Root Cause Analysis (Part I)
http://www.jcaho.org/accredited+organizations/sentinel+
event/rca_assisttool.doc

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Root Cause Analysis

• Examines the reasons an error occurred
• Suggests changes to the system that can prevent the incident from happening again
• Seeks to identify the underlying causes of a sentinel event
Root Cause Analysis

• In order for the JCAHO to consider a root cause analysis acceptable it must:
  • focus primarily on systems and processes,
  • progress from special causes in clinical processes to common causes in organizational processes,
Root Cause Analysis
continued

• repeatedly dig deeper into the cause by asking "why" at multiple levels,

• identify changes that could be made in systems and processes, either through redesign or development of new systems or processes, that would reduce the risk of such events occurring in the future,

• be thorough and credible.
Blameless culture

• By instituting policies that address the underlying issues raised by the root cause analysis, a facility is able to prevent a repeat incident.

• Employees are much more likely to report adverse events or near misses in which an adverse event was narrowly missed if they know that doing so may result in change to the system, not disciplinary action against them personally.
Blameless culture

• Ultimately, addressing the underlying failures in the system that allowed an error to occur is much more useful than blaming the individuals involved.
Framework for Conducting a Root Cause Analysis-JCAHO

Brief description of event

– Briefly summarize the circumstances surrounding the occurrence including the patient outcome (eg, death, loss of function).
Framework for Conducting a Root Cause Analysis

Who participated in the analysis?

– Include a list of all team members that participated in the analysis by position and title. Please DO NOT include any names!
Framework for Conducting a Root Cause Analysis

When did the event occur?

– Include the date and time the event took place.
Framework for Conducting a Root Cause Analysis

What area/service was impacted?

– Include the full variety of services impacted by the event.
Framework for Conducting a Root Cause Analysis

5. What are the steps in the process, as designed? *(A Flow Diagram(s))*

A. Flow-chart the process as designed.
B. Flow-chart the process as it is usually done.
C. Flow-chart the process as it was done when the sentinel event occurred.
D. Identify risk points and their contribution to the event.
E. Flowchart the process with improvements.
Framework for Conducting a Root Cause Analysis

What human factors were relevant to the event?

– Evaluating the role of human performance factors that may have contributed to an error.
Framework for Conducting a Root Cause Analysis

How could equipment performance affect the outcome?
– List the various equipment utilized for that patient during the health care stay.
Framework for Conducting a Root Cause Analysis

What controllable factors directly affected the outcome?

– Identify factors that may have contributed to the event that the organization has the ability to change by making process improvement changes.
Framework for Conducting a Root Cause Analysis

Where there uncontrollable external factors?

– Uncontrollable external factors are those FEW factors that the organization cannot change that contribute to a breakdown in internal processes.

– Although a factor may be beyond the organization’s control, the organization may be able to minimize the factor’s effect on patients.
Framework for Conducting a Root Cause Analysis

What other areas or services are impacted?

– List all other areas that have the potential for a similar event to occur.

– This will assist in implementing risk reduction strategies in other pertinent high-risk areas.
Framework for Conducting a Root Cause Analysis

To what degree is staff properly qualified and currently competent for their responsibilities?

– Include all staff present, not just those that were determined to be involved with the event
Framework for Conducting a Root Cause Analysis

How did actual staffing compare with ideal levels?

– Was there appropriate staffing at the time of the event to address the required workload?
– Keep in mind if it was a weekend, change of shift, holiday, break time.
– Document the actual staffing in area of occurrence versus planned staffing according to the staffing model.
Framework for Conducting a Root Cause Analysis

What are the plans for dealing with contingencies what would reduce effective staffing levels?

– Summarize current plans in place to deal with staffing deficiencies.
Framework for Conducting a Root Cause Analysis

How has staff performance in the relevant processes been assessed? When was this last performed?

– Consider staff performance relative to the specific processes associated with the event.
Framework for Conducting a Root Cause Analysis

How can orientation and in-service training be improved?

– Was all staff oriented to the job responsibilities, organization, and policies and procedures regarding safety, security, hazardous materials, emergency, equipment, life-safety, treatments, and procedures?
– Are policies revised/updated, evidence based, and readily available?
– Have policies or procedures changed without providing additional training?
– Was a new policy developed and staff training conducted?
– Do float staff or agency staff receives training within the areas they are assigned?
– Is this documented?
Framework for Conducting a Root Cause Analysis

To what degree is all information available when needed?

- Was information from various patient assessments completed, shared, and accessed by members of the treatment team as required by policy?
- Was the patient correctly identified?
- Was the documentation clear and did it provide an adequate summary of the patient’s condition, treatment, and response to treatment?
- Was the level of automation appropriate?
- Identify what information systems were utilized during patient care.
Framework for Conducting a Root Cause Analysis

To what degree is communication among participants adequate?

- Look at this content to cover verbal and lack of verbal/written communication.
- Physician to....
- Nurse to....
- Tech to....
- Pharmacist to....
- Hierarchical issues....
- Cultural issues....
Framework for Conducting a Root Cause Analysis

To what degree was the physical environment appropriate for the processes being carried out?

- Look closely at the environment the patient was in or was transferred to/from. Spaces, privacy, safety, and ease of access are a few items to consider.
- Was work performed under adverse conditions (hot, humid, improper lighting, cramped, noise, construction projects)?
- Had there been environmental risk assessments conducted?
- Did the work environment meet current codes, specifications, and regulations?
- Was the work environment appropriate to support the function it was being used for?
Framework for Conducting a Root Cause Analysis

What emergency and failure mode responses have been planned and tested?

– Had appropriate safety evaluations and disaster drills been conducted?
– Had provisions been planned and available to support a breakdown in operations?
Framework for Conducting a Root Cause Analysis

To what degree is the culture conducive to risk identification and reduction?

– Did the overall culture of the facility encourage or welcome change, suggestions, and warnings from staff regarding risky situations or problematic areas?

– Does management establish methods to identify areas of risk or access employee suggestions for change?

– Are changes implemented in a timely manner?
Framework for Conducting a Root Cause Analysis

What are the barriers to communication of potential risk factors?

– What is your organization doing to break down barriers to effect change?

– Has the organization identified barriers to effective communication among caregivers?

– If there are no barriers, what have you done and how do you know it has been successful?

– Be specific.
Framework for Conducting a Root Cause Analysis

To what degree is the prevention of adverse outcomes communicated as a high priority?

– Explain leadership’s role and how it is put into practice, provide examples.
Framework for Conducting a Root Cause Analysis

What can be done to protect against the effects of uncontrollable factors?

– When looking at uncontrollable factors review the system the patient went through.
The END

• Proceed to the post test
• Print the post test
• Complete the post test
• Return the post test to Dr. Sandra Oliver
• TAMUII 407i
Post test 1

• True or False: Medical errors only occur at substandard medical facilities.
  – True
  – False
Post test 2

• A(n) _____ seeks to identify the underlying causes of a sentinel event.
  – investigation
  – accreditation review
  – sentinel event
  – root cause analysis
The Institute of Medicine's report, "To Err is Human," encouraged _____.

A. the development of error reporting that focused on identifying and fixing common errors in the system
B. blaming and punishing the individual worker who committed the error
C. instituting a fee structure under which workers must pay a specific amount for every error discovered
D. health care facilities to quit trying to eliminate medical errors because they will always occur