Well-trained, highly-educated healthcare professionals strive each day to provide the best and safest care for their patients. However, despite ongoing efforts, preventable medical errors persist as the number three cause of death in the United States, following only behind heart disease and cancer.¹

**Chance of harm²**

1 in 1 million while in an aircraft

1 in 300 while in a healthcare setting

**BEYOND WHAT AND WHY**

When medical errors occur, the natural reaction may be to determine which employees were involved and to terminate their employment. The assumption is the employees did something wrong. Though that may be the case, there is no guarantee that the same incident will not occur again, with other employees involved, unless the healthcare facility digs deeper to understand exactly what happened, why it happened, and what needs to change to prevent future mistakes.

This is where root cause analysis comes in. The American Society of Risk Management defines the root cause analysis (RCA) process for the healthcare industry as a “systematic analysis of an event or near miss that has occurred within the healthcare setting.”

“Understanding what happened is only one piece of the puzzle. To minimize the likelihood that similar mistakes will be made again, healthcare facilities need to implement sustainable changes to processes, policies, and environment. Analysis plus action will help ensure safer patient care and working conditions for staff.”

– MARYBETH RHODES
RN, MN, CPHRM, Risk Management Consultant,
The Hanover Insurance Group

[1] The number three cause of death in the United States is preventable medical errors.
[2] The chance of harm is a statistical probability of an event occurring.

continued ▶
When performing RCA, organizations should consider the goals they want to achieve. Common expectations of RCA include:

- Identifying and implementing sustainable systems-based improvements that provide safer patient care
- Identifying methodologies and techniques that will lead to more efficient and effective use of RCA
- Promoting the utilization of tools to evaluate the RCA process so that significant errors or flaws are realized and remedied prior to implementing the action items
- Employing RCA as a focused review of the systems and processes involved in the delivery of healthcare and not on individual action

Root cause analysis should not be a tool used to discipline employees involved. To do so would impede a culture of safety and decrease the chance of errors being brought forth in the future.

LEARNING FROM MISTAKES

Root cause analysis at a glance

When conducted properly, RCA can help us learn from our mistakes. How organizations handle RCA should be documented and reviewed annually. Keys to success include:

- Support and involvement of leadership team
- Documentation of what incidents should go through RCA
- Starting RCA within 72 hours of an incident
- Establishment of a four- to six-person team, including at least one person who has expertise in the RCA process
- A consistent approach to the investigation, including utilization of such tools as interviews, flow charts, diagrams, barriers, five whys, action hierarchy, accountability and measurement
- Determination of actions to be taken and timing
- Ongoing measurement of the changes and improvements
- Feedback to staff, patient, and family on findings

Given how busy all healthcare professionals are, it is tempting to forego RCA, but given what is at stake—patient and staff safety—it is advisable to take the time and understand what caused a medical error. If not, it will eventually re-occur.

Sources:
3. Six Sigma What is Root Cause Analysis