

Hospital Name
Root Cause Analysis Agenda
Date

Introductions and Purpose of Root Cause Analysis

Ground Rules

- 1. With very few exceptions, no one intends to make an error in caring for patients.** We are here to discover how our system can be improved.

- 2. Everyone here is a professional.** We are not concerned with WHO. We will use a structured questioning process to determine WHAT happened and WHY it happened.

- 3. What is said in this room about who specifically said or did something stays in this room.** Specifics about this event are important ONLY if they allow us to determine how to minimize the chances that this type of error will happen again. The proposed system changes are what we focus on when we leave the room.

Gather the facts...Establish a timeline of events

Understand what happened...Determine the processes and systems directly associated with the event and how human factors contributed to the error

Identify the root causes of the event using causal statements

Causal statements must follow five rules:

1. Clearly show the cause and effect relationship.
2. Use specific and accurate descriptions of what occurred rather than negative and vague words.
3. Identify the preceding system cause of the error and NOT the human error.
4. Identify the preceding cause of procedure violation.
5. Acknowledge that failure to act is only causal when there is a pre-existing duty to act.

Example: During rounds, the physician may give a verbal order for a medication, which increases the likelihood that he/she will not see the drug allergies listed on the order sheet and will order a drug to which the patient has a documented allergy.

Determine potential improvements in processes and systems that will minimize reoccurrence of the event

Create action plans to implement changes...determine what needs to be done, who should be accountable for the change, when the change should be completed, and how you will know the change was successful.