Root Cause Analysis

Tip Sheet

Root cause analysis (RCA) is a tool risk and patient safety professionals use to discover the root cause(s) of a healthcare event or close call to identify appropriate solutions. The goal is to find out what happened, why it happened, and how to prevent it from happening again. It is a non-punitive, non-blaming process that does not focus on the "who."

Leadership should officially charge an RCA team to conduct an investigation of an event. The team should interview and include those involved in the event, but organizational decision makers should retain accountability for actions to prevent recurrence of the event. Patients and families should not be members of the RCA team because this would present a conflict of interest for them. Alternately, RCA teams often include a patient representative who can voice the perspective of patients.

RCA does not take the place of debriefing. Typically, a debriefing immediately or closely follows the event and provides immediate support to those involved in the situation. Personnel trained in quality, risk management, or patient safety should schedule RCA soon after the event. The individuals involved in the situation typically work as a team with the facilitator to identify all potential root causes.

When should you use RCA?

Each healthcare organization must determine the types of errors or events they will to conduct RCA for. Ideally, organizations will perform a systematic analysis of any event that harms patients or almost does. Organizations should identify and carry out actions to mitigate future similar situations or harm.

In determining when to follow an event with RCA, additional factors to consider include the number and types of events that typically occur in the organization and the level of harm they cause, the frequency of the situations in which events occur, and the number of trained professionals available to conduct RCAs and follow up on action plans. Commitment of organizational resources for RCA and follow-up is necessary to mitigate risk and advance a culture of safety. Because several sources estimate that it takes 40 hours for an experienced quality, risk, or patient safety professional to conduct RCA, organizations should also consider the necessary staff time to conduct RCA.

How do you conduct RCA?

RCA methodologies are based on human factors engineering. There are many processes, methodologies, and approaches to conducting RCA. Most involve a series of questions to

uncover less-evident potential causes, creation of a flow diagram, and use of cause-and-effect diagrams.

Several templates are publicly available to assist with RCA, including those developed by the VA National Center for Patient Safety, which provides a guidebook and slides, the Institute for Healthcare Improvement (IHI), and the Joint Commission. (The end of this document lists links to tools available for public use.)

Team training resources

A very short IHI video titled "What is RCA?" can help new teams understand the nature of RCA. The VA Center for Patient Safety offers a more comprehensive video for use as just-in-time training for newly chartered RCA teams using the VA methodology and tools.

Best practices

Best practices related to RCAs include the following:

- ☐ Schedule and conduct RCA as soon after the event as possible, preferably within 24 hours.
- ☐ Determine decision makers accountable for organizational actions resulting from RCA, and include them on the team.
- ☐ Interview staff, physicians, and others who were present at the time of the event to understand the factors in the event.
- ☐ Conduct RCA using a trained facilitator; a comprehensive, standardized approach; and performance analysis tools and techniques. Use VA comprehensive triage questions. *
- ☐ Complete follow-up to the RCA as soon as the team has investigated or explored all factors potentially impacting the situation, within 45 days if possible.
- ☐ Develop specific and time-directed action plans for each finding.
- ☐ Monitor completion of follow-up actions on an ongoing basis until all actions are completed.
- ☐ Monitor impact of actions on prevention of future similar events.

References

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