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Committed to your health.℠

Root Cause Analysis

Why things happen

Secret -

- There is really no such thing as a root cause

- There are contributing factors – and there is no end to them

Purpose of a Root Cause Analysis

The purpose is to prevent harm to patients, staff and visitors

NOT to lay blame – we are moving from “who did it” to “why did it happen”.

Do Not Use RCA if…

This appears to be deliberate, criminal, or related to substance abuse

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When to Use RCA

- Adverse events
- Sentinel events
- Close calls

AND

Anytime you are concerned about:

- A process due to repeated errors
- The possibility of serious errors
- Errors that are of a high cost to anyone

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Use the RCA –
To Answer the Critical Questions

- What happened (or is still happening)?
- How did it happen?
- Why did it happen?
- How can we prevent it from happening again?
- What can we learn from this?

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Protect Members, Staff, Others

What immediate actions may need to be taken?

Examples:

- Equipment removed from service
- Unit closed
- Medication recall

First Steps

- Identify the RCA as a Quality Assurance activity
- Discuss with Leadership:
  - The reason for the RCA
  - The appropriate team members
  - Any history on this subject
- Write a charter

Assemble the Team

- Choose team members who are familiar with the process
- Choose team members who are unfamiliar with the process
- Select a leader
- May also select a facilitator
- Choose internal/external resources

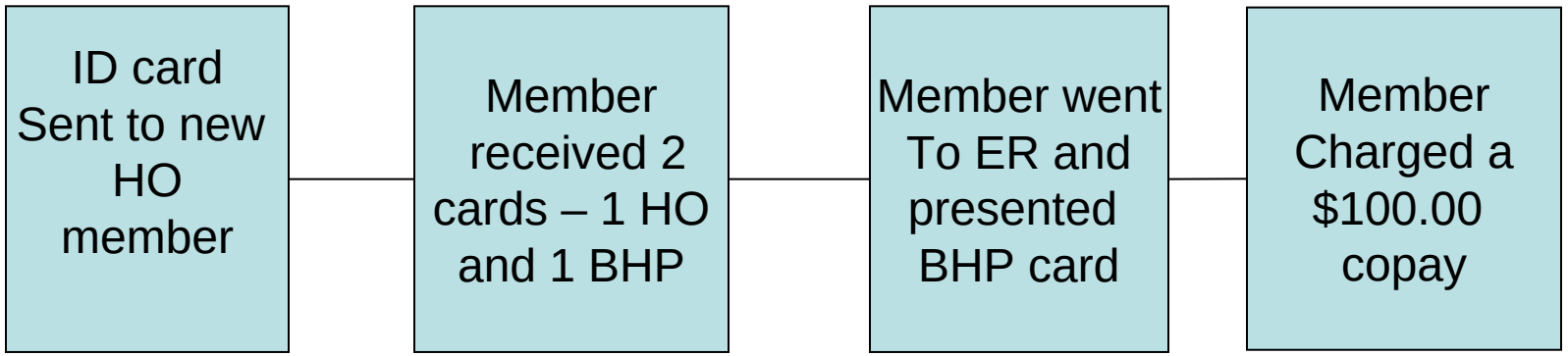
Prepare the Team

- Emphasize confidentiality.
- Clarify the “no blame” philosophy
- Discuss the role of the team – to learn what happened and to prevent a similar event
- Is there literature on this?

Identify What is Already Known

- Write a statement of what occurred
- Discuss the boundary of the event – where do you begin and end
- Prepare a flow chart of what you know regarding activities and decisions from the beginning to the end of the event. (This allows everyone to see the event in the same way)

