This is the first training in a new DBHDS Risk and Quality Management training series designed to help providers develop and manage an internal risk and quality program.

Each of the webinars will be approximately 30 minutes long to make it easy for everyone to fit them into their busy schedules.

Future webinar topics will include
• Monitoring events through risk triggers and thresholds
• How to make incident reporting systems work for you
• Assessing your organization’s risk
• Mortality reviews, and
• Identifying consumer health risks.
Welcome to our training -- Root Cause Analysis, Part 1.

In Part 1, we are going to review the basics of Root Cause Analysis and introduce you to the ‘5 Whys’ approach to analyzing an event.

In Part 2, we will demonstrate how a root cause analysis can help you to identify the underlying causes of an event by working through an example.
Let's start by taking a look at what we consider to be a Root Cause Analysis.

The first thing you may notice in this slide is that a root cause analysis is intended to analyze serious and unexpected incidents, not routine events. There may be times when you have a high number of routine events that cause some harm.

Second, the approach focuses on systems, processes, and outcomes. It does not focus on people. Yes, you will analyze who did what but you are looking for systems and process problems, not personnel problems.

By process I mean a group of activities that are related and organized and are repeated. Processes can lead to an output or they can achieve a certain goal. Examples of processes with which most people are familiar are the admissions and discharge processes, the medication administration process, the person centered planning process, an individual’s personal care process, and the billing process. For each of these processes there are certain steps you must take and there is an outcome.

Systems are complex sets of processes that involve many parts. Those parts may be activities or they may be mechanical. An example of system is a provider payment system, which will involved billing processes and reimbursement processes and coding processes. An example of a mechanical system is the heating/cooling system of your home, which has controls and thermostats, a heat pump, a furnace, fans and coils. A group home has processes and systems. For example, the admissions process, the scheduling process, the person centered planning processes, and risk and quality improvement processes as well as mechanical systems such as the heating/cooling system and the hot water system.

Finally, a Root Cause Analysis is about taking action. When you identify the root cause of an
In the previous slide, I said that a Root Cause Analysis focuses on systems, processes and outcomes, not people. That’s important, because this process is not about placing blame or punishing people.

A root cause analysis begins with the assumption that no one comes to work intending to make a mistake or to hurt someone.

That’s not to say that a root cause analysis never uncovers intentional acts of harm. That may happen and when it does, you must take the appropriate action.

However, the root cause analysis should focus on systems failures.
When you’re conducting a root cause analysis, it’s not enough to find out what happened, to keep an incident from happening again, you need to find out why it happened.

- Why was the wrong medication given?
- Why did that person fall and break her leg?
- Why did it take so long to evacuate the building when there was a fire?

The answers to these questions will ultimately lead you to more questions that in turn will lead you to the root cause.

Once you’ve identified the root cause you will know what actions you need to take to reduce the risk of another similar event.
When should you conduct a root cause analysis?

You should conduct a root cause analysis any time there is a serious incident that did or could have resulted in a death or a permanent disability to someone, whether that someone is a consumer, staff member, volunteer, visitor or anyone else who is on the grounds of or participating in your program.

For example,
- an unexpected death,
- an event that caused a person to become blind or
- a disaster such as a fire that did or could have resulted in the death of everyone in the building.

But you don’t have to stop there. You can conduct Root Cause Analyses on:
- Any unusual incident
- A series of related incidents. For example, medication errors that occur repeatedly on the same shift.
- Incidents that may not cause a permanent disability or death but that cause harm happen often. For example, frequent fractures, especially of feet, toes and fingers.
There are times when you **DO NOT** conduct a root cause analysis.

When someone cause harm intentionally.
When someone breaks the law.
When illegal substances or alcohol are involved.
And when there is an allegation of abuse or neglect.

For all of these actions, there are separate processes that you need to implement, either through law enforcement, through your human resource office, or other avenues.

We are not going to address these processes in this training. We want to keep our focus on root cause analysis.
The best way to conduct a root cause analysis is by convening a team. That team should be made up of people who were involved in the event and people responsible for the processes or systems.

It doesn’t have to be a large team. It can be only 3 people. If yours is a very small organization that employs only a few people, you might want to have everyone involved in the RCA.

If your organization is very small and it is impossible to convene a team, you can have a single individual conduct the root cause analysis. If you do this, that person should be a manager or supervisor who was not involved in the incident.
Getting to the root cause of an incident can be difficult, especially for those involved in the incident. Staff will be worried about being punished or found to be at fault. People may be defensive about what they did or why they did it. That makes it all the more important to begin any root cause analysis by setting some ground rules for the team.

• Treat each other and the people you interview with respect

• Listen and be open minded. Don’t come into the room with preconceived ideas about what happened. Don’t be defensive. You’re not there to place blame.

• Confidentiality. Don’t discuss what you learned except with your team and with management. And remember, what is said in the room where the RCA takes place stays in the room. Don’t turn around and tell anyone else what was discussed.
Now that you’ve convened a team, you’re ready to start.

The first step is to look at all records of the incident including incident reports, medical records, service plans, logs, video tapes, whatever you can find. If a record is related to the event, it should be made available to the team and the team should review it.
Next you want to find out what happened from the perspective of the person or people involved – the medication aide who gave the wrong medication, the staff on duty when the power went out, the van driver who saw the person trip getting into the vehicle.

