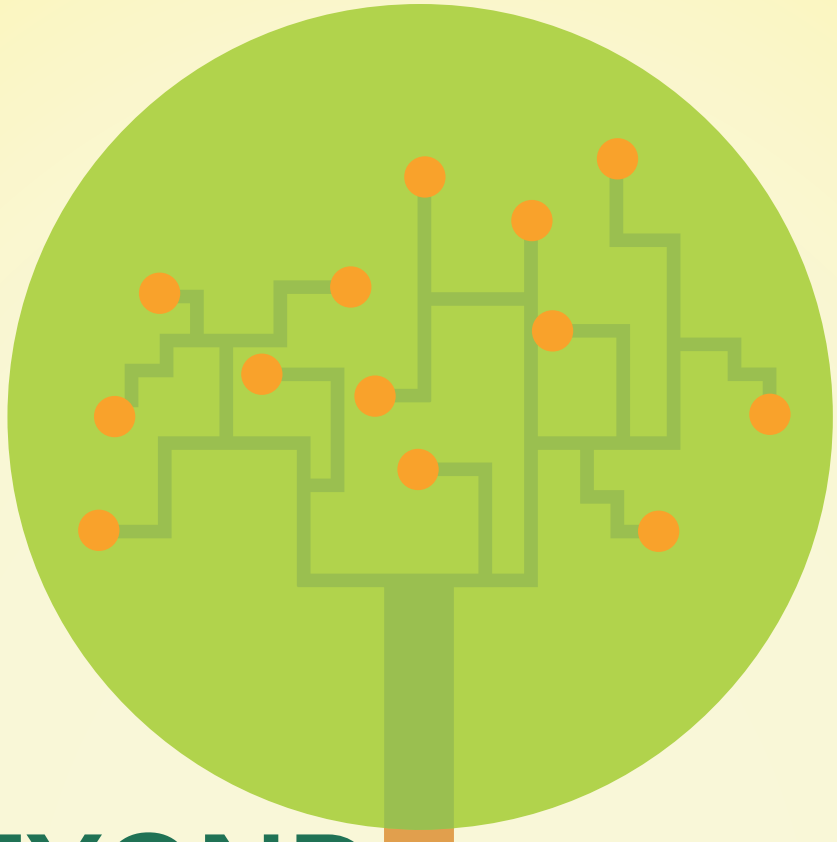
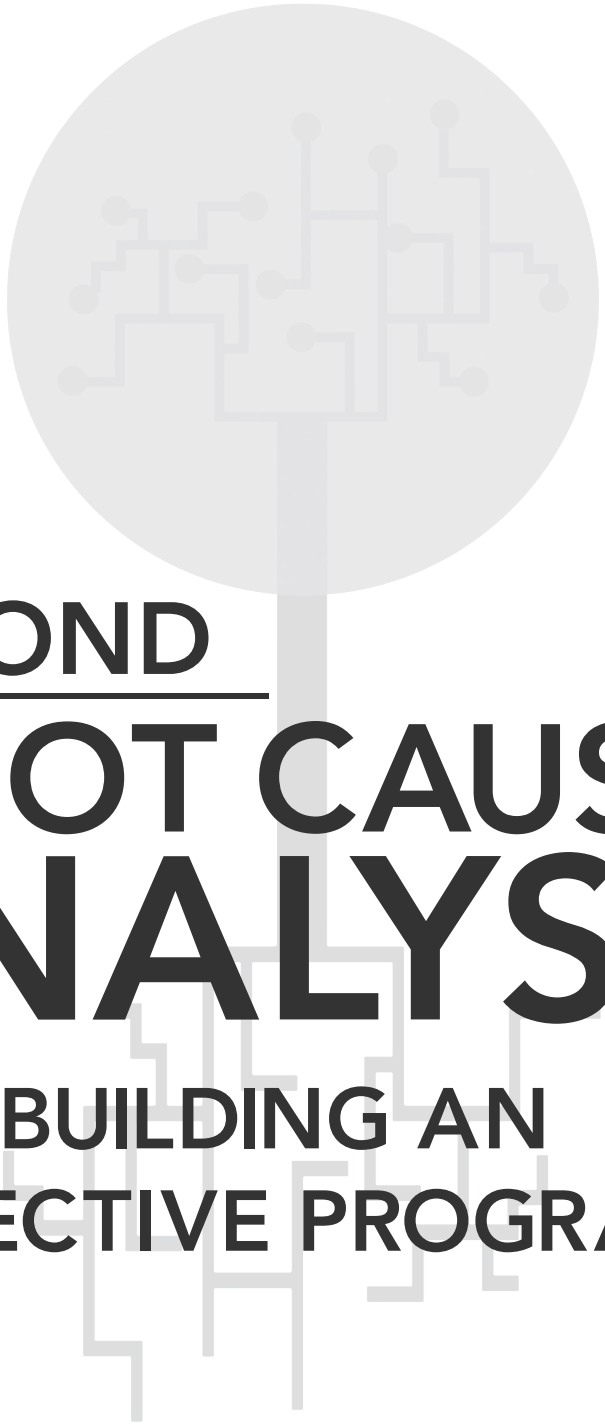