Flowchart... fictitious example



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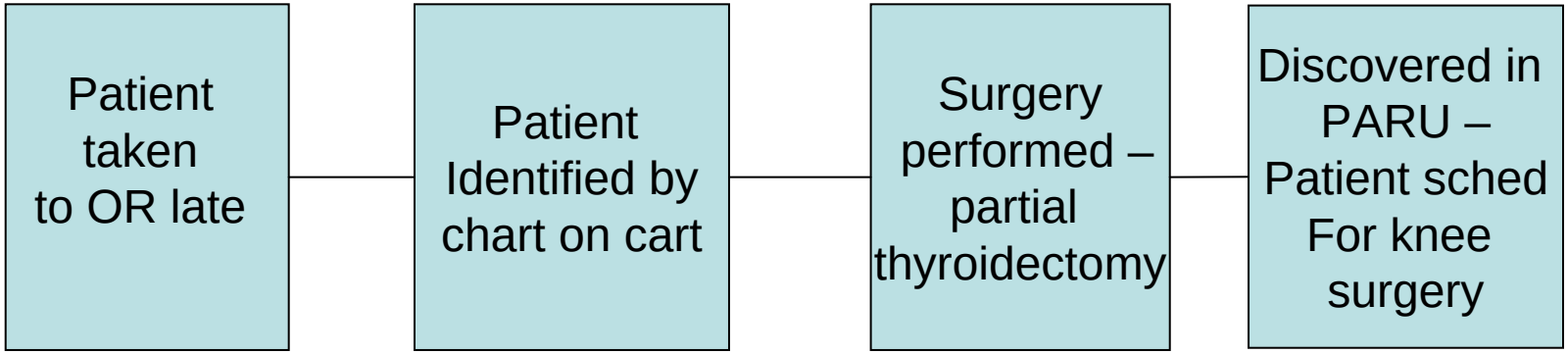
Flowchart... fictitious example



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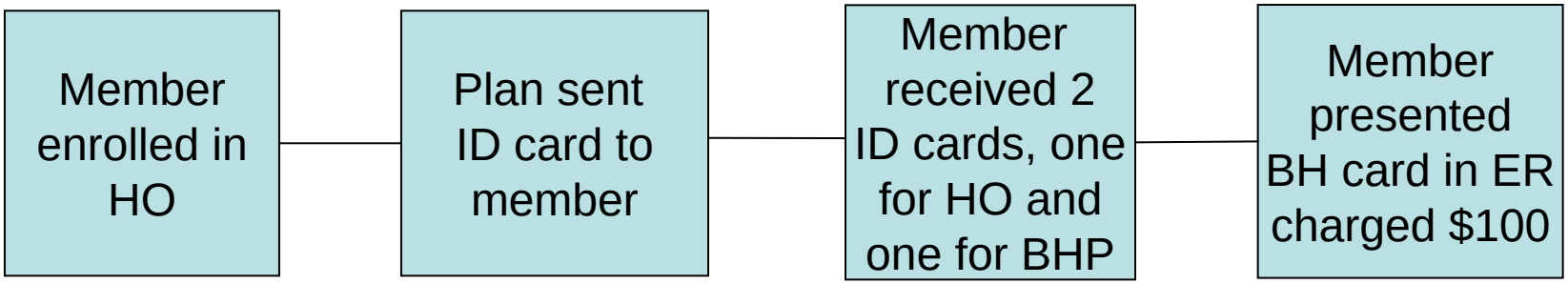
What Else do you Need to Know?

- What are the gaps in the information?
- Why did each step in the process occur?
- What do you need to know to fill in the gaps?
- Where can you get the information?

Flowchart... fictitious example



Is there a possibility of double enrollment?

How can 2 IDs be sent?

Does the member know which plan is hers?

How was the error discovered?

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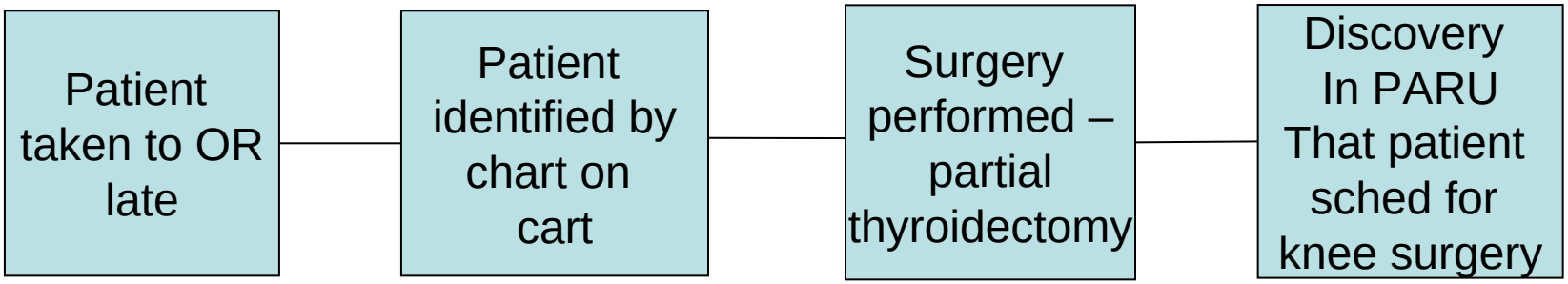
Flowchart… fictitious example



Why was patient late?