How many people you interview depends on the nature and the seriousness of the event. If an event involved many people, you want to interview all of them but an event that involves only one person may only require you to interview that person.

When you interview, remember that this is not a criminal investigation and you’re not looking to determine if someone was at fault – you are looking for the facts in order to solve a problem. Don’t put the person you’re interviewing on the defensive.

You want the people you’re interviewing to feel safe so they will tell you everything they know.

You want to ask questions in a manner that helps them to remember the details because in a root cause analysis, the details matter.

You can record the interviews and make transcripts but you can also just take notes – good notes. If you do decide to record the interviews, you need to assure those you interview that you are doing this only to get the facts right. In either case, make sure you know who was interviewed and that person’s account of the event.
Here are some possible interview questions.

These are general questions. You should develop questions that address the specific incident for which you are conducting a root cause analysis.
It isn’t always possible for safety reasons to observe the typical action in progress, but with a little creativity, you can watch a similar process.

For example, you don’t want to start a fire but you can have an unannounced fire drill.

You don’t want to restrain someone unnecessarily but you can have staff demonstrate on each other how a restraint technique should be performed.

On the other hand, there are many processes you can observe in action. You can, for example, watch medication being given or watch someone being transported in a wheelchair.

Whatever process you’re studying, take the time to observe it.
You need to know the exact date and time of the incident.

That should lead you to identify environmental conditions or events that may have had an impact on the incident.

For example,
• weather conditions that caused someone to slip and fall,
• a traffic accident that caused a staff person to be late for work,
• a party taking place that diverted everyone’s attention away from the incident taking place in the next room
• or anything else that made that date and time unique.

Write down the date and time and document the environmental conditions associated with that date and time.
You’ve interviewed the person or the people who were involved in the incident, but there may be people who you could not interview or who you chose not to interview.

Take a few minutes to list everyone who was involved, how they were involved, and if you interviewed them, what they said during their interviews or why you elected not to interview them.

Were they participants in the incident?
Did they witness the incident?
Were they on duty during the incident?
Are they still with the agency or did they leave after the incident?
Were they consumers, staff, visitors?
Use the information you now have to describe what happened and do this as a team to make sure that everyone understands the sequence of events, based on the interviews, the incident reports, and other sources of information.

Write it down. Start from the beginning and move through the sequence of events, step by step, until you reach the critical incident. This is important, especially since people you interview often remember the sequence of events out of order. It will be up to the team to uncover the exact order of events.
Next, write down what actions were take immediately following the incident.

How did staff respond?
What was the order of the responses?
When did each response take place?
Again, you need to know what happened, when it happened, and who did what and I what order.
The next step is to compare what happened to what should have happened – before, during and after the incident. Compare the actions taken to the requirements in policies, procedures, regulations, accreditation standards, or laws.

Your intent here is not to find blame with someone for not following policies and procedures, or for doing something incorrectly. You are simply establishing the facts.

It is possible that everyone responded according to policies and procedures.

It’s also possible that there were no policies and procedures to follow.
Now you know what happened and what should have happened and this is where most people are inclined to stop. They know what the policy and procedures said should have happened, they know what was done and they think they have the answer or, more often, the person responsible. But that’s not the root cause.

Remember, we’re not looking for someone to take blame, we’re looking for systems problems that create situations that lead to serious incidents.

Now you must state the problem. The problem isn’t that policies and procedures weren’t followed, the problem is why the event took place. Why did someone go into a coma unexpectedly? Why did someone choke and die? Why did someone fall and break her leg? Be very specific when you state your problem.
There are many ways to conduct a root cause analysis and some are very detailed and complex but they all focus on one simple approach – asking questions.

If your organization has never conducted a root cause analysis. . .
    if you have a small organization. . .
    if you seldom have events that require a root cause analysis . . .
    if time is an issued and by that I mean that you need to get to the root cause quickly. . .

You should consider the ‘5 Whys’ approach to Root Cause Analysis. It’s simple, it’s easy, it’s quick, and it’s a well-respected approach for conducting a root cause analysis.
The ‘5 Why?’ Approach

★ Start by asking “Why did this happen?”
★ Look at your answer and ask “Why did that happen?”
★ Ask “Why?” again... and again... and again
★ About 5 “Whys” gets you to the root of the problem

The ‘5 Whys’ approach involves looking at any problem and drilling down by asking: "Why?" or "What caused this problem?"

It’s called the ‘5 Whys’ because it usually takes about five questions to get to the root cause. Sometimes it will take less and sometimes it may require a few more questions, but five is about average.

There are some important things to remember when you’re using the ‘5 Whys’ approach:

• you want clear and concise answers,
• you want to avoid answers that are too simple, and
• you don’t want to overlook important details.

Start with the problem statement you’ve developed and ask, “Why did this happen?”

Typically, the answer to the first "why" prompts another "why" and the answer to the second "why" will prompt another and so on until you reach your root cause.

This technique can help you to quickly determine the root cause of a problem. It’s simple, and easy to learn and apply.
This is the end of Part 1: An Overview of Root Cause Analysis.

Thank you for participating. I hope you will complete Part 2 of the training, where we will take an example and show how you can use a simple and effective technique, called the ‘5 Whys’ to conduct your root cause analysis.
Hello. My name is Marion Greenfield. I am the Director of Risk, Quality and Health Information Management with the Department of Behavioral Health and Developmental Services.

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