

Root Cause Analysis

Framework for conducting a root cause analysis

- for use during first RCA team meeting

Root cause analysis

When and how?

A systematic method used to establish

- **What** happened?
- **Why** did it happen?
- **How** can it be prevented from happening again?
- but **never** 'Who is to blame?'

When an adverse event has had serious consequences for the patient

- Actual or potential
- Death or major loss of function or risk of same

= score 3

	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

Actual injury/potential risk of injury

Stages of the analysis

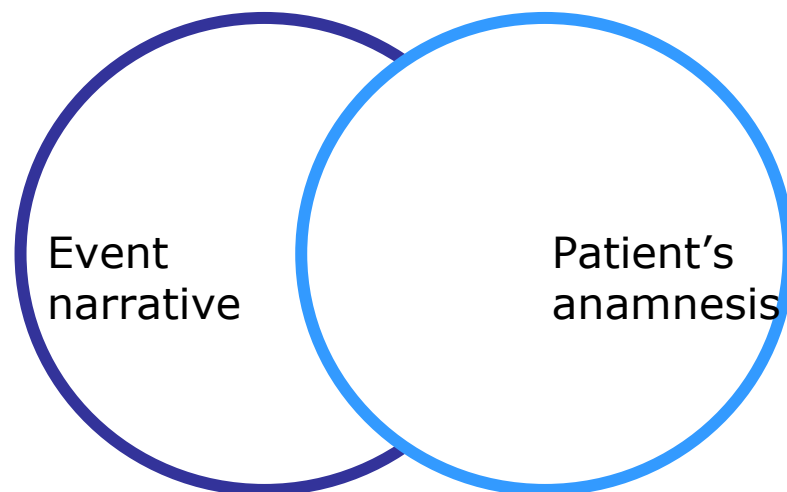
Tryg Patient

1. Begin investigation of the adverse event
2. Determine the sequence of events
3. Identify contributory factors
4. Identify tentative root causes
5. Gather additional data and perform literature review
6. Discuss, determine and confirm identified root causes
7. Prepare action plan
8. Generate report and obtain approval

- The team meets as quickly as possible after the event
- Ensure the following
 - Meetings held on neutral ground
 - No interruptions – no mobile telephones
 - Fixed times
 - Mandatory attendance
 - Confidentiality
 - Introduce the team to the RCA method

- A precise chronological ordering of the chain of events that preceded the occurrence of an adverse event
- Narrative description and/or using flow chart

- The event sequence is based on the narrative of the event, but may include elements of the patient's anamnesis



Root Cause Analysis Handbook

- Communication (C)
- Training (T)
- Scheduling (S)
- Environment and equipment (E)
- Rules/policies/procedures (R)
- Barriers (B)

- The team reviews the supplementary questions in the Handbook (pages 21-40) relating to the areas in which contributory factors are defined
 - The team asks: "why" and answers: "because..." until it no longer makes sense

- The root cause analysis is not part of the patient medical records; therefore:
 - Do not include personal registration numbers (CPR numbers) or other information that could identify the patient
- No names or other information that could identify the healthcare professionals involved in the event
- The root cause analysis is an internal working document
 - It is the property of hospital administration and the unit(s) involved

- Local instruction
 - Within the unit(s) involved in the event
- General instruction
 - At the hospital, eg
 - through the quality council, newsletters
 - On a national basis
 - through www.dpsd.dk