

## ROOT CAUSE ANALYSIS

# Meeting Agenda

1. Confidentiality
2. Swiss Cheese Philosophy
3. FLOW CHART
4. Gems for Process Change
5. How is our patient doing now?
6. SCSC philosophy of care for the patient.
7. Confidentiality

# ROOT CAUSE ANALYSIS

## Root Cause Analysis Meeting Agenda

1. Confidentiality
2. Swiss Cheese Philosophy
3. Show FLOW CHART or a FISHBONE (This can be done before the meeting to expediate the process or can be done together by the team.)
4. Gems for Process Change
5. How is our patient doing now?
6. SCSC philosophy of care for the patient.
7. Confidentiality

*Agenda Scripts and Helps.....*

### **Confidentiality**

It is important that everyone in this room does not share specifics about the happenings in this patient's case that pertain to the actions of the individuals involved in this case.

Because...

If this case were to go to court, they could question anyone and everyone you talked to as well as those involved in the case.

The opinions stated to co-workers or friends and family could be used as facts.

### **Swiss Cheese Philosophy**

“Multiple small errors in a complex system reach the patient ONLY when the many holes in the protective barriers align to let them through”.

- Accidents rarely occur from a single error.
- The precipitating event can be a relatively trivial malfunction or an external event.
- Errors are Gems, tools to safety (tools to perfection).
- “The most fruitful lesson is the conquest of one's own error. Whoever refuses to admit error may be a great scholar, but he is not a great learner.” vonGothe

### **Process Flow Chart**

- Purpose - Identify the actual ideal paths of a process
- What - A pictorial representation showing all steps in a process
- Why - Assists in uncovering deviations from the expected process causing opportunities for improvement

How

- Draw a flow chart of what actually happens in a process step by step
- Draw a flow chart of what should happen in a process step by step
- Compare the two charts - Differences results in problems

Start of process

- Start of Process - Ask what is the very first event that triggers the beginning of a process
- Process Step - The next sequential activity that occurs
- Decision - Ask “Does this activity always occur?” Yes or No
- If Yes move to next step
- If No - Detail what actually happens in a box to the side.

# ROOT CAUSE ANALYSIS

## **Fishbone or Cause Effect Diagram**

This tool describes a relationship between variables. The undesirable outcome is shown as effect (head), and related causes (bones) are shown as leading to, or potentially leading to, the said effect.

How to Develop

- Titles at the Top - Don't lose sight of the problem!
- Head of the Fish - Description of the problem
- Spine of the Fish - Points towards the problem signifying all potential causes lead to the problem
- Few large bones - Categories of potential causes
- Small bones - the deeper causes of the problem

Notes

Be Wary! Make sure to clarify and refine the scope of the project so the cause analysis does not become overwhelming! A limitation to the tool: complex interactions between causes can be overlooked.

## **Holes in the Process**

Go through each step. Discuss where that step was or could have been a “hole in the cheese” or breach in the safety net. How could that step, if done differently, prevented the whole occurrence.

(Document on the RCA Minutes under “Causal Factors”.)

## **Gems for Process Change**

Go through each “hole” or actual or potential place for a breach in safety. Discuss the options of how it could be done differently and safer. Talk about what more you/we/they need to know to make this change.

(Document on RCA Minutes under “System Changes” and “Education”.)

## **How is the Patient Doing Now?**

Review what adverse consequences the patient experienced both the immediate, and the risk for long term consequences.

## **SCSC Philoosphy in Care of the Patient**

If a bad outcome happened at our center, we feel badly for the patient. We want to take care of the patient no matter how it happened or who was involved. We believe patients entered our building trusting in us and expecting that nothing bad would happen. We are sorry for their bad experience and are willing to help them out.

## **Confidentiality**

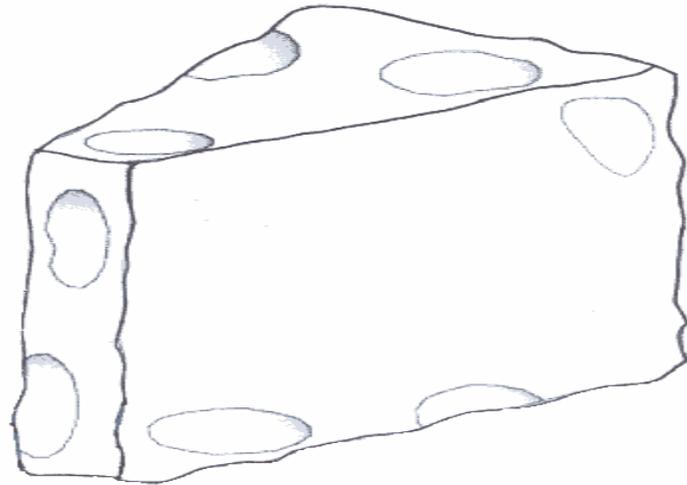
While it is very important for use to share the GEMS with our co-workers – letting another person in on what could make the patient safer is what this National Patient Safety Goal stuff is all about -- It is not OK to tell others about how this nurse that surgeon or those techs behaved or functioned in this case.

