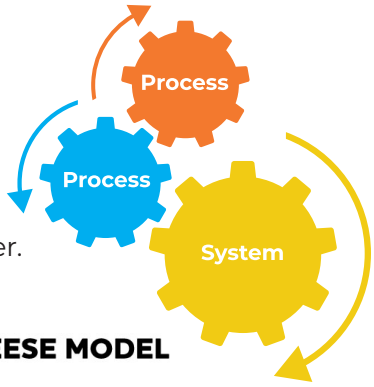
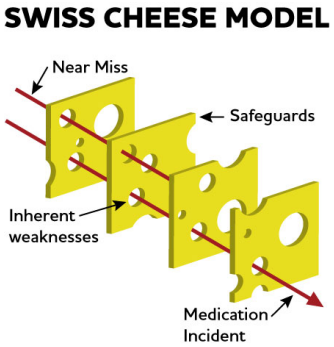
CARE COORDINATION

Guidance for Performing Root Cause Analysis (RCA) With Performance Improvement Projects (PIPs)

A Root Cause Analysis (RCA) is a structured process conducted by a team of people most familiar with the event and work processes being reviewed. An effective RCA identifies breakdowns in processes and systems, rather than the performance of individuals.



- A system is a group or combination of related things or parts that function together.
- A process is a systematic sequence of related actions to produce a desired result, often done in a specific order.
  - Processes often span organizational boundaries, linking people, the flow of information, and other resources to create value and deliver results



Goals of an RCA:

- Identify the root causes of an event that resulted in an undesired outcome.
- Develop corrective actions to prevent/eliminate the event from recurring.

Planning

Step 1: Identify the event to be investigated and gather preliminary information.

- What is the problem? (Objective statement of what went wrong.)
- What is the expected outcome? (Objective statement of what will happen when a solution is tested and found to successfully prevent the problem from recurring. Not a solution.)

Step 2: Charter, Facilitator & Team Selection.

Charter includes:

- Scope of the project – a start and end point.
- Expectation for changes to be linked to identified root cause(s).

RCA Team includes people who:

- Are familiar with the processes and systems associated with the event, including frontline staff.
- Have personal knowledge of the event. (If not available to participate, can contribute through interviews.)

Notes

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RCA Meeting

Step 3: Describe what happened.

- Create a timeline of the event with the sequence of steps leading up to the event.
- Use information gathered in Step 1.
- Include only the facts – not what caused the facts to happen.
- Ensure there is agreement about what happened before moving on to Step 4,

Ask:

- Does the timeline adequately tell the story of the event? (If not, the timeline may need to be expanded further back in time or expanded to include what happened after the event.)
- Does each step in the timeline derive directly from the step it precedes? (If not, add missing steps.)
- Is each step in the timeline pertinent to the incident under investigation?

(Answers may be yes, no, not sure – keep only the yes and not sure steps in the final timeline.)

Step 4: Identify contributing factors.

For each step in the timeline (Step 3), identify the contributing factors (e.g., situations, circumstances, or conditions that collectively increased the likelihood of the incident). Curiosity leads to discovery.

Ask:

- What was happening at this time that increased the likelihood that the event would occur?
- What might have happened to increase the likelihood the event would occur?
  - Was a recommended practice not followed?
  - Were there any procedure workarounds that may have been used?
  - How did staffing, at the time of the event, impact the eventual outcome?

Remember to consider only the factors that were present and known to those involved at the time – not what was realized after the fact.

Step 5: Identify the root causes.

All incidents have a direct cause. The direct cause is not the root cause. Contributing factors are not root causes.

The root cause is the occurrence or condition that directly produced the incident. Use the 5 Whys to dig deeper into each contributing factor. Use a Cause & Effect diagram to visually represent possible causes.

To determine if the team has truly identified the root cause vs. a contributing factor,

Ask:

- Would the event have occurred if this root cause had not been present?
- Will the problem recur if this cause is corrected or eliminated?

Tip: Staff not following procedures is not a root cause.
Dig deeper to determine why the procedure was not followed to determine the root cause.

STOP! When the RCA Team says:

- Who Cares?
- We don't know anymore!
- That's just how it is!
- Or similar statements.

Notes

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RCA Meeting (continued)

Step 6: Design and implement changes to eliminate the root causes.

- Team evaluates each root cause to determine how best to reduce or prevent it from triggering another harmful event.
- Choose at least one action that addresses each root cause. This usually requires the creation of a new process or making a change to the current process.
- Important to include people who:
  - will be directly impacted by the change in the design and implementation of the new process to build buy-in and/or prevent unintended consequences.
  - are supervisory/management staff as they know about various systems, facility resource allocation priorities, feasibility and costs associated with corrective actions.
- Be clear about next steps (who will do what, by when?).
- Short-term solutions rarely address root causes.
- If a specific action cannot be accomplished due to current constraints, look for other ways of changing the process to prevent a similar event from happening in the future.

When developing corrective actions,

Ask:

- What safeguards are needed to prevent this root cause from happening again?
- What contributing factors might trigger this root cause to recur? How can we prevent this from happening?
- If an event like this happened again, how could we stop the trajectory before there is harm?
- If a resident were harmed by this root cause, how could we minimize the effect of the failure on the resident?

QAPI Committee Follow-up

Step 7: Measure the success of the changes.

- RCA should reduce the risk of future harmful events by minimizing or eliminating the root causes.
- Evaluation of the success of an RCA team usually occurs after the team disbands and becomes the responsibility of the individual designated to monitor the corrective action.
- The QAPI Committee oversees all QAPI activities, which includes reviewing the effectiveness of all improvement projects.
- As each action plan is implemented, mechanisms are established to gather data to measure the success of the corrective action plan.
- What is measured should answer these questions affirmatively:
  - Did the recommended corrective actions get done?
  - Are people complying with the recommended changes?
  - Have the changes made a difference?
- A PIP is successful when:
  - Measures of success are monitored over time.
  - The goal is attained (e.g., process changes made & sustained, no recurrent events).
  - There is confidence the change is permanent.

References

Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)
https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf

Reason's Model of Accident Causation: aka the Swiss Cheese Model
https://pharmacyconnection.ca/how-swiss-cheese-can-help-visualize-medication-safety-risks

Cause and Effect Diagram
https://www.ihi.org/resources/tools/cause-and-effect-diagram

RCA Nursing Home Affinity Group Session Nursing Home Readmission Affinity Group: Root Cause Analysis - NQIIC (allianthealth.org)
https://quality.allianthealth.org/conference/nursing-home-readmission-affinity-group-root-cause-analysis/

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ROOT CAUSE ANALYSIS TEMPLATE

Instructions

Facility completes prior to the RCA Meeting.
Facility scribe completes during RCA Meeting.
Facility QAPI Committee completes until corrective actions are fully implemented, changes are being adhered to and changes made are making the intended difference.

Team Facilitator:	Date RCA Started:	Date RCA Ended:
Step 1 - Identify the Event To Be Investigated:		

Step 2 - RCA Participants:		
Name	Position	Role in RCA

Define Scope of RCA
Start Point
End Point

Step 3 - Describe What Happened (brief narrative description of the event):
Brief narrative description of event
Timeline of event

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Step 4 - Contributing Factors:

Step 5 - Root Causes & Step 6 Changes to Eliminate Root Causes:			
Root Cause	Change to Implement	Responsible Person/Group	Completion Deadline

Step 7 - Measure Success of Changes:		
Change to Implement	Measures of Success *(How will we know changes resulted in an improvement?)*	Reporting Schedule/ Person/Group Responsible for Reviewing Results

Signature of RCA Team Leader		Date	

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