BEYOND ROOT CAUSE ANALYSIS

BUILDING AN EFFECTIVE PROGRAM

KENNETH R. ROHDE



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BUILDING AN EFFECTIVE PROGRAM

KENNETH R. ROHDE

HCPro
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ABOUT THE AUTHOR

Kenneth R. Rohde

Kenneth R. Rohde is president of KR Rohde LLC, a consulting company specializing in helping organizations deal with their problems. He brings more than 32 years of experience in quality management to his work with hospitals, medical centers, power plants and high-risk manufacturing facilities across the country. Rohde's roles in performance improvement and project management make him uniquely qualified to assist medical staffs and hospital leaders in developing solutions to their toughest challenges. He instructs, speaks, and consults in the areas of error reduction strategies, root cause analysis, improving performance through process simplification, effective procedure writing, apparent cause analysis, engineering effectiveness and error reduction, failure modes and effects analysis, effective data collection, analysis and trending, and patient safety evaluation and improvement.

Previously, Rohde was a senior consultant with The Greeley Company, and has served as a director for Performance Improvement International and director of corrective actions processes at Westinghouse Electric Company. He has also participated in or managed projects to improve business effectiveness and business development for healthcare, nuclear power, and manufacturing facilities around the globe.

Rohde is the author of *Occurrence Reporting: Building a Robust Problem Identification and Resolution Process, Effective Process Management: Improving Your Healthcare Delivery, Failure Modes and Effects Analysis: Templates and Tools to Improve Patient Safety, Making Your Data Work: Tools and Templates for Effective Analysis, Building Your Culture of Safety: Six Keys to Preventing Medical Errors,* and the *FMEA Reference Toolkit: Essential Templates and Charts for Your Hospital*.

CHAPTER 1
Why Another Book on Cause Analysis?

In this chapter:

- Why this book is different
- How the book is designed to help you find what you want

"I don't do root causes, but I need to manage the overall process," said the risk manager.
"I need a quick refresher before I do a big analysis."
"I'm a pro at root cause analysis. I just need to figure out the rest."
"My boss just told me I own it. What to do, what to do?"

The plane crashes, the ship sinks, the train derails, the power plant leaks—all of these are major events we hear about in the news. Somewhere, behind the scenes, you know that there will be a team of people working to deal with the event.

Healthcare is no different. Every day in hospitals, physician practices, clinics, and care facilities, serious events happen—some with very severe outcomes. Just like in other industries, there is also (hopefully) a whole infrastructure in place to deal with the event, determine why it happened, and improve the safety of the patients, staff, physicians, and community. This infrastructure includes the risk managers, nursing leadership, oversight committees, and senior leadership of the healthcare organization.

This book focuses on helping all the players understand how to approach events that occur, figure out what caused them, and implement realistic improvements. We naturally try to do this, but our

efforts are often piecemeal—more like a game of whack-a-mole than a focused effort. An event happens, we have some root cause meetings, someone gets frustrated, we choose some corrective actions, they never get done, and the event happens all over again. Then, of course, the chief medical officer says, "I thought you fixed that!"

There is a better way. In this book, we take the basics that you are likely familiar with and knit them into an integrated approach to dealing with events. The goal of this integrated approach is to provide a robust, sustainable, and workable program.

This book is designed to:

- Fit all the pieces into an integrated program
- Focus on how healthcare really does cause analysis
- Be fast and simple to use
- Provide what you need to know

Integrated Program Approach

Cause analysis is part of something bigger

Sometimes we forget that root cause analysis (RCA) is just one part of our overall process to identify and resolve problems. When we lose the connection to the rest of the process, RCAs can take on a life of their own. They can get scary, complicated, slow, and often ineffective.

In this book, we try to make sure that the leadership and cause analysis teams understand how all the parts fit together and that RCAs, while important, are seen as just one part of a bigger integrated approach.

All the parts must work together

If RCAs are the only tool available to help the organization understand the underlying causes of problems, that puts everyone in a bind. RCAs take time, so the organization does fewer of them. That leads to less understanding of problems, which results in less effective solutions and slower improvement.