Why did RN not check ID band?

Why did MD perform wrong surgery?

How did the discovery happen?

Avoid Hindsight Bias

- It is human nature to think we know why something happened without investigating
- It is also common to associate the cause of the failure with the action just preceding the event.
- Is this a cascading error?

Interview

- Those involved in the event
- Those who are familiar with the work process
- Anyone who may be able to provide information about the events in question or the process in general

Interview cont.

- The interview can be done by the team, by part of the team, by one team member or someone outside of the team.
- The team should develop the interview tool regardless of who the interviewer is.

Key Questions – Communication

Communication

- Were problems with the system identified and communicated?
- How are patients assessed for language and literacy?
- Was this a surgical patient on a medical floor?

Training

Were employees trained for the procedure by a trainer or by a fellow-employee?

Environment/Equipment

Environment/Equipment

- Is the work area suitable?
- Is the equipment reliable?

Rules, Policies and Procedures

- If the policies and procedures were not used, what got in the way of their usefulness to the staff?
- What rules are used to make decisions?

WHY??????

Keep asking why until the answer is no longer within the boundary of the analysis or no longer makes sense in relationship to the event.

Field Trip

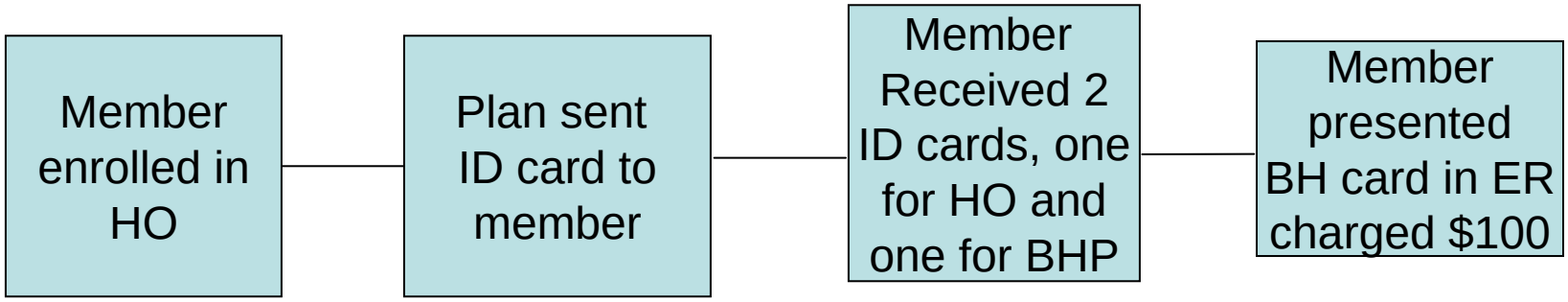
The Three “Actuals”

- Go where the work is actually done
- Talk to the people who actually do the work
- See what actually happens

Final Flow Chart

Create the flow chart with the information you have acquired – putting the information related to the events in the flow under each event.

Flowchart… fictitious example



Member had been previously enrolled in BH

There are two different sources of information in system

Member only knows she has state insurance

Member borrowed money to pay copay – neighbor told her she had HO

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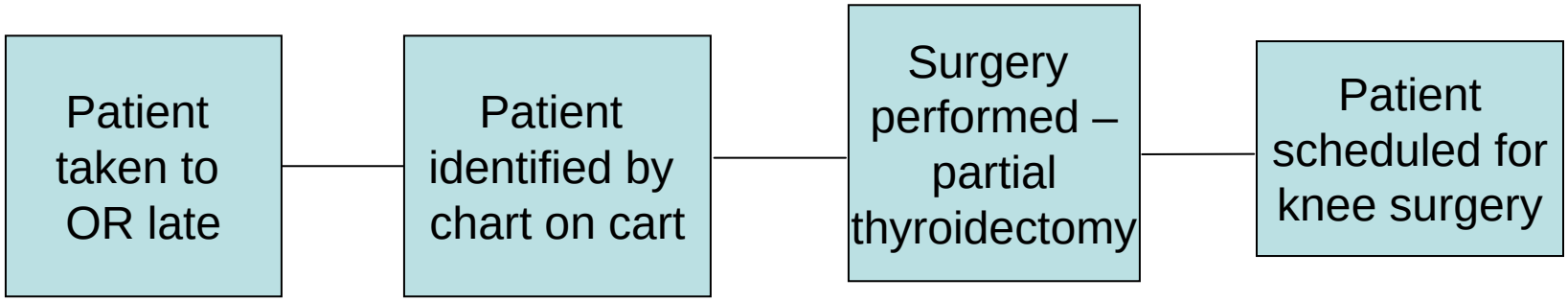
Flowchart…



