Getting to the Root Cause

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Who's Around the Virtual Table

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Objectives

- Build on the information shared in the previous webinar on 6/30/21 Planning the Change…SMART Goals, Process & Outcome Measures
- Explore the tools to investigate & plan your quality improvement project.
- Define a Root Cause Analysis (RCA)
- Identify different types of actions
- Apply concepts of RCA when investigating an adverse event or near miss

First Step… "Houston we have a Problem"

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The *starting* point for any improvement effort is:

- Recognition of a problem
- Identification and elimination of the "root cause"

Steps in Problem Solving

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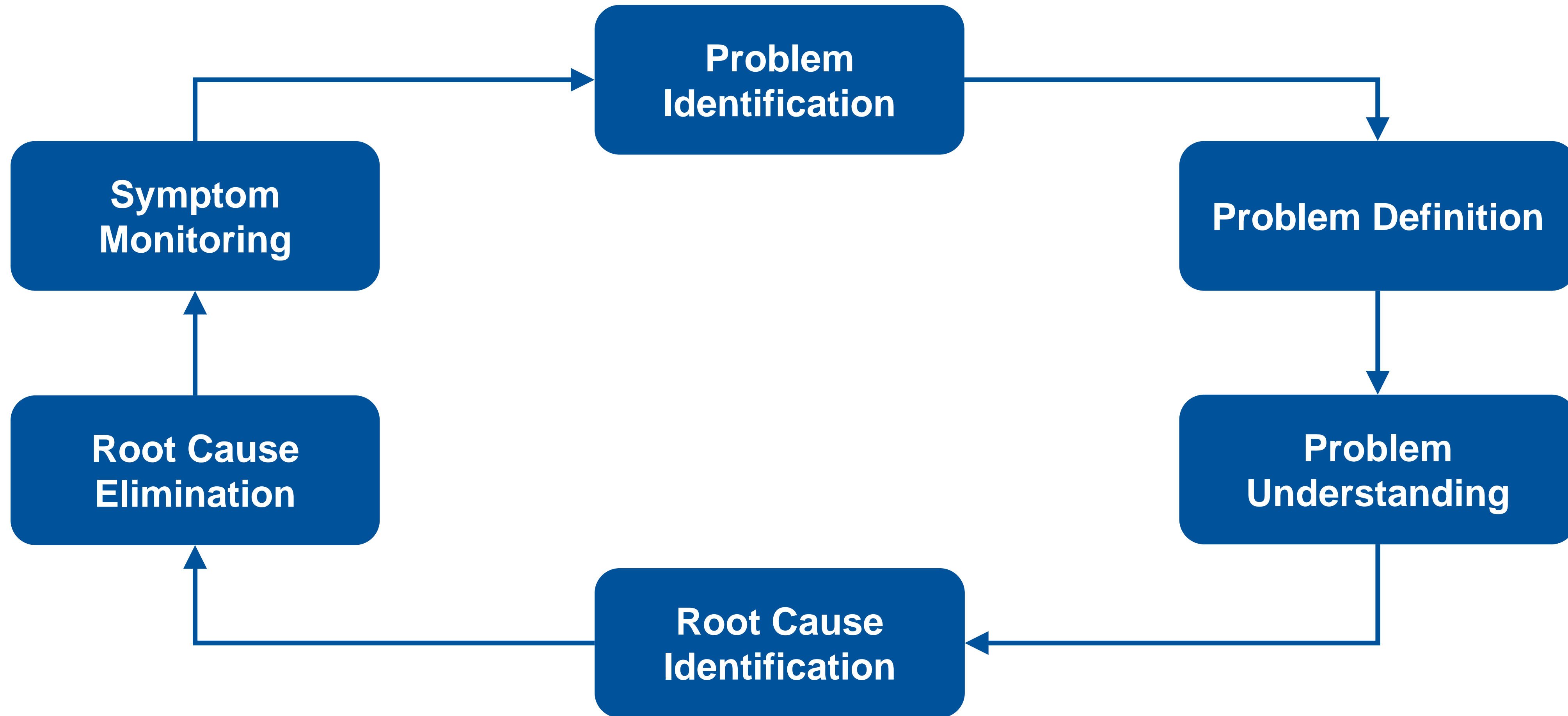

