From Incident to Insight: Effective Root Cause Analysis for Your ASC

Leapfrog ASC Public Reporting Program Webinar

July 16, 2026

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Giant Leaps for Patient Safety

Introductions

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Discussion Agenda

- Welcome and Introductions
- ASC Survey 2.0: Taking Responsibility for Never Events
- Root Cause Analysis in ASCs
- Steps of Effective RCA
- Action Planning and Resources

Some Errors Are So Egregious They Should Never Happen

- In 2006, the National Quality Forum released a report that included 29 “serious reportable events” – serious, harmful, preventable – in hospitals and surgery centers.
- That same year, CMS came out with a public statement on Never Events, in which it announced its intention to work with Congress, hospitals, and other organizations to reduce payments for Never Events and to provide more information to the public about when they occur.

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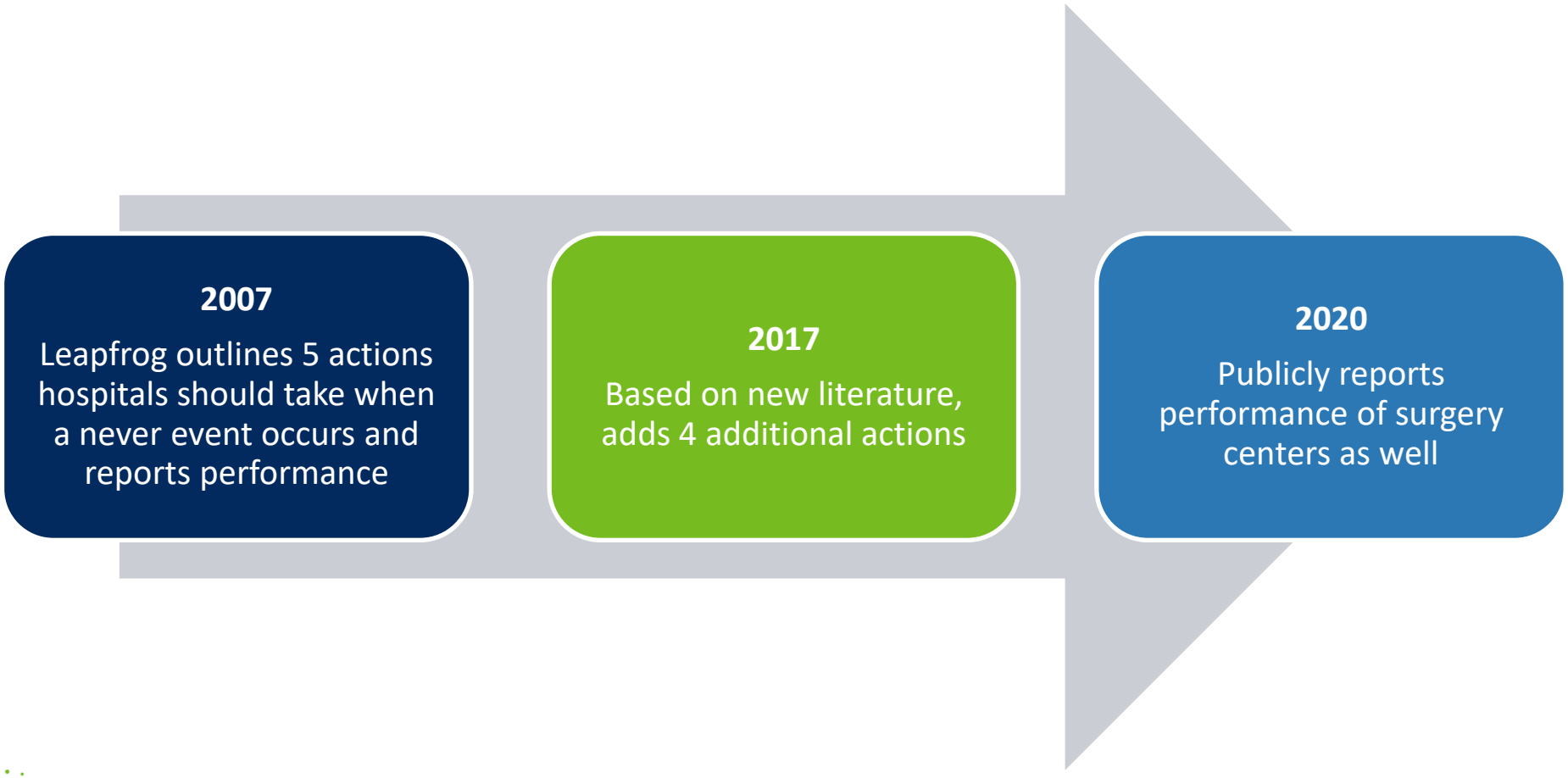
Leapfrog's Never Events Policy



