Liberty QualityCare®

Tools and Techniques for facilitating RCA:

Sequence Analysis

Flowcharting

Brainstorming

Common Cause and Effect Factors

Ishikawa "Fishbone" Diagram

Performances Improvement Plan

Effectiveness of Actions Plan

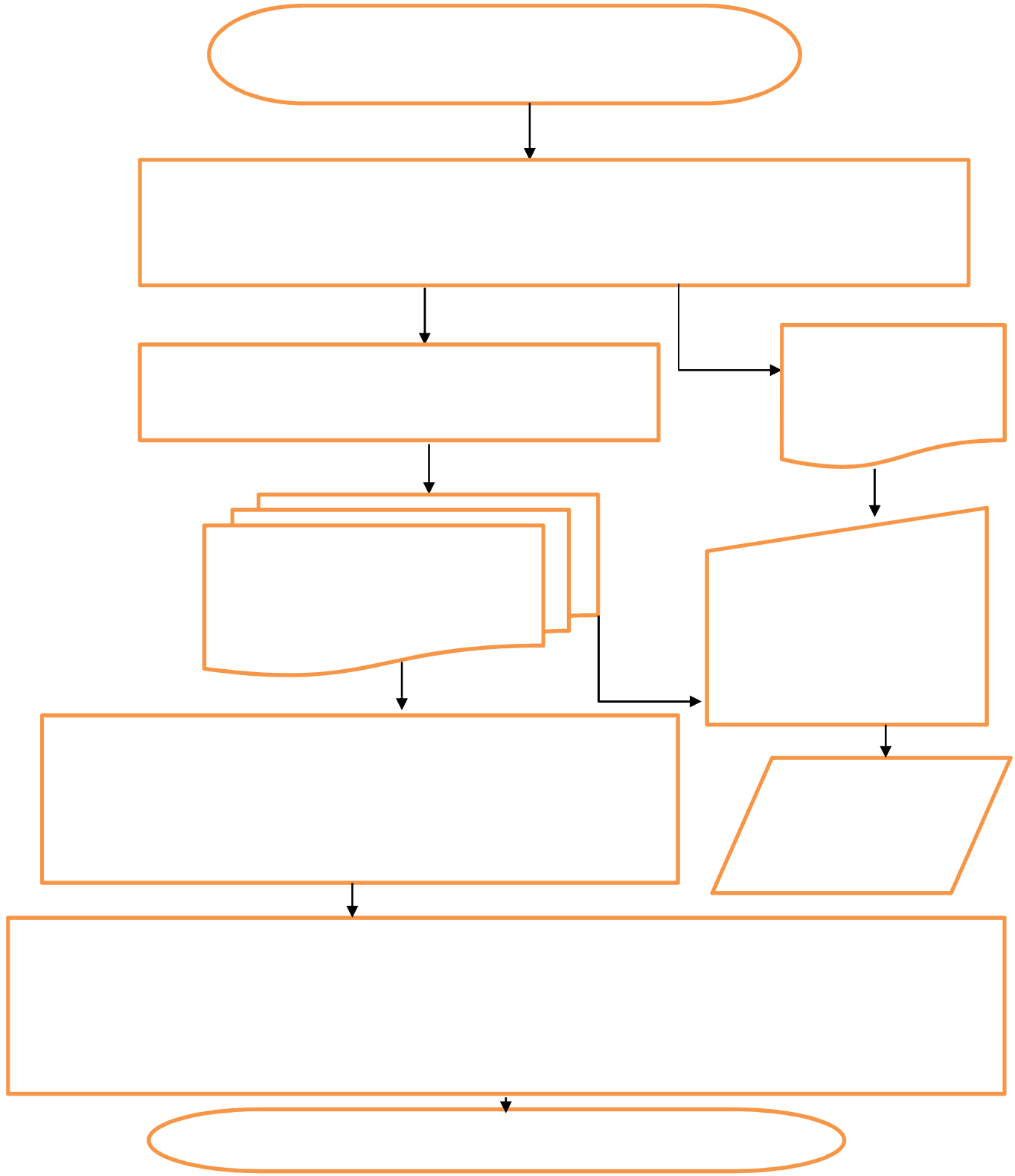
Sequence Analysis Form

This form will identify the sequence of events in order for the flowcharting to be completed – best done in advance of the first RCA meeting

RCA is a structured analytic process that requires careful and exacting review of events, process and activities that are associated with the incident/significant event. In order to be prepared for the flowcharting step, it is important not to make assumptions and an RCA is often very different than what "should" have happened. This step is important prior to the formal flowcharting since it will provide the "raw" information that the RCA team will need to create a flow of what actually happened. List below in chronological order, what took place from the beginning of the event until the end of the incident/significant event:

Date	Time	Who	People, Methods (Leadership, assessment planning) , Equipment, Documents

Flowcharting Form



BRAINSTORMING STEPS

The RULES FOR BRAINSTORMING:

1. For purposes of the group session all members are of equal rank
2. The RCA leader and RCA team scribe are selected and do not participate in idea generation, clarification or evaluation. The **recorder will use the blank ISHIKAWA (Fishbone) diagram to record the ideas generated**.
3. Do not criticize by word or gesture any idea
4. Only one idea at a time may be shared by a participant
5. No individual should be permitted to dominate the group
6. Leader should encourage everyone to participate at each stage
7. Leader must make it clear that there are no "dumb", "stupid", or insignificant ideas and that barriers both physical and process should be also be identified
8. People can pass when it's their turn, but can add ideas on later turns.
9. Freewheeling unrelated ideas are OK and encouraged.
10. When everyone passes on a complete turn, the brainstorming session is over.
11. An idea list is created by the team scribe and placed under the correct cause/effect heading : People, Documents, Methods, Equipment and each should be coded: CE=Caused Event; PC= Proximal Cause to Event; CF=Contributory Factor of Event; PF = Possible Contributory Factor of Event; NF= Non-contributory Factor to Event
12. The idea list (ISHIKAWA (Fishbone) Diagram is turned over to the leader. Both the Flow Chart and the ISHIKAWA (Fishbone) Diagram are utilized to complete the Framework for a Root Cause Analysis and Action Plan form.

SOMETIMES THE MOST UNLIKELY IDEA TURNS OUT TO BE THE SOLUTION

COMMON CAUSE and EFFECT FACTORS:

People Factors:

- ☐ Workload: Staff levels were not adequate to carry out the assigned duties within timelines
- ☐ Awareness: Staff was not aware of what tasks they needed to do and when to do them
- ☐ Supervision: Staff was not provided with consistent supervision
- ☐ Competency Evaluation: Pre-Hire competency did not reflect necessary experience
- ☐ Staff did not have supportive relationships with peers
- ☐ Prioritization for staff tasks was not consistent with Liberty expectations
- ☐ Staff did not have a positive and supportive relationship with the patient/individual
- ☐ Patients/individuals we serve/residents/clients/releasee's did not adhere to treatment
- ☐ The medical /health status of the individual was complex and required closer monitoring
- ☐ Patient/individuals we serve/residents/client/releasee required the presence of supervision
- ☐ Patient/individuals we serve/residents/client/releasee was placed in a unique situation

Document Factors:

- ☐ There was no formal written Liberty policy or procedure to govern the event
- ☐ Staff was not able to reference Liberty policy, guidelines forms
- ☐ Functional Assessments including Risk Assessments were not present
- ☐ Physical Assessments including contraband search was not present
- ☐ Inadequate care planning
- ☐ Inadequate policy requirements for training of Liberty employed and subcontracted staff
- ☐ Inadequate policy requirements for patient/individual/resident/client/releasee funds
- ☐ Inadequate distribution process for new Liberty policies

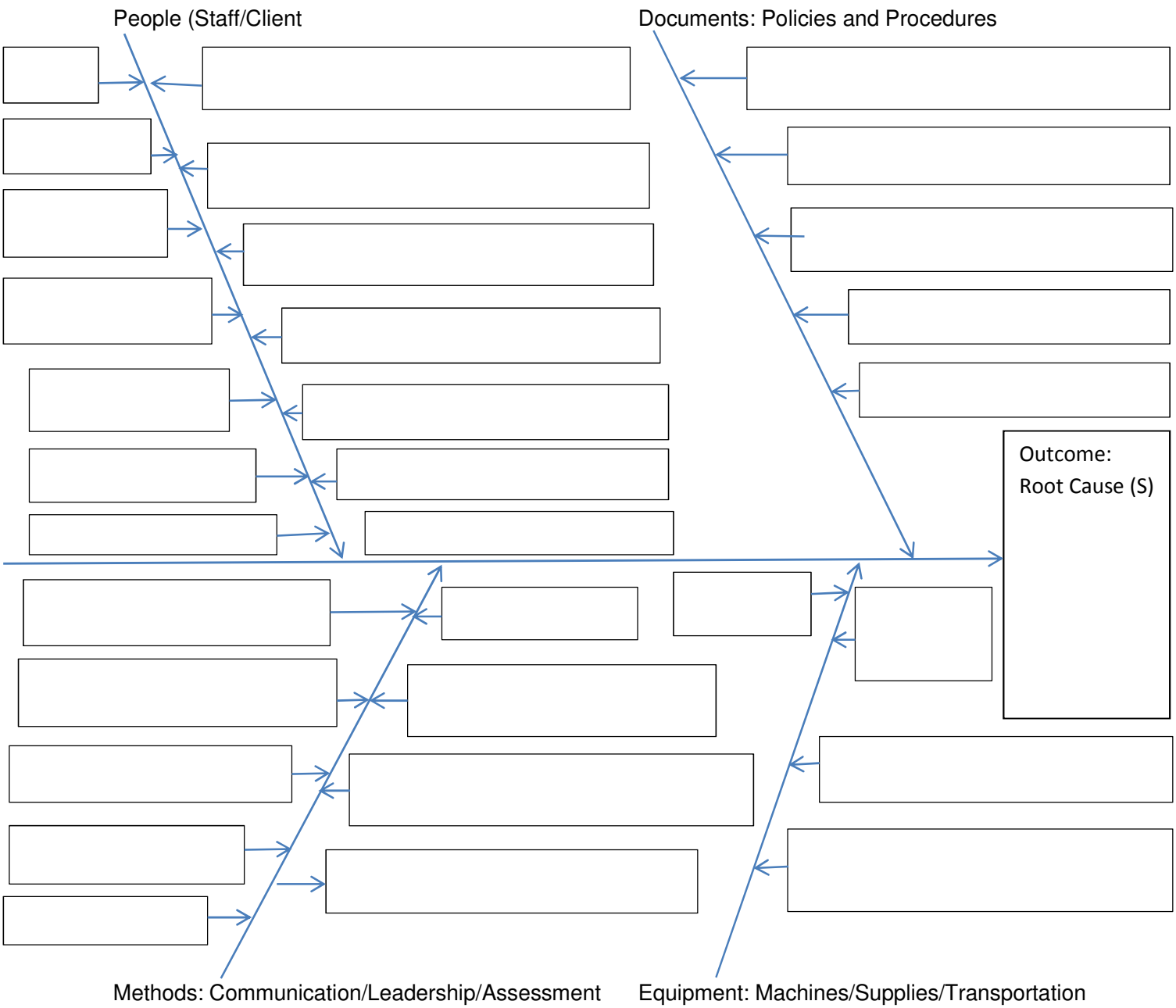
Equipment Factors:

- ☐ Delay with established transportation
- ☐ Adaptive Equipment not available
- ☐ Poor Labeling or Instructions with equipment
- ☐ Equipment was not used as intended
- ☐ Equipment had defects or not assembled properly
- ☐ Potency of medication was compromised by exceeded expiration date
- ☐ Medication was poorly labeled, confusing labeling or packaging similar to other medication

Method Factors: Assessment, Planning, Environment, Leadership, Communication

- ☐ Safety Standards/Codes were not met
- ☐ Emergency plans not visible of inadequate for the particular incident/significant event
- ☐ The environment was noisy with distractions
- ☐ The program/service had a culture that did not emphasize safety
- ☐ The program/service did not support quality improvement initiatives
- ☐ The program/service had an atmosphere of negative consequences from investigations
- ☐ The program/service care planning process did not include vital components
- ☐ Staff was confused about the chain of command and who was responsible for what
- ☐ Staff did not have good communication with the patient/individual we serve/client/resident
- ☐ Staff did not adequately communicate with each other
- ☐ Staff did not adequately communicate with families
- ☐ Staff's accesses to information was inadequate, confusing or difficult to locate
- ☐ Staff had inadequate information technology support

The Ishikawa ("Fishbone") Cause and Effect Diagram



A FRAMEWORK FOR A ROOT CAUSE ANALYSIS FOLLOWING A SENTINEL EVENT

Level of Analysis	Questions	Findings	Root Cause?	Ask Why?	Take Action?
	What are the details of the Event?		☐	☐	☐
What Happened?	When Did the Event Occur (Date, Day of Week, Time)		☐	☐	☐
	What area /service were impacted?		☐	☐	☐
The process or activity in which the event occurred	What are the steps in the process, as designed?	Refer to the Flowchart which was the process that DID occur	☐	☐	☐
Why did it happen?	What steps were involved in (contributed to) the event?		☐	☐	☐
People	What Human Factors were relevant to the outcome?		☐	☐	☐
Equipment	How did equipment performance affect the outcome?		☐	☐	☐
Method	What Environmental factors directly affected the outcome?		☐	☐	☐
	To what degree is the culture conducive to risk identification and prevention?		☐	☐	☐

A FRAMEWORK FOR A ROOT CAUSE ANALYSIS AND FOLLOWING A SENTINEL EVENT

Level of Analysis	Questions	Findings	Root Cause?	Ask Why?	Take Action?
Documents	What are the Policy and Procedure barriers to communication of potential risks?				
Controllable factors	To What degree is the prevention of adverse outcomes communicated as a high priority? How?				
	What systems are in place to identify environmental risk?				
	What emergency and failure-mode responses have been planned and tested?				
Uncontrollable Factors	What factors are truly beyond the program/service's control?				
	What can be done to protect against the effects of these uncontrollable factors?				

A FRAMEWORK FOR A PERFORMANCE IMPROVEMENT PLAN

Rank	Risk Strategy/Action steps	Estimated Cost	Additional considerations for implementation	Owner of Action Steps	Date to implement

Signature of RCA Team Leader

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Date the Performance Improvement Plan was approved

A FRAMEWORK FOR A MEASURING THE EFFECTIVENESS OF ACTIONS

Rank	Data Elements use to measure effectiveness of each risk strategy/action	Outcomes of each measurement	Owner of measurement	Date of completion
1				
2				
3				

Recommendations/ Additional Strategies/Action Steps:

Signature of RCA Leader

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Date of Effectiveness of Action Plan Approved