



Institute *for*
Healthcare
Improvement

This presenter has nothing to disclose.

Root Cause Analysis: Turning Data and Information into Learning and Improvement

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Objectives

1. Describe the current RCA approach of your organization.
2. Discuss the use of the data and information gained from an RCA to prevent, detect and mitigate harm to patients
3. Develop a clear connection from root cause analysis to improvement in patient care and reduction of harm



Agenda

Introductions- participants and course (5)

Model (5) 10

Exercise- Experience with RCA (5) 15

The RCA Process- (25) 40

Case Study- (20) 60

BREAK

Exercise #1-Fishbone (20) 20

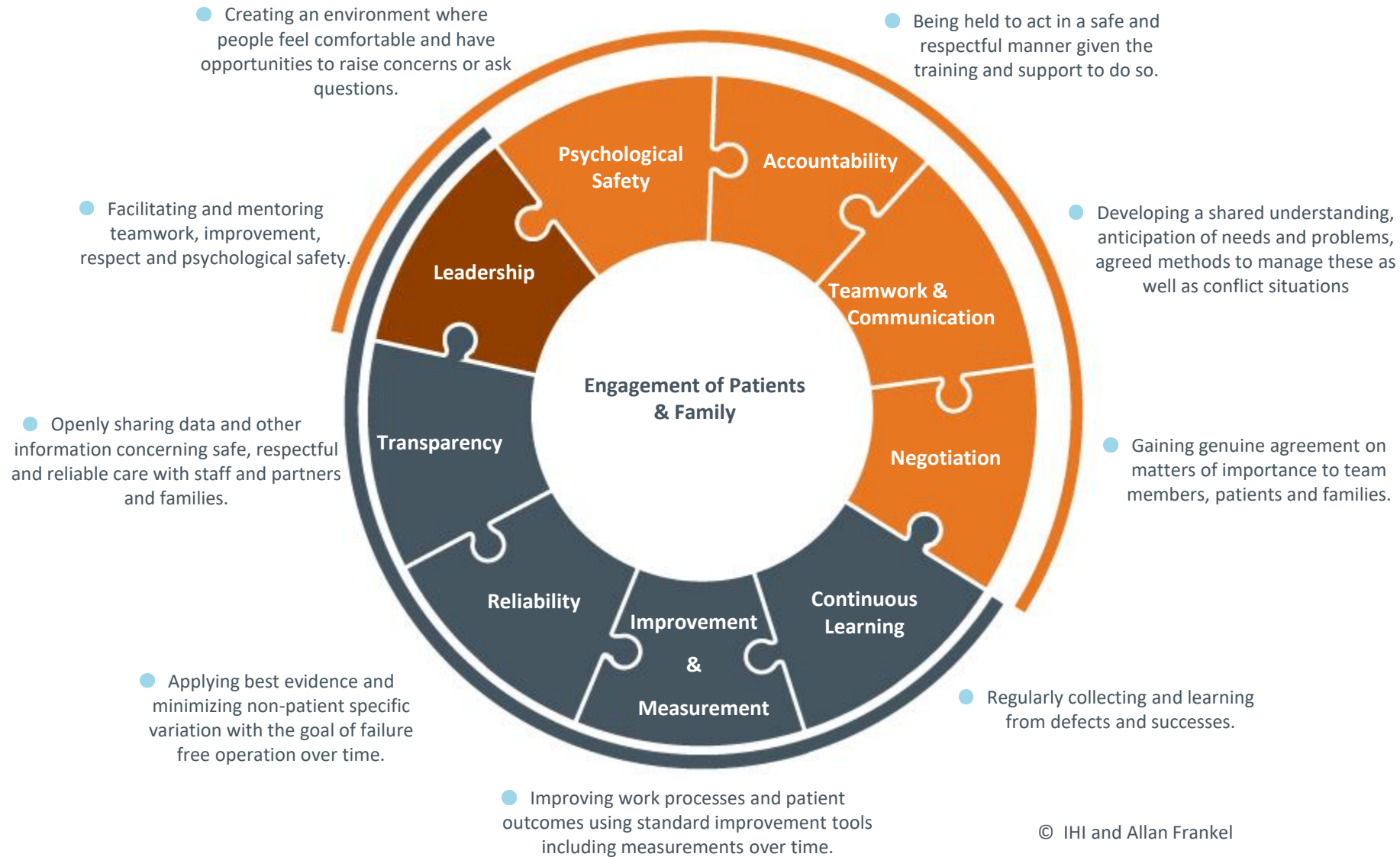
Exercise #2- Information Gathering (10) 30

Exercise #3- Prioritizing (15) 45

Putting it all Together



Framework for Safe, Reliable and Effective Care



What's been your experience?