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Never Events Policy: The Original Five Principles

Since the inaugural 2019 Leapfrog ASC Survey, ASCs have been asked to commit to nine actions when a never event occurs. The first five are the policy's original principles:

1. **Apologize to the Patient.** Give an apology to the patient and/or family affected.
2. **Report the Event.** Report to a national accreditation agency, state program, or Patient Safety Organization within 15 business days.
3. **Perform a Root Cause Analysis.** Conduct a prompt, thorough RCA to identify causal factors and improve systems and processes.
4. **Waive Related Costs.** Waive costs directly related to the event so the patient and third-party payor are not billed.
5. **Share the Policy.** Make a copy of the never events policy available to patients and payors upon request.

Never Events Policy: Four Additional Principles

Leapfrog added four principles in 2017, informed by AHRQ's CANDOR toolkit and new research on root cause analysis:

6. **Interview Patients & Families.** Gather evidence for the root cause analysis from patients and/or families who are willing and able.
7. **Explain Prevention Steps.** Inform patients and families of the actions taken to help prevent the event from recurring based on the root cause analysis.
8. **Support Caregivers.** Provide nonjudgmental, confidential support to staff involved in the event.
9. **Conduct an Annual Review.** Review compliance with all nine elements of the policy for each event that occurred, every year.

Together, all nine principles form the standard ASCs are scored against.

Which Events Must Be Included in the Policy?

The policy applies to the National Quality Forum's list of serious reportable events (“never events”) — 25 event types apply to ambulatory surgery settings, across six categories:

- **Surgical/Procedural Events** — e.g., surgery on the wrong site, patient, or procedure; retained foreign objects
- **Product or Device Events** — e.g., death or injury from contaminated drugs, devices, or biologics
- **Patient Protection Events** — e.g., discharge of a patient to the wrong person
- **Care Management Events** — e.g., death or serious injury from a medication error
- **Environmental Events** — e.g., death or serious injury from a burn, fall, or electric shock
- **Criminal Events** — e.g., care provided by someone impersonating a licensed clinician

Facilities must report a “never event” within 15 business days of determining it occurred to one of the following external agencies: state agency, qualified accreditation organization, or PSO.

Scoring: Taking Responsibility for Never Events

ASCs are scored on their adoption of the nine Never Events principles, in four tiers:

Performance Category	Requirement
Achieved the Standard	Policy adheres to all 9 principles of the Never Events Policy
Considerable Achievement	Policy adheres to the original 5 principles, plus at least 2 of the 4 additional principles
Some Achievement	Policy adheres to the original 5 principles only
Limited Achievement	Facility responded to the section but does not yet meet Some Achievement

Original five principles: apologize, perform a root cause analysis, report to an external agency within 15 business days, waive related costs, and share the policy on request.

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Public Reporting = Awareness & Accountability

Responding to Never Events

Surgery centers should have a never events policy that includes all nine (9) actions that should occur following a "never event," which includes apologizing to the patient and not charging for costs associated with the never event.

ACHIEVED THE STANDARD

SHOW LESS

The ASC apologizes to the patient and/or family following a Never Event: **Yes**

The ASC reports the Never Event to an external agency: **Yes**

The ASC conducts an analysis of how the why the event occurred: **Yes**

The ASC interviews patient and/or family involved in the event to gather evidence for the event analysis: **Yes**

The ASC informs patient and/or family of the action(s) taken to prevent future events: **Yes**

The ASC waives all costs directly associated with the event: **Yes**

The ASC supports caregivers involved in the event: **Yes**

The ASC makes a copy of this policy available to patients and payors upon request: **Yes**

The ASC performs an annual review to ensure compliance after all Never Events: **Yes**

Who We Are.

ECRI | The Most Trusted Voice in Healthcare

ECRI is an independent, nonprofit organization improving the safety, quality, and cost-effectiveness of healthcare globally. With a team of over 500 experts, and more than five decades of industry expertise, we deliver transformative insights to enable better care. At ECRI, we believe **every person** deserves safe, reliable care.

ISMP Institute for Safe Medication Practices

ISMP is the global gold standard in medication safety. ISMP runs the only national voluntary medication error reporting program. ISMP's work has resulted in numerous improvements in clinical practice, public policy and drug labeling for safety.

