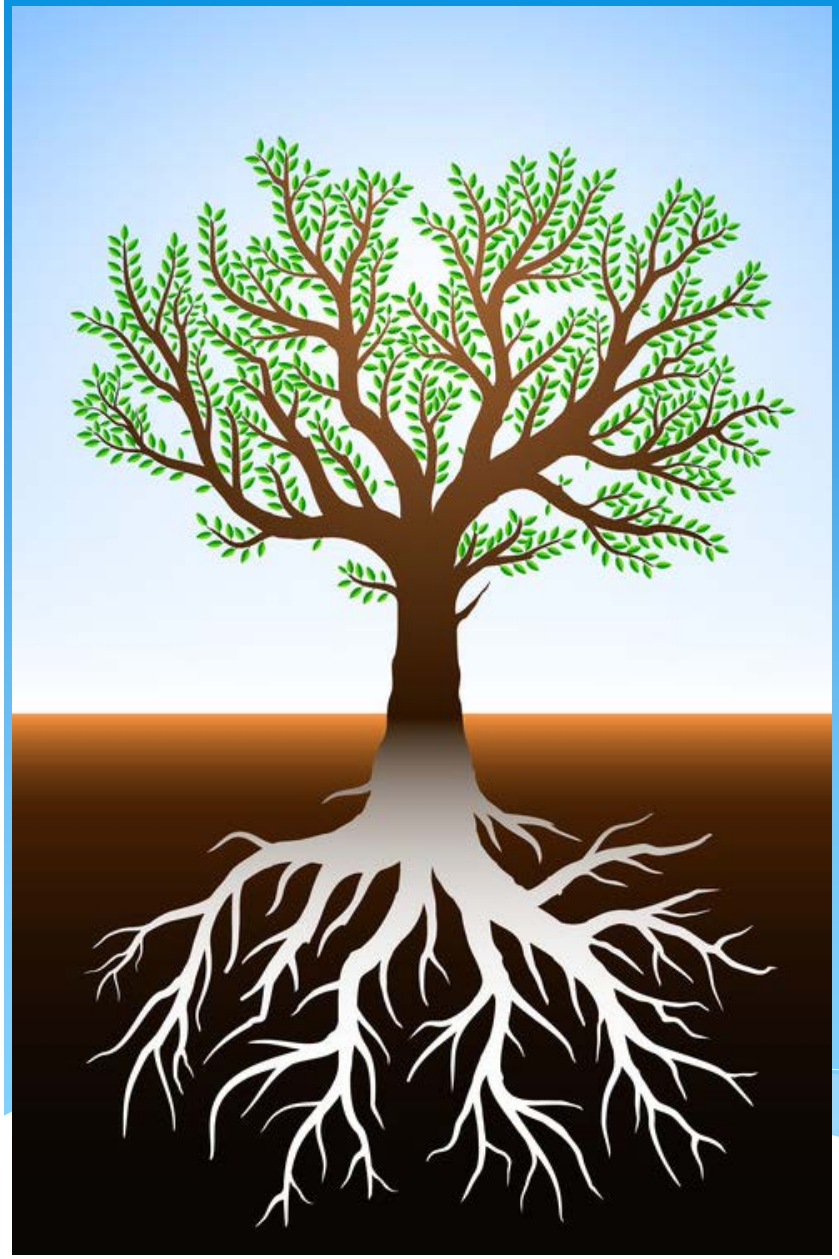


RCAs in Action - Approaches and Tools to Maximize Your Effectiveness as a Risk Manager

