QAPI Affinity Group Session V

Root Cause Analysis

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How We Got Here

- A charter was developed and given to the Performance Improvement Team using data that identified an area for improvement
- The Performance Improvement Team created a goal statement based on the problem identified in the charter
  - Defined team and responsibilities
  - Created a goal statement using the SMART worksheet

How We Got Here, cont.

- The Performance Improvement Team completed a process analysis using flow charting to identify areas in the process that require improvement
- What if the process seems to be working as intended?
  - If this happens, consider brainstorming to identify potential areas for improvement.
  - Be sure you both observe the completion of the process and speak to those responsible for it on multiple occasions before determining it is not a process problem.
  - Typically if the process is being completed as it was designed, brainstorming will lead to a previously unconsidered area that may need to be added to the process

Third Key to a Successful PIP

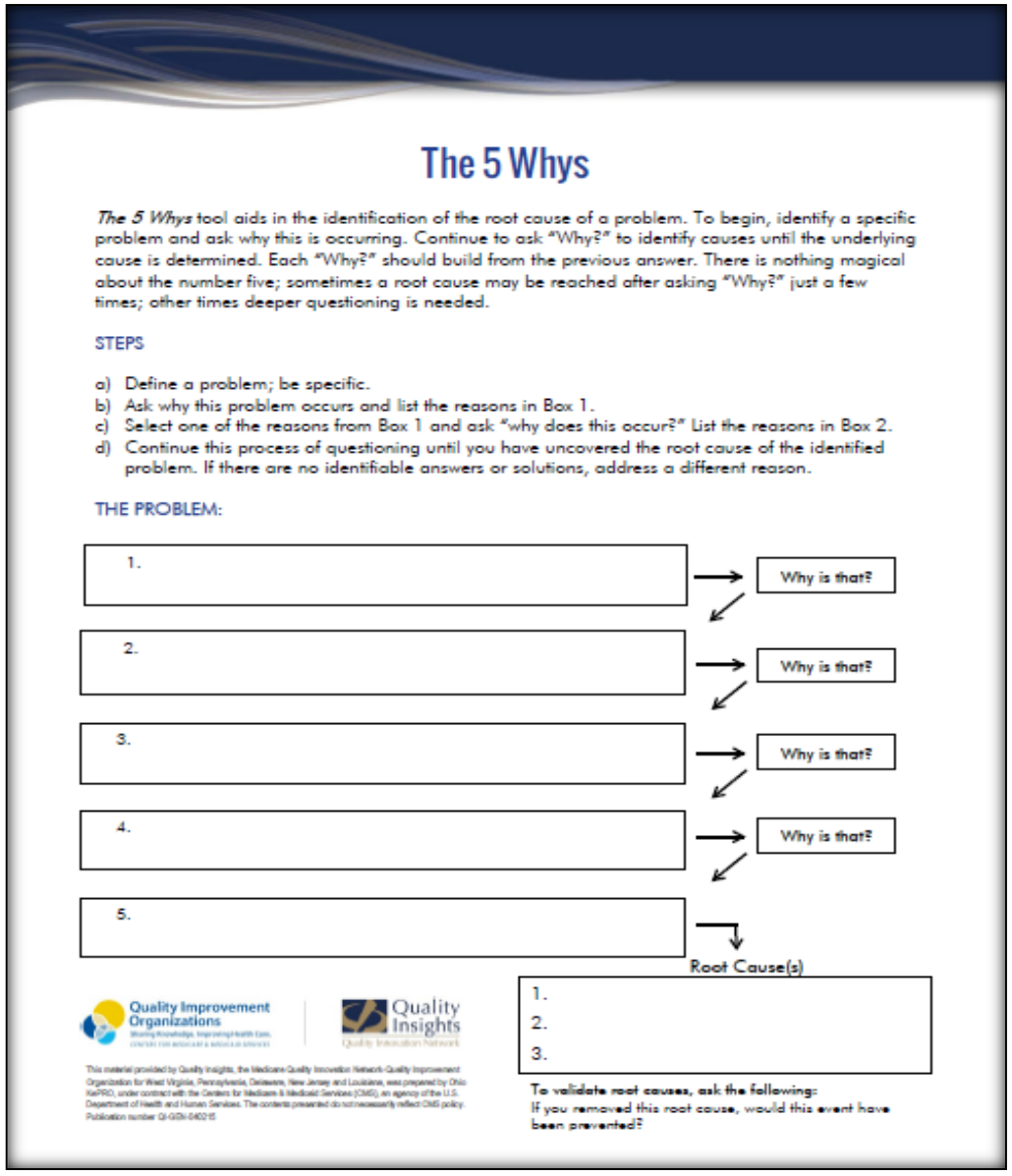
- What changes can we make that will result in improvement?
- Flow charting is the first step in analyzing potential changes that need to be made
- Now that the specific problem area has been identified we must determine what the actual cause of the breakdown is.
- Going to the area involved and observing can assist PIP team members in completing a root cause analysis
- PIP team members should not be the only individuals participating in RCA. EXAMPLE: When considering why resident concerns are increasing related to coffee temperatures, RCA could be done with dietary department, floor staff as well as residents
- The purpose of completing multiple RCAs is to view the issue from as many different perspectives as possible

