TOOL: Root Cause Analysis

What is the tool?

Root Cause Analysis is a process for identifying the fundamental causal factor(s) underlying variations in performance. The RCA can include the occurrence or possible occurrence of an event that could lead to patient harm (commonly referred to as a "near miss") and is most commonly used after an event has occurred.

When should the tool be used?

Following the occurrence or near occurrence of an undesirable event that could result in patient harm, an RCA can uncover contributing factors and help organizations identify opportunities for improvement to deliver safer care.

Example: A 78-year-old male is admitted for coronary artery bypass surgery. The patient developed atrial fibrillation and hypotension after the operation and was treated with vasopressors. His condition stabilized and he began working with a physical therapist who noted an open wound on his sacrum. A skin assessment revealed an eraser-size wound with purple coloring around it. A wound, ostomy and continence nurse was consulted, who described the wound as unstageable and made recommendations.

Best practice	*Describe the deviation*	*Contributing factor*
Pressure injury risk (Braden scale) and skin assessments were documented on admission and daily	Assessments were not documented	Inconsistent shift-change handoffs
Patients with impaired sensory perception, mobility and activity as defined by the Braden scale had the following interventions documented: • Repositioning q2 hours • Heels off of bed • Appropriate support surfaces (for pressure redistribution)	Patient's unstable condition and lack of turning led to an unstageable pressure ulcer.	Nursing concern was stabilizing the patient, which led to infrequent head-to-toe skin assessment and repositioning.

Action taken/ to be taken	*Person responsible for action plan*	***Measurement strategy:** (Includes methodology, goal, sampling strategy, frequency and duration of measurement. Includes a threshold that will trigger additional analysis and/or action if not achieved.*	*Reporting and communication*
Staff training/ education on skin assessment and repositioning protocol	Clinical education, unit manager	• Educate providers on skin assessment and frequency of assessment. • Identify at-risk patients. • Assess staff understanding; nurse managers or skin champions to review 50% of all charts for compliance for 10 days. • Provide 1:1 and just-in-time training as needed.	• Review in staff meetings. • Share data at QI meetings.
Monitor compliance of best practices	Unit manager, skin champions	• Direct observation of all licensed staff to assess application of best practices • Implement turning program; nurse managers or skin champions to review 50% of all charts for compliance for 10 days. • Provide 1:1 and just-in-time training as needed.	• Review in staff meetings. • Share data at QI meetings.

REFERENCES:

1. Minnesota Department of Health: "Root Cause Analysis Toolkit."
2. Minnesota Department of Health: "Root Cause Analysis Worksheet."