Root Cause Analysis Basics

A RESOURCE GUIDE FOR HEALTHCARE MANAGERS

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No matter what event or near miss sets the process in motion, every RCA includes:

- Information gathering
- Thorough analysis of that information
- Development of recommendations
• An action plan
• Reporting to hospital leadership and other departments, The Joint Commission, and state agencies.

Getting started means gathering information. As soon as possible after the event, you must gather together the people who are closest to the event, along with the medical records, the equipment, and anything else pertinent to the event for discussion and analysis. Right away, you might be faced with a challenge: staff members may be reluctant to provide all the necessary information for fear of reprisal. This is why a blame-free process is so important.

**The importance of a blame-free process**

Once you have gathered the people who witnessed the event or participated in it, you want them to analyze what went wrong. To do this successfully, the organization must have a blame-free culture and the format and temperament of the team conducting the RCA must be focused on the systems and processes and how they failed to provide safe care. The RCA team must not be looking for the one participant who failed to provide safe care.

In the heparin example mentioned in this book’s introduction, it would be counterproductive for the team to turn to a nurse and say, “You gave the wrong dose. Be more careful; otherwise, we will fire you.” This will not prevent future heparin mishaps. An effective RCA team has to understand that careful, licensed professionals must be supported by systems that enable them to do the right thing.
In the heparin example, we have a product in different doses that has similar packaging, similar and small-type labeling, the same name, and the same manufacturer. Hospitals have identified this product as one that might be misidentified or one that is prone to misidentification. The prevention strategy isn’t to tell the staff to be careful. (After all, that isn’t a strategy.) The prevention strategy is to plan visible warnings and safety measures such as the following:

- Physical separation of the two dosages
- Supplemental labels for the two dosages
- Bar coding
- Double-check processes
- Elimination of access to one of the products

The RCA team has to drill down through the sentinel event or near miss and find out what part of their safety system broke down, what could have been done differently, and what will be done differently in the future.

The benefit of the RCA process is that you find the root causes, not just the proximate causes. In other words, you determine the underlying reasons why the error occurred. Fixing only the proximate causes will allow the same error to occur again, whereas fixing the root causes prevents the same error from reoccurring due to the same root causes.
Chapter 1

**Note:** A root cause is an underlying cause of an error. A proximate cause is one that is a direct cause of an event, is easily found, but is also superficial. If a patient receives incorrect medication, a proximate cause would be that a caregiver gave the patient the wrong medication. A root cause of the same event would be that the medication was incorrectly labeled.

A simpler way to differentiate the RCA process from proximate cause identification is that an RCA isn’t a band-aid on a major problem; it’s an intervention that identifies the more fundamental reasons for the error, creates lasting change, and ensures additional safety.

**Joint Commission expectations**

The Joint Commission has established two content expectations for the RCA process: The work product is expected to be thorough and credible. To assist organizations in this endeavor, The Joint Commission has posted two documents on its Web site, www.jointcommission.org:

- An RCA framework
- An RCA matrix

In addition to the tools and tips in this book, The Joint Commission’s framework and matrix tools can help you get started and explain where you should go with the analysis. These documents can help an inexperienced team go through the analysis and keep drilling down through all the potential factors to avoid stopping the analysis too early.
The Joint Commission has also established a timing expectation for the process, requiring that an RCA be completed within 45 days of the event, or when the hospital became aware of the event. This timing expectation is occasionally confusing, because sometimes organizations believe that they have 45 days to conduct an RCA after The Joint Commission finds out about the sentinel event.

This is not the case, nor does it make sense. For the RCA to be effective:

- The issue must be current
- The staff’s recollection of the facts must be as detailed possible
- The evidence must be available for analysis

Therefore, conducting the RCA as soon as possible after the event makes sense, as opposed to waiting until The Joint Commission or some other external body pushes you to do something.

**Barriers to effective RCA: Confidentiality**

The confidentiality of the RCA process is an issue for many hospitals, and is a barrier to the information gathering and reporting components of the process. For the RCA to be effective, it is important that all participants feel free to be
open, frank, and willing to help the organization find out what went wrong, without fear of retribution. Therefore, the work product of this effort should not be used later to help sue participants for their self-identified contribution to the error.

Most states do offer legal protection for RCA information, but questions have arisen about sharing confidential RCA documentation with The Joint Commission, and whether sharing that information means the RCA findings are open to what is known as disclosure during a legal proceeding. Because of this concern, The Joint Commission offers accredited hospitals five different options to review the thoroughness of the RCA process.

The simplest option is to just mail the RCA to The Joint Commission. Joint Commission staff will review the documents, discuss any questions with the hospital, and formally approve the RCA, action plan, and measures of success. At the end of this process, The Joint Commission destroys the documents.

