Root Cause Analysis Training
Investigation process and practical application
Housekeeping

Confidentiality

www.cddft.nhs.uk
About you?

- Name
- Role
- Previous experience in RCA or other investigations
- Your personal objective you wish to achieve from the course
Patient Safety Training Programme

Overview of patient safety & Incident Reporting

- Duty of Candour
- Root Cause Analysis
- Effective Report Writing
- Incident Reporting (IT Module)
Summary – Overview of Patient Safety

- In-depth knowledge of patient safety and why we report incidents
- Ability to apply the NRLS guidelines to reporting incidents
- Describe examples of incidents and the agreed harm level
Summary - Duty Of Candour

- Apologise to patient/relatives/carers
- Document apology in patients notes
- Written apology

www.cddft.nhs.uk
Aim

To understand the theory underpinning root cause analysis and to provide practical skills and knowledge to investigate safety incidents.
Objectives

At the end of the session, individuals should be able to:

- follow an agreed template to produce an RCA report that meets the required Trust standards
- identify system failures and behavioural elements that lead to incidents
- share lessons learned trust-wide to mitigate an incident happening again
- understand the links between the risk management process, safety culture and reactive investigation processes – and ensure patient safety is on your team’s meeting agenda.
- Produce SMART objectives as part of the action plan.
- conduct a Root Cause Analysis (RCA) investigation
Format for the day

- **Morning**  
  Root Cause Analysis - Tools/Techniques
  Getting started/investigation process

- **After lunch**  
  Case Studies (Implementation of Tools and Techniques)
  Embedding a safety culture
Root Cause Analysis - definition

- RCA is a structured investigation that aims to identify the true causes of a problem and the actions necessary to eliminate it. *(Anderson and Fagerhaug, 2000)*

- RCA looks at the whole system within which a problem, error or incident has occurred, including human factors.
Basic elements of a good RCA investigation

1. WHAT happened
2. HOW it happened
3. WHY it happened
   - Unsafe Act
   - Human Behaviour
   - Contributory Factors

Solution development and feedback
Why do things go wrong?

Why do things go wrong….

- **Slip**
  - Attention Failures
    - Giving incorrect dose

- **Lapse**
  - Memory Failures
    - Forgetting to request X-ray/test
    - Full physical exam on an agitated patient
    - Miscalculation of medication dose
    - With good intent
    - Shortcuts
    - Deliberate deviation
    - Intended to cause harm

- **Mistake**
  - Rule-based
  - Knowledge-based

- **Violation**
  - Reasoned
  - Routine
  - Reckless
  - Malicious
What does this say?

60 Regular Insulin Now

Exercise
https://www.youtube.com/watch?v=IGQmdoK_ZfY
Activity

How many passes did you see?

Did you see anything else in the DVD?
Root Cause Analysis Process

Step 1
Nominate a facilitator and bring a team together

Step 2
Gather the information

Step 3
Contributory factors

Step 4
Findings & Identify the root cause
Step 3 – Contributory factors
**Positive contributory factors**

Not all influences on patient safety incidents are negative. Some factors have made a positive contribution to reducing harm e.g. because of good staff emergency training, patient survived severe harm.

**Care Delivery Problem (CDP)**

A problem related to direct provision or process of care. These are usually actions or omissions by members of staff. A CDP can also involve absence of guidance to enable action to take place e.g.

- failure to monitor, observe or act
- incorrect (with hindsight) decision making
- not seeking help when necessary.

**Service Delivery Problem (SDP)**

Refers to those acts or omissions that are identified during the analysis of a patient safety incident, but are not associated with direct provision of care. They might be associated with the decisions, procedures and systems that are part of the whole process of service delivery e.g.

- failure to undertake an environmental risk assessment
- failure of the system for ensuring all new telephones have the emergency number for switchboard on them
- equipment failure.
Five ‘whys’

- Tool that enables investigator(s) to identify the causes for each problem.
- Best suited to simple and non-complex problems
- Quick and easy to teach
- 3 – 5 – 7 whys?
Generating Solutions

- Keep it simple
- List all recommendations for change and prioritise for effective implementation
- Draw up an action plan
- Involve patients and staff
- Use SMART objectives (Specific, measurable, achievable, relevant, timed)
The Trust operates a Being Open Policy

The investigation findings will be shared with the patient and family to ensure a transparent process.

