

# RCA<sup>2</sup>



# RCA 2

Improving Root Cause  
Analyses and Actions



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A faint, light blue ECG (heart rate) line graphic is visible in the background of the slide, centered behind the text.

RCA<sup>2</sup>

# Improving Root Cause Analyses and Actions



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Adverse events and “near misses” often occur because of problems with the systems that healthcare organizations use to deliver patient care.



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SFX: monitor alarm



Finding out what went wrong—and why—is the key to preventing it from happening again.  
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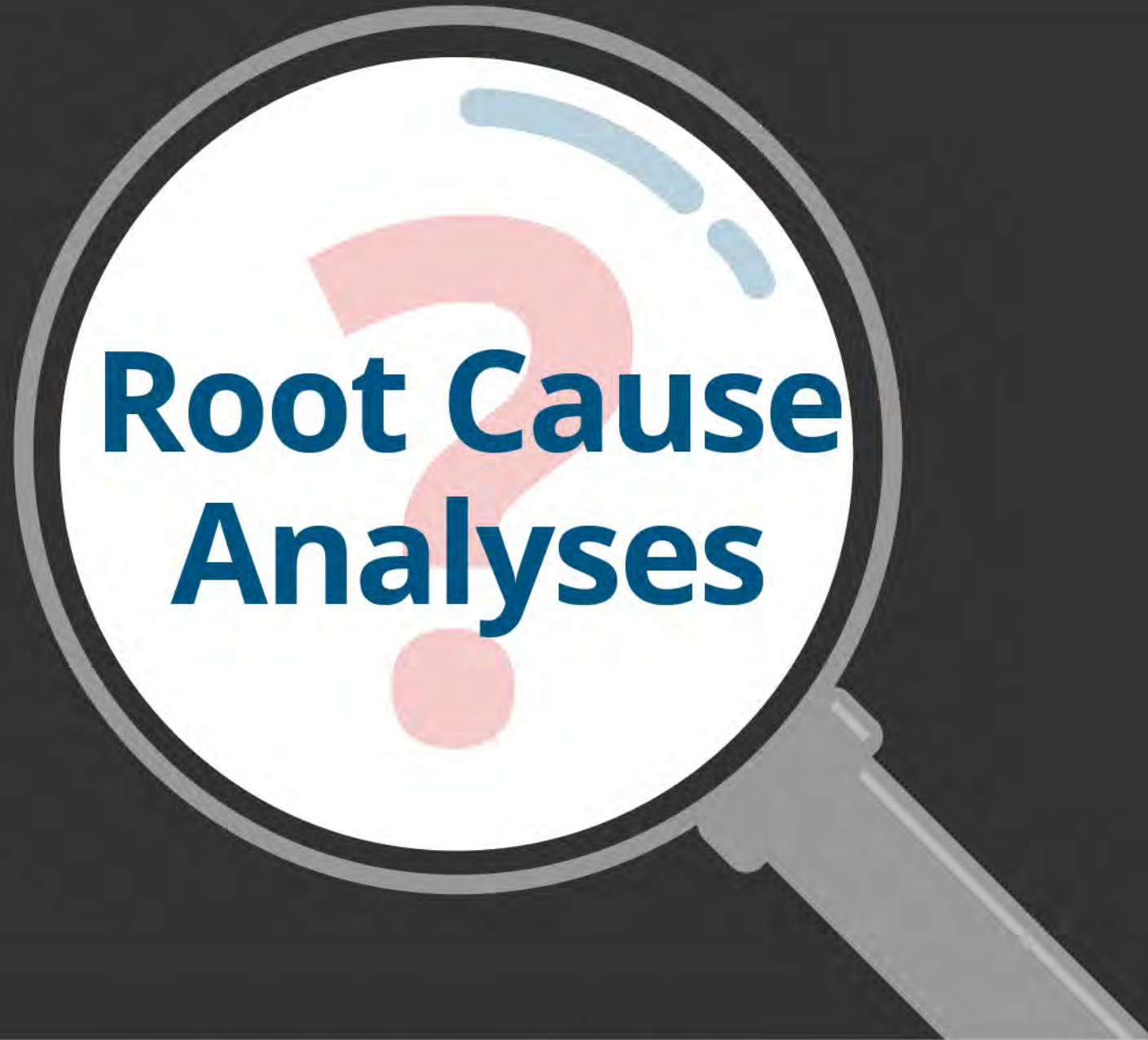
But often, root cause analyses don't go deep enough.



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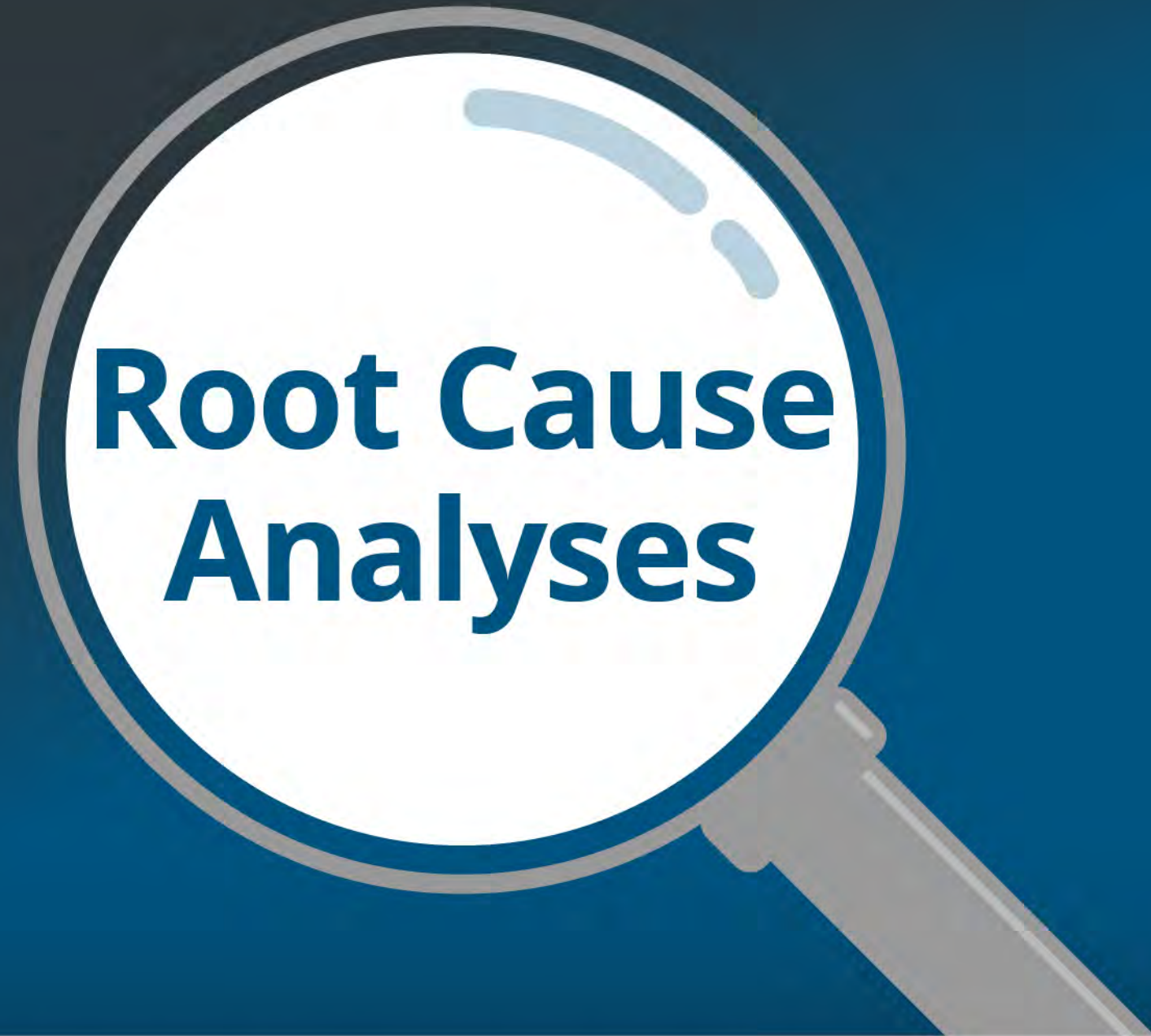


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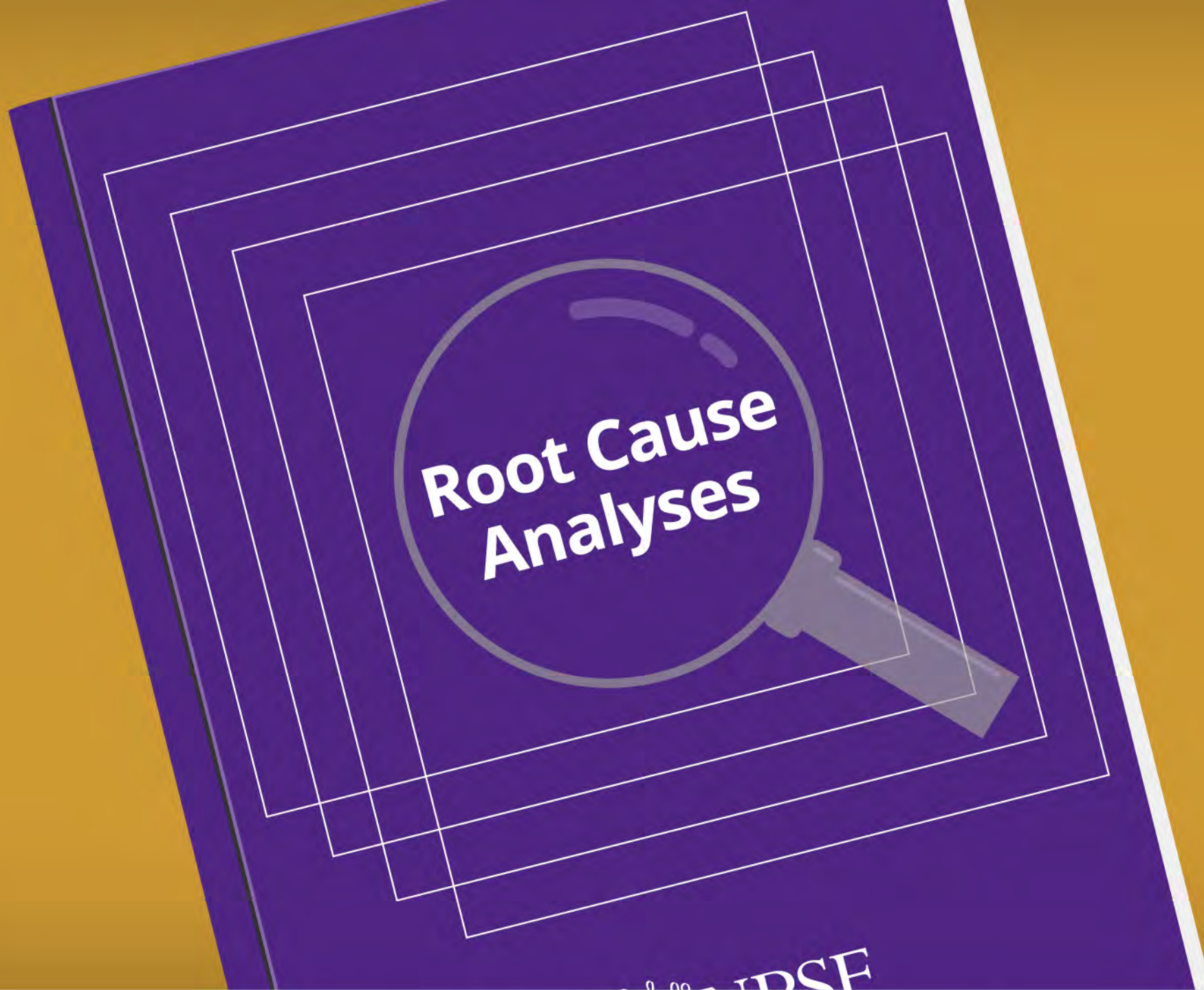


