow sites and programs. Covers all clinical, behavioral, environmental, and medication-related safety events, including falls, medical emergencies, medication errors, environmental hazards, self-harm, aggression, or information breaches.

III. Definitions

Safety Event: Any unexpected or preventable occurrence that results in or has the potential to result in harm or injury.
Sentinel Event: A severe safety event resulting in death, serious injury, or major risk requiring immediate leadership response and regulatory reporting.
Root Cause Analysis (RCA): A structured, systematic process used to identify the underlying causes of an event to prevent recurrence.
Near Miss: A situation that could have resulted in harm but was identified before it occurred.

IV. Policy Statement

REACH for Tomorrow fosters a non-punitive reporting environment encouraging staff to report all safety events, errors, and near misses. All events are investigated to determine causes, contributing factors, and corrective measures to improve safety and prevent recurrence. Findings are reviewed by the Safety and Risk Management Committee, Medication Management Committee (if applicable), and Quality Improvement Committee.

V. Procedures

A. Event Identification and Immediate Response
• Any staff discovering a safety event must ensure immediate safety and medical stabilization.
• Notify the Director of Medical and Clinical Services (DMCS) and Program Supervisor immediately.
• Secure any evidence related to the event (environment, equipment, medications).
• If serious harm, hospitalization, or death occurs, notify the Executive Director within 1 hour per OAC 5122-26-13.

B. Event Reporting
• Complete a Safety Event Report Form within 24 hours of occurrence or discovery.
• Submit reports to the DMCS for review and classification (Level I–III).
• Level I – Near miss/no harm; Level II – Temporary harm; Level III – Serious harm/sentinel event.

C. Initial Review and Risk Assessment
• The DMCS reviews all reports within 48 hours.
• Determine if an RCA is required.
• Escalate sentinel or repeat events to the Safety Committee and Executive Director.

D. Root Cause Analysis (RCA) Process
• RCA team includes DMCS, Program Supervisor, involved staff, and QI representative.
• Process includes event chronology, causal factor charting, root cause identification, and corrective action planning.
• Findings are documented on the RCA Worksheet and entered into the Safety Event Tracking Log.

E. Corrective and Preventive Actions
• Develop and document an action plan listing responsible staff, target completion dates, and verification steps.
• The Safety and Risk Management Committee tracks completion and verifies effectiveness.

F. Trending, Reporting, and Committee Review

• All events are logged and trended quarterly for frequency, severity, and type.
• Data reviewed by Safety, Medication Management, and QI Committees.
• Findings are integrated into the Annual Risk Management and Quality Improvement Reports per CARF §1.M.

VI. Confidentiality and Documentation

All reports, RCA findings, and logs are confidential and protected under HIPAA and 42 CFR Part 2. Data are used for quality improvement, not discipline. Aggregate results are shared for prevention and education only.

VII. References

- CARF 2025 Standards Manual: Sections 1.H, 1.M, 2.F
- OAC 5122-26-10: Incident Notification and Reporting
- OAC 5122-26-13: Critical Incident and Risk Management Requirements
- DEA 21 CFR 1304: Controlled Substance Recordkeeping
- SAMHSA Risk Management Guidelines (2024)

Safety Event Report Form

To be completed within 24 hours of event occurrence or discovery. Submit to Director of Medical and Clinical Services.

Date of Report: Program / Site:

Reporter Name / Title: Phone / Email:

Client Name / ID (if applicable): Witness(es):

Event Type (check all that apply):

☐ Fall / Injury ☐ Medication Error ☐ Aggression / Behavioral ☐ Self-Harm ☐ Medical Emergency

☐ Environmental / Equipment ☐ Security / Privacy Breach ☐ Other: _____

Event Level (select one):

☐ Level I – Near Miss / No Harm ☐ Level II – Temporary Harm ☐ Level III – Serious Harm / Sentinel Event

Description of Event:

_____
_____
_____

Immediate Actions Taken / Person Notified:

_____
_____

Client or Staff Outcome (if applicable):

_____
_____

Corrective / Preventive Actions Proposed:

_____
_____

Reporter Signature: _____ Date: _____
Director of Medical and Clinical Services Review: _____ Date: _____
Executive Director Review (if applicable): _____ Date: _____