The JUST CULTURE Co.

The Just Culture Company helps healthcare organizations lead cultural transformation in the workplace to create accountable, supportive, and efficient cultures that better serve patients and healthcare workers.

Root Cause Analysis- Enterprise Safety Management

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Advancement in ASC Patient Safety

82%

of ASCs document all home meds, visit meds, and allergies

vs. only 50% of hospital outpatient departments

Source: Leapfrog Group, 2025 ASC Survey data

2,100+

ASCs contributing to national quality benchmarking

Representing nearly 3 million patient admissions per quarter

Source: ASC Quality Collaboration, 2025

37

ASCs earned Leapfrog's Top ASC designation in 2025

A 16% increase over 2024

Source: The Leapfrog Group, December 2025

Room to grow in safety culture infrastructure

Only 40% of ASCs administer a biannual patient safety culture survey and implement improvements from the results. And only 46% report having formal processes in place to identify and mitigate patient safety risks. These gaps represent the greatest opportunity for the field — and the reason this webinar exists.

Never events policy adoption: 5-year trend

In 2025, 78% of ASCs achieved Leapfrog's Never Events Standard – up from 53% in the inaugural Survey Year (2020) showing strong adoption and implementation improvement over the years.

Source: Leapfrog Group, February 2025 presentation data

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Challenges Exist

01
Small, lean teams with limited time

02
Tools designed for hospitals, not ASCs

03
Episodic contact limits data collection

04
Physician staffing infrastructure

05
Fear of liability and blame culture

06
Infrequent events create inexperience

07
Unclear external reporting requirements

Structural / resource barriers

Cultural / process barriers

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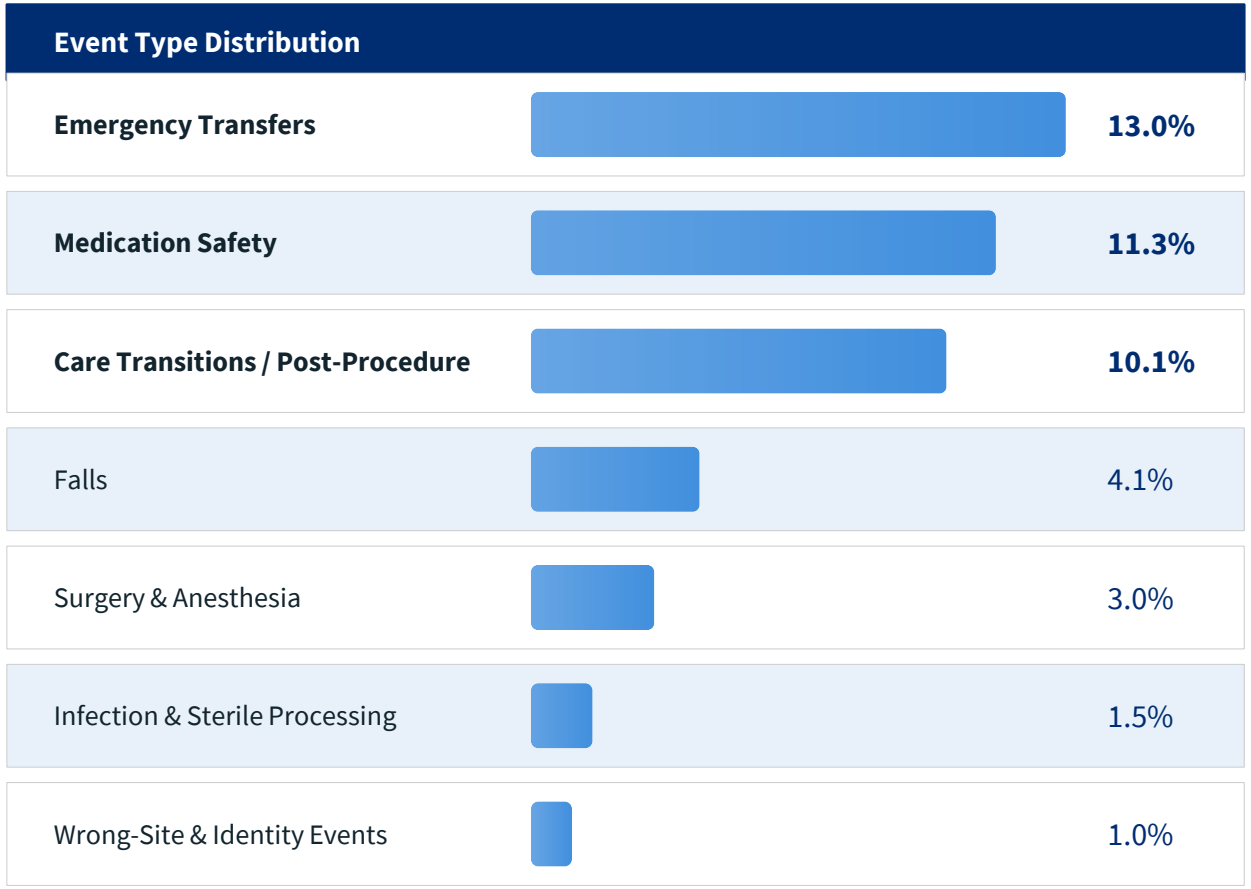
Real-World Event Data From Ambulatory Surgery Settings