That's why the National Patient Safety Foundation created RCA-squared.

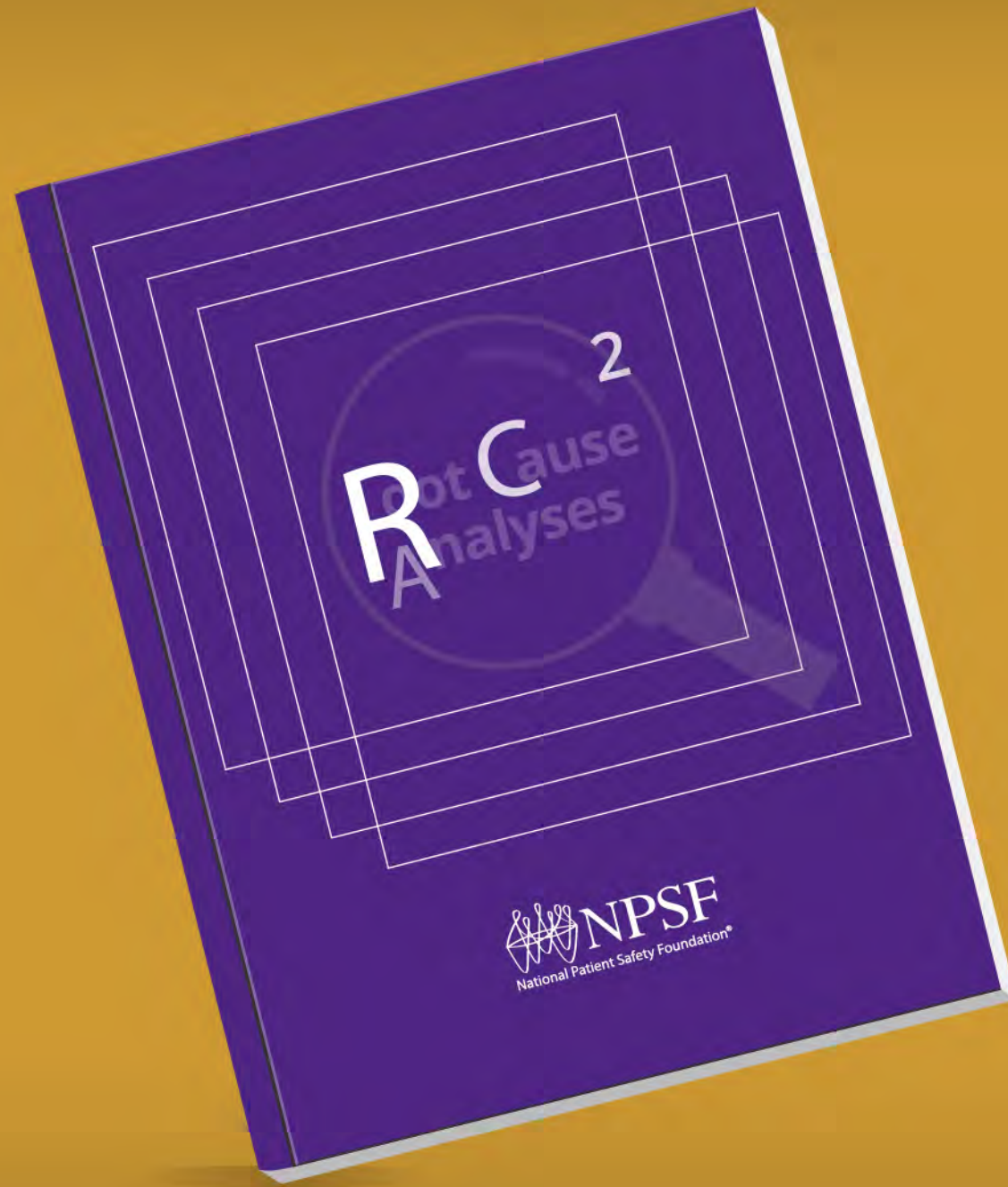


# Root Cause Analyses

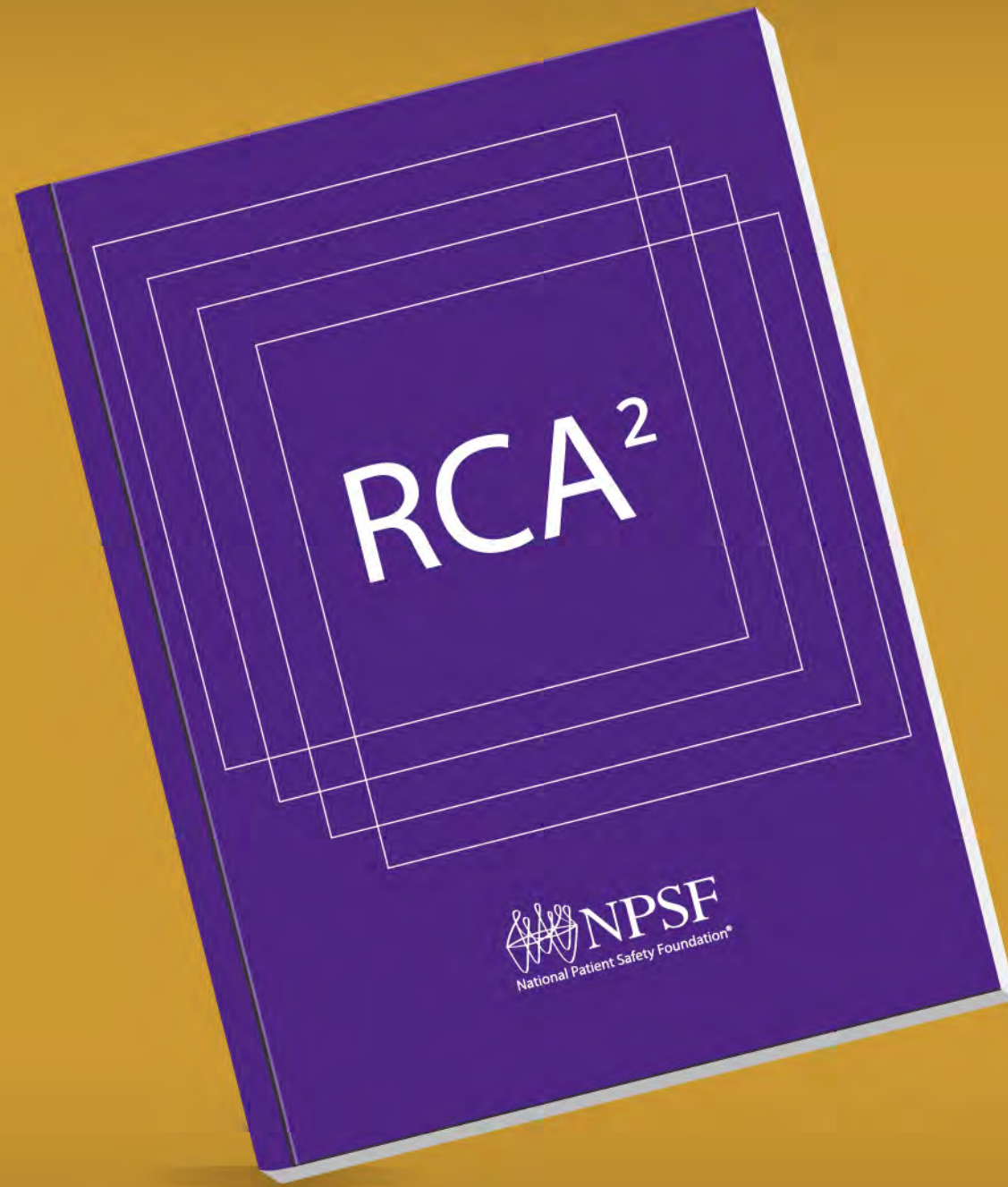
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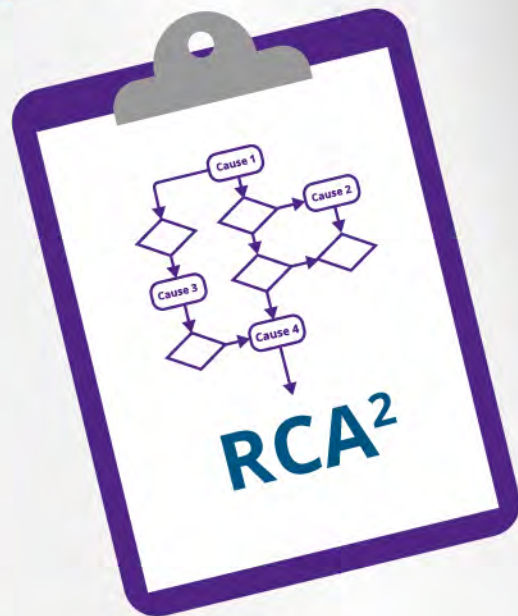


