

WASHINGTON STATE DEPARTMENT OF HEALTH

PATIENT SAFETY-ADVERSE EVENT PROGRAM

Conducting a Root Cause Analysis

Introduction

In 2006 the Washington legislature passed a law (RCW 70.56) that requires health care facilities to notify the department within 48 hours whenever any of the serious reportable events adopted by the National Quality Forum occur. That notice must include the facility name, the type of event identified and the date of discovery or confirmation of the event. The purpose of this reporting system is to collect data on adverse events in a proactive, non-punitive manner so we can learn from such events and identify trends that may reveal organizational, operational, cultural, systemic, and environmental problems. From more data, resulting information can be utilized to prevent future occurrences.

RCW 70, 56 specifies that:

1. Facilities must conduct a root cause analysis of each adverse event utilizing the procedures and methods identified by:
 - The Joint Commission on Accreditation of Health Care Organizations; or
 - The Department of Veterans Health Affairs National Center for Patient Safety; or
 - Another nationally recognized root cause analysis methodology with permission from the DOH Patient Safety Adverse Event Program.
2. Create and implement a corrective action plan for each adverse event consistent with the findings of the root cause analysis. Each corrective action must include:
 - How each finding will be addressed and corrected
 - When each correction will be completed
 - Who is responsible to make the corrections
 - What actions will be taken to prevent each finding from reoccurring; and
 - A monitoring schedule for assessing the effectiveness of the corrective action plan including who is responsible for the monitoring schedule.
3. Submit a root cause analysis (RCA) to DOH within 45 days following confirmation that an adverse event has occurred.

Recommendations and Helpful Hints for a Conducting Root Cause Analysis (RCA)

The recommendations for conducting a root cause analysis outlined below were developed from the Department of Veterans Affairs National Center for Patient Safety website and the Joint Commission Sentinel Event website.

The ultimate goal of a root cause analysis is to make patient care as safe as possible.

Medical facilities should be prepared to learn as much as possible about the contributions to and causes of every patient care situation that did not turn out as planned. The intent is to create change so that similar unplanned situations do not reoccur.

The Patient Safety Improvement Handbook developed by the Veterans Administration is available on the Department of Veterans Affairs National Center for Patient Safety website www.patientsafety.gov and may be copied and utilized to assist in the conduct of Root Cause Analysis (RCA).

The JCAHO website www.jcaho.org provides additional help when conducting a root cause analysis. The section devoted to Sentinel Events provides many helpful documents.

Other directions for conducting an RCA have been published. Please check with the Patient Safety-Adverse Event Program if you do not utilize the VA or the JCAHO Sentinel Event documents.

Step 1:

Determine that an Adverse Event occurred.

Often adverse events do not become evident or are not confirmed at the time of occurrence. Facility leaders must determine if the events match the serious reportable events adopted by the National Quality Forum. Once the adverse event has been confirmed and the date determined report the event to DOH.

Step 2:

Charter an RCA Team:

Once the decision to conduct an RCA has been made, the next step for Facility Leaders (preferably the Administrator) is to “charter” an RCA team comprised of members from disciplines and services. The goal of the RCA is to determine the reasons why an event occurred and then to identify strategies to prevent reoccurrence. Staff members involved in the event are some of the best sources of information about an event, but because of their involvement in the event it is recommended that they are not included as RCA team members.

Step 3:

Conduct a RCA

Determine the RCA process to use. If you do not utilize the VA or JCAHO Sentinel Events format for conducting an RCA please call the Patient Safety-Adverse Event Program to review your choice.

The characteristics of an Acceptable Root Cause Analysis outlined below are reprinted from the JCAHO Sentinel Event website.

Thorough

- Identify facts of the case –Who, What, Where, When so that the event is understandable
- Description of the processes involved in the event
 - ✓ As designed
 - ✓ As usually performed
 - ✓ As performed this time
- Analysis of the underlying processes and systems—See JCAHO Sentinel Event “Minimum Requirements” matrix (www.jcaho.org) for identification of areas to be reviewed
- Identify possible underlying (root) causes
- Suggest potential improvements

- Include an action plan
- Include a strategy for measuring effectiveness of proposed changes

Credible

- Participation by leaders and those closest to the process
- Internally consistent
- Explains “N/A” or “No problem”
- Considers relevant literature

Step 4

Develop an Action Plan

Create and implement a corrective action plan for each adverse event consistent with the findings of the root cause analysis. Each corrective action must include:

- How each finding will be addressed and corrected
- When each correction will be completed
- Who is responsible to make the corrections
- What actions will be taken to prevent each finding from reoccurring; and
- A monitoring schedule for assessing the effectiveness of the corrective action plan including who is responsible for the monitoring schedule.

Consider the following list of ***Effective Risk Reduction Strategies*** as outlined by JCAHO:

- The safest thing to do is the easiest
- System makes errors difficult
- Redundancy is built in
- Simple/standardized procedures
- Procedures are automated
- Training and competence are rigidly reinforced
- Risk points are eliminated

Step 5

Measure Effectiveness of Plan

- Develop a strategy to evaluate the changes outlined in Step 5.
- Audits or reviews need to be actual observations of actions implemented as a result of the root cause analysis. Chart reviews must be concurrent reviews.
- Discussions with health care delivery staff helps to determine effectiveness of strategy so that adjustments can be made.

Other tests

- Plan needs to be applicable to multiple events
- Same “root causes” derive from different events

Step 6

Send a copy of the RCA and the corrective action plan to DOH within 45 days.

- Remove all patient and health care staff identifiers. Just the facts, please.

- Mail a copy to:
Linda Furkay, PhD, RN
Patient Safety-Adverse Event Program
PO Box 47852
Olympia, WA 98504

Step 7

Utilizing the Root Cause Analysis Evaluation Criteria document, program staff will evaluate your RCA and discuss the findings and plan with you. The RCA Evaluation Criteria document and all RCA documents will be returned to you.