



RHQN Newsletter November 2009

Root Cause Analysis (RCA) in Three Meetings

This month's Members Conference Call took on one of the most angst producing processes in healthcare. Whether you are a large facility or a small rural hospital, the thought of having to do a root cause analysis because of an adverse or sentinel event sends chills down your spine (it certainly does mine). September's article in all of the Hearst newspapers (including the Seattle PI online newspaper) drew nationwide attention to hospital adverse event reporting (or maybe I should say under reporting). Such in depth articles, which raise questions about healthcare transparency and error reporting, serve as a catalyst for state legislation mandating adverse event reporting and adding possible punishments for failure to report.

The stress of having to do an RCA is a major roadblock to adverse event reporting. If we could get past the RCA stress phenomenon, the rest is just process. That sounds so simple, so easy, and so logical. But, simple it is not. In order to do an RCA well, you need the proper tools, you need to be very organized and you need to be patient. What in the world does patience have to do with conducting an RCA? Staff view conducting an RCA as a "witch hunt" whose goal it is to identify someone responsible for the adverse event and finding a way to punish them. In order to get optimal cooperation of staff in doing an RCA, staff have to understand that the RCA's intent is to evaluate processes, look for errors or weaknesses in the processes, and create action plans to correct weaknesses in processes. RCA's are not designed to "pin blame" and should never be used to do so.

The first step in reducing the angst of completing an RCA is picking a good template. There are four available options: 1) the Joint Commission framework, 2) the VA template, 3) the Canadian model, or 4) a form which you develop and have approved by the Department of Health (Linda Furkay) in advance of conducting the RCA. Each of these templates follows an outline conducive to completion of the RCA in three meetings. Once you have selected a template with which you are comfortable, practice with it. We have RHQN member facilities that do RCA's for all employee injuries, chemical spills, or other more routine occurrences, just for practice. In other words, get comfortable with the form. You will find that the RCA template you have chosen is divided into three logical parts. They are the data gathering section, data analysis and action formulation section, and the action plan implementation and evaluation section.

The second step in conducting a strong RCA is selecting the right team. As was mentioned in the Members Conference Call, there are several departments or individuals which often are under-represented at RCAs. They include Laboratory, Pharmacy, Radiology, Engineering, and Environmental Services (Housekeeping, Food Services, etc). The preference is to invite more people to your RCA than you may need at the end. It is much more difficult to bring someone into an RCA late and be forced to bring them up to speed than it is to have them at the table from the beginning.

When you have your team in place, the first of three RCA sessions can begin. The first session should focus entirely on fact finding. Inherent in this fact finding is asking the question “Why?” over and over until you have reached the true ‘root cause’ of the adverse event. We, almost jokingly, refer to this as asking the five ‘whys.’ The conference call went into details about determining timelines, maintenance data, and interviews with staff.

The second RCA session should be devoted to developing and implementing action plans based on the first session’s findings. These action plans focus on areas of staff competence and training, communication, policy and procedure revision, information availability, and administrative support. Each action plan must have concrete timelines and data collection points. Timelines must be of sufficient length to demonstrate that the changes you put into place are working and have been incorporated into the staff’s routine. At the end of this session, action plans have been implemented.

The third, and last, session of an RCA should focus on evaluating the results of action plan implementation. The DOH will expect updates from your facility, based on the timelines you developed and submitted to them within the forty-five day window. Pertinent data should be gathered and analyzed. This analysis would indicate if the action plans are working or need to be revised. Although the third session of an RCA seems simple, it is probably the most difficult. It is one thing to propose an action plan to correct a problem or error; it is another thing to implement it successfully. Be very objective and do not be afraid to change course, if needed.

An audio recording and all materials from the conference call are on the RHQN website at: www.rhqn.org/resources/presentations.htm.

If you have questions about adverse events, conducting a root cause analysis, need assistance, a consultation, or would like to have the RHQN conduct Adverse Event/RCA training at your facility, please contact Randy Benson, RHQN Executive Director, at (206) 577-1821 or randyb@wsha.org.

Subspecialty Peer Review

We would like to remind members that the RHQN offers subspecialty medical chart peer review. To obtain a subspecialty chart review, consult with your peer review physician or contact Lori Martinez (RHQN Executive Assistant) at lorim@wsha.org for more information. At this time, we are able to provide subspecialty peer review in general surgery, orthopedic surgery, sleep lab, anesthesia/CRNA, and Radiology. There is a fee for this service based on the size of the chart(s) to be evaluated.

Upcoming Member Conference Call

The next members’ conference call will be on December 8th at 10:30 a.m. If you have topic suggestions for 2010, please call or e-mail Randy Benson, RHQN Executive Director at (206) 577-1821 or randyb@wsha.org.

- December 8, 10:30 a.m. **“The Clinical Quality Improvement Primer: Witnessing to Best Practice,”** presented by Bev McCullough, RHQN Quality Improvement Manager

If you have ideas, comments, questions, need additional resources or a consultation, contact Randy Benson, RHQN Executive Director, at (206) 577-1821 or randyb@wsha.org