Surgery did not give floor notice. In a hurry to pick Up patient

ID band was blurry. ID machine does not work well – New machine denied in budget

MD was rushed – room overbooked. MD had only met patient once – two months ago

Discovery made by patient

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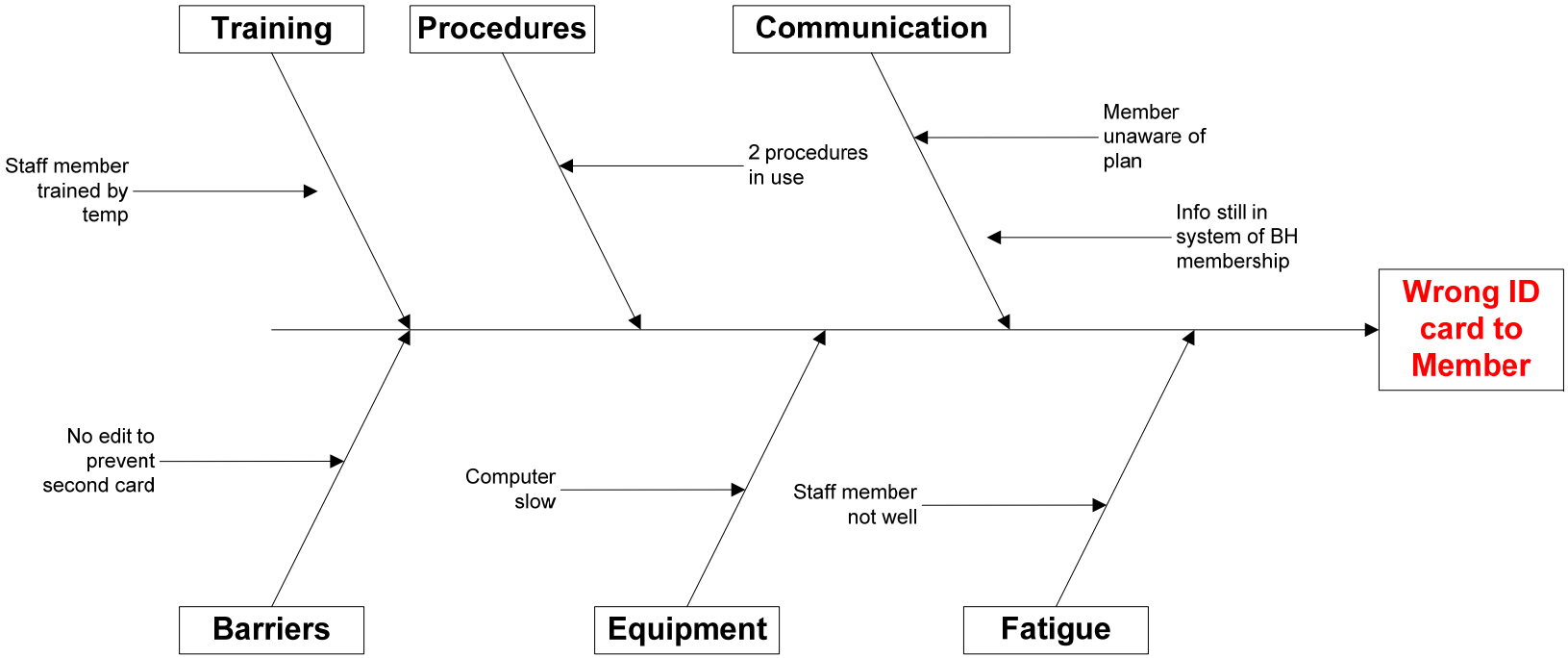
Identifying Contributing Factors (root causes)

- Find relationship among errors
- Failure to follow procedures is not a root cause
- Were there any corrective actions taken in the past for an event similar to this?