AHRQ Harm Score	Count	% of Total
No Value Reported	2,262	50.4%
No Harm	1,109	24.7%
Mild Harm	424	9.4%
Unknown	395	8.8%
Not Mapped	203	4.5%
Moderate Harm	87	1.9%
Severe Harm	**6**	**0.1%**
Death	**6**	**0.1%**
Total	**4,492**	**100%**

Source: ECRI and ISMP PSO ASC Adverse Event Data



Poll: ASC-Specific RCA Challenges

Of these challenges, which most impacts your ASC's ability to perform RCAs?

- ☐ Physician staffing infrastructure
- ☐ Fear of liability and blame culture
- ☐ Small, lean teams with limited time
- ☐ Infrequent serious events create inexperience with RCA
- ☐ Tools and frameworks designed for hospitals, not ASCs
- ☐ Unclear external reporting requirements
- ☐ Episodic patient contact limits data collection

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Lean Team, Lean Process: Right-Sizing RCA for ASCs

Effective RCA in an ASC is about structured thinking. The process scales to your team size and event severity.

Right-size the team

3–5 members covers most events: safety lead, direct care staff, and a physician. Expand only if scope warrants it.

Use structured templates

Standard hospital RCA forms are more than most ASC events require. Use a streamlined template that covers Leapfrog elements 3, 6, and 7. Build it into a policy.

Document with purpose

Capture required Leapfrog findings and drive real preventive actions—not just checklist completion.

Account for episodic contact

ASCs can't always interview patients in the same setting post-event. Pre-build a patient/family outreach protocol—required for Leapfrog element 6.

Engage physicians early

Physicians are essential but often reluctant. Tie engagement expectations directly to your never events policy.

Build in annual review now

Element 9 requires an annual compliance review. Document it with a checklist mapped to all 9 policy elements—even in event-free years.

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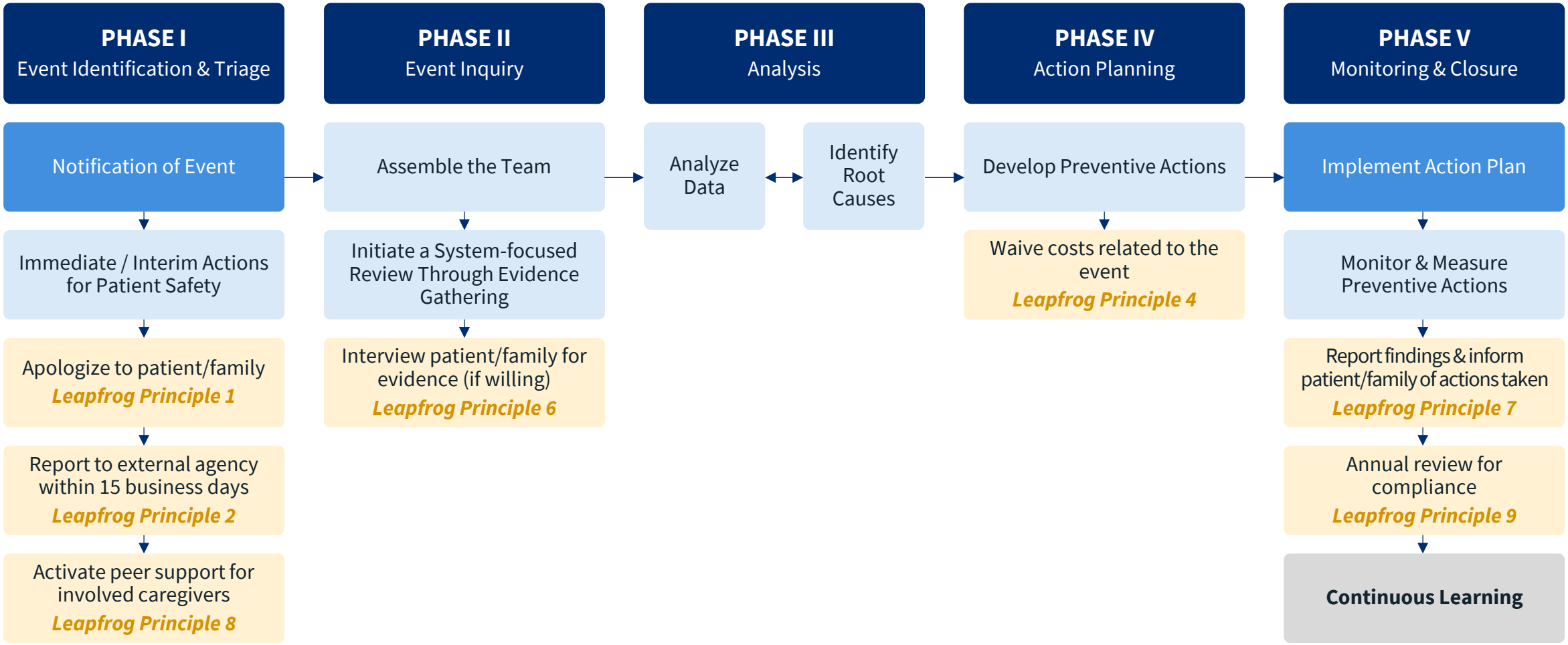
What Makes a Good RCA?