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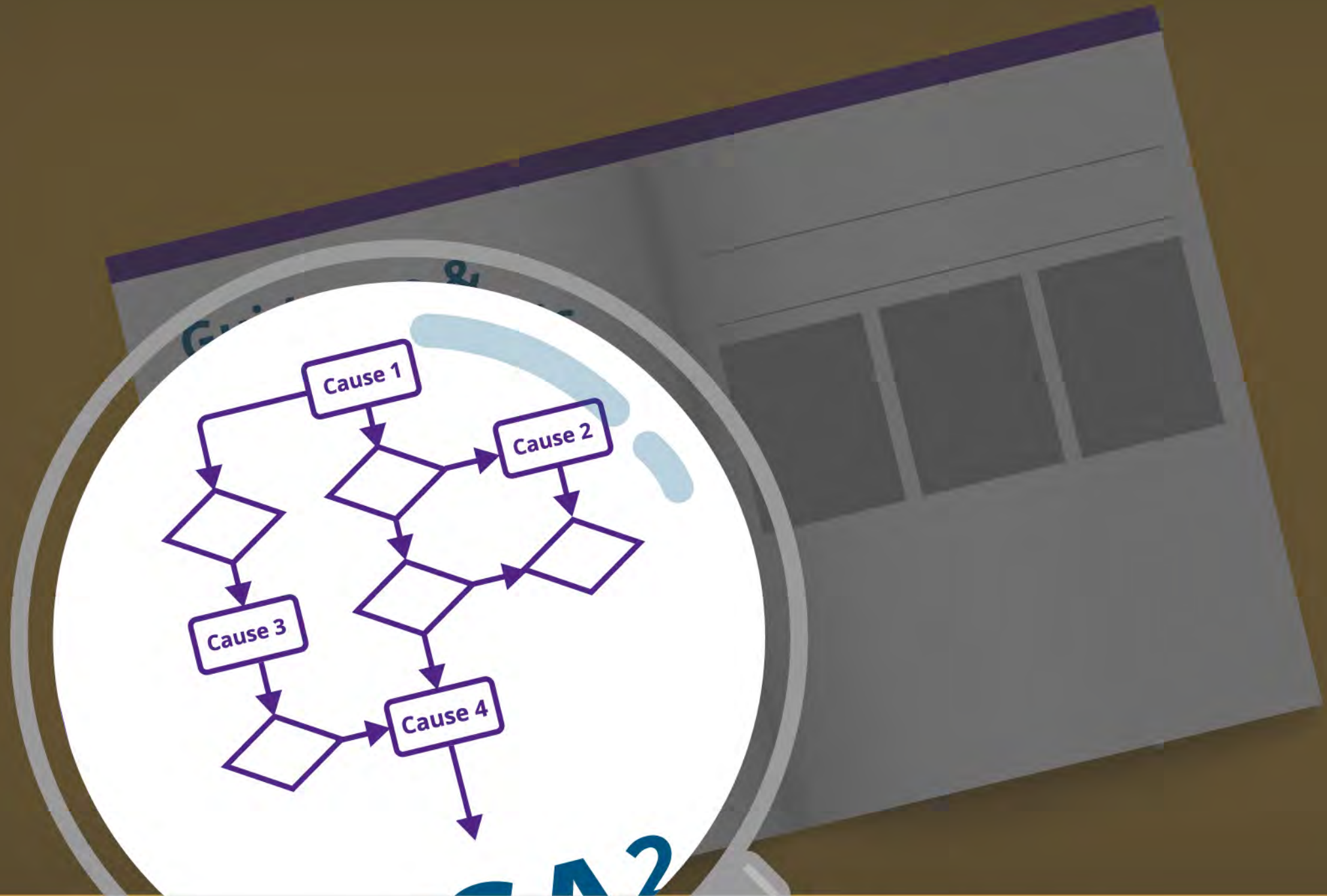
# Guidance & Practical Tools



It provides new guidance and practical tools for root cause analyses,

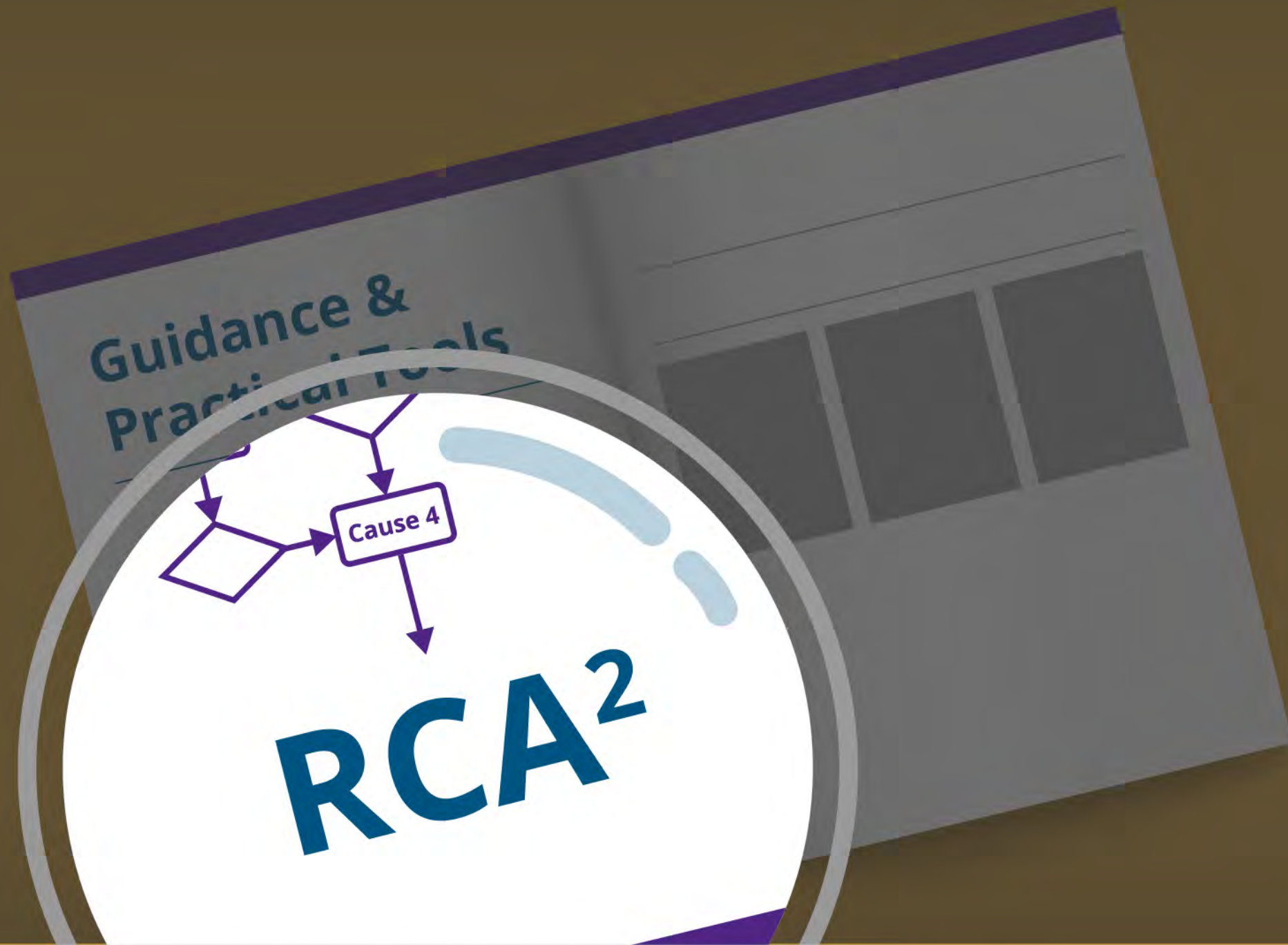


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helping you dig deeper to identify all possible causes of a patient safety event.