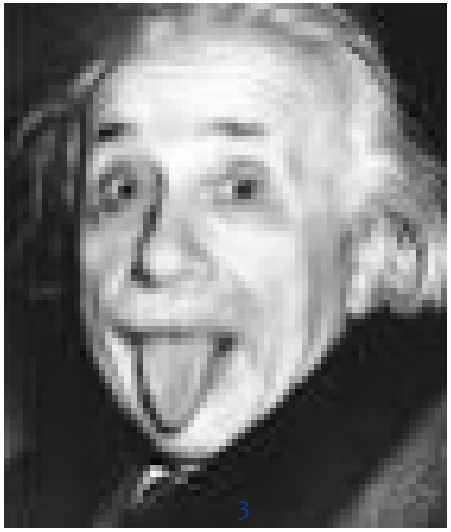
2015 The Year of the RCA

* Spring of 2015 – The National Patient Safety Foundation (NPSF) released its white paper - *RCA² Improving Root Cause Analyses and Actions to Prevent Harm*
* Fall of 2015 – American Society of Healthcare Risk Management (ASHRM) publishes the *Root Cause Analysis Playbook – An Enterprise Risk Management Approach and Implementation Guide*

Insanity

Doing the same thing over and over again and expecting different results.

Albert Einstein



RCA²

Improving Root Cause Analyses and Actions to Prevent Harm

RCA² Improving Root Cause Analyses and Actions to Prevent Harm

* Can be downloaded from the NPSF website
* Created by a core working group and expert advisory council
* Funded by The Doctors Company Foundation
* Has a number of endorsements including TJC and NAHQ

RCA² – Root Cause Analysis and Action

* Healthcare has not always been successful with the RCA process
* What happened, why it happened, the prevention of future harm, actions and measuring the results
* Risk-based prioritization process – can't do it all
* The RCA² team
* Review of the RCA process

The RCA Process

* The healthcare RCA process is not well defined or standardized
* If you have seen one RCA process you have seen one RCA process
* Analysis paralysis
* Ineffective execution
* Lack of adequate measurement

Identification and Classification of Events

* System vulnerabilities vs. individual performance (blameworthy)
* Development of trust in the process → better reporting
* Distinct disadvantage when individuals are not part of the process
* Policy that is fair and consistent
* Feedback

Risk- Based Prioritizing

* How is the patient?
* Event severity vs. outcome severity
* Mathematical formula
* Objective, by a consistent individual

Probability and Severity	Catastrophic	Major	Moderate	Minor
Frequent	3	3	2	1
Occasional	3	2	1	1
Uncommon	3	2	1	1
Remote	3	2	1	1

RCA Team Membership

* #1 Priority - making the patient safe
* Commence review within 72 hours, completed 30-45 days
* Staff members who have RCA team membership as part of their responsibilities, real work
* Scheduled meetings and adequate resources
* Not part of the event being investigated
* 4-6 members plus those that are interviewed
* Team leader, subject matter expert, front line staff, patient representative, a person with knowledge on human factors, recorder

RCA² – Event Review Process

1) The event, hazard or system vulnerability
2) Risk-based prioritization
3) Fact Finding – What happened? triggering questions, interviewing tips, flow diagram
4) Development of causal statements
5) Actions
6) Implementation – specific individual responsibility
7) Measurement and feedback