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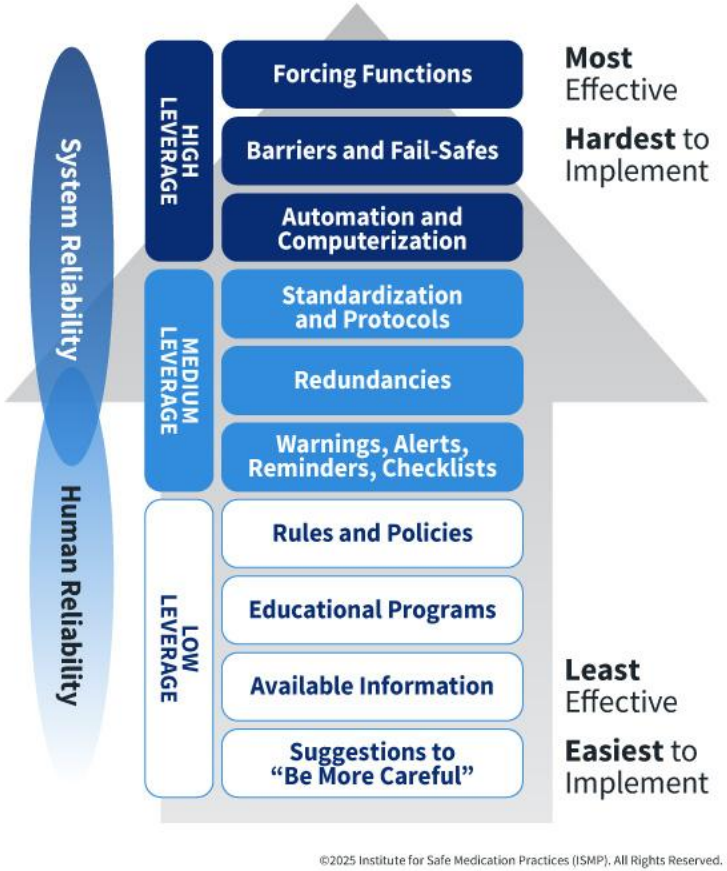
Tip: Contributing Factor Versus Root Cause

Ask: If we removed this factor, would the same event still be possible?
If yes, that is a contributing factor — not a root cause.