- How many RCAs have you been part of?
- How many RCAs does your organisation do each year?
- How many of those are for the same kinds of event?
- How many of those result in sustainable improvement?
- How useful is RCA for improvement?



Build our Continuous Learning System



Case Study

- 5 mins to read the case study in full
- 5 mins to share your reactions with your neighbor
- 10 mins to share our reactions as a group



What is a Root Cause Analysis?

Root cause Analysis is a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems

RCA is applied to methodically identify and correct the root causes of events, rather than to simply address the symptomatic result



To be effective, the analysis should establish a [sequence of events](#) or [timeline](#) for understanding the relationships between contributory (causal) factors, root cause(s) and the defined problem or event to be prevented

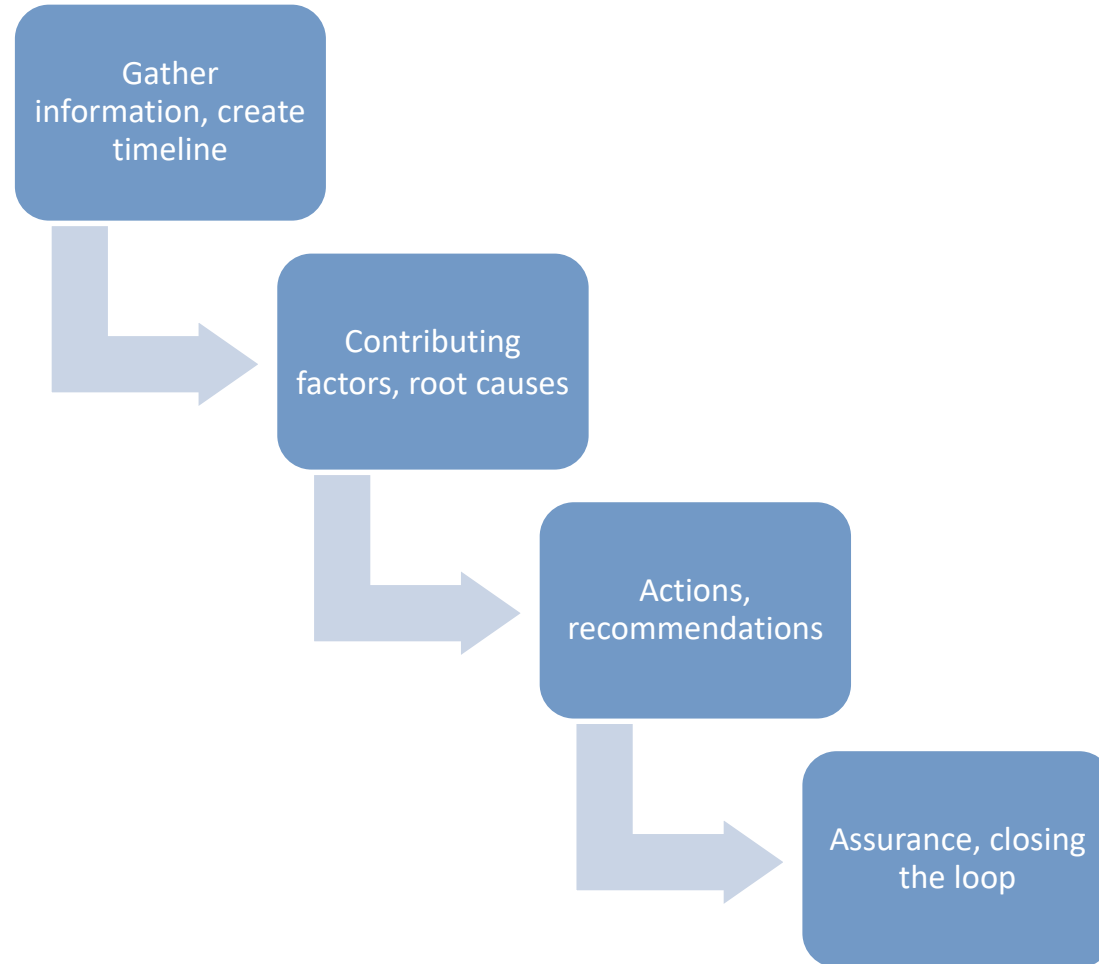


What's the aim of RCA?

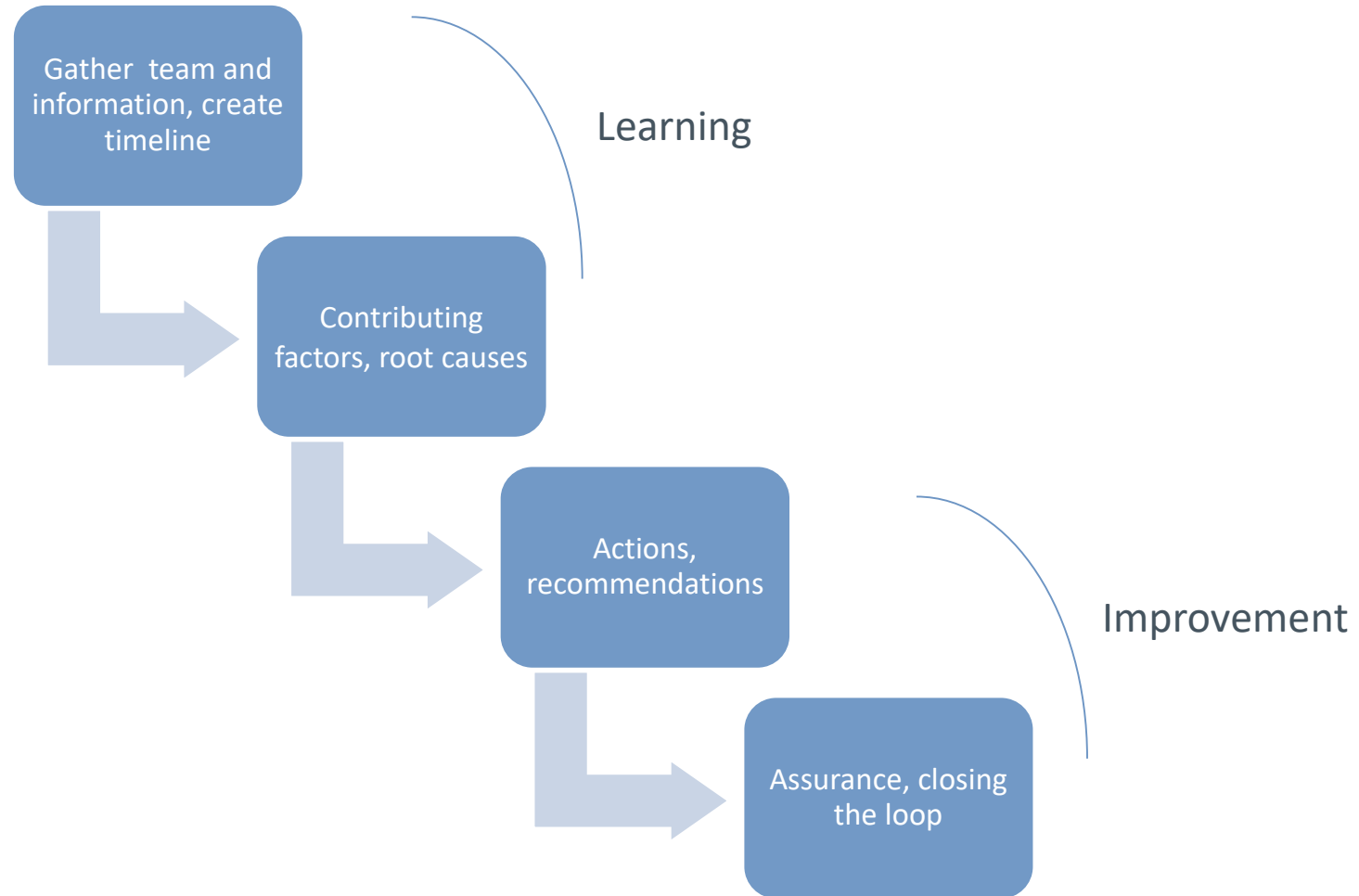
To learn in order to improve



What's the process of RCA?



