

Root Cause Analysis (RCA) Training

On Demand

Part 1 of 3: Preparing for RCA



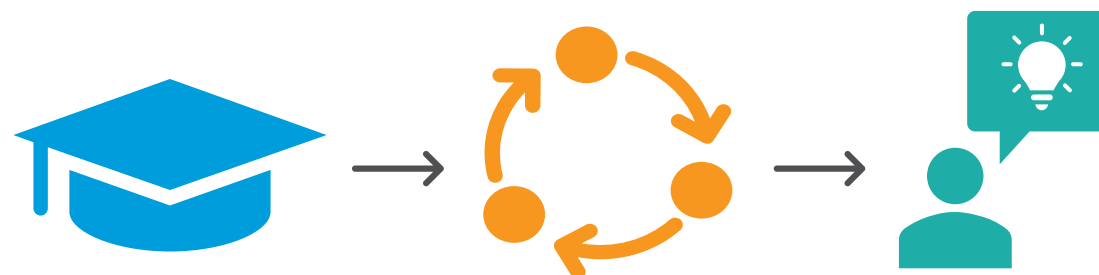
Part 1: Root Cause Analysis (RCA) Learning Objectives

- Define RCA and understand the purpose
- Determine when to use RCA
- Differentiate between root causes and contributing factors
- Identify two types of RCA
- Explain the relationship between RCA and the Quality Improvement process

Begin With the End in Mind

During the presentation, visualize and plan how you will use the information:


- What impactful actions can you take as a result of the information shared today?
- How are you able to increase collaboration within your network to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next week, 30 days..?



What is Root Cause Analysis (RCA)?

- Root causes are unseen or unnoticed faults in the process or system leading to a harmful or unwanted event
 - Often there are several root causes
- RCA is a structured facilitated team process identifying root causes
 - What happened?
 - Why did it happen?
 - Identify breakdowns in processes and systems
 - Helps prevent future events
- RCA is a tool for mitigation strategy planning

When to Use Root Cause Analysis



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When to Use Root Cause Analysis

Root cause analysis (RCA) is a problem-solving method or process for investigating an incident, concern, failure, or an actual or potential problem. RCA should be considered for "close calls" or "near misses" that have the potential for serious or negative outcome. Events that are chronic, recurring, involving communication breakdown, and are systemic in nature are best for this type of in-depth problem solving. Infection spreading and directed plan of correction (DPOC) are adverse events for which RCA reveals vital information to correct or strengthen the involved process. The RCA process is performed by a team to identify breakdowns in processes and systems that contributed to the event and how to prevent them from recurring. Events that can be investigated using the RCA process can be identified from many sources, such as:


- Incident reports
- Any feedback or any type of survey
- An unexpected occurrence that led to individual or staff harm
- A repeating problem

Root cause analysis can be used in many situations, below are a few situations and examples:

Type of Situation	Example(s)
An adverse or sentinel event is an unexpected occurrence involving serious injury or death of an individual	A COVID-19 outbreak or an individual falls which results in a serious head injury requiring hospitalization
Near miss, unacceptable risk or chronic failure	The wrong medication dose is found in the medication cart
Recurring complaints	A family member complains that it took 30 minutes for his mother's call light to be answered. Another family member reports that staff didn't appear for 15 minutes after turning on the call light
Repeating event	75% of all falls occur between 6 and 8 PM
Any time a performance gap is identified	A plan of care was not followed or DPOC (Directed Plan of Correction) and/or any type of infection outbreak

RCA also is not necessary for every concern, incident or problem that arises. Some situations can be managed and resolved quickly such as:

- If it is unlikely to recur based on unique circumstances
- If negative consequences may be minor or non-existent
- If there is no pattern of previous similar events or trends

 It's also important to understand that RCA is not intended to find "who is at fault". Problem solving that is focused on finding and blaming an individual is ineffective. RCA is focused on what systems led individuals to make the choices they did, and changing the systems to change behavior.

- A key step to any quality improvement effort
 - An event resulting in patient harm or death
 - Unwanted events or outcomes that could recur
 - Events or incidents that result in patient, family/representative or staff dissatisfaction
- Directed Plans of Correction (DPOC) and deficiency tags

Steps of Root Cause Analysis



Identify contributing factors

- If the event is likely to occur, even if that situation, circumstance or condition was removed, then it is a contributing factor
- Ask “What was going on at this point in time that increased the likelihood the event would occur?”



