MARTIN LUTHER KING, JR.
OUTPATIENT CENTER
POLICY AND PROCEDURE

DIVISION: **ADMINISTRATION**	**NUMBER**: 1.203
SUBJECT: **ROOT CAUSE ANALYSIS (RCA)**	
SECTION: **PATIENT SAFETY**	**PAGE**: 1 **OF: 3**
REVIEWED BY: QUALITY MANAGEMENT, POLICY AND PROCEDURE COMMITTEE, AND EXECUTIVE COMMITTEE	**EFFECTIVE DATE**: 11/01/07
TO BE PERFORMED BY: ALL APPLICABLE STAFF	**REVISION DATE**: 07/08 **REVIEWED DATE**: 5/27/14, 8/23/16

PURPOSE

To establish a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. (Root Cause Analysis).

Definition:
A root cause analysis (RCA) is a retrospective approach to error analysis that focuses primarily on systems and processes. A root cause analysis is done on all sentinel events and any event as determined by the Risk Manager in collaboration with the Chief Medical Officer and is performed in accordance with the principles of Safe and Just Culture.

The RCA is used to:

1. Standardize the components of the focused review to ensure a common approach and to maximize understanding of the events under assessment.
2. To promote a positive impact in improving patient care.
3. To identify opportunities for improvement of both systems and personnel performance.
4. To ensure focused review of certain events due to the potential risk of litigation and conflict within the organization.
5. To assess a Sentinel Event and to understand how and why the events occurred and to prevent the same or a similar event from occurring in the future.
6. To understand the underlying cause of an adverse event.
7. To reduce variation in a process by determining and classifying causes.
8. “Common cause” variation is inherent in every process and is a consequence of the way the process is designed to work. A process that varies only because of common causes is said to be a ***stable*** process.
9. “Special cause” variation arises from unusual circumstances or events that may be difficult to anticipate and may result in marked variation. A process that varies from special causes is an ***unstable*** process.

POLICY

All Root Cause Analysis documents are privileged and confidential under state law, including Evidence Code section 1157 relating to medical professional peer review documents and Government Code section 6254 relating to personnel records.

A root cause analysis has the following characteristics:

1. The review is interdisciplinary in nature with involvement of those knowledgeable about the process involved in the event.

2. The analysis focuses primarily on systems and processes rather than individual performance.

3. It progresses from special causes in clinical processes to common causes in organizational processes.

4. It repeatedly digs deeper by asking “what” and “why” until no additional logical answer can be identified.

5. It identifies changes that could be made in systems and processes through either redesign or development of new processes, or systems that would improve the level of performance and reduce the risk of a particular Sentinel Event, Adverse Event, or Close Call/Near Miss occurring in the future.

To help adhere to these characteristics, the following five guidelines need to be considered when developing root cause statements:

1. Root Cause statements need to include the cause and effect.

2. Negative descriptions are not to be used in root cause statements.

3. Each human error has a preceding cause.

4. Violations of procedure are not root causes, but must have a preceding cause.

5. Failure to act is only a root cause when there is a pre-existing duty to act.

To be thorough, the RCA must include:

1. A determination of the human and other contributing factors most directly associated with the event and the processes and systems related to its occurrence.

2. Analysis of underlying systems and processes through a series of “why” questions to determine where redesign might reduce risk.

3. Identification of risk points and their potential contributions to the event.

4. Identification of potential improvements in processes or systems that would tend to decrease the likelihood of such event in the future; or a determination, after analysis that no such improvement opportunities exist.

5. Creation of a plan to address identified opportunities for improvement or formulation of a rationale for not undertaking such changes.

6. For all planned improvement actions, identification of the following:

    a. who is responsible for implementation
    b. when the actions will be implemented, including any pilot testing, and
    c. how the effectiveness of the actions will be evaluated

To be credible, the RCA must:

1. Include participation of the individuals most closely involved in the processes and systems under review with participation, support, authorization, and encouragement from the organization's leadership team.
2. Have appropriate and representative team composition.
3. Be internally consistent and not contradict itself or leave obvious questions unanswered.
4. Provide an explanation for all findings of 'not applicable" or "no problem."
5. Include consideration of relevant literature.
6. Articulate a plan for findings to be communicated widely to all those with a significant interest.
7. Include corrective actions, outcomes measures and leadership approval.

If in the course of conducting the RCA it appears that the event under consideration is the result of an intentionally unsafe act, the RCA team must refer the event to MLK Outpatient Center leadership for further consideration. In such a case, the RCA team discontinues their efforts, since MLK Outpatient Center leadership has assumed the responsibility for any further fact finding or investigation.

NOTED AND APPROVED:

_____ _____

Cynthia M. Oliver, Chief Executive Officer Date

_____ _____

Ellen Rothman, M.D., Chief Medical Officer Date

_____ _____

Lessie Barber, R.N., Nursing Director Date

Signature(s) on File.

REVIEWED:						