In this book, we will focus on how to get the following three key methods to work together in a graded approach:

1) Apparent cause analysis
2) RCA
3) Aggregation analysis

Focused on Healthcare Cause Analysis

The basics of understanding why things happen are well developed and apply to virtually all complex systems. An aviation event, a power event, a factory event, and a healthcare event all use very

similar tools and methods. However, like everything in our industry, a healthcare event is "just a little different."

In healthcare, events usually have a direct impact on a patient. In addition, we have the hospital to deal with as well as the physicians. Layered on top of that are healthcare's liability and regulatory aspects, which are more at the forefront than in other industries.

In this book, we strive to take the basic, proven tools and processes and package them in a fashion appropriate to the healthcare world. The tools and tips in these pages are not radically different, but they are practical for our industry.

Fast and Simple to Use

Designed for just-in-time knowledge

There is no lack of books and training classes on how to do a cause analysis, but unfortunately in healthcare, we never have enough time for training. In an ideal world, the senior leadership and oversight committees would be extensively trained in understanding and managing the problem identification and resolution process; all the team leads would be experts, each one heading his or her own experienced team. The reality, of course, is not quite as polished. Often folks are thrown into the world of problem identification and resolution and cause analysis with little formal knowledge or experience.

I would love to see this state of affairs changed in the future, but until then, the goal of this book is to provide just-in-time information that you can use to help you do the best job possible. The book is designed with clearly marked tips so that you can thumb through it before your cause analysis team meetings or whenever you need some additional thoughts about dealing with events.

Designed as a reference guide

The book is designed to support you throughout the whole process of implementation, management, and action.

Chapters 1 through 6 provide a high-level overview of what cause analyses are designed to achieve. This is useful to ensure that the senior leadership and oversight committees are all on the same page and that the expectations for the team are consistent.

Chapters 7 through 13 deal with the practicalities of performing analyses, developing action plans, aggregating causes across multiple analyses, and making sure that the overall process is effective.

Chapters 14 through 17 deal with programmatic matters—how to set up the program, who should do what, etc.

Designed for What You Need to Know

As you go through the book, you will notice that it has tips clearly indicated as below:

> **Tip:**

In addition, the tips are labeled to help focus the different users of the book on areas that likely apply to them. That does not mean that the tip is only for those users, but it helps keep us all focused on what we, individually, need to do.

Simplified Summary and Action Plan Approach

Cause analyses, especially RCAs, often seem to get too big to manage. Then, when we finally finish them, it seems like we spend forever explaining what needs to be done. As one of its key benefits, this book provides a simplified summary and action plan approach that is designed to put all the information together in one place. This approach ultimately boils your analysis down into two documents:

1) One-page causal linkage diagram
2) Simplified summary and action plan

The goal of this approach is to help you organize your work, communicate it effectively, see the big picture, and (hopefully!) get problems fixed to a greater degree.

Who Will Benefit From the Book

Oversight committees

In every organization, there is likely a quality or patient safety oversight committee that, at some level, has been commissioned by the board to ensure that the problem identification and resolution process is working well. Key concepts for this committee are called out with the text "Oversight Committees" in the book's tip boxes.

Cause analysis process owners

At the next level, perhaps in risk management or quality, there will be a process owner who is responsible for making sure that the cause analyses actually get done. This person will likely be responsible for keeping things on track and reporting to the oversight committee. Key process owner concepts are called out with the text "Process Owners" in the book's tip boxes.

Cause analysis team leads and team members

The cause analysis team leads and team members are the ones who actually ask the questions, pull the strings, and put together the clues that lead to good solutions. Key analysis team concepts are called out with the text "Analysis Teams" in the book's tip boxes.

BEYOND ROOT CAUSE ANALYSIS

BUILDING AN EFFECTIVE PROGRAM

Kenneth R. Rohde

Serious events happen every day in hospitals, physician practices, clinics, and care facilities—some with very severe outcomes.

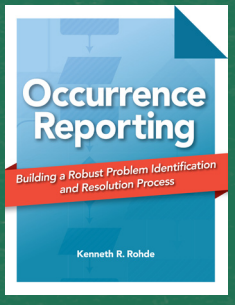
Beyond Root Cause Analysis helps risk managers, quality professionals, nursing leadership, oversight committees, and senior leadership understand how to approach adverse events, figure out what caused them, and implement realistic improvements.

Benefits:

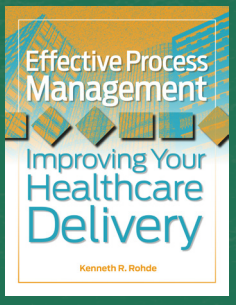
- Step-by-step approach to setting up a cause analysis program
- Practical insight on how to develop meaningful corrective actions
- Easy-to-read format and style that differentiate this book from other root cause analysis products

Other books by Ken Rohde

Occurrence Reporting



Effective Process Management



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