Identify the root cause

- If the event is likely not to recur if that situation, circumstance or condition was removed, then it is a root cause
- Dig deeper into understand “why” the contributing factor occurred
- Discover the mismatches and gaps in the process

Things to Consider When Performing Root Cause Analysis



Use data



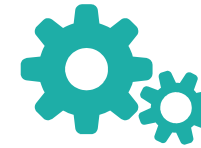
Stick to
the facts



Move beyond
symptoms



Gather
feedback



Understand the
process



Think outside
the box



Take time



Explore the
cause-and-effect
relationships



Avoid jumping
to solutions



Avoid the
one-size-fits-all
global approach



Train your team

Identify and Define the Problem

What is a Problem Statement?

- It is an objective and concise statement of what went wrong, not why, or how
- It does not define the problem as a need for something
- It facilitates a more thorough examination of the problem



Write down your problem statement – be concise!

Two Types of Root Cause Analyses

Five-Why's

- Used for minor or isolated problem
- Simple problem-solving technique
- [Five-Why's Worksheet](#)
- Example videos:
 - <https://www.youtube.com/watch?v=BEQvq99PZwo>
 - <https://www.youtube.com/watch?v=SrLYkx41wEE>


Fishbone Diagram

- Used for major or likely to reoccur problems
- Sorts ideas into useful categories
- [Fishbone Diagram Worksheet](#)
- Example video:
 - <http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx>

For each identified cause ask:

- ✓ Do we have control over this reason?
- ✓ Can we fix this reason?
- ✓ Will it help solve the problem?


Root Cause Analysis Tools




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Facilitators Guide

For the Root Cause Analysis (RCA) Method





The purpose of an RCA is to find out what happened, why it happened and determine what changes need to be made. Facilitating RCA takes skill. Practice is needed to build proficiency and confidence. The steps below outline the process for conducting an RCA.


Facilitation Preparation

- Verify if RCA is needed - [When to Use Root Cause Analysis](#)
- If RCA is applicable, collect related information and data to support the process
- Assess meeting location (physical and/or virtual) to determine capabilities and limitations
 - Select documentation resources for capturing your list of root causes
 - [RCA Tool Selection Guide](#)
 - [Fishbone Diagram](#)
 - [Five-Whys Worksheet](#)
- If the facilitator is not the scribe, select a team member to be the scribe
- Review the quality improvement focus
- Gather supplemental materials (ex. Sticky notes, writing utensils, white board, templates)

Facilitating the Meeting

- Direct the team to create a problem statement as defined in step one of this guide: [Guidance for Performing Root Cause Analysis \(RCA\) with PIPs \(cms.gov\)](#)
- Guide the meeting:
 - Discuss how the RCA method is conducted:
 - "Round robin," random sharing, etc.
 - Document causes on a whiteboard, paper, using a computer, etc.
 - Keep the team on track applying the [RCA Pathway](#)
 - Ensure causes shared by the team are documented
 - Help determine if causes are facts or opinions
 - Encourage the team to ask three questions for each cause:
 - Do we have control?
 - Can we fix it?
 - Will it help solve the problem?
 - Assist prioritizing the reasons, enabling transition into the planning phase, which includes eliminating each of the identified root causes

<https://www.telligengiconnect.com/resource/facilitators-guide-for-the-root-cause-analysis-rca-method/>



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Root Cause Analysis Tool Selection Guide

Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an event, such as an adverse event or near miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain corrections by including team members who have personal knowledge of the processes and systems involved in the problem or event to be investigated.

Affinity Group

Affinity Grouping is a brainstorming method in which participants organize ideas into common grouping and identify common themes using multi-voting and cards, flip charts, whiteboards and/or post it notes. Groups may be required to meet more than once and take more than one day to complete brainstorming.

5 Whys

The Five (5) Whys is a simple problem-solving technique that helps to get to the root of a problem quickly. The Five Whys strategy involves looking at any problem and drilling it down by asking: "Why?" or "What caused this problem?" While you want clear and concise answers, you want to avoid answers that are too simple and overlook important details.