Patient/family will be offered feedback on the investigation once the process has been completed.

Action plans should be SMART (specific, measurable, achievable, realistic, time related).

www.cddft.nhs.uk
Action plan evidence and monitoring

- Evidence of action completion on safeguard – for example team meeting minutes, bulletins
- Monitoring of actions takes place on a weekly basis by the Director of Nursing and Care Group Governance Leads
- Close the loop
Writing the investigation report

- Keep it clear, concise and relevant to the investigation
- It must be factual
- Consistent use of dates and times
- Anonymise the report, use job titles and do not identify specific hospitals, or wards
- Use full English in the main sections of the report, not note form
- Keep medical terminology to a minimum - if abbreviations are used, provide an abbreviations list
- Think about who the potential audience - patients, carers, coroner, solicitors
What NOT to do:

- Speculate
- Attribute blame
- Deny responsibility
- Provide conflicting information from different individuals
- Use complicated, medical terminology excessively
http://www.youtube.com/watch?v=IJfoLvLLoFo
Let's Take a Quiz
Case Studies Group work

- Head Injury
- Fall
- Delay to Diagnosis
- Never Event
Task 2

Identify Contributory factors
Identify Root Cause
Task 3

Create a poster showing journey from:-

1. Identified Care/Service delivery problems
2. Lessons Learnt
3. Recommendations for action
Case Studies
Sharing lessons learnt to improve safety culture

Creating a safety culture which is just, open, fair, and learning

Increasing skills in patient safety via training programme

Energising and mobilising action via Sign up to Safety

Reviewing in depth via the Patient Safety Collaboratives
Patient Safety Training Programme

Overview of patient safety & Incident Reporting

- Duty of Candour
- Root Cause Analysis
- Effective Report Writing
- Incident Reporting (IT Module)

To book on further modules contact Course Bookings

www.cddft.nhs.uk
Useful links

- **CDDFT Root Cause Analysis Toolkit:**
  
  [http://intranet/Directorates/CorporateDirectorates/NursingDirector/ClinGov/PatSafety/Root%20Cause%20Analysis/Forms/AllItems.aspx](http://intranet/Directorates/CorporateDirectorates/NursingDirector/ClinGov/PatSafety/Root%20Cause%20Analysis/Forms/AllItems.aspx)

- **National Patient Safety Agency (NPSA) Root Cause Analysis Toolkit**
  
  [http://www.nrls.npsa.nhs.uk/resources/rca-conditions/](http://www.nrls.npsa.nhs.uk/resources/rca-conditions/)

- **Patient Safety Team StaffNet**
  
  [http://intranet/Directorates/CorporateDirectorates/NursingDirector/ClinGov/PatSafety/Pages/default.aspx](http://intranet/Directorates/CorporateDirectorates/NursingDirector/ClinGov/PatSafety/Pages/default.aspx)
Thank you

Patient Safety Team

The Patient Safety team offers support to Care Groups and services to improve quality and safety by reducing harm and sustaining improvements in order to keep patients, staff and visitors safe. The Patient Safety Team is responsible for the delivery of the Boards patient safety programmed, by identifying safety improvements. To achieve the safety agenda for the Trust, the Patient Safety Team are responsible for leading on incident management, Sign up to safety initiative, Duty of Candour, Root Cause analysis and training.

Patient Safety Team Intranet Page can be access via Staffnet

www.cddft.nhs.uk
Useful contact details

**Patient Safety Team, Memorial Hall, DMH**
Tel: 01325 (7)43722

- Claire Adolph  Patient Safety Manager for Integrated Adult / Family Health
- Helen Bowman  Patient Safety Manager for Surgery / Clinical Specialist Services
- Jackie Stoves – Acute and Emergency Medicine and Patient Safety Lead

**Patient Safety Team Intranet Page can be access via Staffnet**

www.cddft.nhs.uk