Applying root cause analysis in a healthcare setting

Most care provided in the United States is safe and high quality, but as healthcare options and treatments advance, new or expanded opportunities for unintentional, preventable harm are created. No matter the size of your facility or the complexity of care offered, using root cause analysis (RCA) is an important part of promoting and maintaining a culture of safety. When an incident occurs, RCA can assist you in understanding what happened and what sustainable changes could help prevent future errors. Having a well-defined criteria of which incidents will undergo RCA will help ensure the success and well-being of your facility’s patients and staff.

TAKING A RISK-BASED APPROACH

Many reasons exist for the recommendation that healthcare entities create a risk-based prioritization system to credibly and efficiently determine what events should be addressed and to what degree and depth the analysis and action should occur. A risk-based approach that considers both the potential harm and the probability of its impact on a patient is preferable over one that looks solely at harm. A proactive approach focuses on what will achieve the the greatest benefit possible for the patient population and allows learning and preventive action to be taken without actual harm occurring.²

Another benefit to this approach is that it allows for quantitative-based methodology for determining which events will undergo the RCA process, thereby allowing for a more transparent process. It is important that this prioritization system is transparent, formal and explicit and is communicated to internal and external stakeholders.

“Frequently, there is a rush to judgment to determine what happened and make changes, such as immediate termination or re-education on how to perform a skill. Based on reviews of claims data, we find these actions to be premature, and worse, they will not prevent future events of the same type.”

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

continued
By utilizing this method there are well-defined levels of severity or outcome, occurrence probability and pre-determined steps that occur once a threshold is reached. This eliminates subjectivity and provides focus to the RCA process.

In order to maintain the integrity of the RCA process, healthcare entities should define events or occurrences that are blameworthy. Commonly noted blameworthy events may include those that involve criminal acts, substance abuse, patient abuse or acts defined by the organization as being intentionally or deliberately unsafe. These types of events should not be included in the RCA process but rather handled through an administrative or human resources process. If, in the course of an RCA, an event is found to be blameworthy or is found to have aspects of that, it should be referred to the designated authority. While these events can still be reviewed for process, the primary responsibility for full investigation should be by the appropriate authority either administratively or through human resources. By clearly defining blameworthy events, organizations maintain the integrity of the RCA process.²

With so much at stake, it is imperative that healthcare facilities document and employ a RCA process to help determine what happened, why it happened, and what steps should be taken to prevent similar errors in the future.

Manage top safety concerns to minimize errors

Most facilities have their own list of top safety concerns, and promoting awareness of these concerns can help prevent future errors and minimize how often a facility will need to implement root cause analysis. Top nationwide concerns to be aware of include:

- Inadequate alarm configuration policies and practices
- Incorrect or missing data in health IT systems
- Managing patient violence
- Mix-up of IV lines leading to misadministration of drugs
- Care coordination events related to medication reconciliation
- Failure to conduct double-checks independently
- Opioid-related events
- Inadequate reprocessing of endoscopes and surgical instruments
- Inadequate patient handoffs related to patient transport
- Medication errors related to pounds and kilograms

Most accrediting organizations as well as state licensing agencies have specific guidelines on the types of incidents that would trigger a RCA and recommended prioritization. You can find more information by visiting the following websites:³ The Joint Commission, American Society for Healthcare Risk Management, Agency for Healthcare Research and Quality, and Veterans Affairs National Center for Patient Safety.

**Sources:**
5. Agency for Healthcare Research and Quality. AHRQ Common Formats.

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