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The Benefits of Using a Structured Root Cause Analysis Process

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Each year in the United States, there are many adverse events reported in healthcare facilities. An adverse event is defined as "an injury that was caused by medical management rather than the patient's underlying disease;" also sometimes called "harm," "injury," or "complication." An adverse event may or may not result from an error. Successful management of an adverse event requires an institutional framework supported by a culture of safety and quality. Providing a structured root cause analysis plan should be the focus of every hospital investigation.

Investigating near misses has key advantages. A near miss is a serious error or mishap that has the potential to cause an adverse event but fails to do so by chance or because it is intercepted. There is no risk of blame or litigation to investigate near misses. When a hospital is serious about learning from all potential errors, near misses provide recommendations for positive change.

Samaritan Albany General Hospital (SAGH) is a medium sized community hospital in the Willamette Valley. We use a structured root cause analysis and reporting plan that has been very effective. It has enabled the staff, physicians, and administration to learn from adverse events and near misses to minimize the likelihood of recurrence.

The first obligation is to protect the patient and family against further harm by providing necessary medical care. Next, clinicians should begin the process of gathering details from the event. Depending on the event, immediately secure implicated drugs, equipment and medical records. All members of the care team will be expected to attend the root cause analysis meeting (including staff, physicians, ancillary departments, risk, quality, and managers). The root cause analysis meeting is scheduled to occur within 1-3 days after the event as the timing of the meeting is of utmost importance.

Staff are encouraged to discuss the events with open and honest communication. At the start of the meeting, every member of the root cause analysis team is given a packet containing:

- Root Cause Analysis Team information
- Policy and Procedure
- A list of events that need to be reported to the Oregon Patient Safety Commission (OPSC).

Using a structure and consistent format at every meeting enables a smooth flow of information. An interview form with questions to discuss the essential components of the

event is used. We may use a diagram as a visual to further explain where the event occurred. After a thorough investigation, a Root Cause Analysis Action Plan is shared with the Department Managers and the Vice Presidents. The Root Cause Analysis Action Plan contains the following:

- Identifies the root cause
- Identifies the causal factors
- Provides a recommendation to prevent recurrence
- Lists the responsible party to implement safety measures in the future

For each event, a Root Cause Analysis Summary Report is shared at the Board of Directors meeting. This report contains the following:

- Description of the event
- The immediate and remedial actions taken
- The root cause
- Other important findings
- Action plans that were developed
- Significance and possible extent of the patient's condition

In keeping with Oregon's North Star Goals to make Oregon the safest healthcare system in the nation, we apply evidence-based practices to provide changes in processes and systems. Expert analysis of events are evaluated by those involved in the event. Recommendations focus on changes in systems and processes, rather than targeting individual performances. Assessing the risk of recurrence and learning from experiences is an important part of the root cause analysis process. We encourage staff to play an active role in identifying and leading efforts to redesign the systems to prevent recurrence.

SAGH has made confidential and detailed reports to the OPSC for each event investigated. Using this approach, SAGH was honored during Patient Safety Awareness Week as one of Oregon's leaders in patient safety reporting. The organizations honored and recognized by the OPSC were leaders in the state's Patient Safety Reporting Program.

Safety is more than the absence of errors. It is the responsibility of everyone to provide quality, efficient, and harmless care to every patient all of the time.

Sheri Johnson, RNC, BSN, MSN, CNS, CPHQ was the Director of Quality Resources at Samaritan Albany General Hospital in Albany, Oregon. Samaritan Albany General Hospital is part of Samaritan Health Services. She recently changed positions to become the Epic Clinical Nurse Champion, The Samaritan System will be implementing Epic in March of 2013. Sheri spent the beginning of her career working in Los Angeles as a NICU and transport nurse. She helped open two NICU's and a newborn follow-up clinic. She moved back to her home state of Oregon in 1999 where she transitioned to Women's Center Manager and then became the Director of Quality Resources.

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