What's the process of RCA?

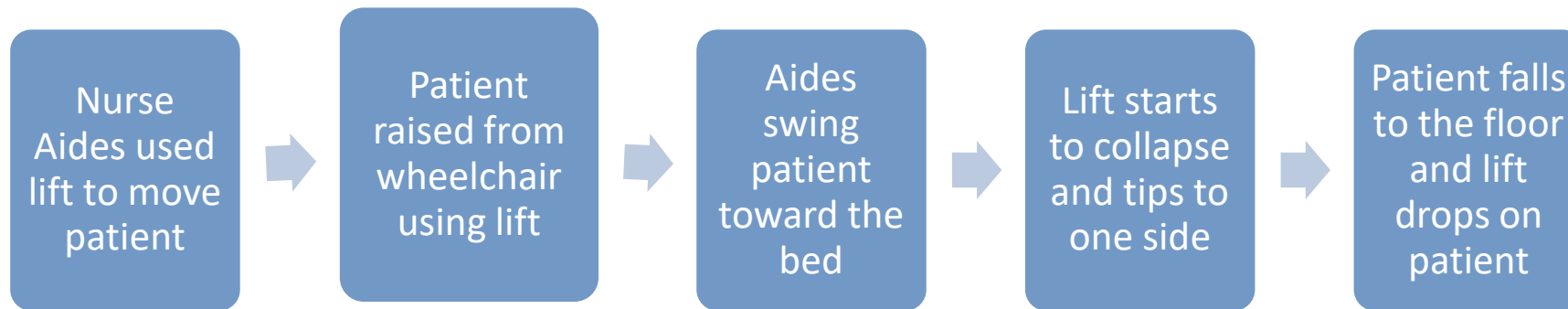


Worst Case Scenario

- Lots of RCA
- Lots of reports
- Lots of resources
- Little or no improvement



A Timeline...Not what we THINK happened but what ACTUALLY happened



Best Case Scenario

- Selective RCAs
- Triangulation of knowledge
- Efficient use of resources
- Evidence of improvement



Our Focus

- Understanding true cause and effect
- Differentiating between system and person dependent issues
- Identifying common causes of harm
- Linking RCA to clear improvement



Exercise #1

- Back to Audrey...
- In groups of 3-5 people, review the case study
- Identify all the potential problems, issues, concerns, questions (What went wrong? When? For whom?)
- Categorize using fishbone
- 20 mins



Fishbone



Exercise #2

- Decide what information is missing
- Prioritize missing information – what is it most important for you to learn about?
- Prepare questions to help you determine cause
- 10 mins



What else do you need to know?



Exercise #3

- Using the new information, for each of your priority issues, discuss and document cause theories
- If you still don't have enough information, make a note of that
- Group the causes into system or individual
- Prioritize your system causes based on frequency (in this case) and significance
- 10 minutes



What are the big system issues...

...and what's causing the big system issues?



How common are these causes?

- How do you find out if your theory about system causes of harm is correct?



Root cause analysis as a force for change....

....can be seen as a threat to many cultures and environments. Threats to cultures are often met with resistance. Other forms of management support may be required to achieve effectiveness and success with root cause analysis. For example, a "non-punitive" policy toward problem identifiers may be required.



