IS THERE LIFE AFTER ROOT CAUSE ANALYSIS?

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Overview

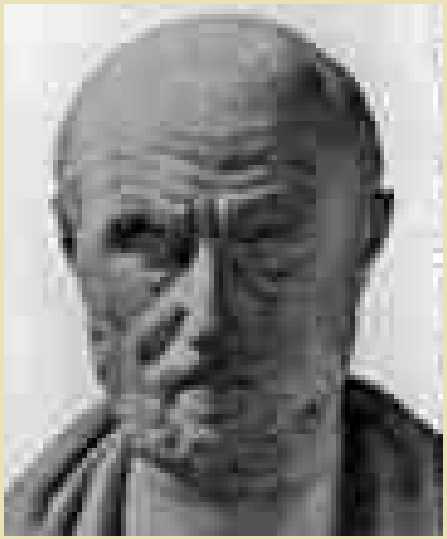
- **History & Human Errors**
- **Adverse Events**
- **Near Miss Reporting**
- **Incident Reporting**
- **Root Cause Analysis (RCA)**
- **Process Improvement**
- **Conclusions**

History

'As to diseases, make a habit of two things – to help, or

at least to do no harm'

Hippocrates (470-410BC)



Pioneers in Health Safety

- UK
  - Prof James Reason
- USA:
  - Prof Lucien Leape
  - Dr Don Berwick
  - Dr Bob Helmreich
- Australia
  - Prof Bill Runciman
  - Dr Ross Wilson
  - Dr Alan Wolff

Human Errors

- "..an absolutely basic tenet…that *all* human beings, without any exception whatsoever, make errors and that such errors are a completely normal and necessary part of human cognitive function."
  - Allnutt, M. 1987

Human Errors

- '…it is an ironical fact that keeping harmed patients and their relatives uninformed about an error mitigates powerfully towards their seeking legal redress."
  - Williamson, J. 2002

Adverse Events

- Main drivers for RCA:
  - Staff
  - Patient
  - Community
  - Legislative/Management Requirements
- Opportunities for learning, investigation and improvement.

Near Miss Reporting

- A step down from an adverse event
- Should always ‘focus the mind’
- Rich ground for analysis but is ‘too close for comfort’
- Aim to increase reporting but decrease number of events

Incident Reporting

- Most rewarding area for study
  - Blocks near misses and adverse events
  - Backbone of Safety Culture
- Most rewarding for staff
  - Proactive
  - Team building
- Most difficult to manage
  - Data capture & analysis
  - Realistic and achievable outcomes

Root Cause Analysis

- Goal:
  - What happened?
  - Why did it happen?
  - What to do to prevent it happening again?
- RCA is:
  - a TOOL for identifying prevention strategies
  - a PROCESS to build a culture of safety
  - BUT it is always RETROSPECTIVE

Root Cause Analysis

- Trendy
- Rigorous
- Expensive
- Potentially harmonizing
- Not an end in itself
- Often the easiest part of the Quality Cycle

Golden Rules

- A good RCA is expensive - a bad RCA is very, very expensive!
- Not all ‘experts’ are!
- A RCA will always generate casualties - it can never be a ‘win-win’ situation
  - Either an ‘Act of God’ or People!

Process Improvement

- Prerequisites:
  - Culture
  - Commitment
  - Resources
  - Skills
  - Tenacity

Culture

- "We - the nursing and other staff - we got sent away to do a lot of courses on risk management and incident reporting and we spent a lot of time away at these courses, but in reality it wasn't happening in our hospital."
  - Bundaberg Hospital - *Commission of Inquiry 2005*

Culture

- Resistance to Clinical Pathways
  - 25 European Union countries
    - Hindle & Yazbeck, 2005
- Breakdown in trust between clinicians and management.

Commitment

- Commissioner: “I would be delighted to hear how many more meetings were attended, how many more memos went back and forth, how many more conferences there were, how many telephone conversations took place before anyone actually did anything.”
  - Bundaberg Hospital - *Commission of Inquiry 2005*

Commitment

- "When I filled in a sentinel event form for …it was downgraded from a sentinel event form to a less serious form and we didn't hear anything about it."
- "…if we see something that is wrong we should report it, but often these incident reports would disappear into a black hole.."
  - Bundaberg Hospital - *Commission of Inquiry 2005*

Resources

- “Peter, you have to understand that this is a business. It’s not a hospital!”
- “Funding used as a threat: Dr Patel had brought in over $500,000 to the hospital by performing elective surgery locally.”
  - Bundaberg Hospital - *Commission of Inquiry 2005*

Skills

- Poor understanding of process
- Wrong Problem
  - ‘Personality problems in the ICU’
- Wrong Recommendation
  - ‘This is a matter that needs mediation’

Skills

- Training in Human Factors
- Graded skill levels across staff
- Willingness to invite ‘external’ scrutiny
- Nurture ‘naturals’
- Beware of ‘experts’
- Reward and recognise self-starting individuals and groups

Tenacity

- RAAF F-111 Deseal/Reseal Inquiry
  - Clarkson, Hopkins & Taylor 2001
- RAAF Safe/Army Safe/Navy Safe Programs
- Defence Occupational Health & Safety Committee
- ‘Hopkins Review’ 2004

Tenacity

- ATSB: Classification of Responses
  - Closed - Accepted
  - Closed - Partially Accepted
  - Closed - Not Accepted
  - Monitor
  - Open
  - No Response

Tenacity

- PDCA Cycle:
  - Plan
  - Do
  - Check
  - Act

Conclusions

- RCA can be a very powerful tool if, and only if, all levels of the organisation are committed to process improvement and can agree on the goals.
- The Australian health sector has come a long way but it still lags well behind the aviation industry.
- Our attitudes and actions will shape the future of patient safety.

THE MESSAGE

Conduct the RCA in a professional manner that hides nothing, determines the truth and makes appropriate recommendations that

Prevent future incidents or events.