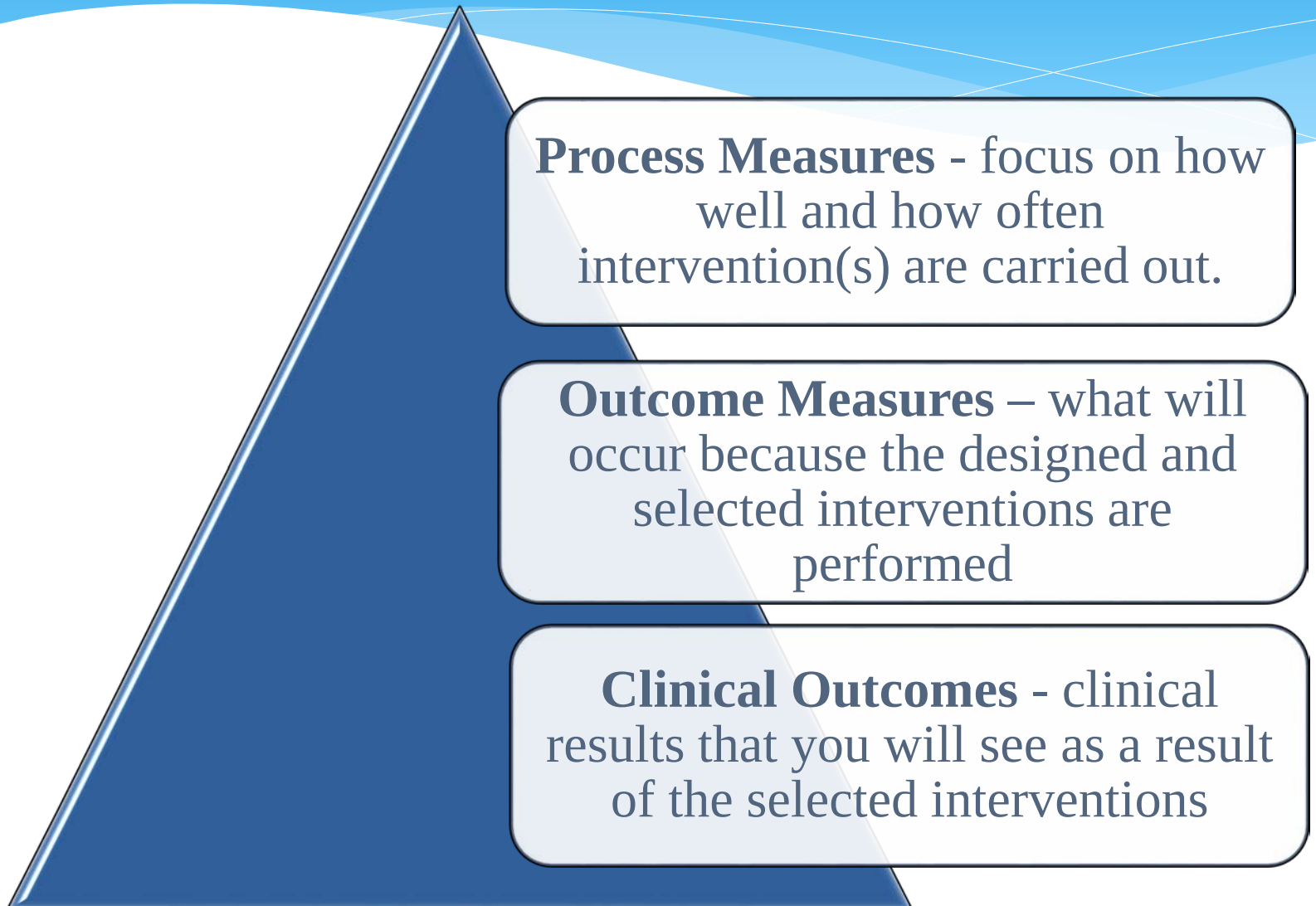
Action Hierarchy

* **Stronger Actions** – Architectural/physical plant changes, new devices with usability testing, engineering control(standardize process), simplify process, standardization of equipment or process and tangible involvement by leadership.
* **Intermediate Actions** – Redundancy, increase in staff/decrease workload, software changes, decrease distractions, simulation training, checklists, standardized communication tools and enhanced documentation.
* **Weaker Actions** – Double checks, warnings, new policy/procedure, training and track for trend.

We Manage What We Measure Actions Without Measure Cannot Show Success



Determine the Outcomes You Want to Achieve



Process Measures - focus on how well and how often intervention(s) are carried out.