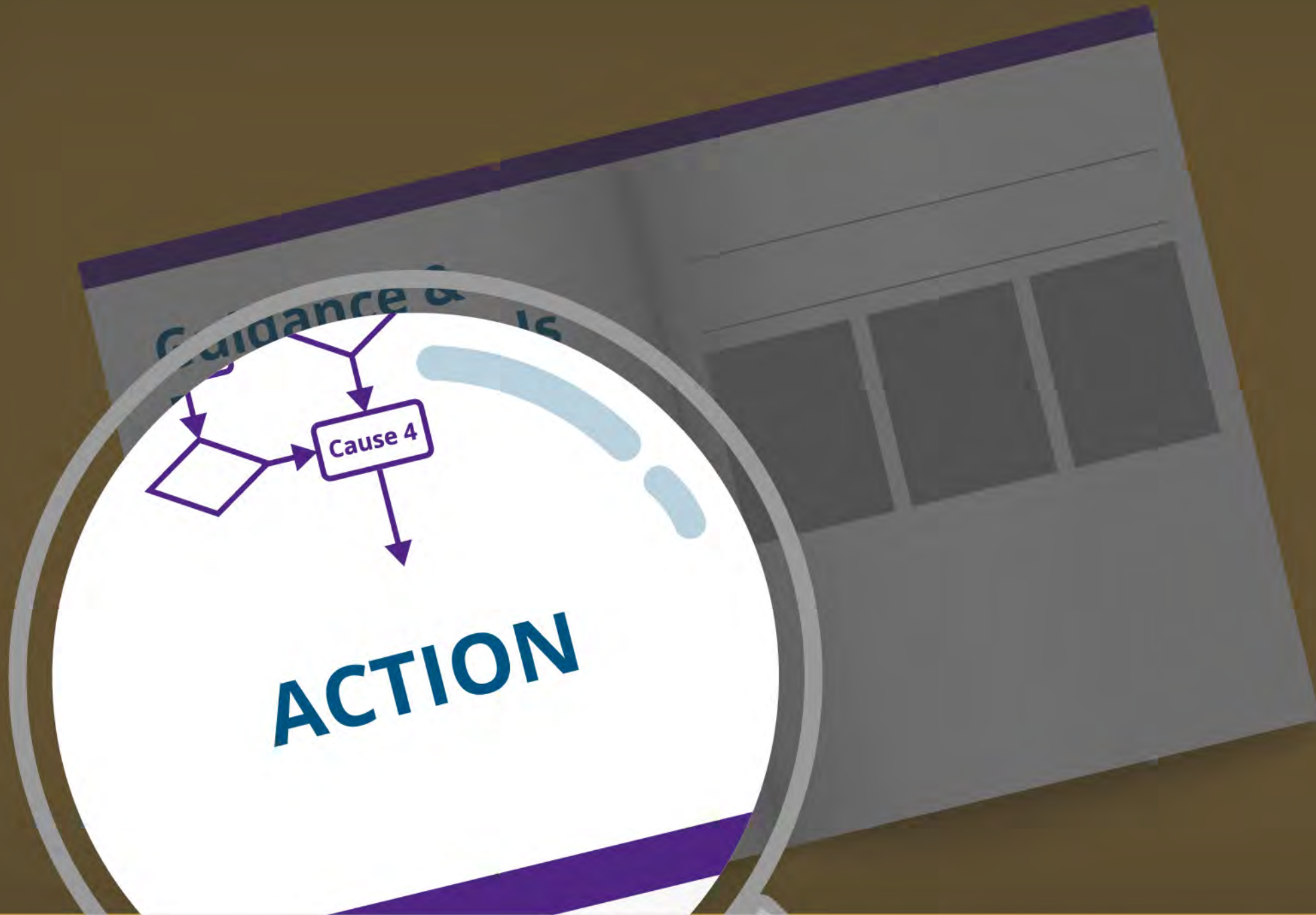




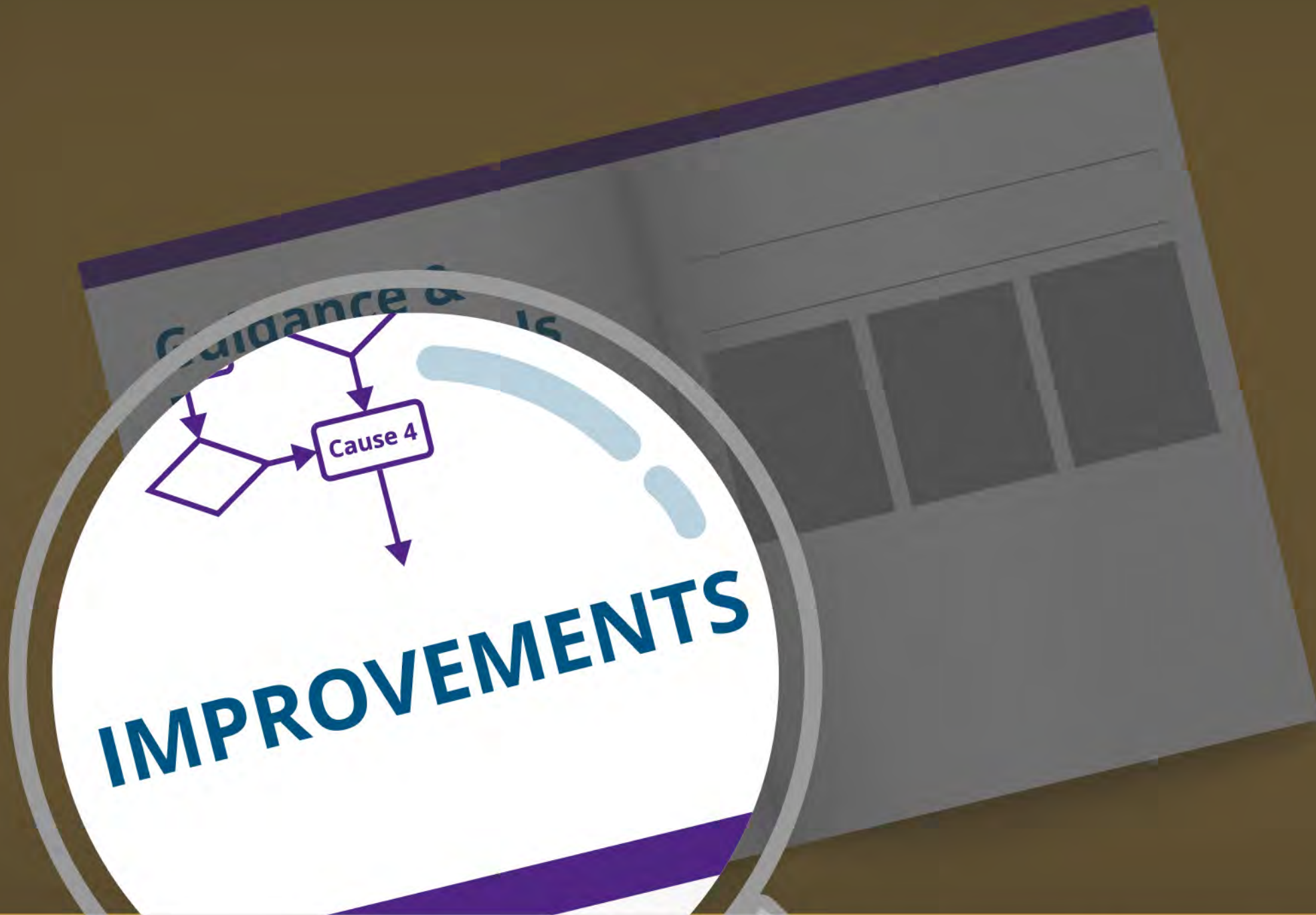
helping you dig deeper to identify all possible causes of a patient safety event.



Plus, RCA-squared adds a second “A” for ACTION to make sure your work produces improvements to prevent future harm.



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Plus, RCA-squared adds a second "A" for ACTION to make sure your work produces improvements to prevent future harm.

# Guidance & Practical Tools



## Three Phases

I

Before  
You Start

II

The  
Analytic  
Work

III

From  
Analyses  
to Actions

The RCA-squared process is divided into three phases:



Ground work before you start, the analytic work, and turning your analyses into actions.  
(Hovers briefly over each of the 3 steps, then moves off camera to the right)