Fishbone

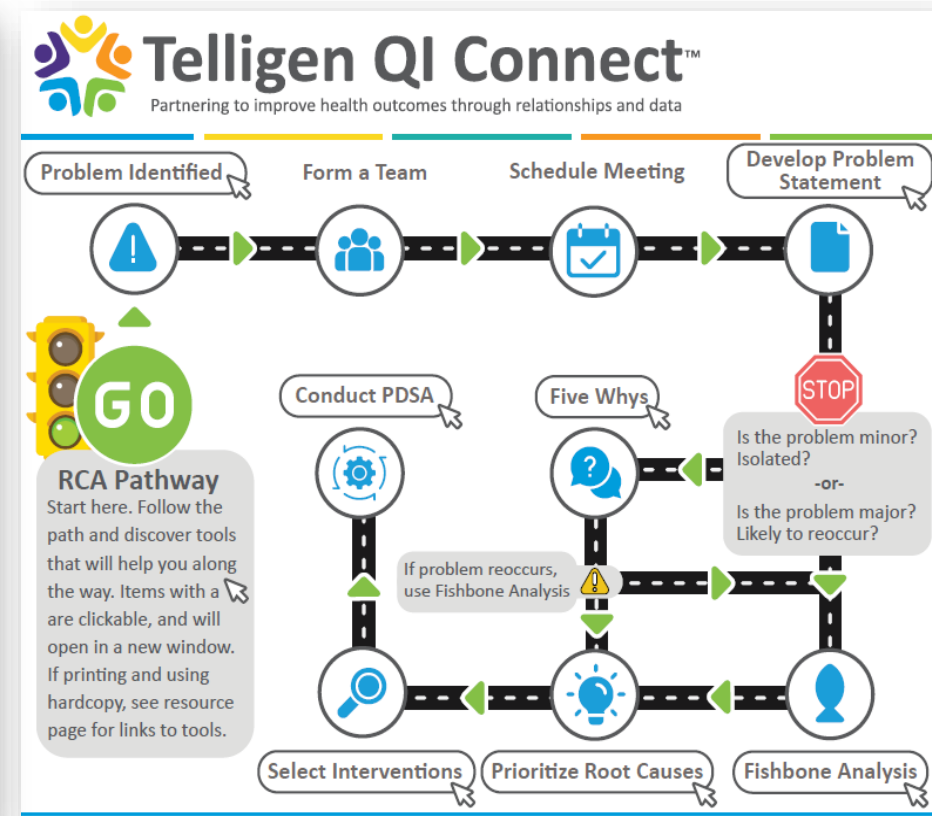
A cause-and-effect diagram, often called a "fishbone" diagram, can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories. A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than the Five (5) Whys tool. Groups may be required to meet more than once and take more than one day to complete the diagram.

If not Affinity Group, Use This Tool to Assist with Selecting Five (5) Whys or Fishbone

Has this problem or a similar problem occurred previously?	Select
Do you believe this is a complex problem?	Select
Have other attempts to solve the problem failed?	Select
Is input from others needed to uncover the root causes?	Select
Is this problem related to resident or staff safety?	Select

- 1 or 2, 'yes' responses, consider using Five (5) Whys
- 3 to 5, 'yes' responses, consider using the Fishbone diagram

<https://www.telligengiconnect.com/resource/root-cause-analysis-rca-tool-selection-guide/>



<https://www.telligengiconnect.com/resource/root-cause-analysis-rca-pathway/>

Team Actions for Improvement Process

Leadership Team

- Identify the problem
Example: *Hand hygiene is not occurring at the appropriate times*
- Review the data
- Create a SMART goal
- Build a Team charter
- Deploy an improvement team
- Support the improvement team

Improvement Team

- Decide RCA type and tools
- Identify contributing factors and root causes for the problem
- Select changes/interventions to eliminate each root cause
- Run Plan-Do-Study-Act (PDSA) cycles
- Create sustainability plan

Resources

- Quality Improvement Process Steps and Tools
<https://www.telligenqiconnect.com/resource/quality-improvement-process-steps-and-tools/>
- Telligen's Resources and Tools:
<https://www.telligenqiconnect.com/resources/>
- Root Cause Analysis Framework:
[rca_framework_101017.pdf \(jointcommission.org\)](https://www.jointcommission.org/rca_framework_101017.pdf)
- QAPI Process Framework Tool:
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf>
- Institute for Healthcare Improvement:
<http://www.ihl.org/>
- Change Packages for Improvement Strategies
 - NNHQCC Change Package
<https://www.telligenqiconnect.com/resource/national-nursing-home-quality-care-collaborative-change-package/>
 - All Cause Harm Prevention in Nursing Homes
<https://www.telligenqiconnect.com/resource/all-cause-harm-prevention-in-nursing-homes-change-package/>

Continue the Knowledge Growth

Watch Root Cause Analysis Trainings On Demand:

- Part 2: Facilitation of the Five Whys
- Part 3: Facilitation of the Fishbone Diagram

Go to [Telligen QI Connect](https://www.telligenqiconnect.com)[™] to locate the recordings and presentations

Telligen QI Connect[™] events web page: <https://www.telligenqiconnect.com/calendar/>

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