

## Helpful Hints and Definitions

**Causal Factor:** Any problem associated with the incident that if corrected could have prevented the incident from occurring or would have significantly mitigated its consequences (defines the problems that caused the incident). This sounds easy enough but people tend to jump to familiar sounding problems; for example, we need better training or a new procedure, rather than focusing on the actual problems involved in the incident. The key to properly defining causal factors is to look for the most general problems and the related information.

Another key when defining causal factors is to make sure that you identify ALL the causal factors. Do not stop when you've identified one obvious causal factor. Ask yourself, 'is this a problem that I could eliminate and thereby prevent the incident or make it less severe?'

Each causal factor can be viewed as an opportunity to improve. To make this improvement happen one must understand the real fixable root causes that allowed the causal factor to exist. Truly understanding the root cause is needed to develop effective corrective actions.

**Root Cause:** The most basic cause(s) which can be reasonably identified; that management has control to fix and if, when fixed, will prevent or significantly reduce the likelihood of the problem reoccurring. Use the TapRooT© Root Cause Tree to find root causes of each causal factor. Use the questions and definitions within the tree because these improve consistency and reduce unproductive discussions among the team members.

Do not jump to conclusions before you analyze the root causes. If you over define the problem such as saying the person did not use the procedure, then you may have already unconsciously eliminated several potential causes. If you designate all the ovals as causal factors you are just making the same mistake several times because you have not clearly defined the problem. Failing to properly identify the most general problems will make analyzing the causal factor's root causes much more difficult.

Corrective actions need to be more than counseling, training and procedure. Think outside the box! Don't run out of gas when you are almost at the finish line. Work hard to develop effective corrective actions and to get them implemented. Before you recommend corrective actions make sure that they are reviewed to see if they are going to be efficient and effective and that they won't cause another unexpected problem.

**Remember: Causing effective change is the reason for the investigation.**

For Assistance Contact your Patient Safety Manager at:



# PATIENT SAFETY

**R**oot

**C**ause

**A**nalysis

Working Today for a Safer Tomorrow



## Know Your Purpose

Causing effective change is the reason for the investigation.

We appreciate your participation in this Root Cause Analysis (RCA). Your expertise will significantly increase this team's ability to identify the root cause(s) that led to this event. The ultimate goal is to help prevent similar future mishaps.

The RCA process is a tool for identifying system breakdown processes to prevent future incidents. Most errors are caused by faulty systems, not faulty people. We want to focus on the systems and processes. Our purpose is not to point fingers and find fault with individuals.

## Confidentiality

All information and documents related to this RCA are covered under 10 USC 1102 and are therefore considered confidential, privileged and protected.

Team members are not to maintain paper or electronic copies of documents related to this RCA.

Please limit email traffic to scheduling meetings and general requests.

DO NOT use email to discuss the specifics of this RCA.

DO NOT discuss this RCA using a cellular phone or via text messaging.

## Ground Rules

All team members must devote time to this process. Team members should not have been directly involved in the event.

## Root Cause Analysis

A thorough RCA uses a multidisciplinary approach and involves those most familiar with the process and system. It requires review of all potential root causes and includes recommendations that will result in changes that can be sustained. The DoD uses the tool TapRooT®, for the RCA process.

The TapRooT® process will guide the team through the basic categories of:

- Procedures
- Training
- Quality control
- Communication
- Management systems
- Human engineering
- Work direction

### Roles & Responsibilities:

**Patient Safety Manager** is the Facilitator for the RCA process:

- Guides the process – there to assist the team
- Ensures reports are completed and submitted

**Team Leader** is the Subject Matter Expert for this RCA:

- Schedules meetings
- Makes team assignments
- Assists Facilitator with developing reports
- Ensures team participation
- Presents RCA to Command

**Team Members** serve as process owners and Subject Matter Experts:

- Determines the root causes
- Develops the action plan

The process may seem cumbersome at first.

Do not worry: You do the thinking and let the facilitator guide you through the TapRooT® process.

## Meetings

Several meetings will be required. The length of the meetings will vary based on needs of the team. The team must decide on dates/times for meetings.

**Everyone must to be present at the first meeting.**

### The first meeting:

- Introduce the team
- Familiarize the team with the TapRooT® process
- Obtain an initial understanding of the event
- Brainstorm /develop the flow diagram SnapCharT®

A SnapCharT® graphically presents what happened during an incident using a series of shapes detailing the process as it occurred. Be sure to include dates/times for sequential accuracy.

This meeting affords the opportunity to identify additional information required by the team and makes assignments if needed.

### Subsequent meetings:

- Review the progress to date
- Update the SnapCharT®
- Work through the Basic Cause Categories
- Organize the root causes
- Generate at least one corrective action for each identified root cause
- Ensure the action is measurable, reasonable and attainable
- Determine who is responsible for the action and measurement
- Establish a timeline for implementation and follow up
- Identify the best way to communicate findings

## Communication of RCA Results

Team Leader will brief the Department Heads of the areas impacted by the team's recommendations ensuring recommendations and corrective action goals are reasonable and achievable. The Team Leader will bring recommendations back to the team to adjust as needed staying true to the findings of the RCA. Once corrections are made, the Team Leader briefs the entire RCA to Leadership.