Cause and Effect Diagram…fictitious example



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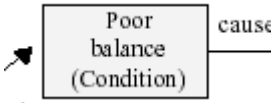

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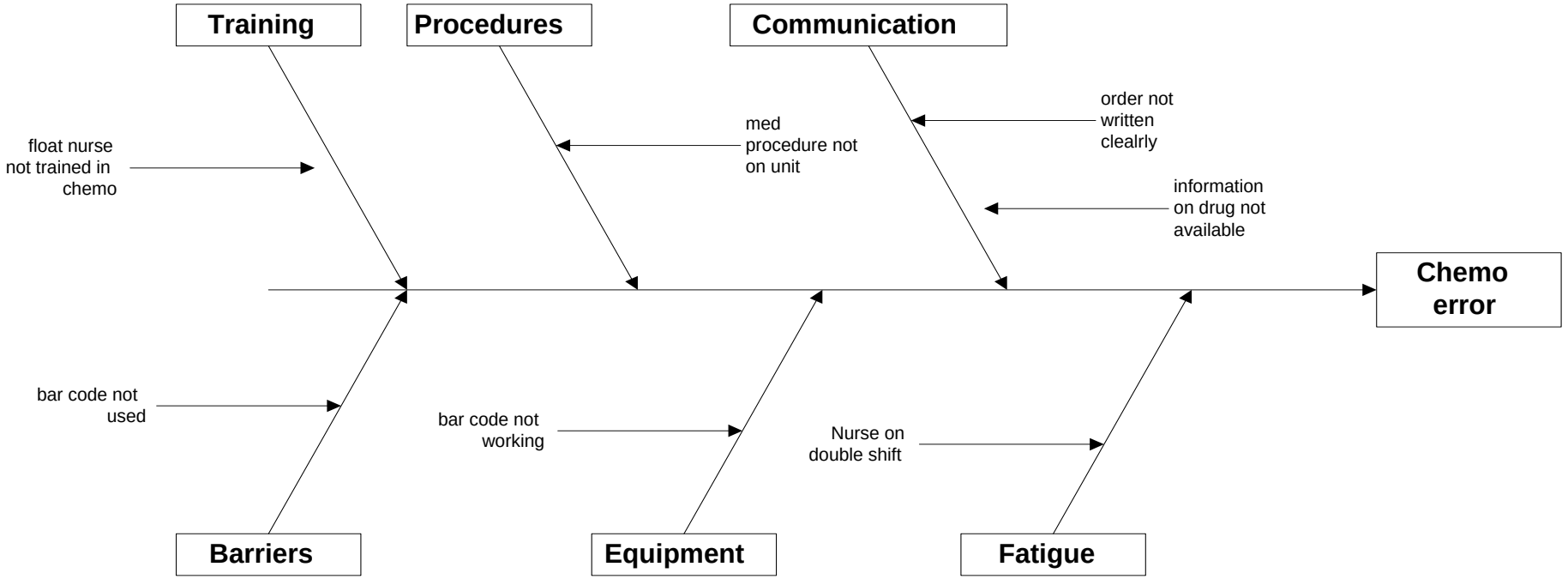