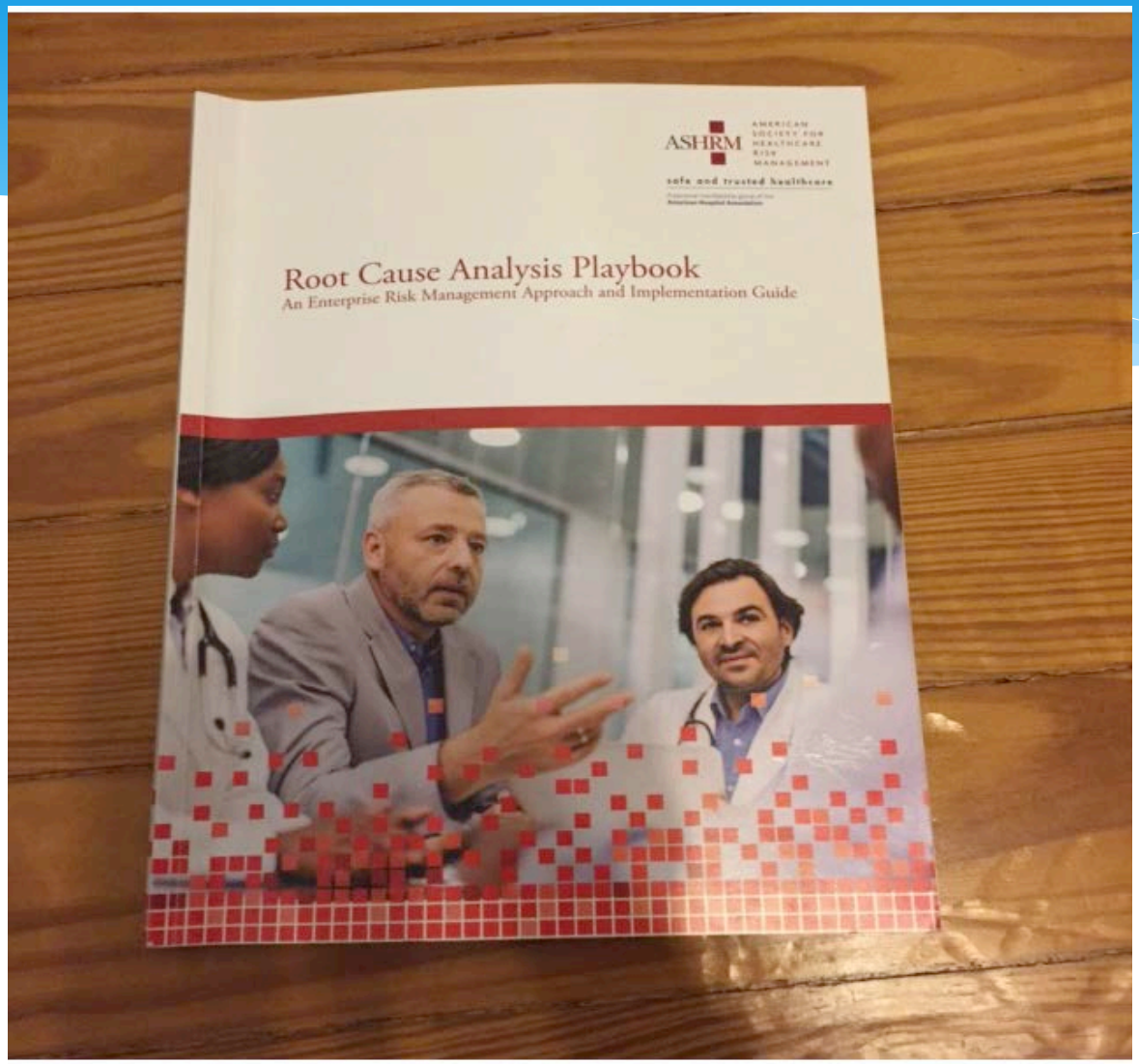
Outcome Measures – what will occur because the designed and selected interventions are performed

Clinical Outcomes - clinical results that you will see as a result of the selected interventions

Feedback and Leadership

* Feedback(TeamSTEPPS) is required to support a culture of safety
* Leadership(TeamSTEPPS) is critical to the success of the RCA process
* Leadership should approve or disapprove all action items
* The RCA2 process should be a recurring item on the leadership agenda
* The effectiveness of the RCA^2 process should be reviewed by leadership annually.

