Root Cause Analysis (RCA)Training

On Demand

Part 2 of 3: Facilitation of the Five Why's

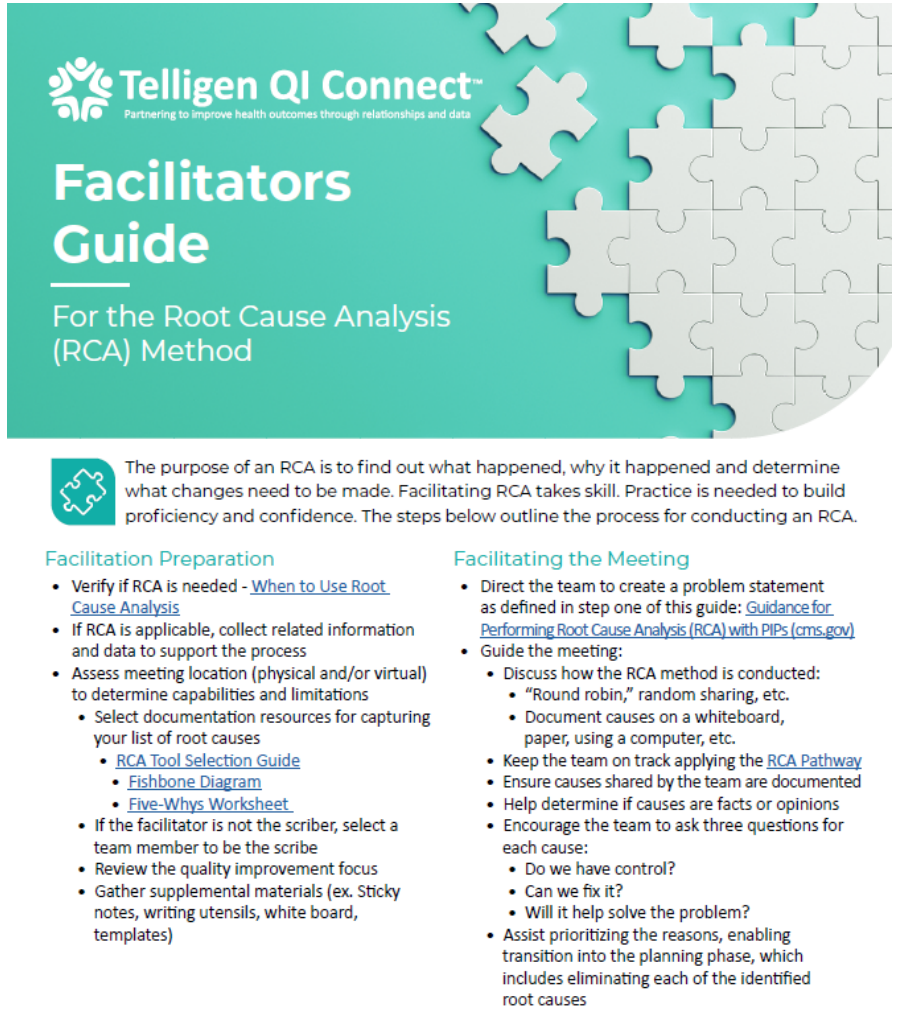
Part 2: Root Cause Analysis (RCA) Learning Objectives

- Define the Five-Why's RCA tool
- Identify when to use the Five-Why's RCA
- Demonstrate a Five-Why's RCA

If you missed part 1 of the RCA training, check it out on demand!

Facilitators Guide to Root Cause Analysis

- Guides the RCA team meeting
- Keeps everyone on track
- Ensures key elements are incorporated during the RCA process



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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 scriber, select a team member to be the scribe
  - Review the quality improvement focus
  - Gather supplemental materials (ex. Sticky notes, writing utensils, white board, templates)

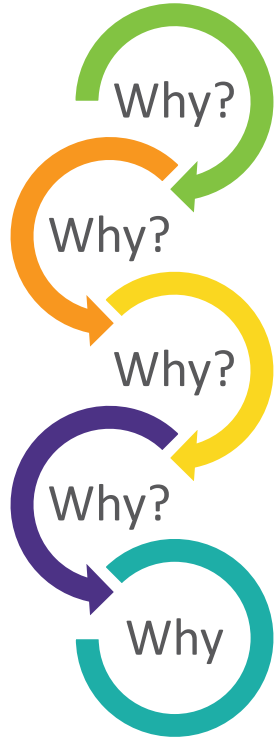
Facilitating the Meeting

- 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.telligenqiconnect.com/resource/facilitators-guide-for-the-root-cause-analysis-rca-method/

