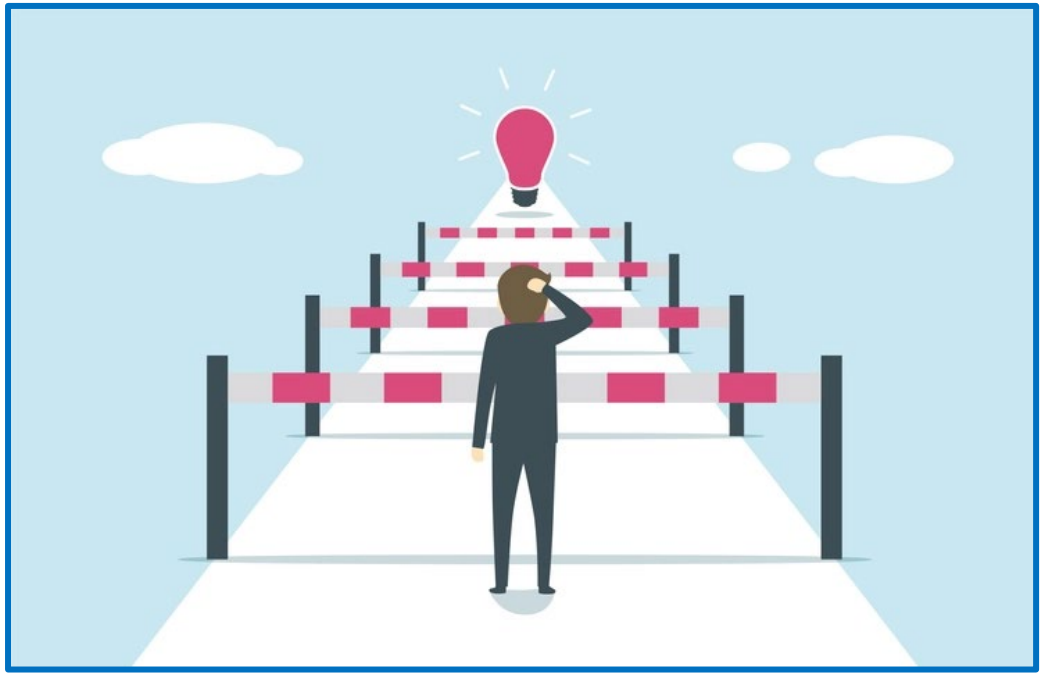
In’s and Out’s of Root Cause Analysis

State Office of Rural Health and Texas Hospital Association
Critical Access Hospital Quality Improvement Boot Camp
Summer 2022

Challenges to Root Cause Analysis

- What are some challenges your organizations face?
- Lack of support and/or understanding
- Reactive
- Punitive
- Inconsistent
- Weak action plans
- Poor Implementation
- Poor Communication



Challenges and Hurdles. Digital Image. 2022. https://medcitynews.com/2022/01/five-challenges-healthcare-faces-in-2022-and-beyond/.

RCA2

- Recommendations to improve how we learn from adverse events and unsafe conditions **AND** to take action to prevent recurrence.

- Benefits:
  - Standardized
  - Systems-based
  - Promotes sustainable improvement

Safety Culture/Just Culture

- Trust and transparency through written policies and actions
- Purpose: to identify systems vulnerabilities, not individual performance
- Findings are not to be used to discipline, shame, or punish

Trust and Transparency. Digital Image. (n.d.). https://www.ahrmio.org/event/building-trust-transparency-and-authenticity/.

Safety Assessment Code Matrix

- Determine Severity
  - Organizational definitions
- Determine Probability
- Include near misses/close calls

PROBABILITY	SEVERITY			
	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

RCA2 Process

- Define and put into writing (policies)
- Timing (triggers/process)
- Meetings (how many, what will be discussed, calendar)
- Team members and roles
  - How many people?
  - Membership
- Interviewing
- Implementation
- Measure/Monitor Impact
- Continuous Communication/Feedback Loop