The events in this case are confidential and are not to leave this room.

The things we learn and change for safer patient care are tools for everyone employed and utilizing this center.

# Swiss Cheese Model

**Multiple small errors in a complex system reach the patient ONLY when the many holes in the protective barriers align to let them through**



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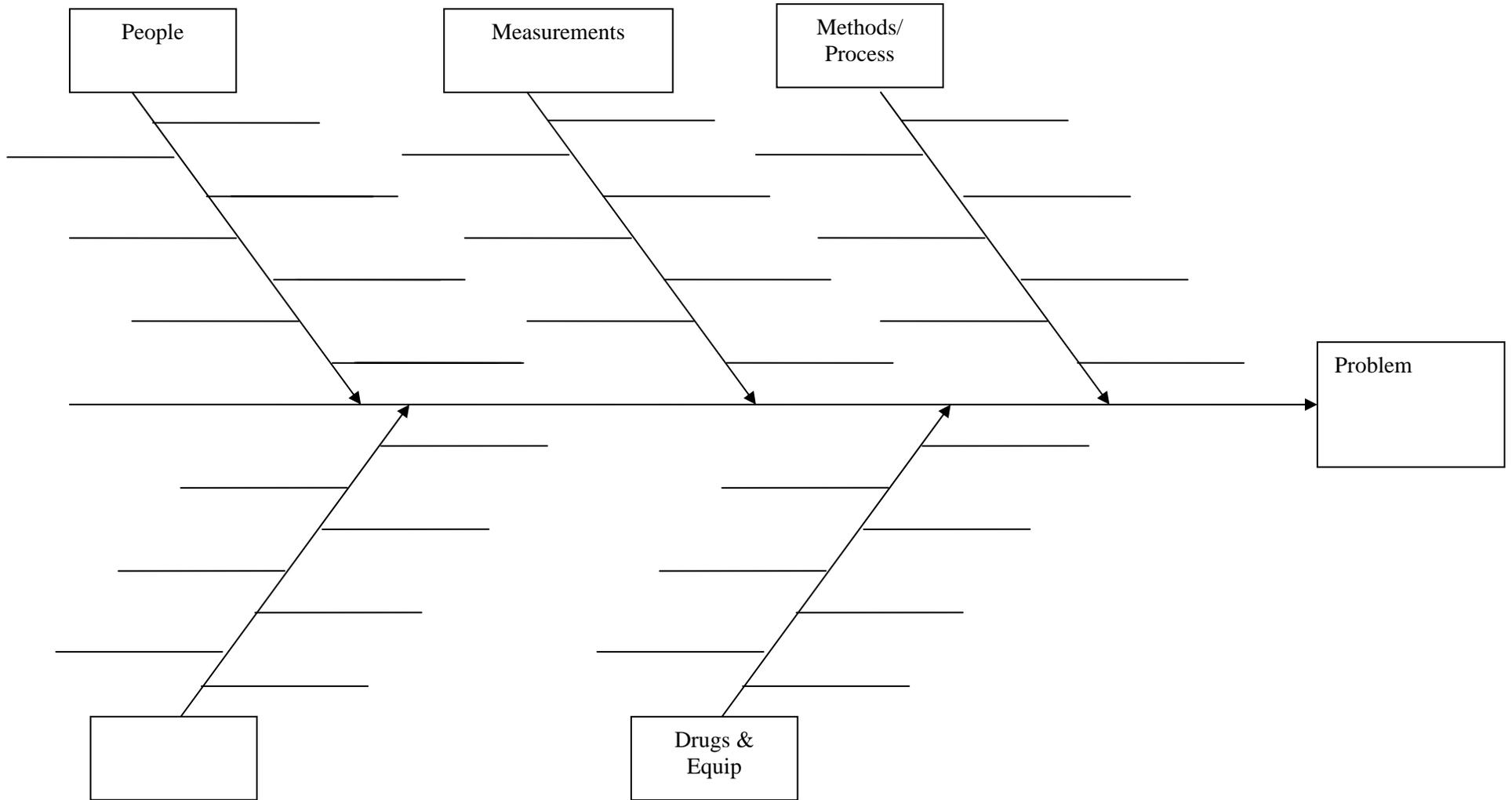
Summary Date:

RCA Team:

<b>Variance (Occurrence &amp; Date)</b>	<b>Adverse Consequences for Patient</b>	<b>Causal Factors “Holes in the Cheese”</b>	<b>Systems changed to prevent variance from happening in the future “Gems or Tools”</b>	<b>Education</b>

# ROOT CAUSE ANALYSIS

## Cause & Effect Diagram



**ROOT CAUSE ANALYSIS**

Process Flow Chart