ASHRM's Root Cause Analysis Playbook
An Enterprise Risk Management Approach and Implementation Guide


ASHRM
AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT
safe and trusted healthcare
Root Cause Analysis Playbook
An Enterprise Risk Management Approach and Implementation Guide

Enterprise Risk Management Approach

* Systems based comprehensive framework
* Maximizes value protection and creation that connects to the organization's total value
* Manages risk across all of the ERM domains
* Promotes a risk aware culture
* Enhances communication (TeamSTEPPS Skills)

ERM Risk Domains

1) **Operational** – the business of healthcare, internal processes, people and systems.
2) **Clinical/Patient Safety** – delivery of care
3) **Strategic** – Focus and direction of the organization
4) **Financia**l – sustainability, access to capital, revenue and expenses, liabilities, malpractice, billing and collections
5) **Human Capital** –the workforce, selection, retention, turnover
6) **Legal/Regulatory** – legal, regulatory and statutory requirements, licensure, accreditation, local, state and federal
7) **Technology** – machines, hardware, equipment, cyber liability
8) **Hazard** – assets and their value, natural disasters, terrorism

Regulations and Accreditation

* RCAs required as part of the CMS Conditions of Participation (deemed status)
* Quality Assessment and Improvement Program (QAPI)
* State Agency or an Accrediting Organization (AO)

42 CFR 482.21 (c) (2)

Conditions of Participation

Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

Accrediting Organizations

* Joint Commission – Comprehensive Systematic Analysis for Sentinel Events
* DNV (CFR and ISO 9001)(500+ Hospitals)
* Center for Improvement in Healthcare Quality(CIHQ)
* American Osteopathic Association Healthcare Facilities Accreditation Program (HFAP)
* American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
* Office based practices and nursing homes

RCA Management Functions and Responsibilities

* An Executive Sponsor
  * Adequate allocation of resources
  * Oversight of performance of the established RCA process
  * Governing of action plan, actions and their results
  * Approves or rejects steps in action plan
* Board involvement
* Facilitator – risk manager/ patient safety professional

Beliefs for an Effective RCA Process

* Good people make mistakes
* Systems and processes are Unsafe
* Work cannot be error free, human factors
* Special causes in clinical process → common cause in organizational processes
* There can be improvement

Identification and Investigation

* Care of the patient
* Timely Notice to management, risk manager and family
* Standardized approach in a fair and just environment
* Gathering of Information, the how and the why?
* Use SSE classification for RCAs – deviation from process and practice that reaches the patient
* Progress through the ERM domains

Triage – Significance of the Event

* Significance determined by deviation in practice and harm to the patient – defining the event
* Review of the literature
* Identifying team: facilitator, subject matter expert, patient representative, trained in RCA process
* Charter outlines scope and expectations
* Designation of executive sponsor
* Preparation process
* Involvement of front-line staff, management and leadership staff as appropriate

Team Structure

* **Method #1** – Trained department manager leads the cause analysis
  * Facilitator is trained in RCA Process
  * Front line staff and management decide risk reduction strategies
* **Method #2** –dedicated resource leads and facilitates

    Interviews of front-line staff, including input

    Leadership and management staff
* **Method #3** (NPSF) Standing RCA team leads and facilitates
  * Standing RCA team
  * Supervisors and managers as long as not in area

Full Investigation

* A problem statement – what happened and what should have happened
* An event time line
* Summary Document
  * Key pieces of the medical record
  * Review of literature
  * Best practices

Meeting Guidelines

* Not a one meeting, one hour lunch session
* Packet should be provided before meeting for review
* Determine root cause(s) and contributing factors
* Create actions
* Assign accountability – a specific individual
* Determine measurement
* Establish a timeline for completion of actions

Tools for the Process

* Apparent Cause Worksheet
* “Why Staircase” outlines
* Risk Investigation Time Line Log
* Serious Safety Event Investigation Checklist
* Interview Guide
* Risk Investigation Witness Log
* Interview Agenda/ Planner
* Contributing Factors Framework- Investigation Tool
* Deviation Determination Guide
* Team Charter Form
* Fault Tree Analysis

Analysis

* Standardized and Evidence Based
* Identification of **Failure Modes**(How?) and **Causal Factors**(Why?)
* **Change Analysis** – what happened, what should have happened and the ideal.
* **Barrier Analysis –** fail, not in place, workaround
* **Event and Causal Factors Chart (ECF) –** accurate sequencing of events, timeline
* **Simulation of an RCA**

Risk Reductions Actions

* Action Planning (TeamSTEPPS)
* Use of action hierarchy – to decrease probability of recurrence, creates credibility for RCA
* Skill, Rule or Knowledge Based Actions
* Approved by executive sponsor, review C-suite and board
* Actions are specifically and individually assigned
* Choice of fixing the person or the system

Measurement

* Demonstrating correction of the problem or not
* Self- assessment
* Validation – Trust and then verify
* Timely, 6 months
* Adjustments as necessary
* Test the process
* Spread



Sustainability



Team – High performing teams complete their work and have high communication expectations and standards to ensure accountability.

