RCA² FAQs and Recommended Resources

Frequently asked questions about the processes and recommendations presented in the 2015 publication *RCA2: Improving Root Cause Analyses and Actions to Prevent Harm*.

Q. What does the RCA² team do?

A. The RCA² team should be officially charged by leadership (preferably the CEO, COO, or CMO) with investigating the adverse event to discover underlying system issues that contributed to or resulted in the event occurring. The work associated with the RCA² process should not be considered "additional duties as assigned"; team members should be given time during their normal work schedule to complete their assignments. Team members who are given time to do the work but do not complete it should be held accountable by leadership as they would if their regular assignments/duties were not being completed.

Q. Who do you consider to be the team members on an RCA2 team?

A. The RCA² team members are those who are assigned by the organization's leadership to officially serve on the team. These are the individuals who attend all of the meetings, conduct the research, interview staff, identify root cause contributing factors, and write the report. In most cases this team also identifies the corrective actions and their associated process/outcome measures, though in some organizations an individual or another team may complete this task.

Q. Why do you recommend that staff involved in the event not be a member of the RCA2 team?

A. When we use the term "member of the RCA² team" we are specifically referring to those individuals who have the ultimate decision-making authority regarding the final output of the RCA². Some people refer to these individuals as the voting members of the team. In order to understand what happened and why it happened, it is necessary to talk openly during the team meetings about the actions of those individuals immediately involved in the event. If those involved are part of this discussion, other team members may refrain from speaking up or may self-censor what they say in order to spare these individuals from further mental anguish or to avoid hurting their feelings.

In the RCA² publication we mention that those involved in the event may be overly harsh when judging their own actions and advocate for corrective actions that others do not think are necessary. Less likely is the possibility that those involved may steer the team from for looking deeply into an area that they feel will not reflect well on them individually. In the authors' opinion, these disadvantages outweigh the benefit of having the involved staff on team.

The involved staff can and should be interviewed, as it is very helpful to understand what actions they think should be implemented to prevent a recurrence of the event, but they should not be the ultimate

deciders of the official output of the RCA² team. This also minimizes possible criticisms that the output of the team was unduly influenced by an inherent conflict of interest. The involved staff also must be given feedback about the final action items that result from the process.

Q. Why do you recommend that patients involved in the event or their family not be members of the RCA² team?

A. As in the answer above, when we use the term "member of the RCA² team," we are specifically referring to those individuals who have the ultimate decision-making authority regarding the final output of the RCA². It is absolutely appropriate to interview the involved patient and/or the patient's family members in most cases. Patients and families can provide helpful information to the RCA² team as the team considers actions they think should be implemented to prevent a recurrence of the event.

Patients and families involved in the event should not be members of the team because, as is the case with staff involved, it is necessary to talk openly during team meetings. If anyone — patients, families, or staff — who was involved in the event participates in these discussions, other team members may refrain from speaking up or may self-censor what they say in order to spare these individuals from further mental anguish or to avoid hurting their feelings.

The thoughts and perceptions of patients and families should certainly be considered in the ultimate recommendations of the team. But including them as part of the RCA2 team would leave the team open to criticisms that the recommendations were unduly influenced by an inherent conflict of interest. Finally, the team should include a member who represents the patient and family voice (e.g., a patient representative) to bring that perspective to all the deliberations.

Q. It looks like implementing a risk-based prioritization system is going to increase the number of events that will require root cause analysis and action review. How do you recommend this be addressed?

A. Using a risk-based prioritization system and scoring each event to determine its actual and potential score (based on the most likely worst-case outcome for your specific organization), as described in the publication, may identify additional events requiring review. Prioritize the work based upon the score with the most severe actual events being reviewed first working toward the least severe potential events, as resources permit. It is highly recommended that an aggregated review program be established. This may be accomplished by prospectively identifying categories of frequently occurring potential SAC 3 events, sometimes called close calls, (e.g., falls, medication adverse events) and establishing a system to collect basic data as they occur, which will be needed to review them.

Q. How do I get leadership involved in the RCA2 process?

A. With the RCA² guidelines, it is essential that the Board and CEO are fully engaged in and supportive of the investigation and improvement process. It is the responsibility of the senior risk and safety leadership to inform and educate executives about the importance of the RCA² process and to illustrate how the process can lead to organization-wide improvements to safety. It is essential to emphasize the future risk

mitigation that can result from a robust process. Presenting a "business case" for safety can also be a useful tool. One strategy to promote leadership engagement is bringing root cause analysis cases and action items to the highest level quality committee meetings as well as to board meetings, so leaders can truly understand the types of events occurring and the importance of a robust RCA² process.

Q. What are some additional resources that support the RCA² process?

A. The following provide additional information and recommendations that are complimentary to the RCA² publication:

Diller T, Helmrich G, Dunning S, Cox S, Buchanan A, Shappell S. The human factors analysis classification system (HFACS) applied to health care. *American Journal of Medical Quality*. 2013 June 27. doi: 10.1177/1062860613491623.

Etchegaray JM, Ottosen MJ, Burress L, Sage WM, Bell SK, Gallagher TH, Thomas EJ. Structuring patient and family involvement in medical error event disclosure and analysis. *Health Affairs*. 2014;33(1):46-52.

Etchegaray JM, Ottosen MJ, Aigbe A, Sedlock E, Sage WM, Bell SK, Gallagher TH, Thomas EJ. Patients as partners in learning from unexpected events. *Health Services Research*. 2016 Oct 24 [Epub ahead of print].

Hettinger Z, Fairbanks RJ, Hedge F, Rackoff AS, Wreathall J, Lewis VL, Bisante AM, Wears RL. An evidence-based toolkit for the development of effective and sustainable root cause analysis system safety solutions. *American Society for Healthcare Risk Management*. 2013; 33(2):11-20. doi: 10.1002/jhrm.21122

Kellogg MK, Hettinger Z, Shah M, Wears RL, Sellers CR, Squires M, Fairbanks RJ. Our current approach to root cause analysis: is it contributing to our failure to improve patient safety? *BMJ Quality & Safety*. [Published online first: Dec. 9, 2016. http://qualitysafety.bmj.com/content/early/2017/02/02/bmjqs-2016-005991 . doi: 10.1136/bmjqs-2016-005991]

Ottosen MJ, Sedlock EW, Aigbe AO, Etchegaray JM, Bell SK, Gallagher TH, Thomas EJ. (2016). Developing the Improving Post-event Analysis and Communication Together (IMPACT) tool to involve patients and families in post-event analysis. *Journal of Nursing & Interprofessional Leadership in Quality & Safety*. 2016;1(1).

Spiess B, Rotruck J, McCarthy H, Suarez-Wincosci O, Kasirajan V, Wahr J, Shappell S. Human factors analysis of a near-miss event: oxygen supply failure during cardiopulmonary bypass. *Journal of Cardiothoracic and Vascular Anesthesia*. 2015;29(1):204-209.

Zimmerman TM, Amori G. Including patients in root cause and system failure analysis: legal and psychological implications. *Journal of Healthcare Risk Management*. 2007;27(2):27-34. doi: 10.1002/jhrm.21122