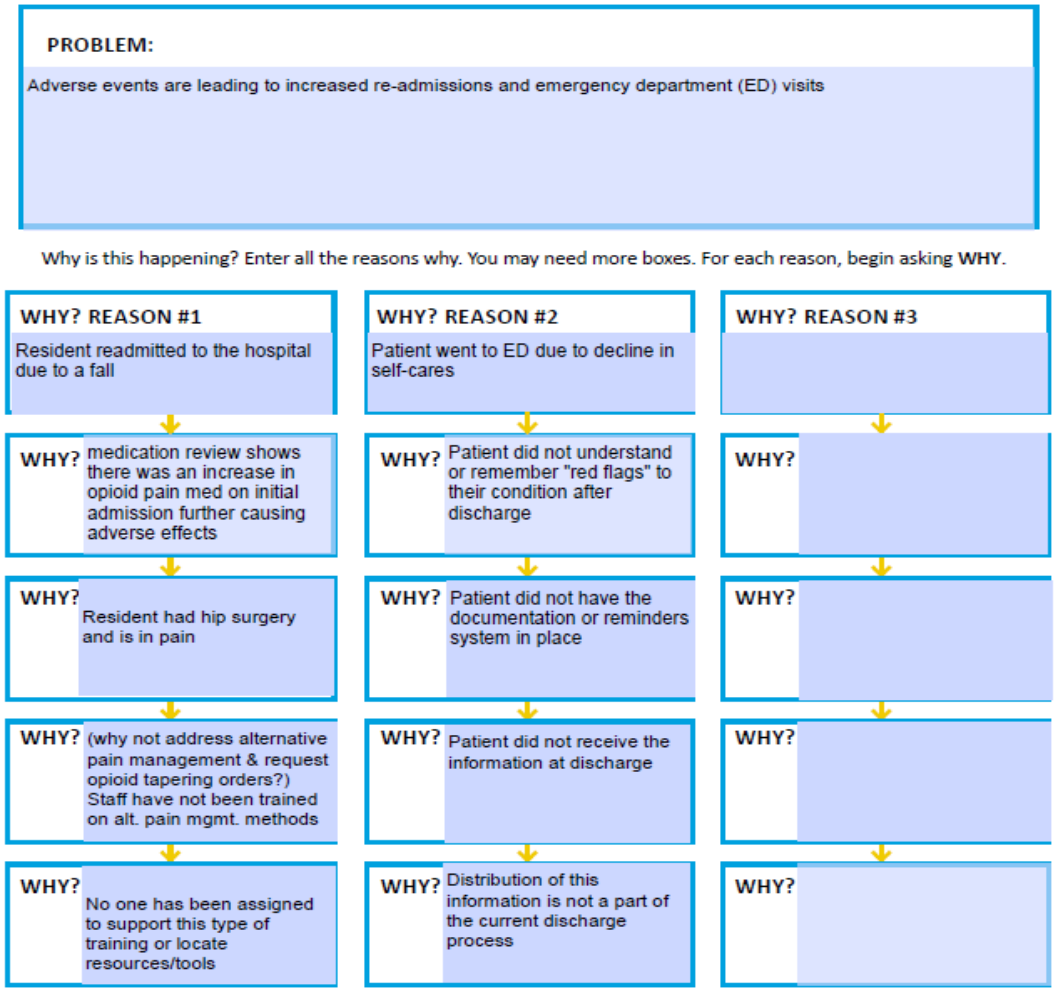
What are the Five-Why's?

- Simple technique to get to the root of the problem quickly
- Drills down by asking "Why?"
- Each answer forms the foundation for the next "why"
- Used for minor or isolated problems



https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/fivewhys.pdf

Five-Why's Worksheet Example



PROBLEM:		
Adverse events are leading to increased re-admissions and emergency department (ED) visits		

Why is this happening? Enter all the reasons why. You may need more boxes. For each reason, begin asking **WHY**.

WHY? REASON #1	WHY? REASON #2	WHY? REASON #3
Resident readmitted to the hospital due to a fall	Patient went to ED due to decline in self-cares	
WHY? medication review shows there was an increase in opioid pain med on initial admission further causing adverse effects	WHY? Patient did not understand or remember "red flags" to their condition after discharge	WHY?
WHY? Resident had hip surgery and is in pain	WHY? Patient did not have the documentation or reminders system in place	WHY?
WHY? (why not address alternative pain management & request opioid tapering orders?) Staff have not been trained on alt. pain mgmt. methods	WHY? Patient did not receive the information at discharge	WHY?
WHY? No one has been assigned to support this type of training or locate resources/tools	WHY? Distribution of this information is not a part of the current discharge process	WHY?