Julie Klinger on Pillars of Sustainablity

Culture, Human Error and High Reliability

* It is all about Culture➔ Behavior ➔Outcomes
* How individuals interact with their environment.
* Skill, rule and knowledge based errors
* High Reliability
  * Sensitivity to Operations
  * Preoccupation with Failure
  * Defer to Expertise
  * Resilience
  * Reluctance to SImplifiy

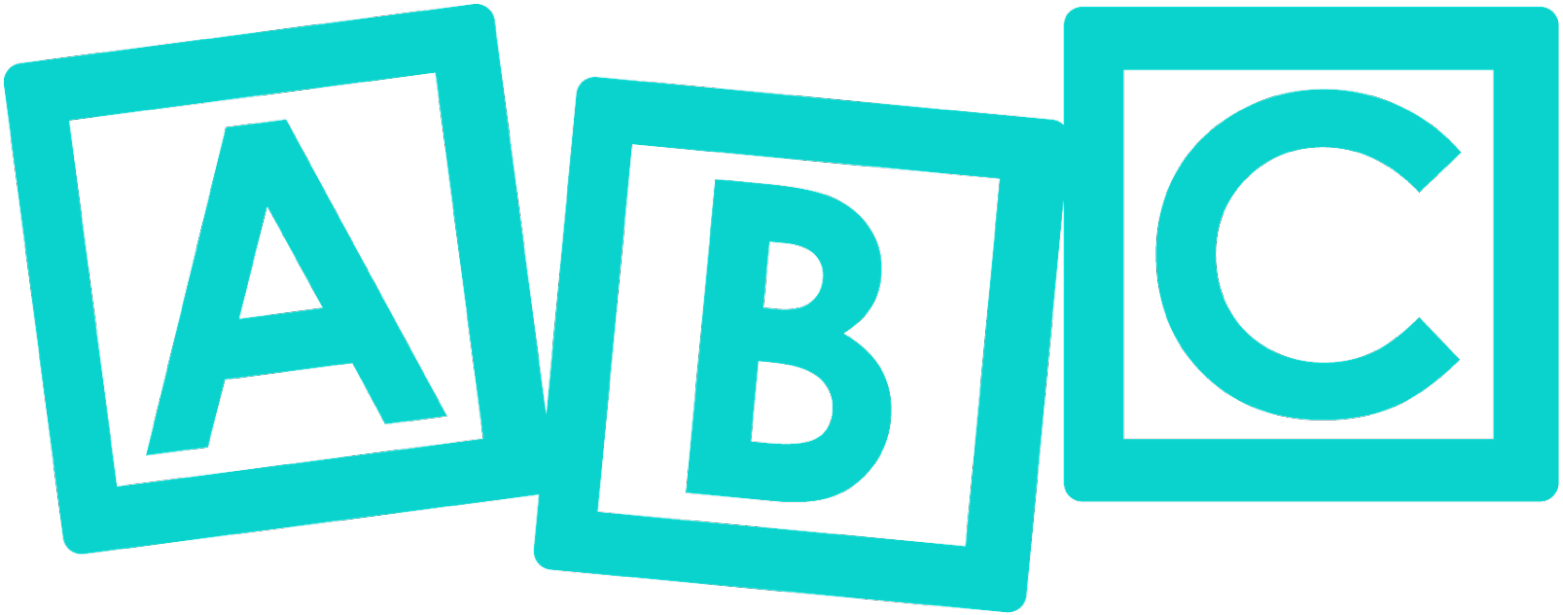
Differences with NPSF Document

* Team Structure Differences(Set v. Situational)
* RCA Review Across all Enterprise Domains
* Discussion of Reliability and Culture
* RCA Order Priority - Using the ASHRM Harm Classification(SSE) vs. Risk Prioritization
* Apparent Cause Analysis (ACA)