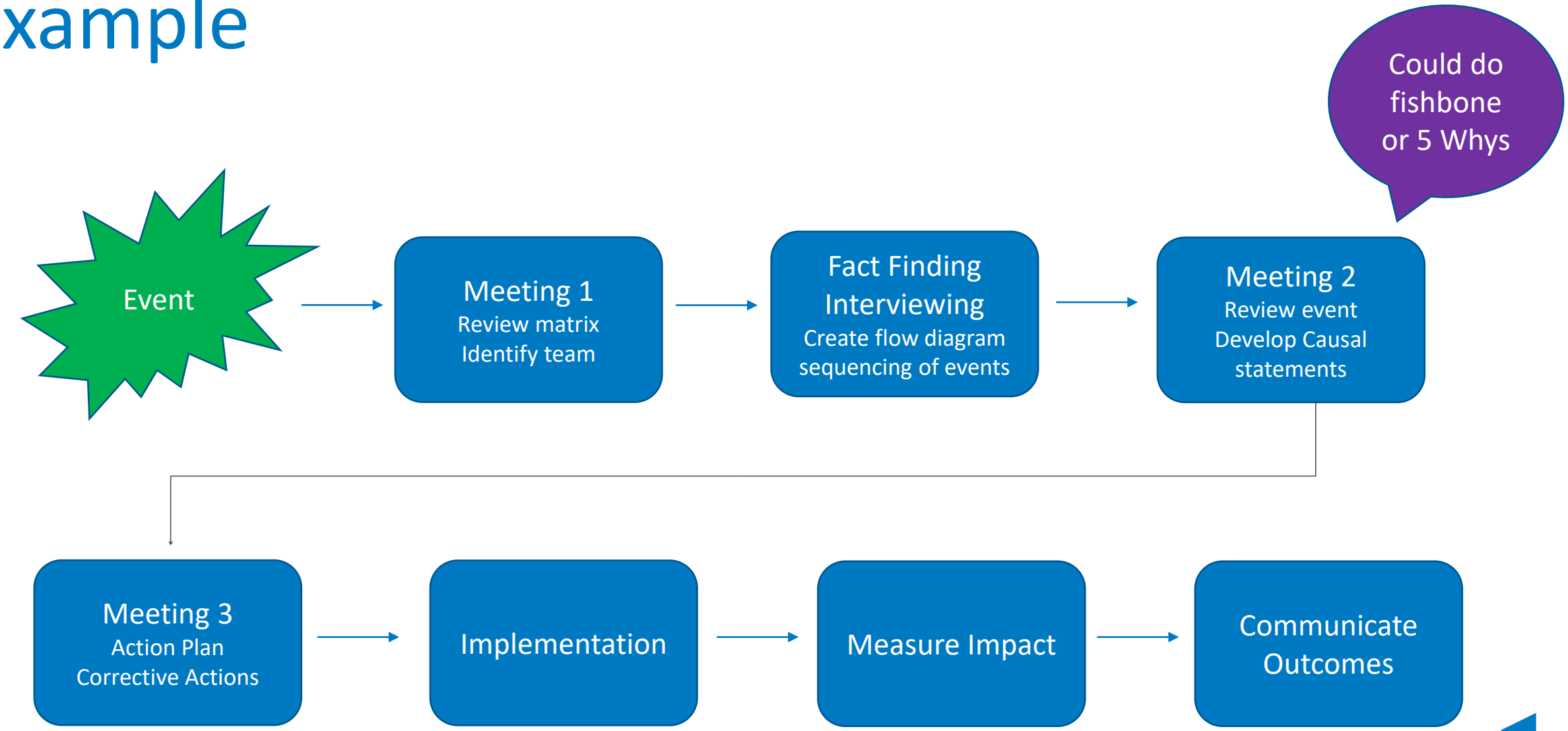
Committee Meeting Graphic. Digital Image. n.d. https://www.freepik.com/premium-vector/men-woman-different-ages-nationalities-sitting-round-desk-group-therapy-brainstorming-meeting_7776228.htm.

Interviewing

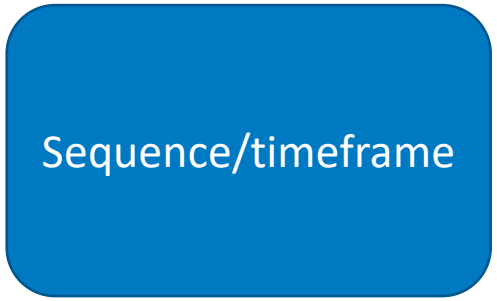
- Critical Element
- Trained on interviewing techniques
- 1:1
- Include patient and family

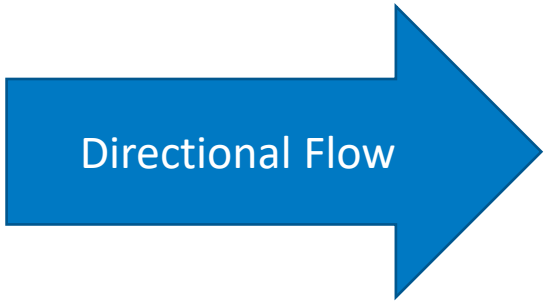
- **Setting**
  - Quiet
  - Neutral
  - limited distractions
  - Comfortable
- **Be prepared**
- **Conversation**
  - Explore what the person knows, remembers
- **Review what was collected/said**
- **Thank you!**