# ance & tical Tools

## Three Phases

I

Before  
You Start

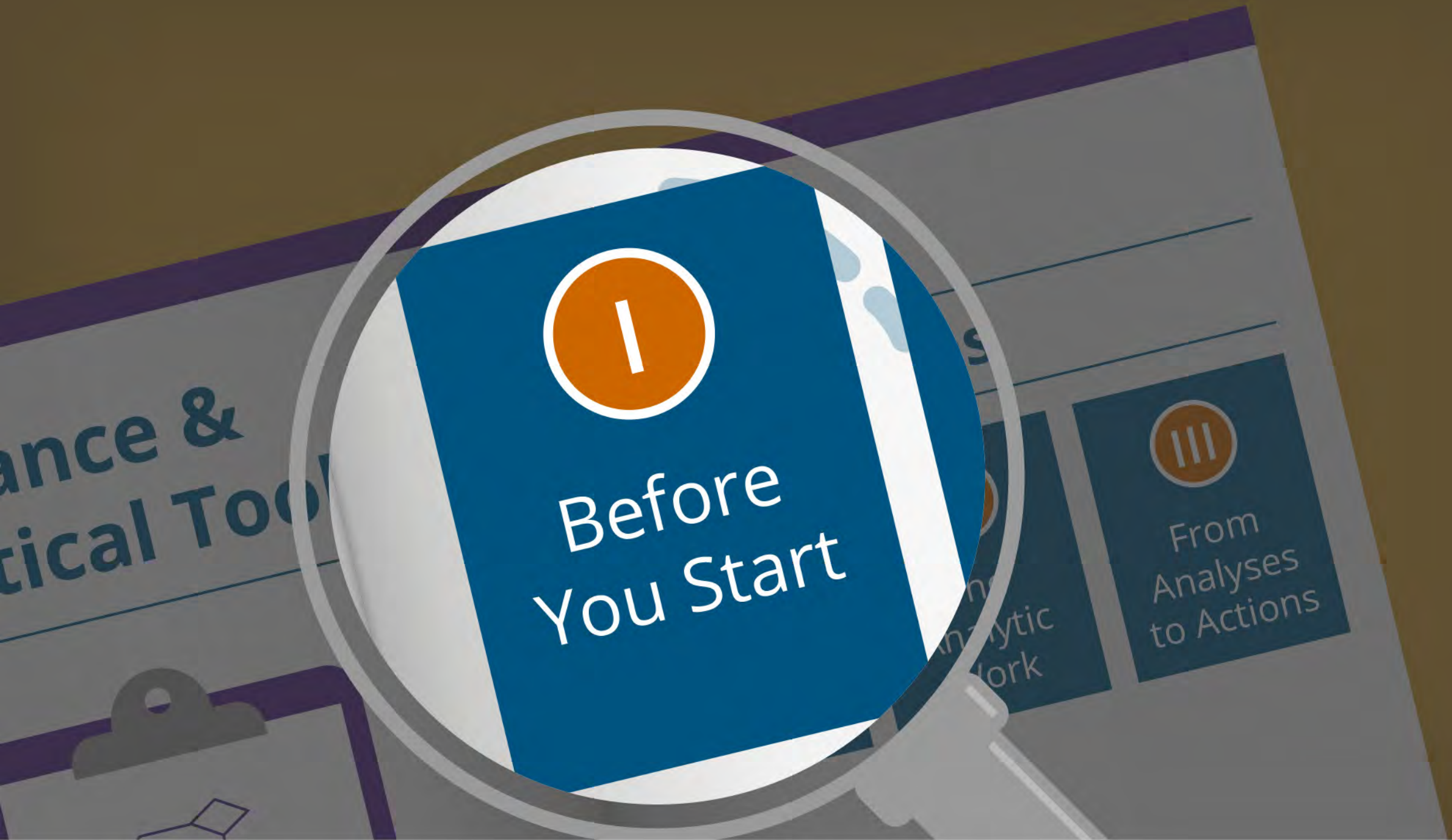
II

The  
Analytic  
Work

III

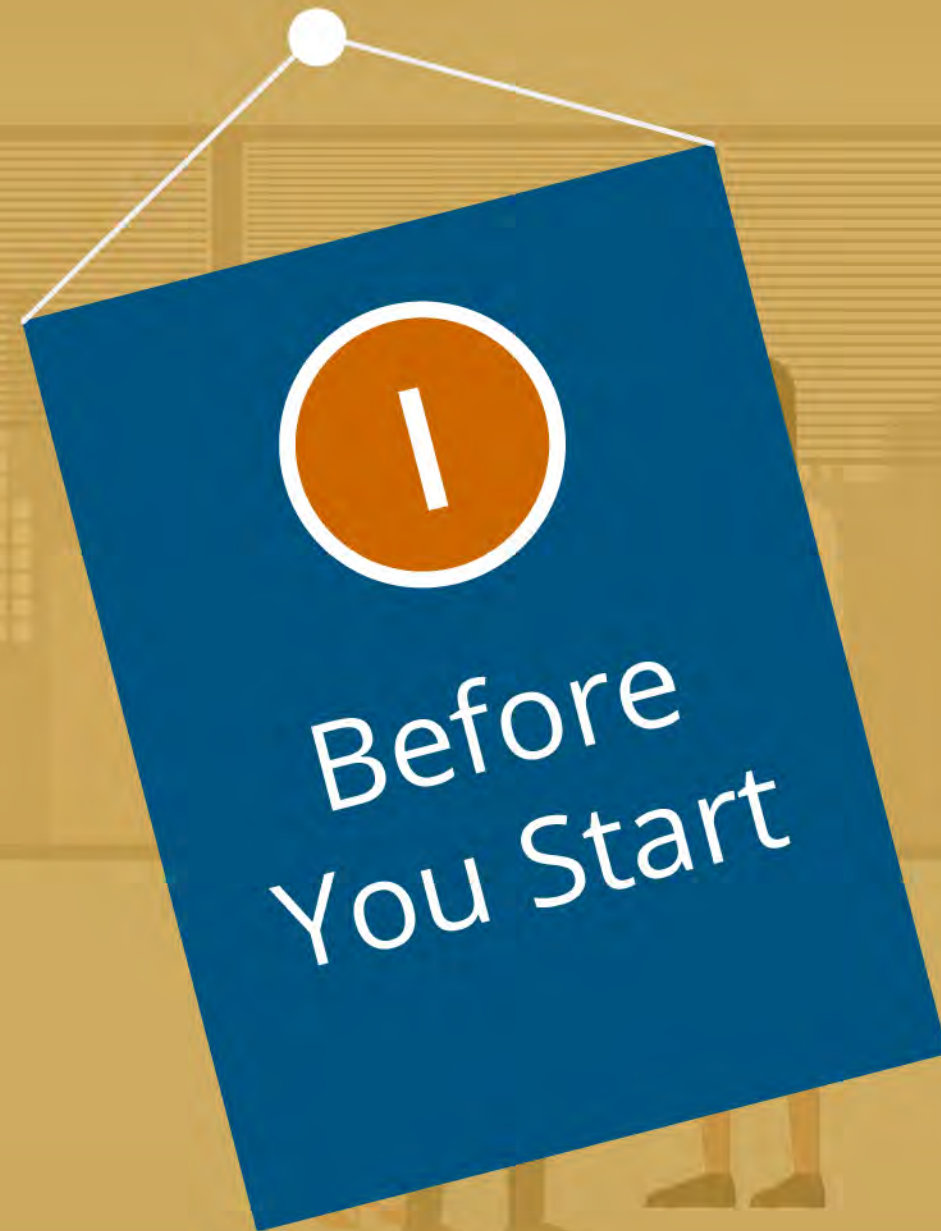
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The RCA-squared process is divided into three phases: Ground work before you start, the analytic work, and turning your analyses into actions.  
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The process will go more smoothly if you have two key pieces in place before you start.





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Before  
You Start



First, you need strong commitment to the work and buy-in from leadership.



Before  
You Start



And you need a safety assessment policy to help determine which events to study using RCA-squared.



Before  
You Start



And you need a safety assessment policy to help determine which events to study using RCA-squared.

# ance & tical Tools

## Three Phases

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Before  
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From  
Analyses  
to Actions

The analytic work begins right after an adverse event or near miss has occurred.



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Gather a strong, multidisciplinary team to lead a thorough fact-finding mission to determine what happened.



## The Analytic Work

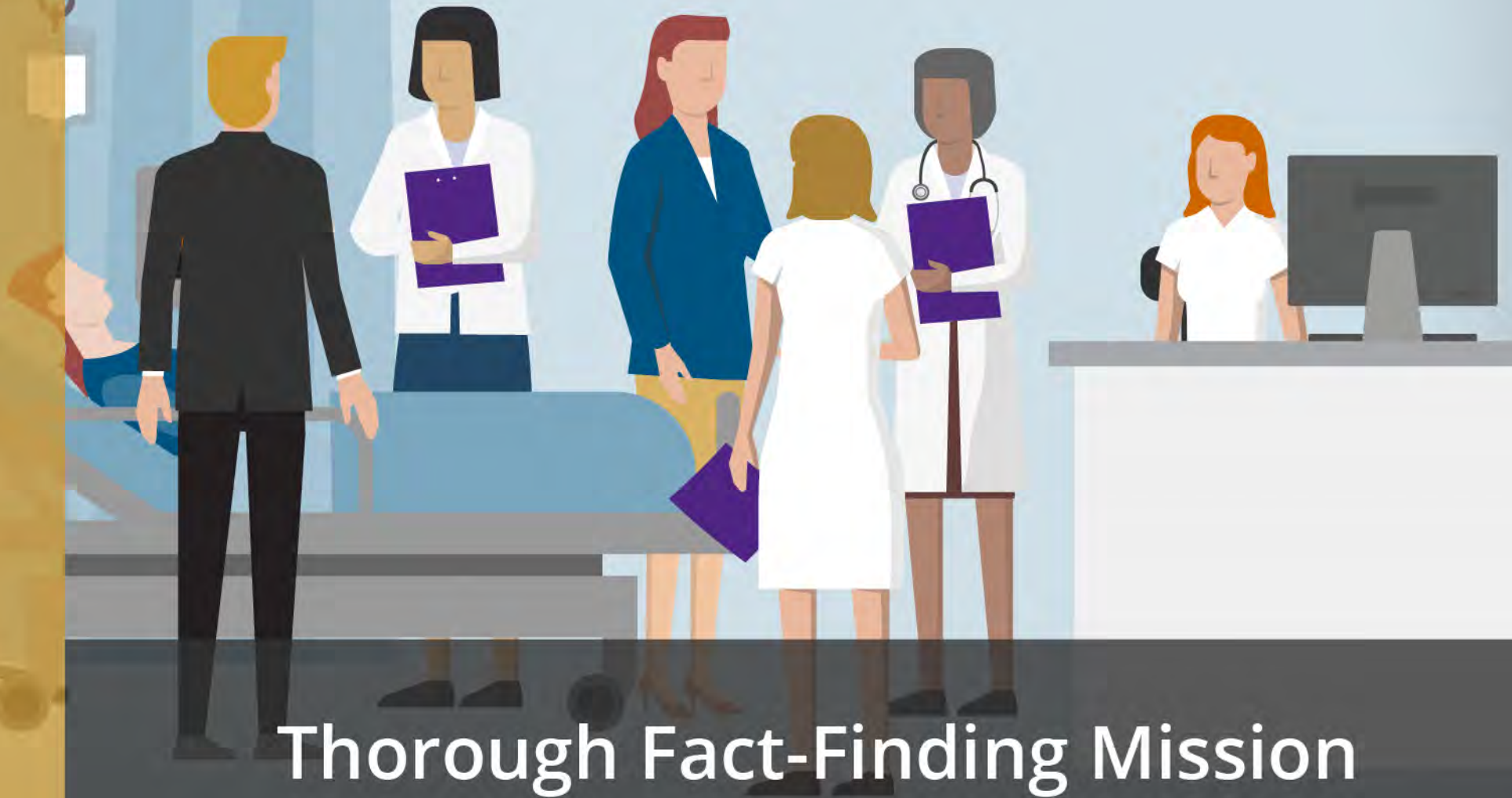


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## The Analytic Work

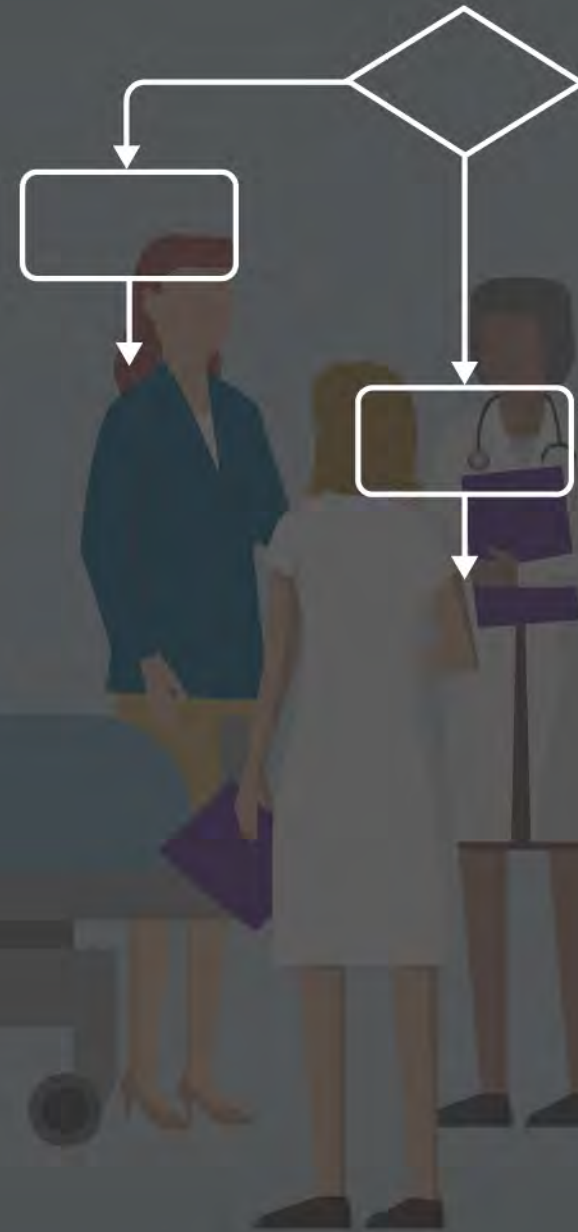


# Thorough Fact-Finding Mission

Gather a strong, multidisciplinary team to lead a thorough fact-finding mission to determine what happened.