Common Emphasis of NPSF and ASHRM RCA Documents

* Standardized process
* Focus on human factors
* Focus on systems and processes – not blame
* Triggering – prompting questions
* Perspective of the patient in the interview process
* Action hierarchy
* Focus on measurement

Patient Safety, RCAs and TeamSTEPPS



TeamSTEPPS Change



Team STEPPS Tools

* **TeamSTEPPS focuses on Leadership, Teamwork and Communication and Feedback all necessary for successful RCAs**
  * Change Management and Action Planning
  * Coaching and Mutual Support
  * Communication
    * Briefing
    * Debriefing
  * High Reliability Organizations(Found in Advanced TeamSTEPPS Course)

TeamSTEPPS Action Planning



TeamSTEPPS Ten Steps in Action Planning

1) Create a Change Team - pick leaders, managers, those others respect, those you can count on.

2) Define the Challenge – What will your barriers be, who will be the nay-sayers?

3) Define the AIM of your Intervention What do you want to accomplish?

4) Design a Plan with Interventions

5) How will you know your interventions are working?

6) Develop an implementation plan for the interventions –education, roll-out, manager engagement.

7) Determine how you will SUSTAIN the effort and changes that you have made.

8) Create a communication plan – Get the message out. You must communicate expectations.

9) Put everything together. Does it fit? Does it flow well?

10) Review and make changes. Be flexible. It won't be perfect the first time.

TeamSTEPPS Coaching



A good coach will make the players see what they can be rather than what they are.

–Ara Parasheghian

TeamSTEPPS Coaching Competencies

Communication

Communicating Instructions
Providing Feedback
Listening for Understanding

Relationships

Building Rapport and Trust
Motivating Others
Working w/ Personal Issues
Confronting Difficult Situations

Performance Improvement

Setting Performance Goals
Rewarding Improvement
Dealing with Failure
Assessing Strengths and Weaknesses

Execution

Responding to Requests
Following Through

Communication



TeamSTEPPS Characteristics of Effective Feedback

* DIAGNOSTIC
  * Developmental in providing team member's a sense of their strengths and weaknesses
  * Most effective when feedback provides precisely what needs to improve
* TIMELY
* RESPECTFUL
* DIRECTED
  * toward improvement
  * learning from mistakes
* CONSIDERATE

Teamwork



Mutual Support

- Collaboration with team members
- Task-related support
- Timely and constructive feedback

Leadership



TeamSTEPPS™

Brief

Planning

- Form the team
- Designate team roles and responsibilities
- Establish climate and goals
- Engage team in short and long-term planning

TOPIC	
Who is on the RCA team?	☑
All members understand and agree upon goals?	☑
Roles and responsibilities understood?	☑
Plan of Action?	☑
Staff availability?	☑
Workload?	☑
Available resources?	☑

Debrief

Process Improvement

- Brief, informal information exchange and feedback sessions
- Occurs after an event
- Designed to improve teamwork skills
- Designed to improve outcomes
  - An accurate reconstruction of key events
  - Analysis of why the event occurred
  - What should be done differently next time

TOPIC	☑
Communication clear?	
Roles and responsibilities understood?	☑
Situation awareness maintained?	☑
Workload distribution?	☑
Did we ask for or offer assistance?	☑
Addressing errors made.	☑
What should change? How should it change? We can improve?	☑

HROs in Advanced TeamSTEPPS

	HRO Concepts				
	Sensitivity to Operations	Reluctance to Simplify	Preoccupation w Failure	Deference to Expertise	Resilience
Brief	X	X	X		
Huddle	X		X	X	
Debrief				X	X
STEP	X	X	X		
Cross Monitoring	X		X		
Feedback		X	X	X	X
Advocacy and Assertion				X	

Source:HRET

Improvement in Patient Safety

Getting:



Being a Bulldog with Lipstick



Leaving Your Footprints On Patient Safety



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