With the second option, facilities can bring their documents to The Joint Commission headquarters, have them reviewed by a sentinel event specialist, and then take the documents back home with them. The third option, is to have The Joint Commission send a specially trained surveyor to your hospital to review the documents, thus avoiding the transmission of confidential work products across state lines.

The fourth option, although somewhat confusing, is to allow the specialist surveyor to come on-site, review your process, interview staff members, and review the medical record, but not actually review the RCA itself.
The fifth option is for the surveyor to come on-site and basically conduct a standards-based review of the hospital’s process for responding to sentinel events. Although this option may sound confusing, it provides hospitals in consultation with their attorneys the additional confidentiality protections of the RCA.

The issue of confidentiality is discussed further in later chapters, and in the questions and answers in Appendix A.

**Deciding whether to report an event**

The first decision an accredited organization has to make is whether to report a sentinel event to The Joint Commission. This decision is separate and distinct from the responsibility to conduct a thorough and credible RCA.

There are two advantages to self-reporting:

1. The officials who conduct the review at The Joint Commission conduct hundreds of RCA reviews each year, and they can potentially offer advice and solutions based on their experience.

2. Organizations can learn from the mistakes of others and can gain insight into other facilities’ understanding of root causes. This sharing of information helps to disseminate problems, and helps others to create strategies for dealing with the same problems.
In addition, The Joint Commission uses these lessons learned to write its *Sentinel Event Alerts* newsletter and to develop and improve its National Patient Safety Goals. These lessons learned were not typically available prior to The Joint Commission’s sentinel events program.

**The role of patient safety organizations**

Several years ago, Congress passed patient safety legislation, a key component of which was development of patient safety organizations, or PSOs, that would have federal protections and could work with healthcare organizations to review and approve RCAs and action plans. Recently, the Centers for Medicare & Medicaid Services drafted regulations that proposed how these entities would be formed, approved, and placed in operation. It is assumed that PSOs will help to reduce concerns regarding disclosure, and hopefully will increase the total level of reporting.

Meanwhile, accredited hospitals have Joint Commission policy expectations to work through, often combined with some mandatory state reporting processes. Unfortunately, some of the state processes lead to public disclosure, which many fear reduces either the frequency of reporting or the depth of reporting and analysis. If we create a blame-free culture in our hospitals that enables reporting and open discussion of sentinel events, we lose that openness if we will eventually read about the details in the newspaper.
RCAs and action plans

This book is will help your hospital create and implement an effective RCA process. Possibly the most important part of that process is the end result—the action plan that the organization puts into place to ensure that a sentinel event or near miss never happens again. Now that we have learned about the root causes of our sentinel event, what are we going to do to prevent it from reoccurring?

In the heparin example included in the Introduction, if we decide to eliminate the use of heparin flush solutions, or if we decide to implement an overwrap on one of the heparin products, when will we do this? And will doing this solve the problem?

This last part of the process is the measure of its success: Did we succeed with the planned changes? These last steps in the RCA process are particularly helpful to busy hospital managers with changing priorities. They facilitate the implementation of change, the measurement of success, and the fine-tuning required to make sure the issue you experienced is not repeated.
Chapter 1

Barriers to effective RCA policies

There are two main barriers to implementing an effective RCA policy:

- **The wrong causes:** RCA teams that identify and fix only the proximate causes of an event will allow the same error to reoccur. An in-depth approach is necessary to identify the more fundamental reasons for the error, create lasting change, and ensure improved patient safety.

- **A blaming environment:** No RCA team will get much useful information from an employee who thinks the hospital is looking for someone to blame. Throughout this book, you’ll find an emphasis on maintaining a blame-free workplace.

In addition, hospitals that are concerned about confidentiality issues may be reluctant to report their findings to The Joint Commission and state agencies, fearing litigation.

Conclusions

RCA is a process that is designed to uncover the root causes of an event or near miss. The components of an RCA include:

- Information gathering
- Thorough analysis of that information
- Development of recommendations
Starting an RCA involves gathering information from the people closest to the event, and pulling together the medical records, the equipment, and anything else pertinent to the event for discussion and analysis. It is imperative that the RCA takes place as quickly as possible, in an atmosphere that is as blame-free as possible. The Joint Commission requires that an RCA be completed within 45 days of the event, or when the hospital became aware of the event.

Confidentiality is a major consideration, and hospitals must understand their state’s event reporting rules and take potential disclosure issues into account as they decide how to proceed with reporting their event and RCA to The Joint Commission.

This general overview has identified some of the concepts and concerns associated with RCAs. Now it’s time to begin building a successful RCA process. Turn to Chapter 2 to get started.
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