Five Why's Tool

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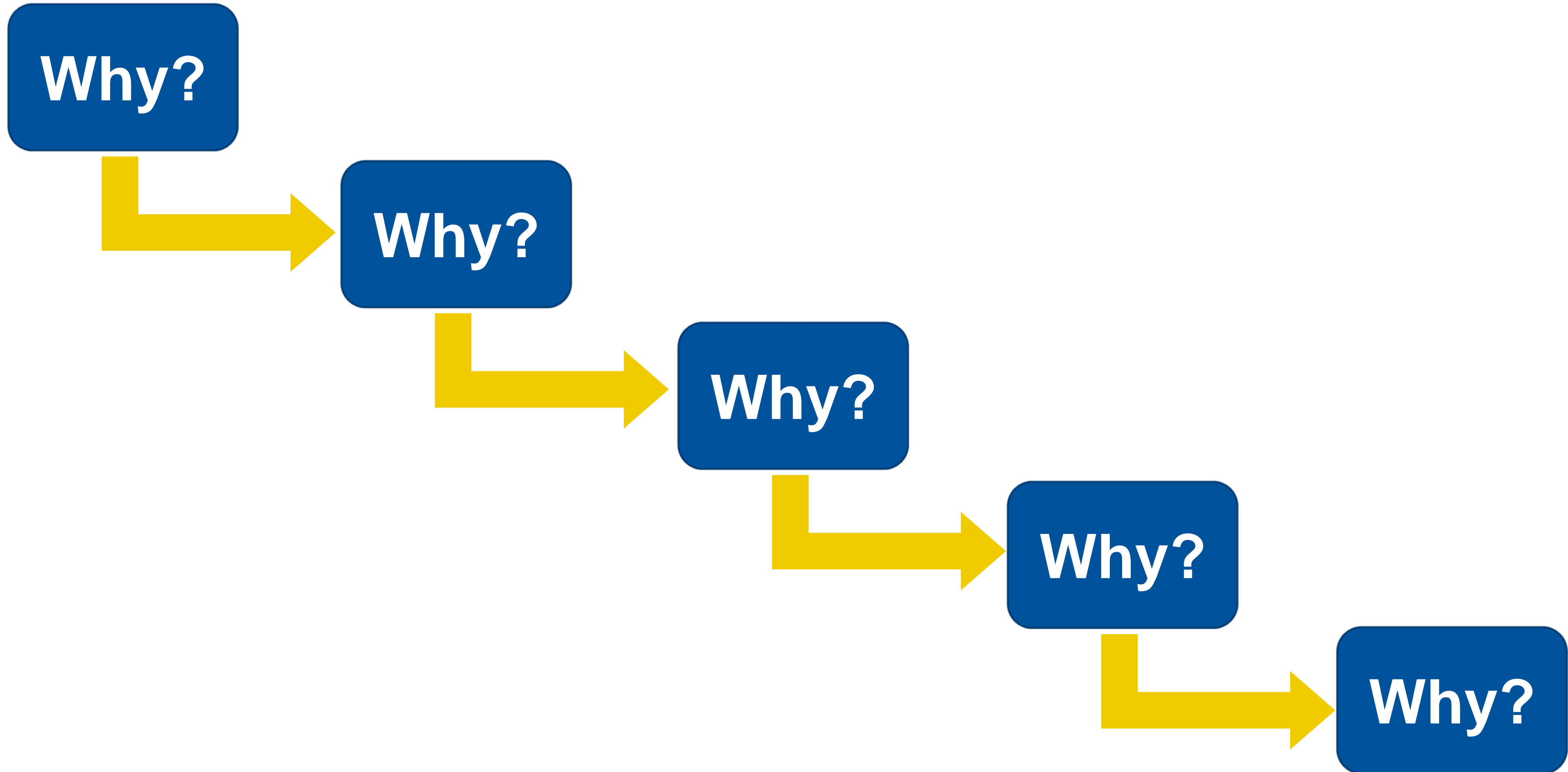

Root Cause Analysis

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- A process for looking at unexpected events and outcomes
- Determine the underlying causes or contributing factors
- Recommend changes that are likely to improve them

Philosophy of RCA

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- **Focuses on systems and processes NOT on individuals!**
- **The "true" problem must be understood before action is taken**
  - i.e., what caused the problem to happen or "root cause(s)"

The RCA Process: 5 Steps

Gather Initial Information & Define the Problem

Fill in the Gaps

Analyze / Identify the Root Cause(s)

