	INDIANA DEPARTMENT OF CHILD SERVICES **CHILD WELFARE POLICY**
	Chapter 17: Residential Licensing **Section 10:** Root Cause Analysis
	Effective Date: November 1, 2023 — **Version:** 2

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POLICY OVERVIEW

When a sentinel event or near miss occurrence takes place in an Indiana Department of Child Services (DCS) licensed residential facility, it is imperative the facility gains a clear understanding of what occurred and why. To improve child safety and outcomes, the facility must complete a root cause analysis to develop, implement, and adjust systems, programs, policies, and practices to address identified issues and prevent reoccurrence. A root cause analysis must be completed with all sentinel events and may be requested to be completed due to a near miss occurrence depending on the severity.

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PROCEDURE

The root cause analysis may be conducted using the Framework for Root Cause Analysis and Corrective Actions or the facility may choose other tools or methods. However, the root cause analysis must include documentation of the analysis, findings, and actions taken to prevent reoccurrence.

The Licensing Specialist will:

1. Notify the Residential Licensing Unit (RLU) Manager upon learning about the possible occurrence of a sentinel event or near miss ;
2. Participate in discussions with the RLU Manager and Residential Clinical Services Specialist (CSS) to determine whether a root cause analysis will be required;
3. Contact the licensed residential facility to schedule a date for completion upon a decision to require a root cause analysis;
4. Provide guidance to the licensed residential facility, as needed, throughout the root cause analysis process;
5. Provide the completed root cause analysis to the RLU Manager and Residential CSS upon receipt from the facility;
6. Collaborate with the RLU Manager and Residential CSS to:
   a. Review details of the sentinel event or near miss, the facility's analysis, findings, and follow-up actions to determine if additional action may be needed;
   b. Provide feedback to the facility; and
   c. Follow-up with the facility regarding the completion and/or continuation of any follow-up actions implemented and/or additional actions required by DCS.
7. Ensure all decisions and actions taken are documented appropriately in the case

management system; and
8. Review the root cause analysis and follow-up actions taken again during the annual licensing review to ensure actions are adequate and continuing, as appropriate. See policy 17.11 Annual Licensing Review for additional information.

The Residential CSS will:

1. Participate in discussions with the Licensing Specialist and RLU Manager regarding the sentinel event or near miss occurrence, and make a recommendation regarding whether requirement of a root cause analysis is appropriate;
2. Review the completed root cause analysis, if applicable, and communicate with the facility to:
   a. Clarify information included in the root cause analysis, as needed,
   b. Request additional information, as needed,
   c. Request documentation of actions taken, and
   d. Make recommendations regarding additional actions to prevent reoccurrence.

3. Collaborate with the Licensing Specialist and RLU Manager to provide feedback to the facility regarding the finalized root cause analysis and arrange for follow-up review of the facility's ongoing implementation of the plan.

The RLU Manager will:

1. Facilitate discussions with the Licensing Specialist and Residential CSS to determine whether a root cause analysis will be required;
2. Assist and provide guidance to the Licensing Specialist and Residential CSS, as needed, with the completion of all requirements; and
3. Ensure all decisions and actions taken, including any deviation from best practice, are documented appropriately in the case management system.

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RELEVANT INFORMATION

Definitions

Near Miss Occurrence

A near miss is an occurrence that would have resulted in a sentinel event, but for timely intervention (e.g., attempted suicide or attempted rape).

Root Cause

The root cause is a factor, which by removal, would prevent the occurrence of the adverse event.

Root Cause Analysis

Root cause analysis is a collaborative process undertaken to understand the underlying factors that led to a sentinel event or near miss and the development of strategies to help avoid similar occurrences in the future.

Sentinel Event

A sentinel event is any unanticipated event in an Emergency Shelter or Child Caring Institution that results in the death or serious physical or psychological injury to a child, not related to the natural course of the child's illness.

Forms and Tools

- Framework for Root Cause Analysis and Corrective Actions

Related Policies

- 17.11 Annual Review for Licensed and/or Contracted Agencies

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LEGAL REFERENCES

N/A

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PRACTICE GUIDANCE- DCS POLICY 17.10

Practice Guidance is designed to assist DCS staff with thoughtful and practical direction on how to effectively integrate tools and social work practice into daily case management in an effort to achieve positive family and child outcomes. Practice Guidance is separate from Policy.

N/A

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