Step 1.1 – Identify the Event

When to Use Root Cause Analysis

Introduction

Root cause analysis (RCA) is a problem solving method or process for conducting an investigation into an incident, failure, actual or potential problem or concern. Events that can be investigated using the RCA process can be identified from many sources, such as incident reports, individual, family and staff feedback, surveys from regulatory agencies, an unexpected occurrence that led to individual or staff harm, or a repeating problem. RCA should also be considered for events that could have potential for a serious or negative outcome, such as "close call" or "near miss" incidents. Throughout the toolkit, these situations will all be referred to as "events", even though they come from a variety of sources.

Root cause analysis can be used in the following situations:

- An adverse or sentinel event is an unexpected occurrence involving serious injury or death of an individual:
    - For example, an individual falls, resulting in a serious head injury requiring hospitalization
- Near miss, unacceptable risk or chronic failure:
    - For example, the wrong medication dose is found in the medication cart
- Recurring complaints:
    - For example, 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:
    - For example, 75% of all falls occur between 6 and 8 PM
- Any time a performance gap is identified:
    - For example, a plan of care was not followed

RCA also is not necessary for every concern, incident or problem that arises. Some situations can be managed and resolved quickly. They are unlikely to recur based on unique circumstances, negative consequences may be minor or non-existent, or there is no pattern of previous similar events or trends. RCA takes time and requires resources to be done well. Events that are chronic, recurring, involving communication breakdown, and are systemic in nature are best for this type of in depth problem solving. RCA is a different process than managing an incident and implementing immediate action to correct the situation. RCA occurs after the immediate situation is resolved: involved individuals and staff are safe; immediate communication to

individuals, families, and staff is concluded; and any external and internal reporting requirements are completed. The root cause analysis process is then performed by a team to identify breakdowns in processes and systems that contributed to the event and how to prevent them from recurring.

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.

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