Event	Contributing factor (What made it easier to fail)	Root cause (What systemically allowed the failure)
Delay of case	The surgeon was unfamiliar with the new instrument tray layout	No standardized instrument tray setup policy exists; changes to supply chain are not communicated to the surgical team before implementation
Antibiotic allergic reaction	The pre-op checklist was not completed for this case	No hard stop in the workflow requires checklist completion before case start; compliance is not audited
Wrong site surgery	The patient was not marked before entering the OR	The time-out policy does not require independent verification of site marking by nursing prior to the surgeon entering the room

Tip: Action Planning



Strong actions
Least reliant on human memory — eliminate or engineer out the failure point

Highest impact

Forcing function for time-out
EHR or scheduling system cannot advance to "procedure start" without completed time-out documentation

Physical redesign of medication storage
Separate look-alike/sound-alike medications into distinct, non-adjacent storage locations with physical barriers

Standardized care pathway
Procedure-specific care maps built into scheduling and clinical workflow, removing reliance on individual recall

Intermediate actions
Reduce reliance on human performance — add redundancy, structure, and support

Moderate impact

Pre-procedure safety checklist
Structured checklist used by two staff members independently before every case, with sign-off required

Dedicated circulator role
Assign a non-scrubbed circulator for all higher-acuity cases to reduce task overload on the surgical team

Standardized handoff protocol
Structured read-back communication tool (e.g., SBAR) required at every care transition point within the ASC

Weak actions
Highly dependent on human memory — necessary but insufficient when used alone

Use as complement only

Staff re-education
Review of wrong-site surgery prevention protocols with all clinical staff; competency validation at annual review

Policy and procedure update
Revised never events response policy distributed to all staff with required acknowledgment signature

Signage and labeling
Updated medication labels and warning signage added to high-risk storage areas and procedure rooms

Tip: Engaging Patients and Families in the RCA Process

Leapfrog elements 1, 6, and 7 all require proactive outreach. Build the process before you need it.

LF #1

Apologize promptly and compassionately

A sincere apology — without admission of legal liability — is both ethically required and required by Leapfrog. Script the opening conversation in advance. Involve the physician.

LF #6

Offer and document the patient / family interview

Interview patients and families who are willing and able. Use a structured guide such as ECRI's PEACE Interview Guide. Document the invitation even if declined.

LF #7

Close the loop: share what the facility will do differently

Once RCA findings and actions are finalized, inform the patient and family of the specific preventive actions your facility will take. This is required by Leapfrog and often the most meaningful step for families.

LF #4

Waive all related costs and document the waiver

Costs must be waived for both the patient and the payor. Coordinate with billing and ensure both physician and facility charges are addressed. Retain written documentation of the waiver.

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Tip: Engaging With the Patient and Family

Show empathy

"We are deeply sorry for what happened to you and your family. We want to make sure your experience and your perspective are central to understanding what went wrong."

Acknowledge their expertise

"You and your family know this experience better than anyone in this room. Can you walk us through what the day felt like from your side — what you noticed, what you were told, and how things unfolded?"

Invite system observations

"Looking back, were there moments where something felt off, or where you wished communication had been clearer? We are asking because those observations often point us toward the system changes that matter most."

Close with transparency and commitment

"Based on what you have shared with us today, we want to make sure we follow up with you on what we find and what we commit to changing. How would you like us to stay in touch with you as this process moves forward?"

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Next Steps: Building Capacity Towards a Formal RCA Process

Immediate Actions — This Month

1. **Audit your never events policy**
   Review your policy against all 9 Leapfrog elements and document any gaps using a yes/no checklist.

2. **Confirm your external reporting pathway**
   Identify which agency satisfies Leapfrog element 2 and confirm the 15-business-day timeline is reflected in your policy.

3. **Assign your RCA lead**
   Identify the person or persons by role who will lead your RCA process. Ensure they have or will receive training.

4. **Develop a patient and family outreach guide**
   Adapt a structured guide for post-event outreach and apology conversations — before you need it.

Short-Term Actions — Next 30 to 90 Days

1. **Run a tabletop RCA exercise**
   Conduct a tabletop exercise using a de-identified near miss or hypothetical scenario to build team readiness.

2. **Formalize your RCA team**
   Establish RCA team composition in writing — including physician role expectations — and communicate to all staff.

3. **Activate your peer support protocol**
   Identify resources, document the protocol, and add it to your never events policy (element 8).

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ECRI Resources and How to Engage

Email us clientservices@ecri.org

ECRI and ISMP PSO Membership

Provides privileged, confidential event reporting that satisfies Leapfrog's external reporting requirement. Includes access to RCA consultation and tools.

ECRI RCA Training Programs

'RCA in Action: Building Foundations' and 'Advanced Principles and Practices' - both available as live virtual programs. Contact ECRI for group rates for ASC teams.

ECRI SafeSystem℠ Solutions

Practical patient safety implementation support designed for ASCs and ambulatory settings.

Enterprise Safety Management (ESM) Consulting: For ASCs seeking to redesign their full event investigation and RCA process.

Human Factors Engineering (HFE) Consulting: For ASCs looking to strengthen safety systems through system-level redesign.

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