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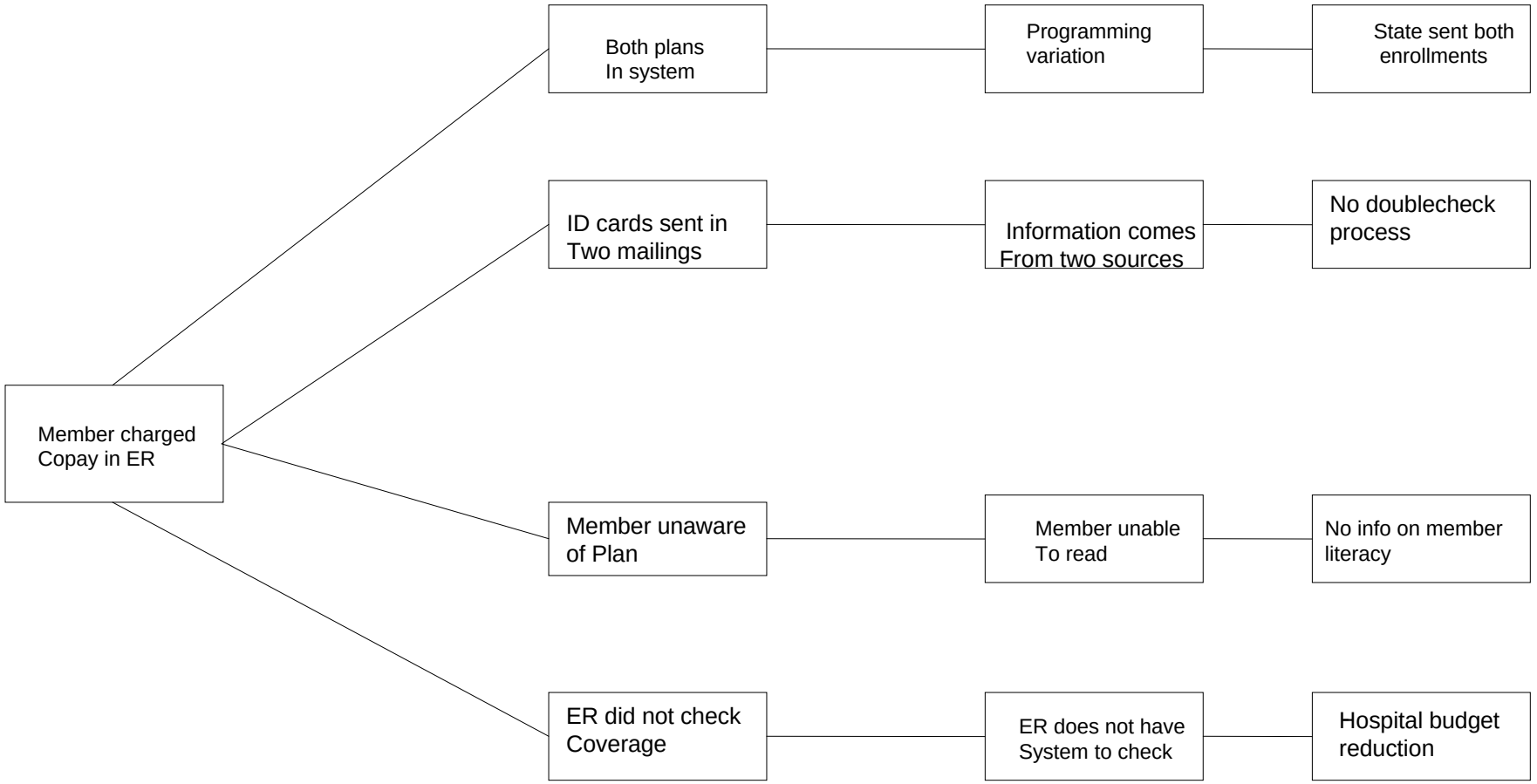
Cause and Effect... fictitious example



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Select the Primary Causes

- If these factors had not been present the event would not have happened

- What is common to all problems with this process?

Select Actions

- Redesign of the process?
- Minor change?
- Development of a new process?

Are the chosen interventions:

- Cheap
- Easy to do
- Likely to succeed

Actions cont.

- Can they be tested prior to implementation?
- Do the people who own the process concur?
- Do those who reported the error concur?
- What could be the unintended consequences?
- Who needs the information on the process change?

Strength of Actions

- Strong: plant or facility change; new device or equipment changes, simplified process, standardization of process
- Intermediate: Read back, checklist, improve documentation, increase staff
- Weak: warning labels, training, new policy

Lessons Learned

- What was learned from the event?
- What was learned from the RCA process?

Evaluation

- Measure the effectiveness not just the implementation of the action.

- What are the unintended consequences?

Resources

- http://www.va.gov/ncps/pubs.html - for root cause analysis tools and triage cards (no fee) _VA's National Center for Patient Safety
- http://www.asq.org/learn-about-quality/cause-analysis-tools/overview/fishbone.html - information on cause and effect (Ishikawa or fishbone diagram) – American Society for Quality

Resources cont.

- Deming, W.E. Out of the Crisis, MIT, 1989
- Memory Jogger II – Brassard and Ritter - Goal QPC
- http://www.hfes.org/web/DetailNews.aspx?ID=102 Human Factors and Ergonomic Society
- http://www.va.gov/ncps/HF_C.html - human factors triage questions

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