Example

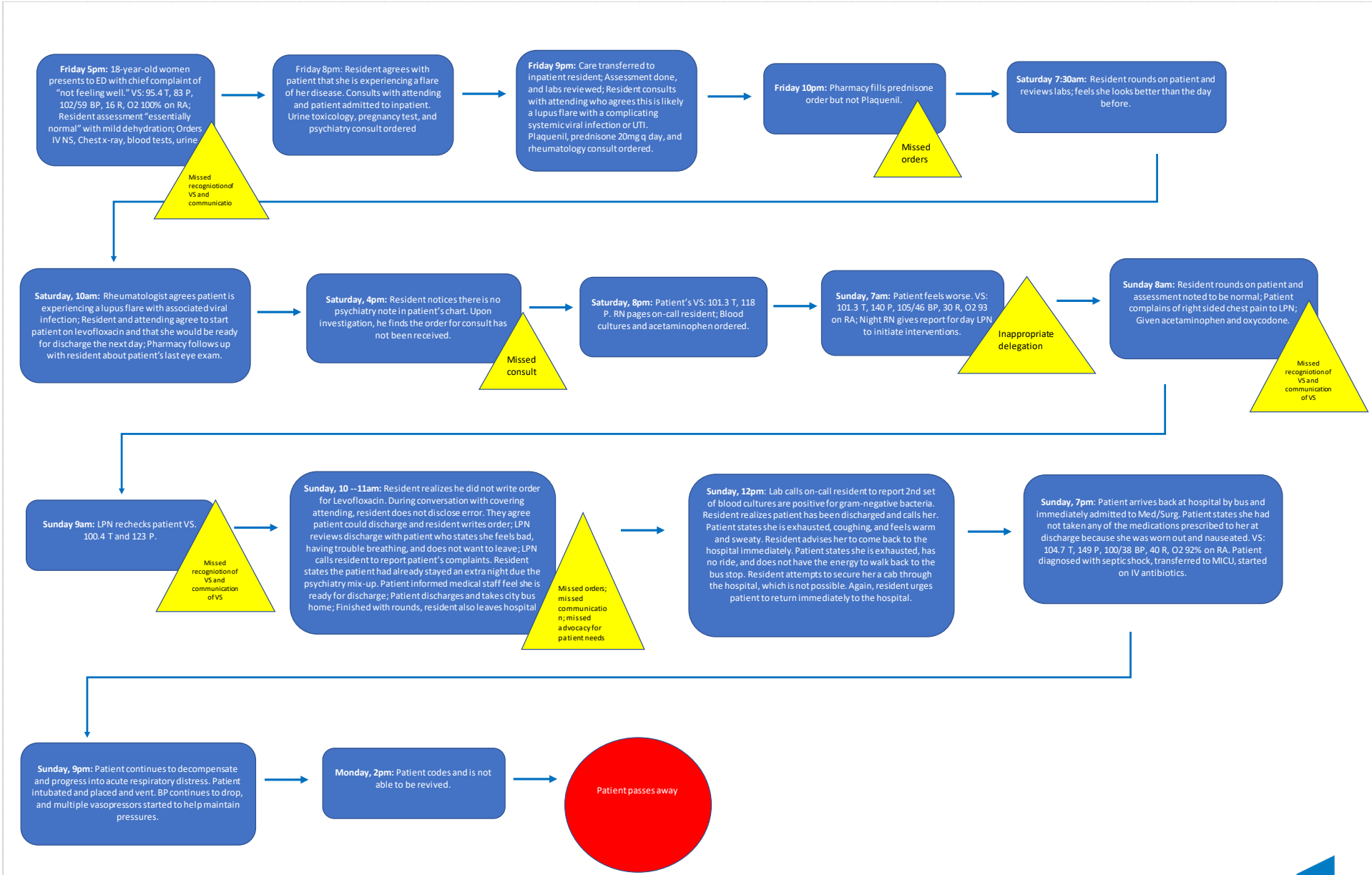

Could do fishbone or 5 Whys
Event
Meeting 1
Review matrix
Identify team
Fact Finding
Interviewing
Create flow diagram
sequencing of events
Meeting 2
Review event
Develop Causal statements
Meeting 3
Action Plan
Corrective Actions
Implementation
Measure Impact
Communicate Outcomes