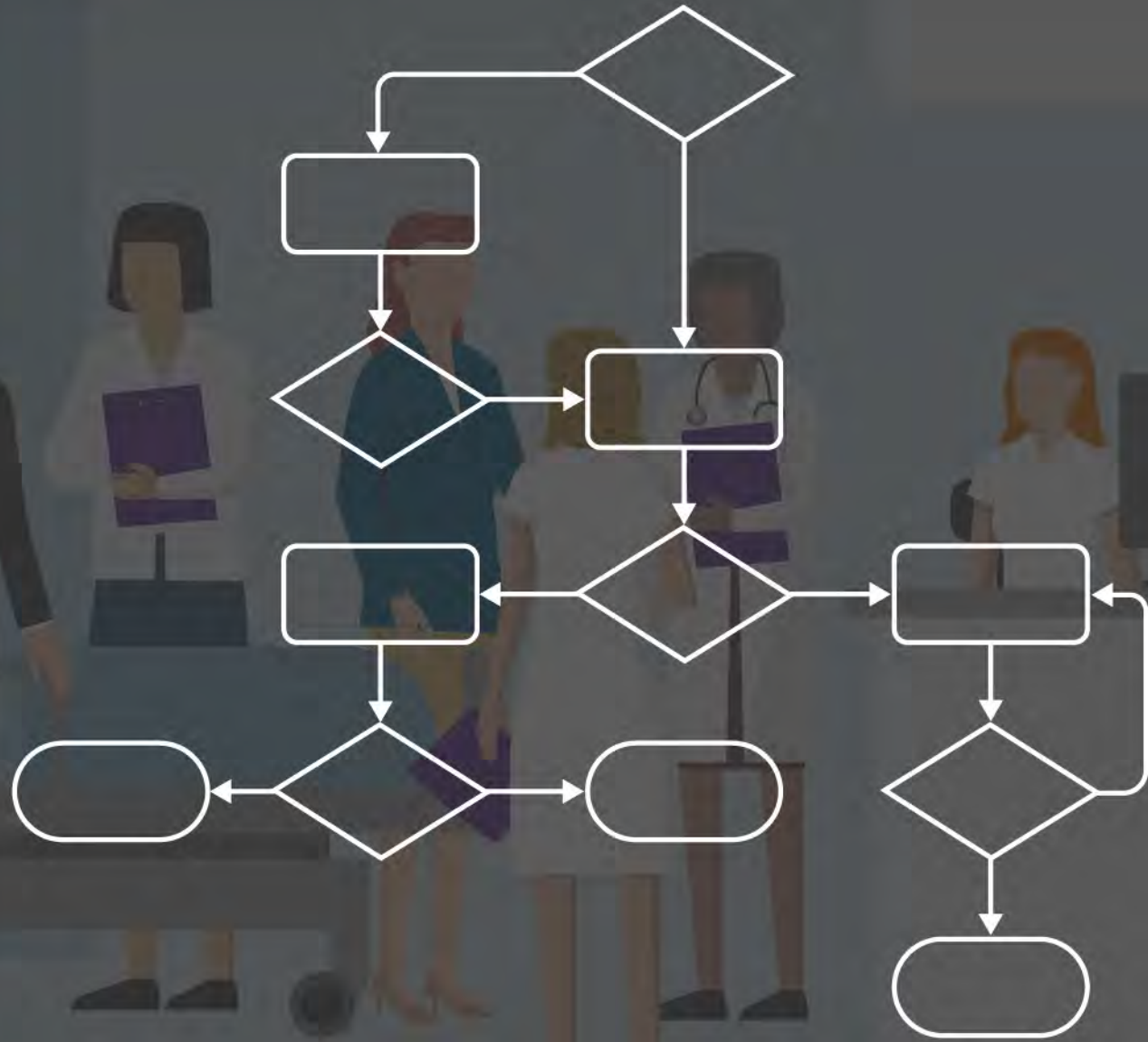
## The Analytic Work



Put together a chronology or flow diagram based on what is already known about the event.



## The Analytic Work



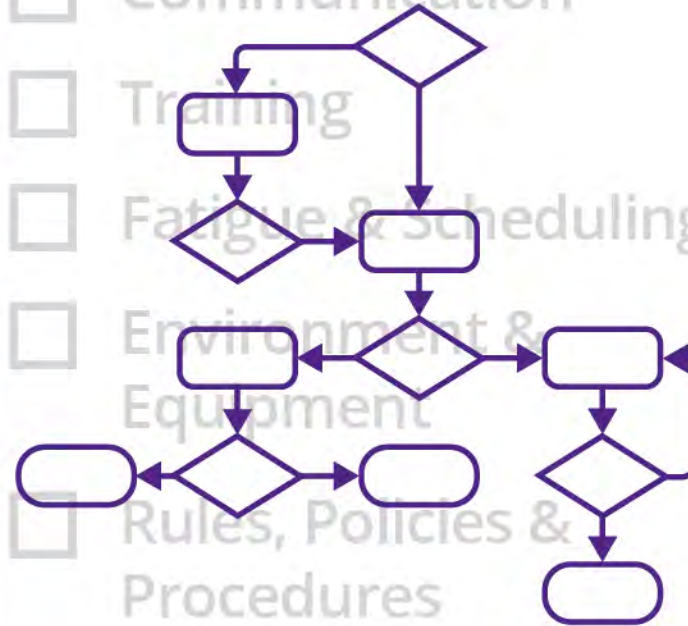
Put together a chronology or flow diagram based on what is already known about the event.





## The Analytic Work

- Communication
- Training
- Fatigue & Scheduling
- Environment & Equipment
- Rules, Policies & Procedures
- Barriers & Controls



From there, the team draws up a list of questions covering every aspect of the event:



## The Analytic Work

- Communication
- Training
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- Environment & Equipment
- Rules, Policies & Procedures
- Barriers & Controls

Communication, Training, Fatigue and Scheduling, Environment and Equipment, Rules, Policies and Procedures, and Barriers and Controls.

**NOTE:** We will record this list, but in final cut will not include it in VO to reduce runtime.



## The Analytic Work

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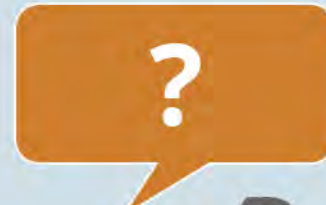
## The Analytic Work



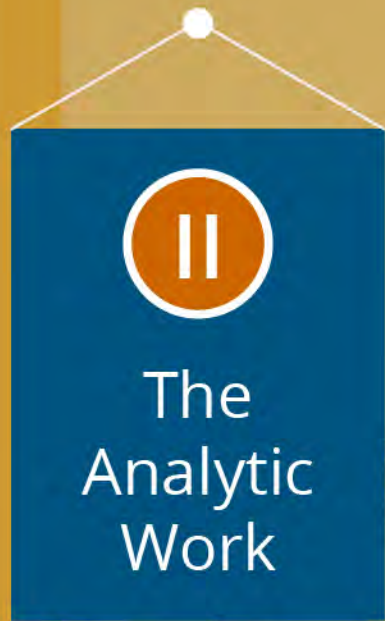
Probe, test, and interview until every question is answered.



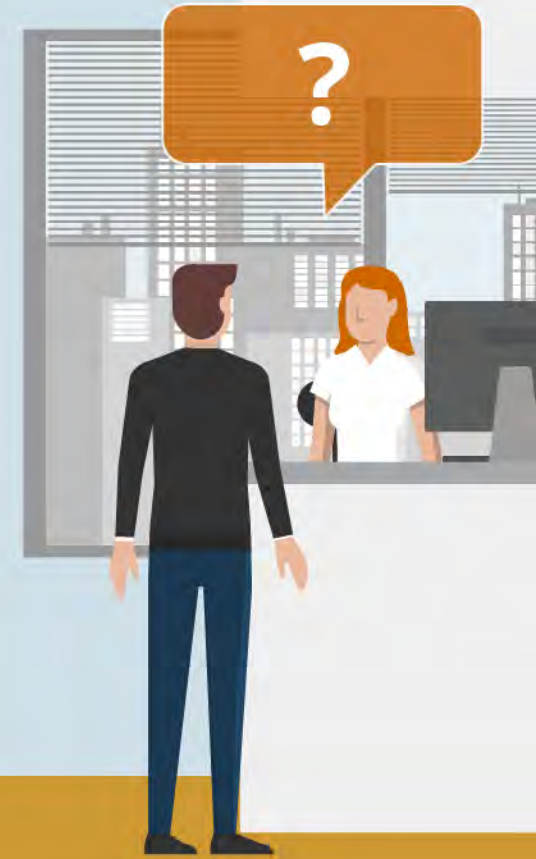
## The Analytic Work



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II  
The  
Analytic  
Work

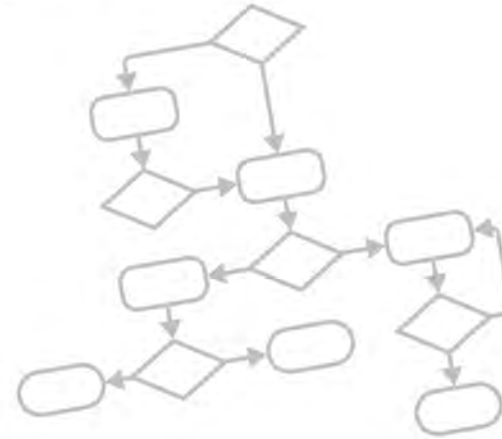


Probe, test, and interview until every question is answered.



## The Analytic Work

# Contributing Causes



With this new information, the team can document the contributing causes.



## The Analytic Work

# Contributing Causes



Write statements that draw a clear “cause and effect” relationship between each underlying factor and the events that followed.



## The Analytic Work

# Contributing Causes

Clear Cause and Effect

Write statements that draw a clear “cause and effect” relationship between each underlying factor and the events that followed.



## The Analytic Work



For instance, it's not enough to say a staff member failed to follow procedure. Identify WHY this occurred.





## The Analytic Work



For instance, it's not enough to say a staff member failed to follow procedure. Identify WHY this occurred.



## The Analytic Work



As an example, noise and confusion in the prep area, coupled with time pressure...



## The Analytic Work



Cause

As an example, noise and confusion in the prep area, coupled with time pressure...



## The Analytic Work



As an example, noise and confusion in the prep area, coupled with time pressure...



## The Analytic Work



... resulted in the injection of an air embolism from an empty syringe.



