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Healthcare Risk Management Update | FOR LEXINGTON INSURANCE POLICYHOLDERS

Root Cause Analysis (RCA): An Overview of Issues to Consider when Conducting an RCA

What is an RCA?

An RCA is a retrospective, structured, interdisciplinary analytical process designed to identify the fundamental causes of an adverse event. By identifying the root cause(s) of an adverse event, healthcare organizations can then determine what behaviors, actions/inactions, and systems/processes need changing to prevent a similar type of event from occurring in the future. An RCA focuses on systems and processes rather than on individual performance and should not be used to assign blame to an individual for their actions/inactions. In short, the goal of an RCA is to determine:

- What happened?
- Why did it happen?
- What can be done to prevent a similar type event from happening again?

What are the steps involved in an RCA?

The RCA process contains multiple steps that involve information gathering, brainstorming, critical thinking and problem-solving. Generally, the steps in an RCA Process include:

1. **Identifying the event needing investigation**: Events requiring investigation can be identified through many sources including, incident reports, inspection surveys, accreditation requirements, patient/family complaints, risk management referrals, etc. It is important that each organization have a detailed process for selecting those events requiring an RCA. Events can include an event, error, or near miss that caused or could cause major/catastrophic injury or death and/or could recur.

2. **Designate a Team Facilitator and assemble an interdisciplinary RCA Team (RCA Team):** An RCA Team Facilitator is chosen to guide the team through the RCA phases, along with four to six team members familiar with the processes and systems pertaining to the event undergoing the RCA. RCA Team members should be able to review and discuss the event in an objective manner. Staff with personal knowledge of the event may be selected for the RCA Team depending on the circumstances, or their input may be included through interviews. Selected team members must commit to active participation and maintaining the confidentiality of all aspects of the RCA.

3. **Formulate a description/timeline of the event:** The RCA Team begins the RCA process by gathering event information and developing a description/timeline of the event based only upon the facts/circumstances known at the time of the event. Each step on the timeline should stem from the preceding event. Sources of information may include: Interviews with individuals involved having direct knowledge of the event; technology reports; documentation; incident reports; complaint reports; and risk management referrals. At this point in the process, the RCA Team focuses on gathering information and gaining an understanding all the circumstances involved in the event, and should avoid jumping ahead to identify causes.

4. **Analyze information to determine contributing factors and identify the root cause(s) of the event:** Next, using analytical tools (e.g. 5 Why's, Fishbone Diagram, etc.), the RCA Team analyzes the information in order to begin to identify contributing factors leading to one or more root causes of the event. Keep in mind that "contributing factors" are not the same as "root cause;" and there may be more than one root cause identified. To distinguish whether a factor is a contributing cause or a root cause, RCA team members ask:

    a. Would the event have occurred if this cause had not been present?
    b. Will the problem recur if this cause is corrected or eliminated?

    If the answer is "yes," the team needs to dig deeper in their analysis to determine the root cause. If answer is "no," the root cause has most likely been identified. Once the root cause(s) is identified, the RCA Team develops a causal statement illustrating clearly for the reader, the causal relationship between the identified root cause(s) and the event occurrence. The causal statement should: not contain subjective descriptors (e.g. "poor," "bad," etc.); not blame individuals for their action/inaction; must identify why a process/procedure was not followed; and demonstrate that there was a pre-existing duty to act.

5. **Design systems/process changes to prevent recurrence of a similar type of event:** Once the causal statement is developed, the focus turns toward identifying/implementing corrective actions to prevent a similar event from recurring in the future. Typically, corrective actions entail a change to an existing process or the creation of a new process. Each identified root cause should have a corresponding "strong" or "intermediate" corrective action, as these types of actions are the most effective approaches to ensuring that the error does not recur. Implementation of the changes should be tasked to a specific individual along with a target date for implementation. RCA Team members should avoid the temptation of developing short term solutions. At this stage in the RCA process, the RCA Team may want to include implementation of corrective actions to other clinical areas using the same process/system, as well as providing an explanation of why the changes are being made in order to educate stakeholders regarding why changes to the current process/system are necessary to prevent recurrence of a similar event.

6. **Monitor the effectiveness of the changes:** Changes must be monitored to ensure that they are affecting the intended goals, i.e. preventing recurrence of a similar type of event. Monitoring is important not only to ensure effectiveness, but also to gain support from staff and leadership. Staff is more likely to observe to the new changes if they can see that the changes are having a positive impact, and leadership is more likely to continue supporting the changes with resources, if they can see that the changes are effective. Monitoring should include specifying:

    a. What will be monitored (including frequency and duration of monitoring)?
    b. Who will monitor?
    c. Comparison against regulatory requirements/benchmarks
        i. Consider both process measures and outcome measures
        ii. Two measures per action helps prevent workarounds
    d. Providing feedback to relevant stakeholders, i.e. leadership

What are the key RCA team meeting ground rules?

As with any group process it is important to set ground rules that lay the foundation for a productive and accurate process. These ground rules include things like:

- Ensuring all voices are equal (position within the organization doesn't matter for this process- everyone is equal)
- Promoting an atmosphere supporting the expression of differing opinions and respect for another's idea
- Confidentiality must be absolute, not only for peer review and document protection, but also to foster open expression of ideas
- Members must commit to attendance
- All assignments must be completed on time
- Decisions made by consensus

Why are some RCA's not effective?

Despite following standard processes, some RCA's do not achieve intended outcomes. There can be many reasons for an ineffective RCA, some recurring themes include:

- Only identifying a single root cause, when there may be more than one
- Issues with quality of the process
- Inconsistent use of analytical tools
- Hindsight bias
- Poorly designed corrective actions
- Inefficient sharing across the organization of lessons learned
- Blaming individuals rather than focusing on processes/systems
- Leadership not involved

Conclusion

The RCA process provides a structured review of processes and systems potentially involved with adverse patient safety events. By focusing on systems and processes, and not individual behaviors, the organization avoids assigning individual blame, and can delve deeply into its systems and processes to determine where changes are needed to prevent recurrence of a particular event.

Additional Resources

- Pennsylvania Patient Safety Authority, Guidance Document for Root Cause Analysis Investigation Form (April 2020): http://patientsafety.pa.gov/pst/Documents/Root_Cause_Analysis/RCA%20Guidance%20FINAL.pdf
- CMS: QAPI, Guidance for Performing Root Cause Analysis with Performance Improvement Projects: (https://www.cms.gov/Medicare/Provider-Enrollment-and Certification/QAPI/downloads/GuidanceforRCA.pdf
- CMS: QAPI, Five Whys Tool for Root Cause Analysis: (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FiveWhys.pdf)
- CMS: QAPI, How to Use the Fishbone Tool for Root Cause Analysis: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf
- AHRQ: Primary Care Practice Facilitation Curriculum, Module 11: Using Root Cause Analysis to Help Practices Understand and Improve Their Performance and Outcomes: https://pcmh.ahrq.gov/sites/default/files/attachments/pcpf-module-11-root-cause-analysis.pdf
- United States Department of Veterans Affairs: Guide to Performing a Root Cause Analysis: https://www.patientsafety.va.gov/professionals/onthejob/rca.asp

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