Example of sequencing shapes

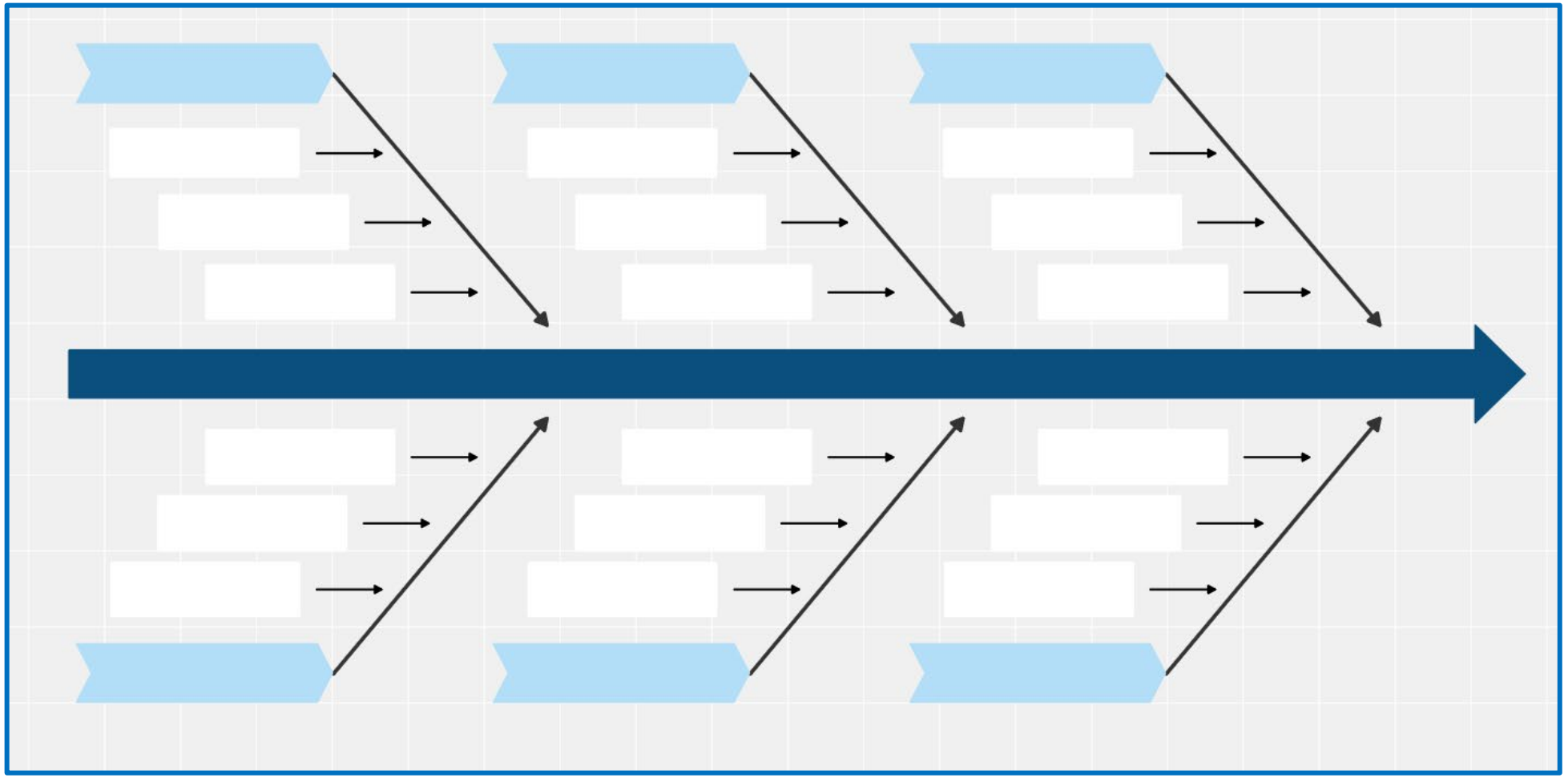




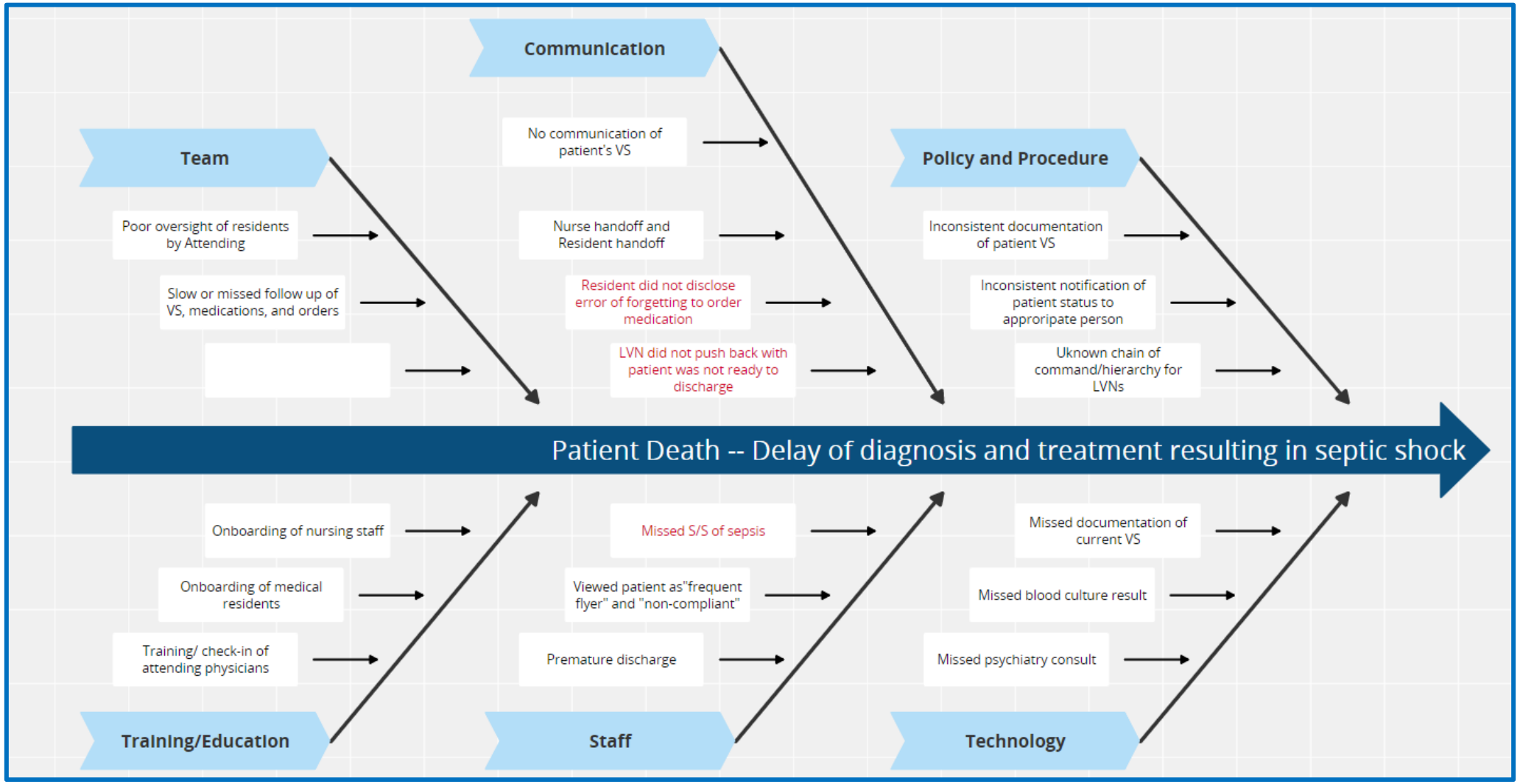
Example from Case Study



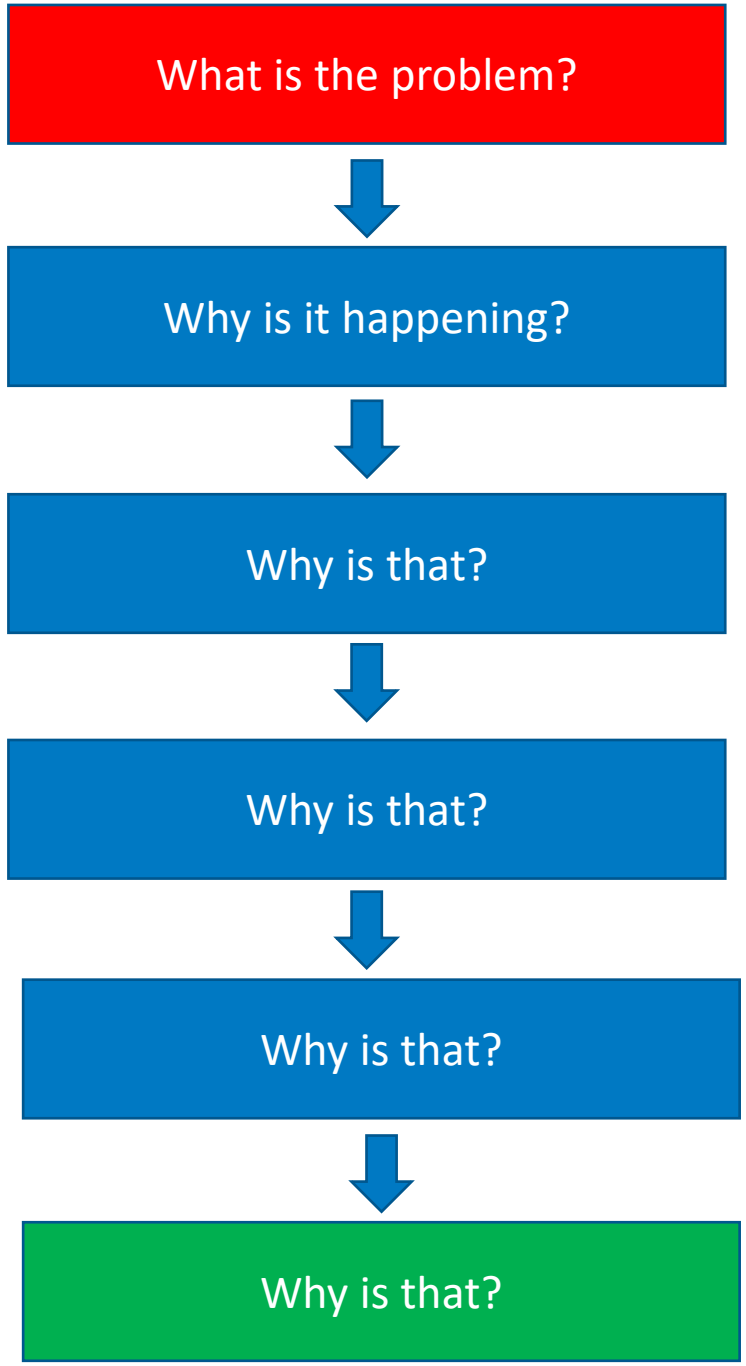
Fishbone



Example from Case Study

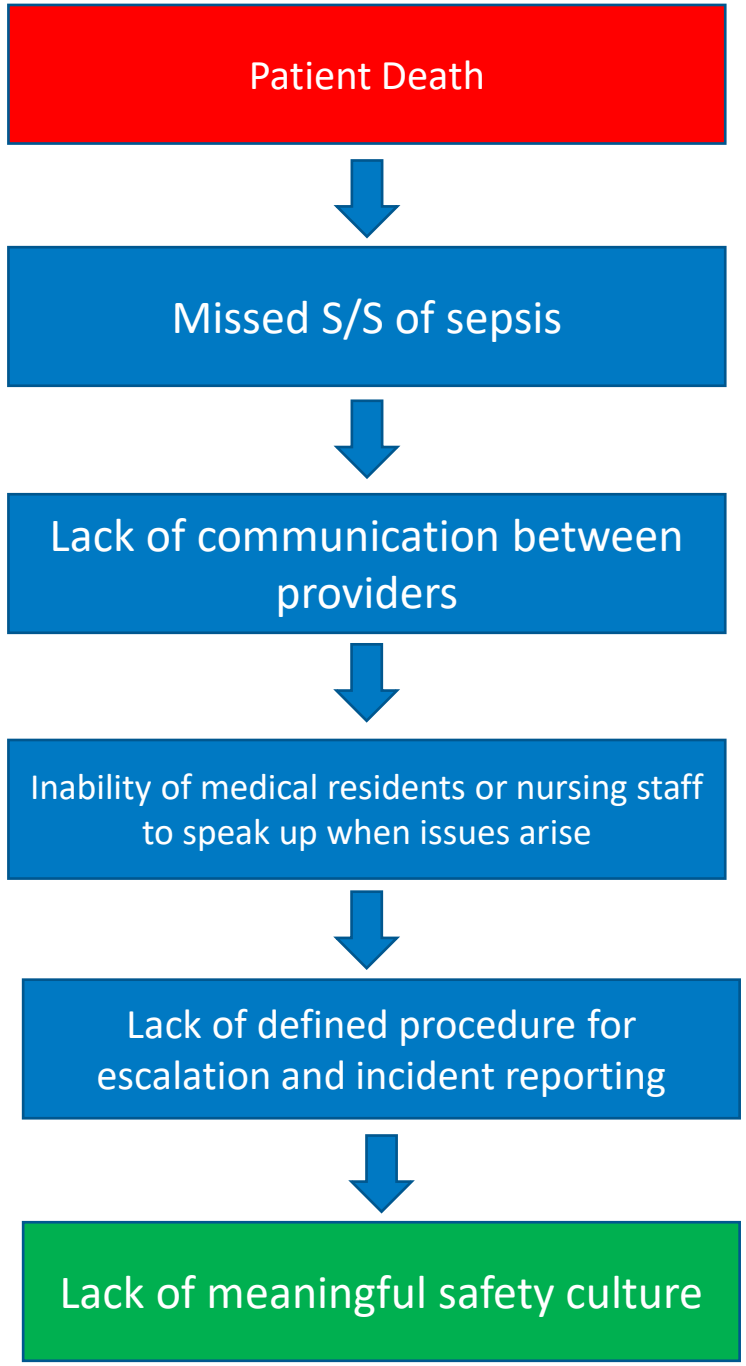


5 Whys



Root Cause

Example from Case Study



Root Cause

Writing Causal Statements

- Five Rules
  - Clearly show the cause-and-effect relationship
  - Use specific and accurate descriptions of what occurred (rather than negative and vague words)
  - Identify the preceding system cause of the error (not the human error)
  - Identify the preceding cause of the procedure violation
  - Acknowledge that failure to act is only causal when there is a pre-existing duty to act