## The Analytic Work



Effect

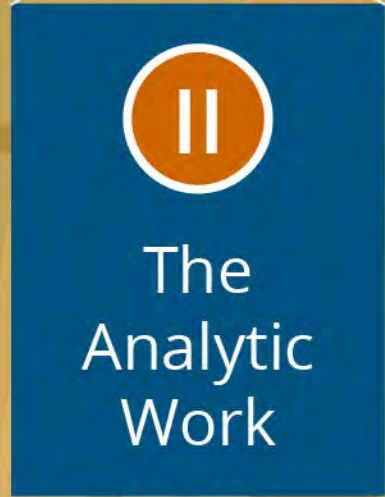
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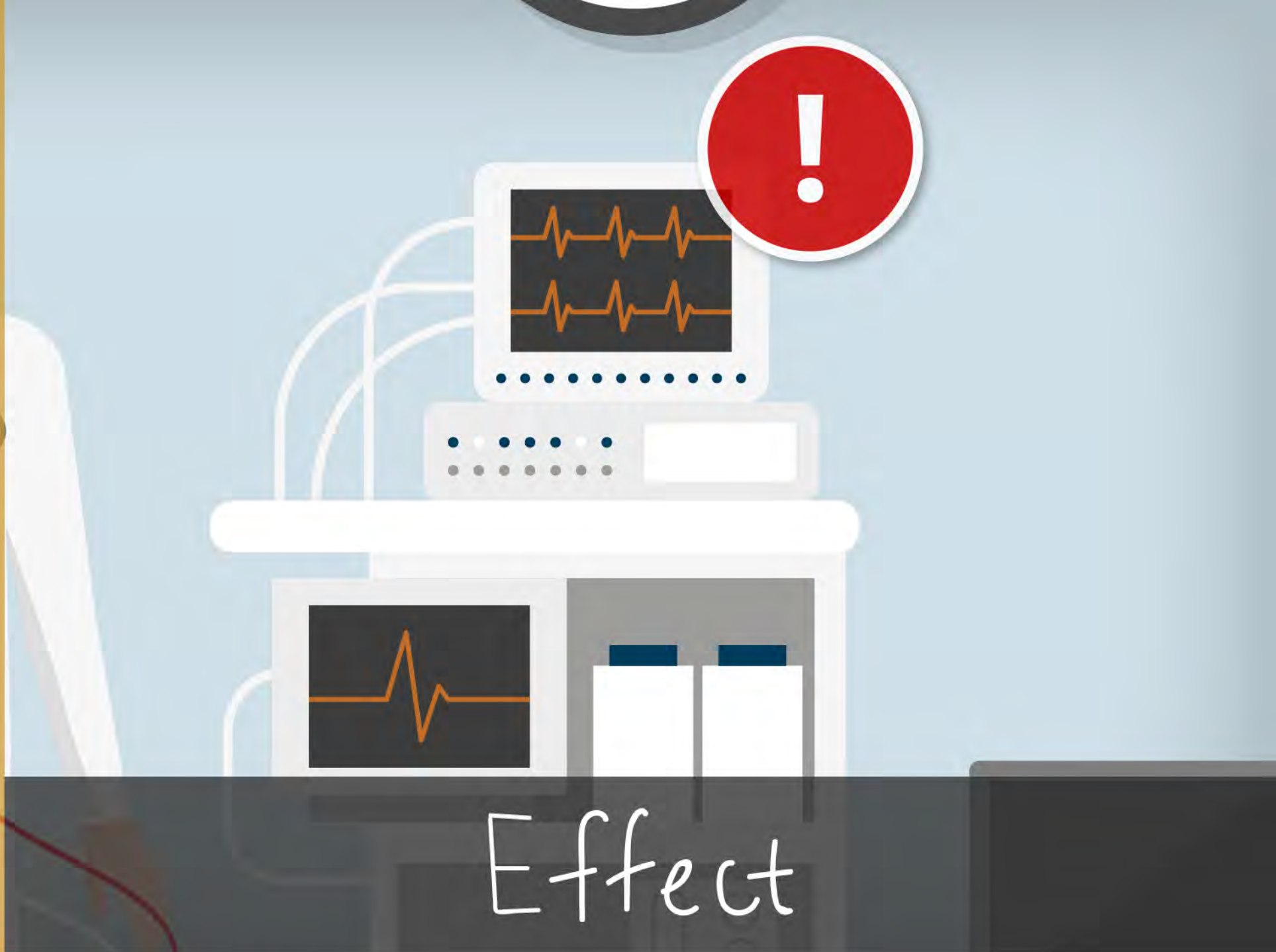
## The Analytic Work



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II  
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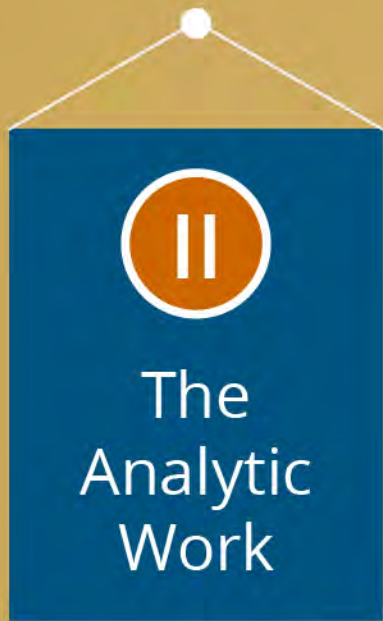


Effect

... resulted in the injection of an air embolism from an empty syringe.

SFX: monitor alarm





II  
The  
Analytic  
Work



Once the team has a better understanding of what went wrong, strong corrective actions can be identified.



## The Analytic Work

# Corrective Actions

### ACTION 1

- \_\_\_\_\_
- \_\_\_\_\_

### ACTION 2

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Once the team has a better understanding of what went wrong, strong corrective actions can be identified.



## The Analytic Work

### Corrective Actions

#### ACTION 1

- \_\_\_\_\_
- \_\_\_\_\_

#### ACTION 2

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### ACTION 3

- \_\_\_\_\_
- \_\_\_\_\_

Once the team has a better understanding of what went wrong, strong corrective actions can be identified.

# ance & tical Tools

## Three Phases

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Before  
You Start

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From  
Analyses  
to Actions

Now it's time to put those plans into action.

ance &  
tical Tools



Now it's time to put those plans into action.



This includes measurement to ensure corrective actions are effective in practice.



From  
Analysis  
to Action



Measurement

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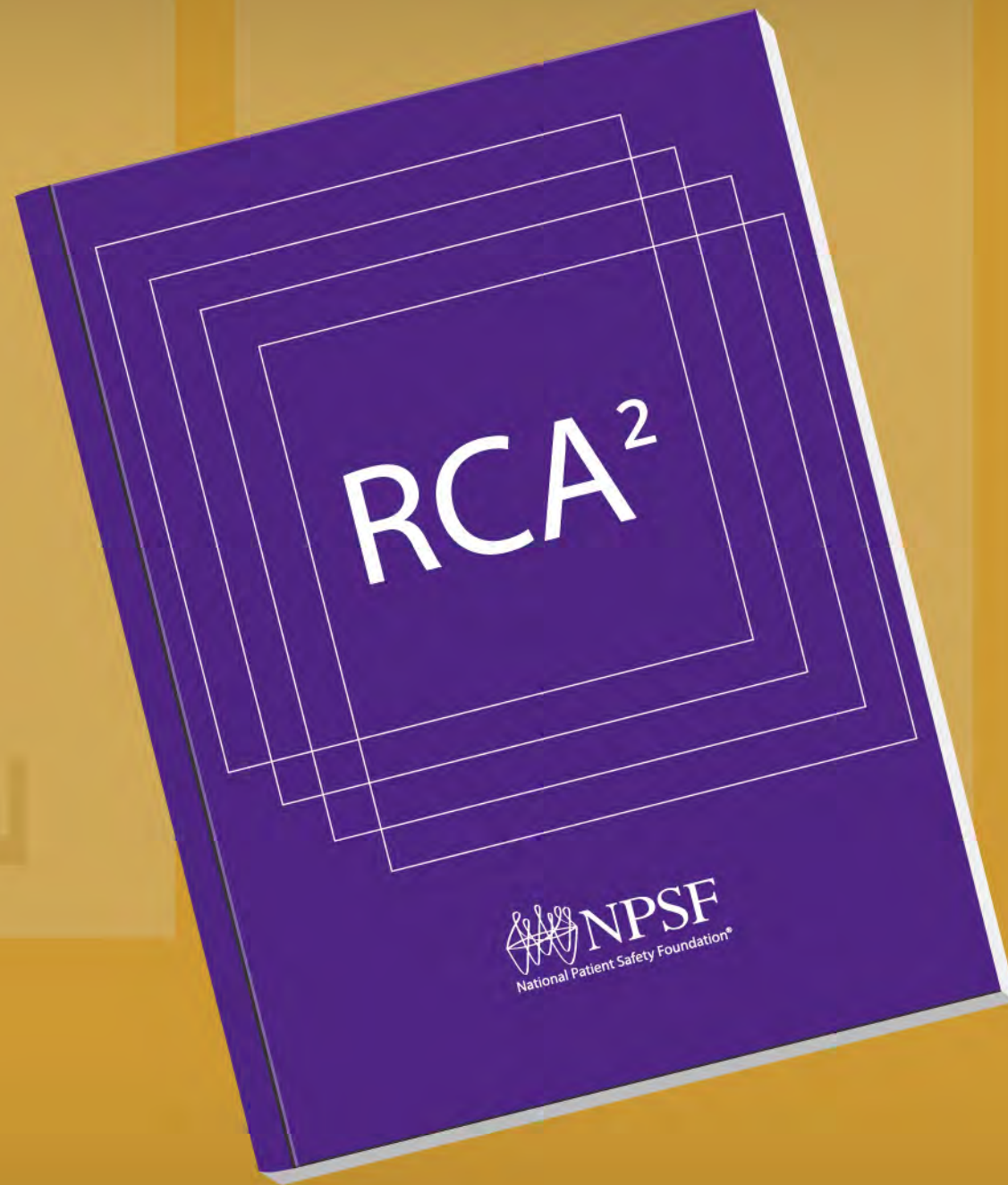
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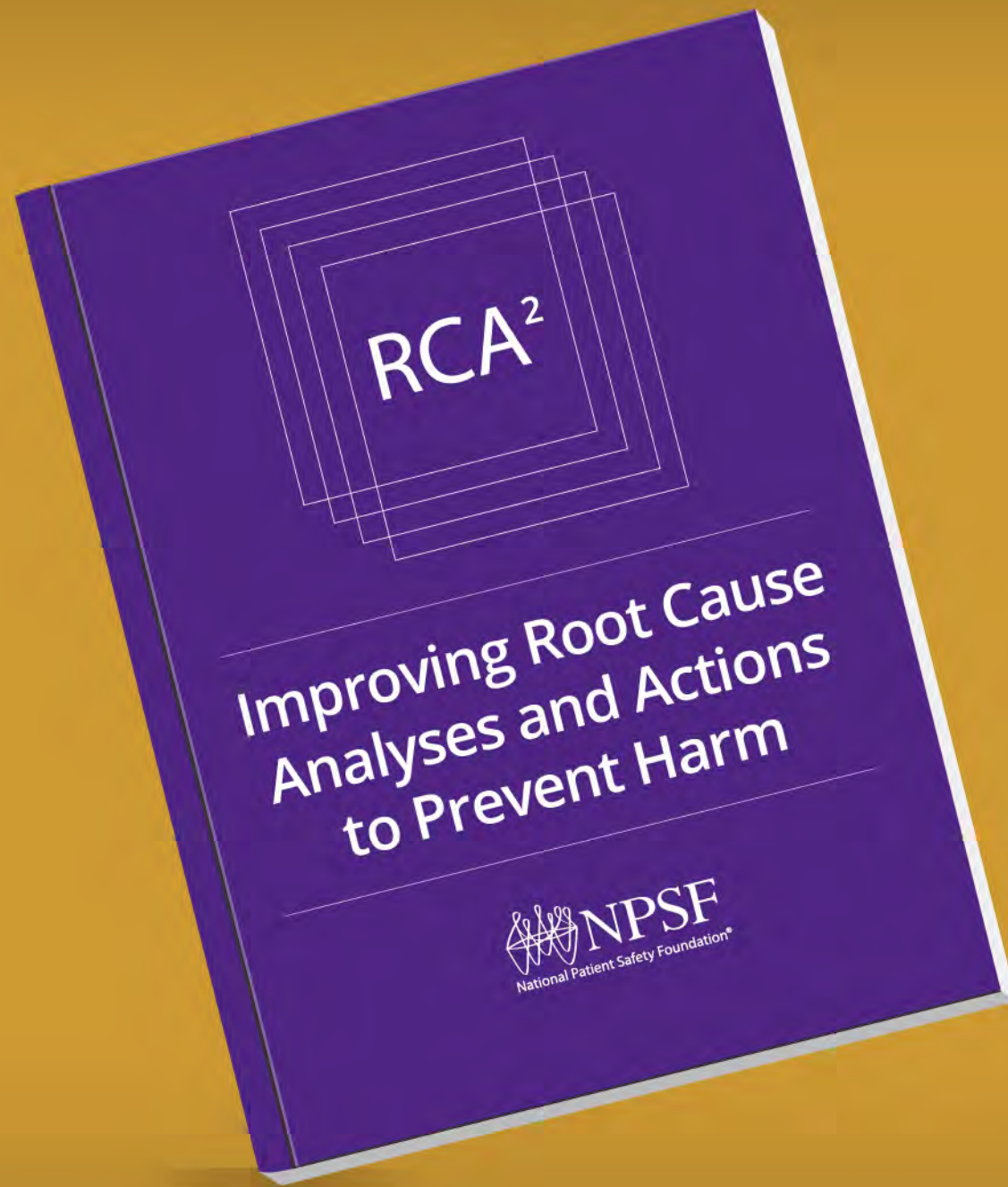
# Measurement