? Residents are readmitting due to sepsis

? Infections worsened

? Delay in response of worsening condition

? Staff did not communicate worsening S/S

? Staff did not understand what S/S to report and the importance of the timing

https://www.telligenqiconnect.com/resource/five-whys-worksheet/

Five-Why's RCA Exercise

Problem: Adverse events are leading to re-hospitalizations and emergency department visits

A) Why are adverse events occurring?

- Not clear understanding of what an AE is
- Side effects from medication that was prescribed
- Discharged too soon from hospital
- Worsening infections not responded to timely

B) Why are side effects occurring with medications prescribed?

- Contraindications with other meds
- no medication reconciliation
- Transcribing of orders – breakdowns
- Allergies were not listed or wasn't checked
- It's a new medication

C) Why haven't we identified the contraindications in the med reconciliation?

- No alerting system in MAR
- Poly pharmacy – changes cause for poor recognition
- Short staff don't have time to look at this detail
- Staff are not aware of what the contradictions are

D) Why are staff not aware of the contraindications?

- They have not been educated
- Agency staffing don't understand
- We don't have quick reference list
- Pharmacist not supportive/engaged

E) Why is there a lack of education?

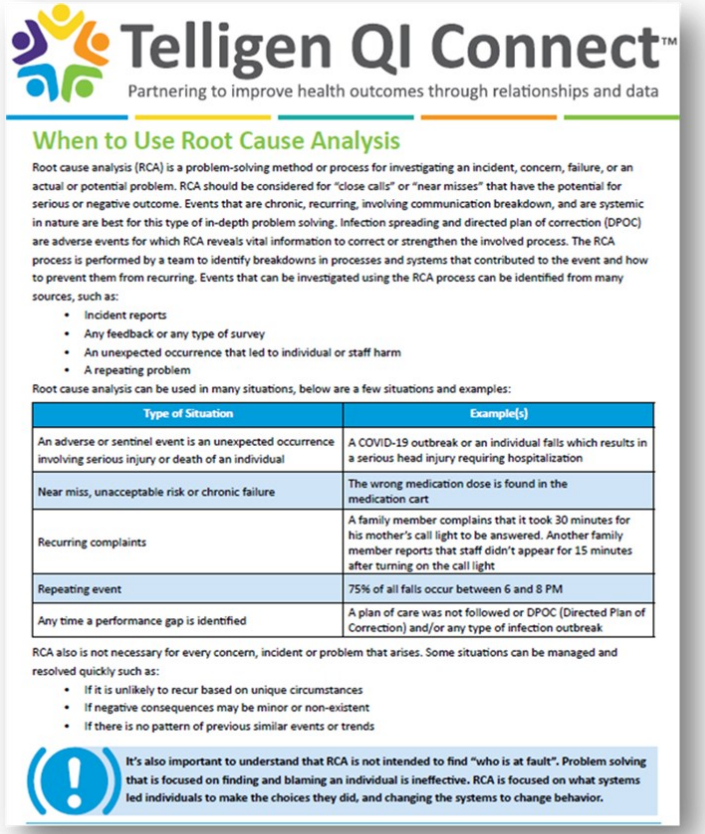
- Breakdown in communication
- Not reviewed on orientation
- No designated person to educate
- We don't know educational what materials to use

F) Why is there a breakdown in communication?

- We don't have tools/resources to support
- No one has been trained on how to communicate (final statements – create a plan)

Note responses in red is used to develop the next "why" statement for this one exampled path leading to the cause

Root Cause Analysis Tools



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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:

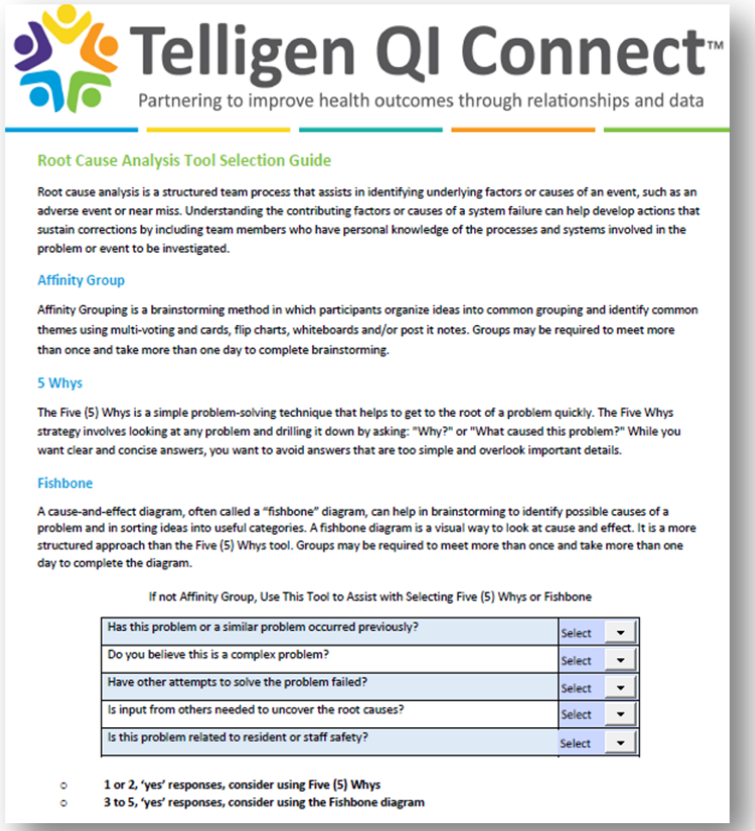
Type of Situation	Example(s)
An adverse or sentinel event is an unexpected occurrence involving serious injury or death of an individual	A COVID-19 outbreak or an individual falls which results in a serious head injury requiring hospitalization
Near miss, unacceptable risk or chronic failure	The wrong 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.

https://www.telligenqiconnect.com/resource/when-to-use-root-cause-analysis/



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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

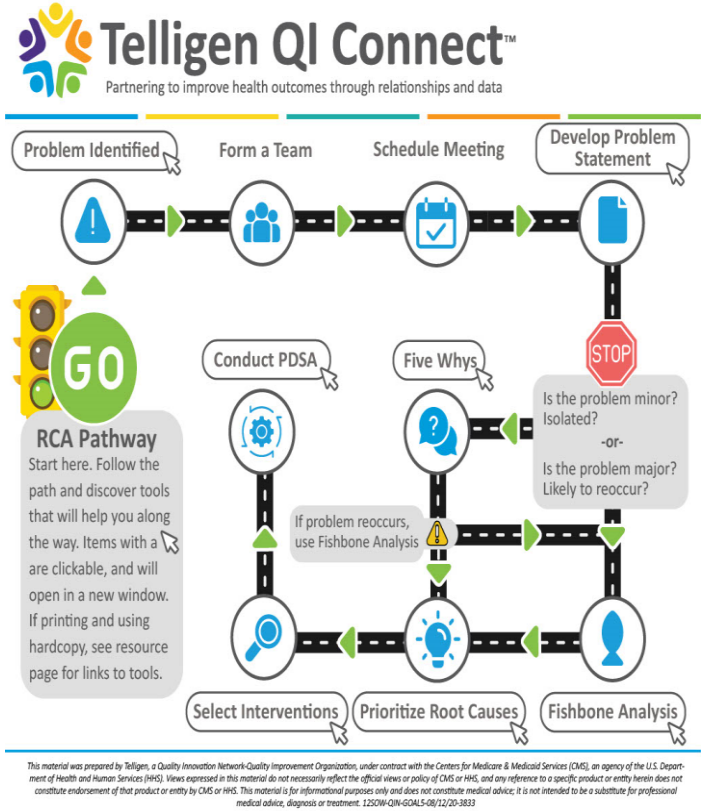
A cause-and-effect diagram, often called a "fishbone" diagram, can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories. A fishbone diagram is a visual way to look at cause and effect. It is a more structured approach than the Five (5) Whys tool. 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.telligenqiconnect.com/resource/root-cause-analysis-rca-tool-selection-guide/



https://www.telligenqiconnect.com/resource/root-cause-analysis-rca-pathway/

Team Actions for Improvement Process

Leadership Team

- Identify the problem
  Example: *Patients are re-hospitalized for sepsis*
- 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

https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf

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)
- QAPI Process Framework Tool: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf
- Institute for Healthcare Improvement: http://www.ihi.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 1: Preparing for Root Cause Analysis
- Part 3: Facilitation of the Fishbone Diagram

Go to Telligen QI Connect™ to locate the recordings and presentations

Telligen QI Connect™ events web page: **https://www.telligenqiconnect.com/calendar/**

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