Develop Action Plan

Recommend & Implement Solutions

Step 1: Gather Initial Information & Define the Problem

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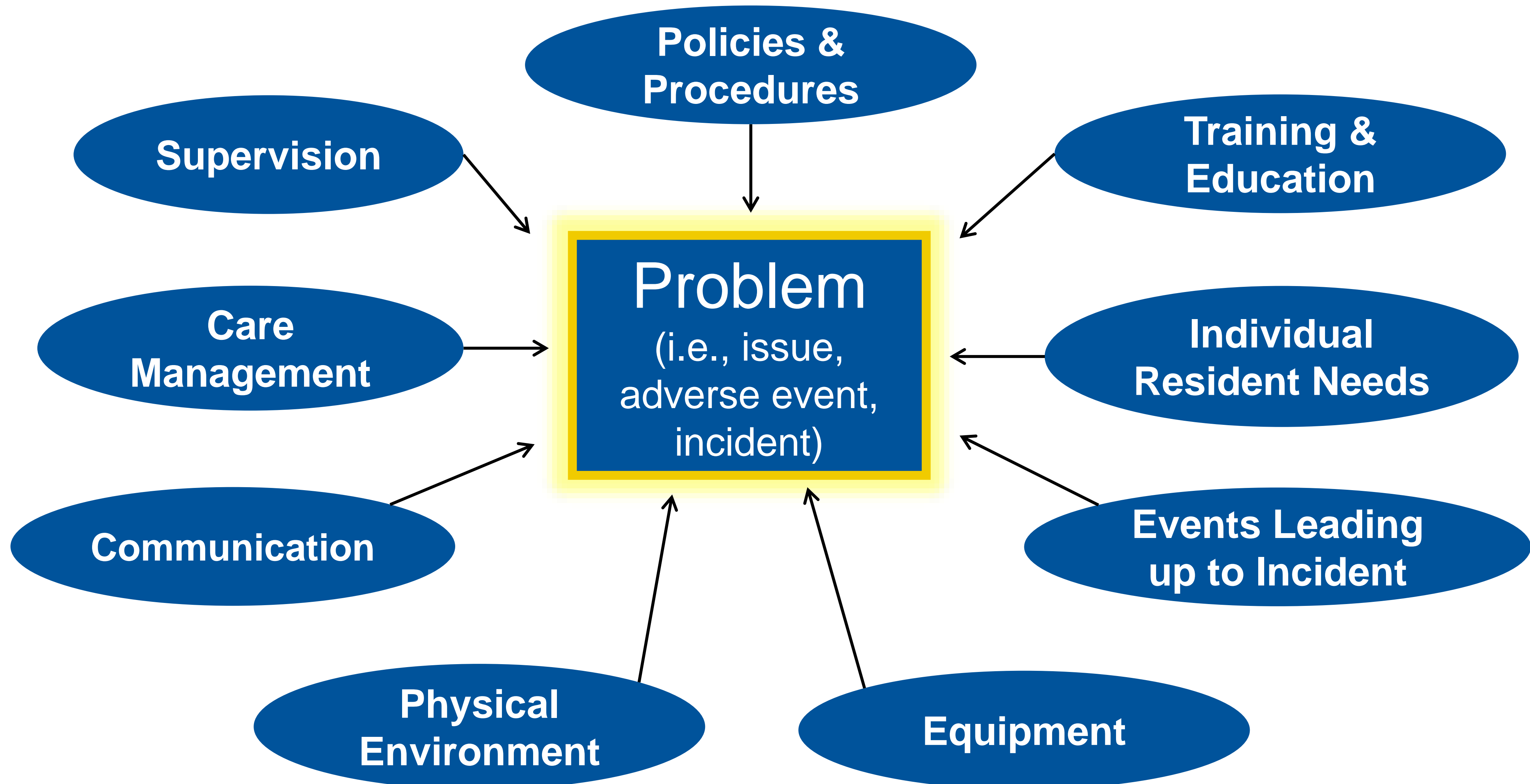
- **The initial information will likely be on the incident report**
- **What are you trying to correct?**
  - Define who, what, when, where, how
  - Brainstorm ideas and then work together to define a single problem

Investigate to Identify Contributing Factors



Step 2: Fill in the Gaps

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- **What other sources might have additional information regarding the problem?**
  - Consult your team/co-workers
  - Interview the resident and/or family
  - Walk through the event where it occurred
  - Review all documentation sources

Getting to the Root Cause

The 5-Whys

- A question-asking method used to uncover the underlying causes of an event
- Ask "Why?" questions until all logical causes (and/or root causes) can be identified
- Uncovering the root cause leads to an Action Plan that is more likely to prevent the event from reoccurring / happening again

Using the 5 Whys Method

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Resident fell in room (Problem)

She tripped over a chair — PLAN: Move or remove chair

She didn't see the chair

The room was dark (no nightlight)