This includes measurement to ensure corrective actions are effective in practice.





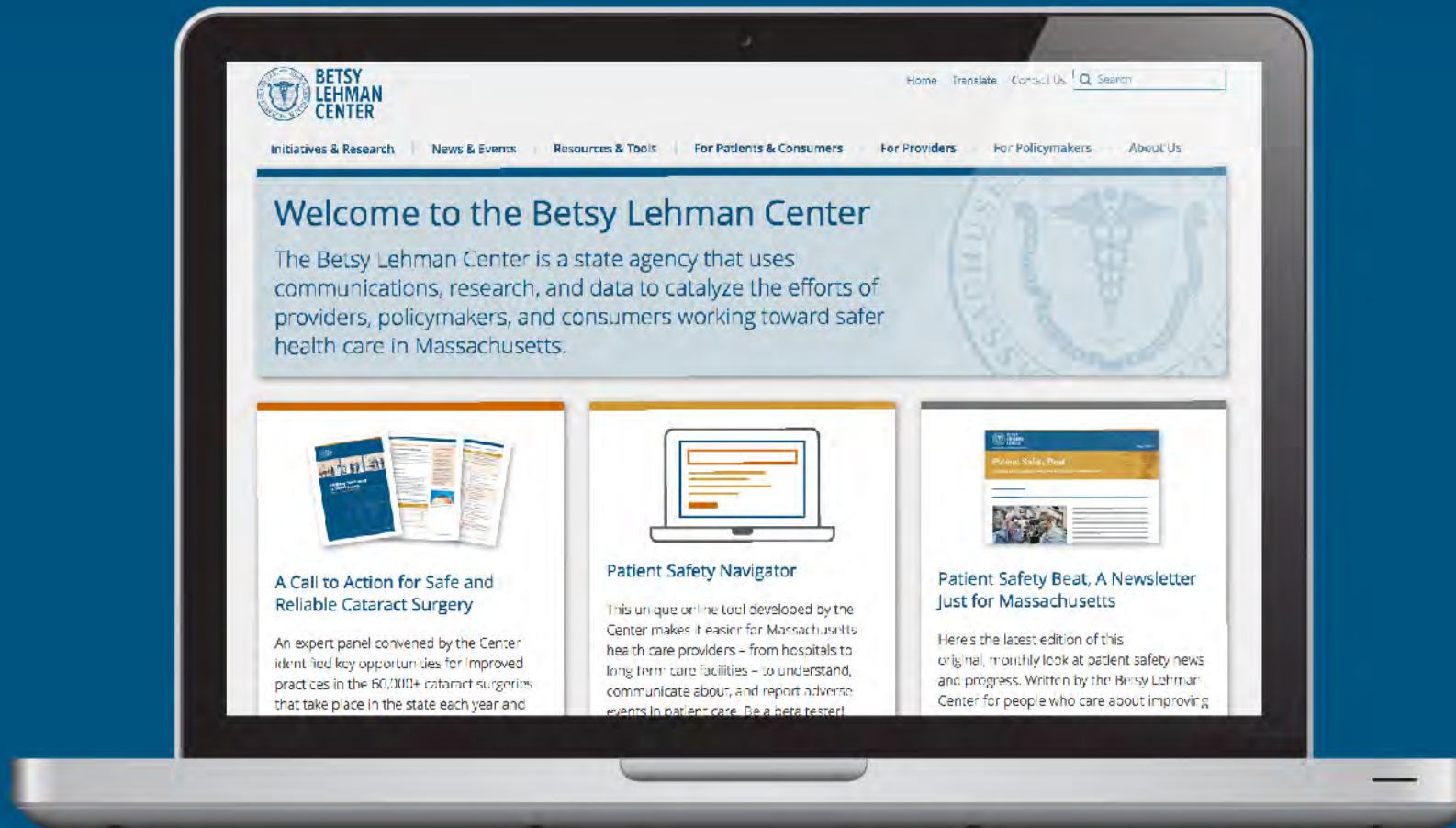
RCA-squared is a powerful tool for improving root cause analyses and actions to prevent harm in today's complex healthcare environments.



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To get started, visit the Betsy Lehman Center online and click on The Patient Safety Navigator.

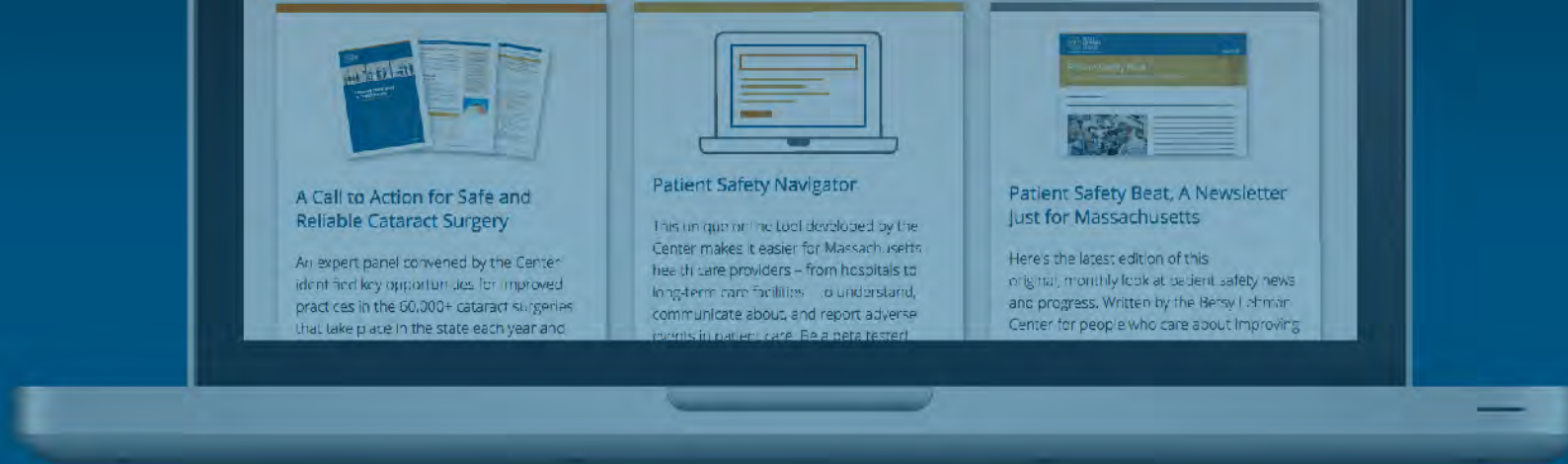


**BetsyLehmanCenterMA.gov**

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You'll find all the tools you need to put RCA-squared to work for your organization and its patients.



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