Using Root Cause Analysis to Create a Shared Vision

- Root Cause Analysis is the next step toward developing the “intervention” in the Performance Improvement Project
- The most effective Root Cause Analysis is completed when a facility has embraced the theory of **Just Culture**
- Use Root Cause Analysis to support shared vision and sense of team

5 Whys and Fishbone Diagrams

- Both methods rely on a clear problem statement
- For our purpose we will examine the 5 Whys approach
- Occasionally the 5 Whys will not identify a root cause, when this happens moving to the Fishbone Diagram will force all areas of the problem area to be explored
- Requires the person administering the analysis to keep the questions on track without leading the response
- Individual administering the test must remain non judgmental and operate with a Just Culture mind set
- Can be administered to a group or to individuals



The 5 Whys

The 5 Whys tool aids in the identification of the root cause of a problem. To begin, identify a specific problem and ask why this is occurring. Continue to ask "Why?" to identify causes until the underlying cause is determined. Each "Why?" should build from the previous answer. There is nothing magical about the number five; sometimes a root cause may be reached after asking "Why?" just a few times; other times deeper questioning is needed.

STEPS

a) Define a problem; be specific.
b) Ask why this problem occurs and list the reasons in Box 1.
c) Select one of the reasons from Box 1 and ask "why does this occur?" List the reasons in Box 2.
d) Continue this process of questioning until you have uncovered the root cause of the identified problem. If there are no identifiable answers or solutions, address a different reason.

THE PROBLEM:

1. → Why is that?
2. → Why is that?
3. → Why is that?
4. → Why is that?
5. → Root Cause(s)

1.
2.
3.

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To validate root causes, ask the following:
If you removed this root cause, would this event have been prevented?

Tips for competing the 5 Whys:

1. Develop clear problem statement
2. With each response ask, "If the most recent response were corrected is the problem likely to reoccur?" If the answer is "yes" the response is most likely a contributing factor and not the root of the problem. Continue to question
3. Most likely will require 3 to 5 Why cycles
4. Many problems will have more than one Root cause

Common Barriers to Root Cause Analysis

- Problem statement is not clear
  - Example: Why do people fall vs. Why do people on the dementia unit fall in the hour before dinner
- Root Cause dialogue does not keep problem statement as focus
  - Can not allow the Why path to stray to a different problem. Example: People fall because night shift doesn't check on them.
  - In this case the RCA should be directed back to the problem statement while mentally recording the potential of a separate issue
  - Remember not to discourage people from contributing when this happens. In this case no response is “wrong,” but explain the need to keep to the problem statement as written
- Responses too general
  - Example: People fall before dinner because they are old and can’t walk, vs. People fall before dinner because staff is toileting and they are bored
- Remember that, with practice this process becomes easier

Summary of Information Presented

- Review of steps leading to RCA in an official PIP
  - Data used to identify problem
  - PIP is chartered
  - Goal statement created
- Just Culture and Shared Vision
  - Importance of creating a team approach to problem solving
- Use of the 5 Whys Worksheet

For next week

- Moving from the root cause of a problem to a solution
- Rapid Cycle Improvement
- Plan-Do-Study-Act cycles
- Things to consider for next week
  - How does your facility create a shared vision?
  - How do you currently tackle change?

Discussion

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