# Quality Improvement Basics

## Root Cause Analysis, Part 1

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## Objectives

After completing this module, participants will be able to

- Define the purpose of a root cause analysis (RCA)
- Discuss when to do an RCA
- Explore who to involve in an RCA



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# Root Cause Analysis

- A focused review of an event or unintended outcome
- The intent is to learn from adverse events and unsafe conditions and take action to prevent their occurrence in the future



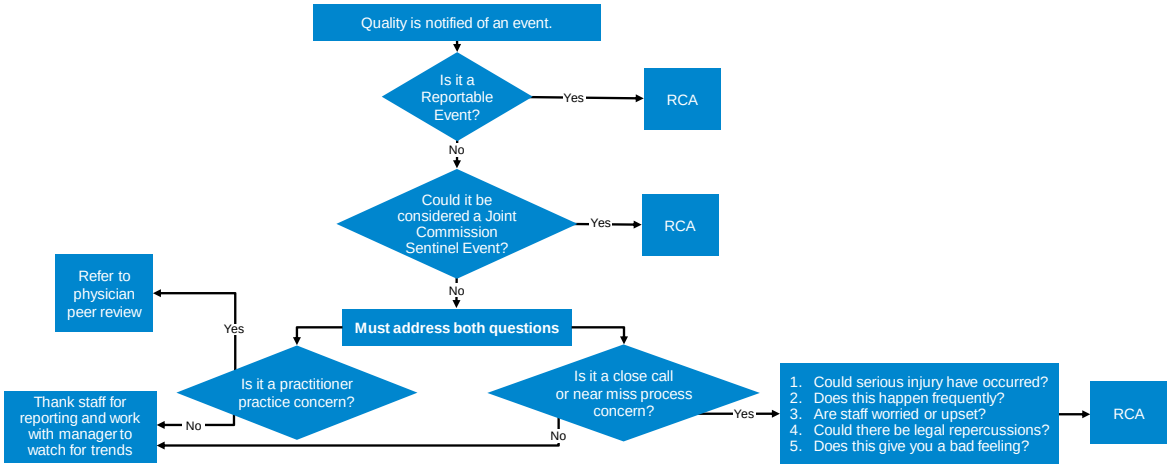


# When do we do an RCA?

- Events which have resulted in harm, or could have resulted in harm
- Reportable or sentinel events
- Near misses
- Repeated problems

# RCA Decision-making Algorithm

## Hospital Example for a Procedure-related Reportable Adverse Event








# Characteristics of an RCA

- Systematic process for identifying the most basic causal factor or factors for an undesirable event or problem
- Focus is on process and systems, not individuals
- Frequently ask “why”
- Confidential
- Conduct as soon as possible
- Goal is to learn

# Who is involved in an RCA?

- Two schools of thought
  - Those involved in the event are present at the RCA
  - Those involved provide information to the RCA team
- Facilitator
- Recorder





# RCA Asks Many Questions

- What happened and why?
- Where did things break down?
- What are the system issues?

# In Summary

- The goal of the root cause analysis process is to learn and help make changes to prevent recurrence of adverse events or problems.
- It can be helpful to develop an algorithm to determine when to conduct an RCA. Consider factors such as whether the event resulted or could have resulted in patient or staff harm, if there are regulations or accrediting organizations that require an RCA, or if the problem is recurring.
- Consider thoughtfully who to involve in an RCA and how and when to involve them. For example, persons involved in the actual event need to be share their detailed description of what happened, and they may be part of the RCA team.





# Where to Learn More

- National Patient Safety Foundation. *RCA2: Improving Root Cause Analyses and Actions to Prevent Harm*
- VHA National Center for Patient Safety – *Root Cause Analysis*

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