Liberty Healthcare Corporation
Liberty QualityCare®
Standard Operating Policies- Root Cause Analysis

Title:	**Root Cause Analysis**	**Effective Date:**	**10/03/2013**
Author:	**Robin Burkert, LSW**	**Last Review Date:**	**12/10/2021**
Location:	**All Locations**	**Last Revision Date:**	**04/06/2020**
Functional Area:	**Administration**		

POLICY

Root Cause Analysis (RCA) is a tool utilized by Liberty managers as part of the ongoing performance process. When Liberty managers decide to utilize RCA, the Vice President, Performance and Quality (VPQ), notifies the Executive Officers when the RCA is initiated and when it is completed.

RCA represents a structured approach to the investigation and analysis of significant adverse events or system deficiencies that require improvement. Liberty encourages the use of RCA as an analytic process designed to help identify factors that have contributed to or have directly caused a major adverse event or systems failure. Liberty expects that the results of an RCA will be utilized to guide and direct changes to processes, the environment, and human behavior or reduce the probability that the adverse event will occur in the future. Liberty recommends initiating this process of discovery in an attempt to find out exactly WHAT happened, WHY it happened, and HOW it can be prevented from happening again.

The goal of RCA is prevention, with the focus on understanding, not on *blame.* Driven by standards established in the health care industry, Liberty has given increased attention to RCA since we agree with the basic premise that errors and failures are the result of flaws in the system, not simply the action or inaction of people. Consequently, unlike the traditional process of investigation, Liberty supports the use of RCA and our investigations should not focus on finding out *who* made the mistake, but rather *why* the mistake was made. Liberty encourages its Leadership to have an emphasis on the factors that directed or allowed a person or persons to make the mistake in the first place.

PROCEDURE

THE RESPONSIBLE PARTY TO INITIATE AN RCA:

1. Although any Liberty staff can recommend an RCA, the Program Director, the designated on-site Administrative Manager or, if no Program Director or Manager exists, the Contract Manager authorizes the RCA project.

WHEN TO USE THE RCA:

Liberty understands that an RCA is a demanding process that requires a commitment of time and energy and therefore the integrity of the RCA process can only be maintained when there is an investment of time and resources. Since RCA is a very structured process that requires users to go through a series of step – by – step activities, Liberty recommends selecting events for RCA if any one (1) of the following established criteria are met:
The cause of a MAJOR system failure is not evident

1. There is significant risk to Liberty if a problem is not corrected
2. There are repeated failures that are ascribed to Human Error
3. There is a Sentinel Event that results in death or serious injury
4. There are a series of incidents that could result in death or serious injury.

STEPS FOR CONDUCTING AN RCA:

A. CLARIFY THE ISSUE:

1. An RCA should be conducted one incident or adverse event at a time. If there are multiple incidents of the same type, it is usually best to complete each RCA separately and then integrate the findings.
2. Make sure that there is a clear understanding of the facts surrounding the incident or adverse event.
3. Inquire with those that might have information and think outside the box but be aware of emotions that might alter perceptions of the incident or adverse event.
4. Gather documentation that may be relevant and take note of any personal observations that will contribute to understanding the incident or adverse event.
5. Set aside a time and place to talk with people privately to be clear about explaining the purpose of an RCA, what will happen during this process and what will be done with any information that is given.

B. ASSEMBLE THE REVIEW TEAM: MEMBERSHIP SHOULD BE FORMALLY APPOINTED OR ASSIGNED BY A SENIOR LEADER AT LIBERTY AND REFLECT INDIVIDUALS WITH KNOWLEDGE OF THE INCIDENT/ADVERSE EVENT AND ANY POLICY OR PRACTICE REQUIREMENTS ASSOCIATED WITH THE TYPE OF SERVICE OR ACTIVITY INVOLVED IN THE INCIDENT/ADVERSE EVENT – MOST TEAMS WILL INCLUDE FIVE (5) TO SEVEN (7) INDIVIDUALS

1. When possible, a Performance or Risk Management staff will be assigned to the RCA.
2. Additional members should include a management or supervisory representative responsible for the Liberty program or service in which the incident or adverse event occurred.
3. The Liberty program or service investigator OR the person most familiar with any investigation that has been completed.
4. A content expert with knowledge of best practices.
5. One (1) or two (2) persons who were directly involved in the incident.