Turning Into Improvement

More Reliable Improvements:

- Simplify process and remove unnecessary steps
- Standardize equipment or process
- Change physical surroundings
- Testing equipment with end users before buying
- Human Factors considerations such as forcing functions which force the user to complete an action)



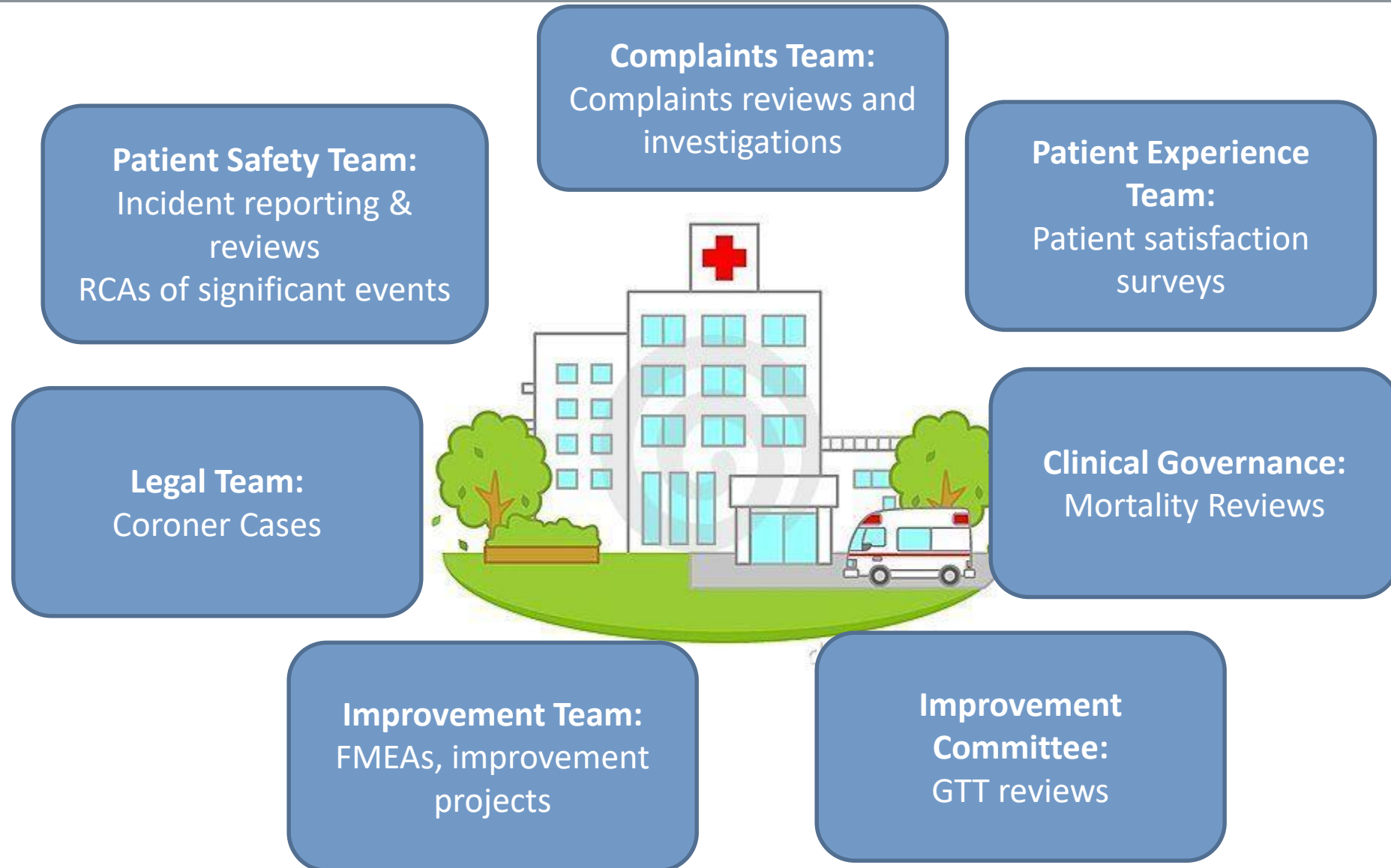
Turning Into Improvement

Less Reliable Improvements

- Training and education
- Another checklist
- Additional double checks
- Warnings and labels
- A new or adapted procedure/memorandum/policy
- More study and analysis needed



I have all this data.....



I have all these priorities.....