Nightlight not part of service plan — PLAN: Night lights in all rooms

Resident initially assessed as NOT at risk for falling — PLAN: Review fall risk assessment process and update as needed

Examples of Actions by Hierarchy

Stronger Actions	Intermediate Actions	Weaker Actions
❑ Architectural changes.	❑ Increase in staffing/decrease in workload.	❑ Double checks.
❑ Simplify the process /remove unnecessary steps.	❑ Checklist/cognitive aid.	❑ Warnings and labels
❑ Standardize equipment or process.	❑ Eliminate look and sound alike products.	❑ New procedure/policy.
❑ Tangible involvement and action by leadership in support of patient safety.	❑ Read back	❑ Training
	❑ Enhanced documentation or communication.	❑ Additional study/analysis.
	❑ Redundancy	

Developing Actions to Eliminate the Cause

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- Be specific and clear
- Give them to a “cold” reader to see if they make sense
- Specifically address the root cause
- Test the actions or simulate process changes before facility-wide use
- Check with the process owners

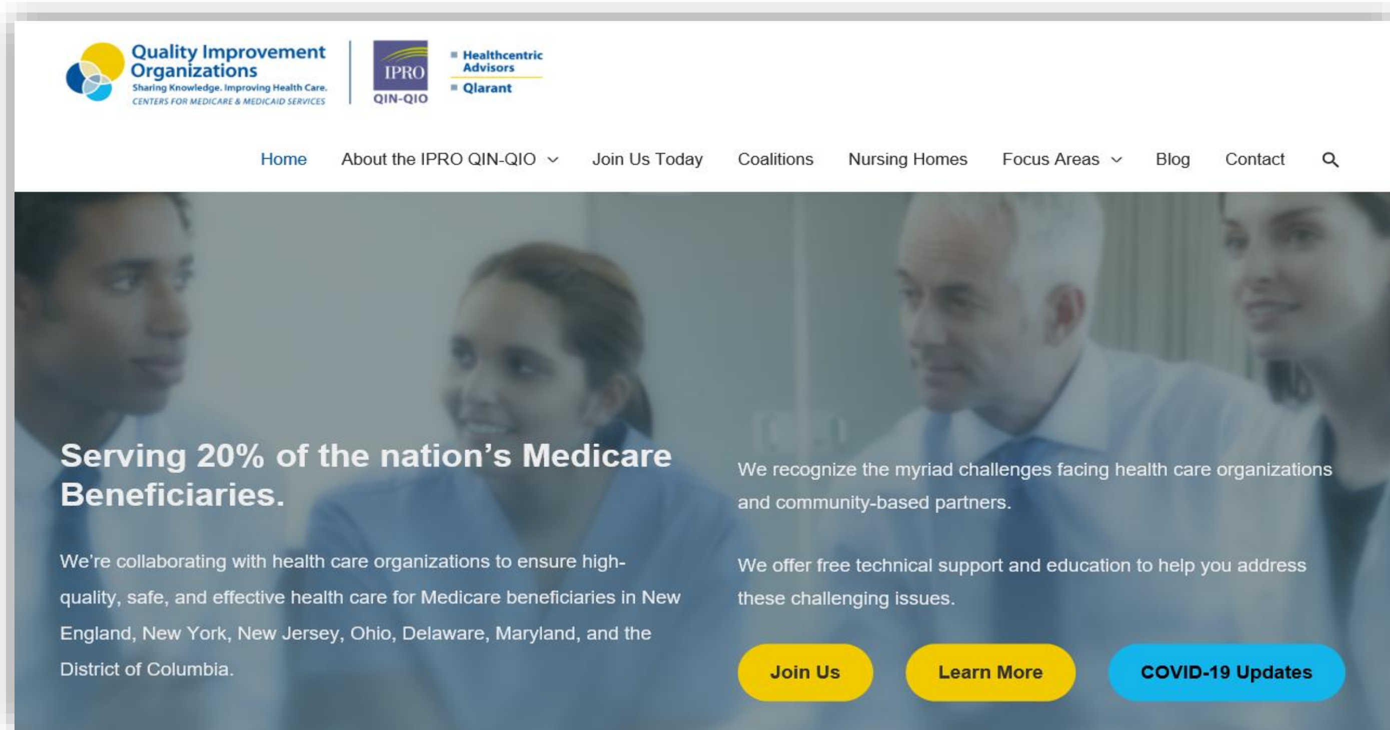
Questions

Comments

Feedback

Learn More & Stay Connected

https://qi.ipro.org/



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Thank you for your continued efforts to keep us safe.

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