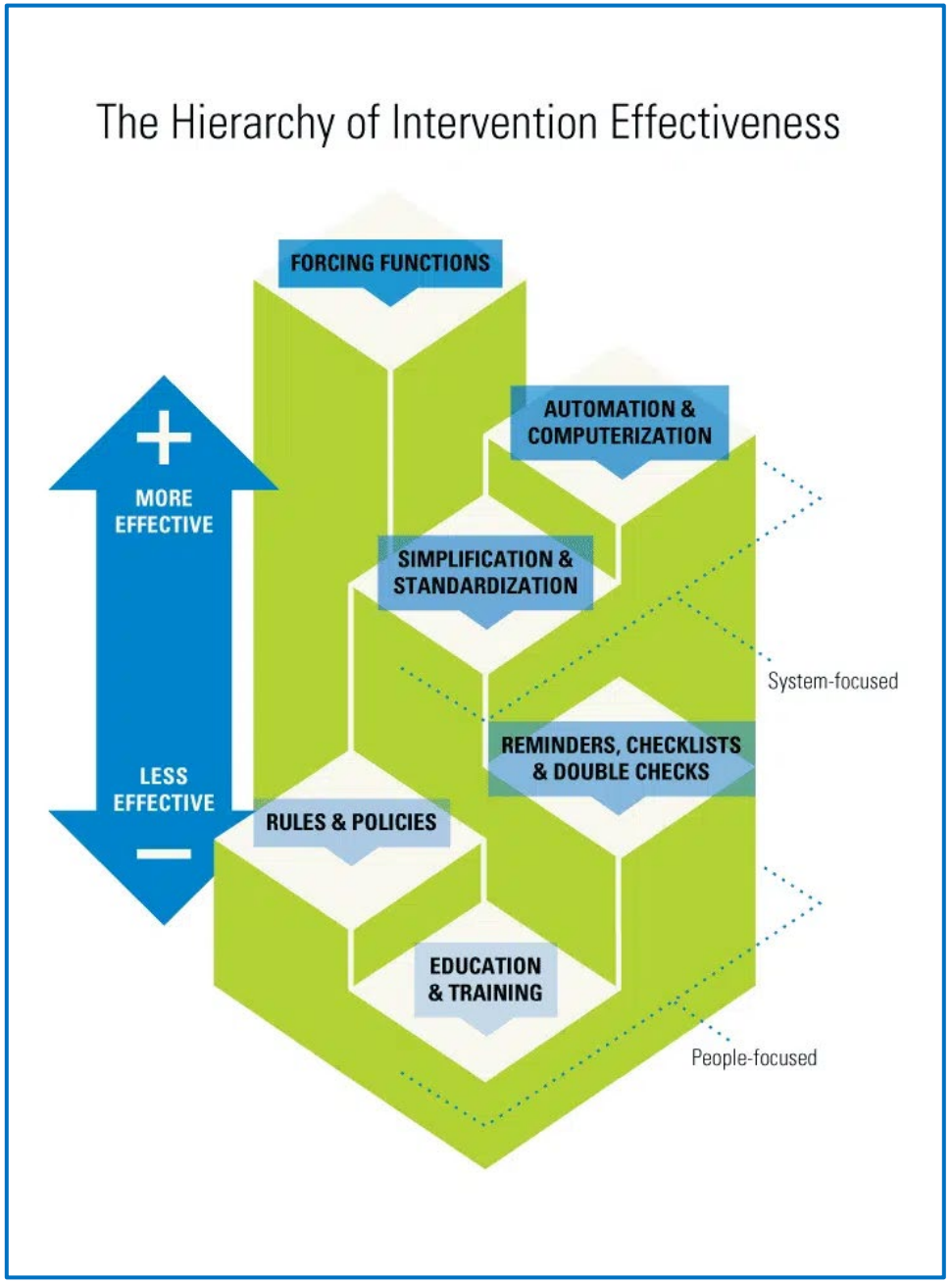
What is the root cause?

What are the contributing factors?

Causal Statements from Case Study

Rule	Case Study
Show cause and effect	• The missed identification of abnormal VS led to missed communication between nursing and physicians. • The missed notification of error (resident did not order antibiotics) led to inappropriate discharge.
Be specific and accurate	• Nursing and physicians did not communicate regarding abnormal VS. • Resident did not disclose error to attending physician.
Human error must have a preceding cause	• Nursing was hesitant to communicate with physician after being “scolded” • Resident was hesitant to communicate with attending after being “scolded”
Procedure violation must have a preceding cause	• LVN was brand new to facility and unsure of policy and procedure. • Resident had been reprimanded by attending in past and did not feel safe disclosing error.
Failure to act is only causal when there is a pre-existing duty to act	• Inexperienced LVN and delayed delegation of tasks led missed identification of abnormal VS and limited communication between providers. • Negative relationship between resident and attending led to missed orders and inappropriate discharge of patient.