C. ASSIGN ROLES AND RESPONSIBILITIES

1. At a minimum, the roles of Team Leader and note-taker need to be assigned.
2. The above leadership group will be responsible for work in-between formal meetings and should be prepared to commit at least three (3) to five (5) hours beyond the time directly spent in meetings.
3. The other RCA members can be assigned to assist with collection and organization of other data and information that will be utilized during the RCA.

D. COLLECT INFORMATION

1. The RCA team leadership should identify important and relevant documents and information that will be needed by the RCA team. This information will vary based upon the type of incident/adverse event under RCA review but could include yet are not limited to: Standard Operating Procedures, Autopsy Report, Interviews, clinical record, etc. Listing the sequence of events in chronological order is important prior to the first RCA Meeting and this information should be brought to the first RCA Meeting to facilitate the creation of a flowchart. Formal literature searches and reviews are very helpful to gain an increased awareness of systems available across the country. In addition, call colleagues in other states to gather ideas that can be shared with the RCA team members. All information should be shared with the full RCA team. The RCA Team can use this additional information to think about approaches to solving the factors or clusters of factors that will identified in the RCA.

E. INITIATE ROOT CAUSE ANALYSIS (RCA)

1. Schedule and organize the RCA meetings – usually it will require two (2) to three (3) RCA meetings - allow for adequate notice and select a location that has sufficient space without distractions. Include any visual representation equipment you will need, i.e. larger maker board, Flip charts, PowerPoint for slides, etc.
2. Explain the RCA Process at the first full meeting of the RCA team – use PowerPoint slides or other visual handouts stressing the goal of prevention as a key focus of any RCA.
3. Review the incident/adverse event and include all of the collected information.
4. Create a flowchart of exactly what happened using the sequence analysis form as a guide – Make notes on the flowchart to identify any deviations from what standard or best practice suggests.

5. The designated RCA team leader initiates the brainstorming session following the established rules and the RCA team scribe records all of the factors identified by the individual team members and records the findings on an Ishikawa (Fishbone) Diagram under the appropriate heading: People, Documents, Method, Equipment.
6. The RCA team members and the RCA team scribe will review the "Fishbone" Diagram and using the above-mentioned categories, will cluster factors within each category in order to "drill down" common factors before the team voting for causes begins.
7. The RCA Team will now begin the voting process for the causes or the most fundamental reasons that led to the error. Each of the factors or cluster of factors are voted on by all of the RCA Team members and RCA Team members can vote multiple times on those factors they believe led to the error.
8. The RCA team scribe records the number of votes next to each factor or cluster of factors – i.e. (10).
9. The three (3) factors OR cluster of factors with the highest RCA team scores will be identified as the Root Causes on the Ishikawa (Fishbone) Diagram.
10. The RCA Team will begin to create a Performance Improvement Plan by identifying solutions to the Root Causes identified.
11. For each solution, the RCA Team will discuss effectiveness, feasibility, estimated costs and any special considerations that this solution could pose when implemented.
12. In addition to the RCA Leader, each solution must have an identified owner which is recorded by name with a specific month, day and year that this solution will be implemented.
13. The RCA Team must then identify specific strategies that will measure the effectiveness of each identified solution with identified owners recorded by name to measure effectiveness and with specific month, day, year of data analysis.
14. The RCA Team leader and RCA team scribe will prepare a DRAFT Performance Improvement Plan and distribute this plan to all RCA Team members with a specific deadline for additional comments. Be sure to be prepared to provide rationale for the RCA Team findings and be prepared for any objections or issues with Liberty leadership when they review the plan.
15. Report findings and the Performance Improvement Plan to Liberty's appropriate Contract Manager and the VPP/CCPO.
16. The RCA Team leader will make the necessary revisions and work with the RCA team scribe to prepare a final Performance Improvement Plan.
17. The RCA Team leader will sign the approved Performance Improvement Plan and record the date and send a copy to the appropriate Contract Manager and the Vice President, Performance/Corporate Compliance/Privacy Officer.

**Note: The Vice President of Performance and Quality, Robin Burkert is available to assist with doing the Root Cause Analysis which can facilitate training in this process. Robin can be contacted at robin.burkert@libertyhealth.com or 610-668-8800 Extension #121.

Approved by: Robin Burkert Digitally signed by Robin Burkert Date: 2022.02.02 08:03:12 -05'00' _____

Revision History

Version	Date	Author	Summary of Changes
#1	10/03/2013	Judith Ann Shields	Policy created
#2	04/06/2020	Judith Ann Shields	Annual review, no changes made
#3	12/10/2021	Robin Burkert	Annual review, no changes made