Action Hierarchy



Implementation

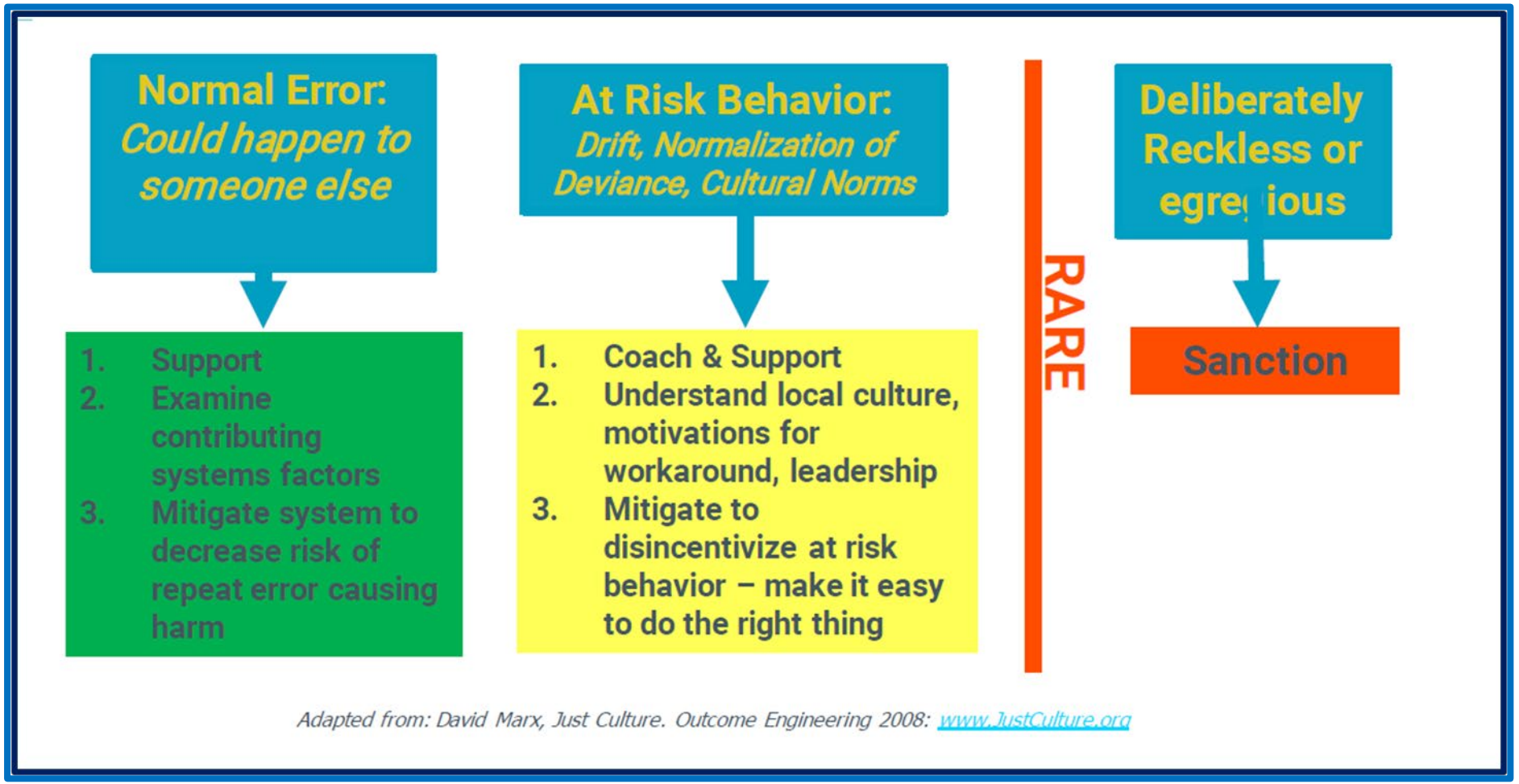
- Staff engagement and buy-in
- The “why”
- Clear Direction
- Clear communication
- Transparency
- Removal of barriers
- Follow Up
- Leadership

All hands in. Digital Image. 2019. https://journals.rcni.com/nursing-management/cpd/teamwork-in-nursing-essential-elements-for-practice-nm.2019.e1850/abs.

Measurement of Effectiveness

- Each action must have a measure and must address the causal statement
  - Process
  - Outcome
- Identify person accountable to action item
- Establish timeframes for evaluations
- Team Leader manages putting this together
- The executive owner ensures this is done and action items are completed

Just Culture and Blameworthy Events



Communication!

Communication between the team. Digital Image. 2019. https://paradoxmarketing.io/capabilities/sales-marketing-integration/insights/the-importance-of-business-communication-in-your-organization/.

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Thank you!