

RCA TEMPLATES AND PROCESS

2023

Agenda

- PSWP protecting the work product
- Introductions/Attendance
- Defining the Goals
- Setting Agenda
- Action planning

PATIENT SAFETY WORK PRODUCT (PSWP)

"Portions of the discussions or data presented at this meeting will be Patient Safety Work Product, and will be submitted to our Patient Safety Organization, ECRI Institute, as outlined in our Patient Safety Evaluation System. Please maintain the confidentiality and privilege afforded by the Patient Safety and Quality Improvement Act, by returning or shredding handouts at the end of he meeting and not sharing such information outside appropriate settings within our organization."

Lessons learned from this meeting may be shared within the organization. Please don't use peoples' names, just use general terms.



ROLL CALL

Name	Role	Department/Title
		Patient Safety
		Risk Management
		System Quality
		Nursing Quality
		Front line -
		Front line -
		Frontline –
		Frontline -
		Executive Sponsor/s (Optional)
		Nursing Education
		Others



PROBLEM STATEMENTS

1) Issue and timeframe and location (don't place blame or solution generate)

- Problem statements promote broad thinking about all the factors and opportunities for improvement
- Focus on outlining gaps in performance: "Variation in the process causes inefficiencies and delays"



GOALS AND DESIRED OUTCOME OF MEETING

- Finding the right root cause
- Building consensus on contributing factors
- Developing high reliability action planning
 - Feasible Is it possible?
 - Doable Can it be done? By Whom? In what time frame?
 - Short and long term What can be fixed now, what needs development?

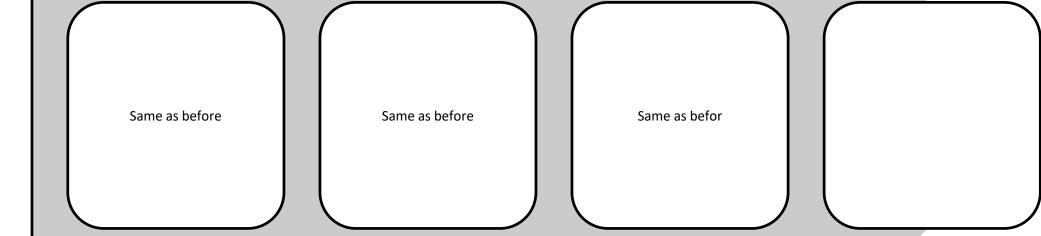


FOCUSED TIMELINE – CONDENSE DOWN FROM

Date

- Visual Timeline
- Vitals
- Nursing Notes
- Interview insights
- Medications
- Orders
- MD notes
- Ancillary notes
- Interventions
- Procedures/Surgeries
- Codes
- •Lines/Tubes/Drains, Nursing Flowsheets

DETAILED VERSION





5 WHY'S OF ROOT CAUSE -EXAMPLE

The 5- Why's

A question asking method to
uncover the underlying cause of an
event. Uncovering the root causes
leads to action plans that are more
likely to prevent the event from
happening again.



ACTION PLANNING

Problem Statements:

1) Restate them here

Action ideas	Who	Does what	By when	How monitor effectiveness

OPPORTUNITIES OR GAPS

Analysis Question based on investigations

• Trigger examples from investigation/findings

More analysis questions

More analysis questions



Safety Event Title:			
RL Events #:	Lead Facilitator:	Executive Sponsor:	
Event Date:	Date of		
	Analysis	Event Location:	
	Meeting:		
Patient Names			
Problem Statement:			
Analysis and Action Planning Team:			

Results of analysis and action planning

Root Cause	Contributing Factors	Action	Responsible Person	Due date	Measurement of Effectiveness

CONFIDENTIAL PATIENT SAFETY WORK PRODUCT.: Protected under the Patient Safety and Quality Improvement Act (42 CFR § 3). This information is for University of Utah Health Care Peer, Patient Safety or Care Review committees to evaluate and improve health care and patient safety pursuant to Utah Code Ann. Section §26-25-1 et seq. and Utah Code Ann. §58-13-(4)&(5) and is NOT PART of the medical record. It is also classified as "protected" under the Government Records Access and Management Act, Utah Code Ann. §63G-2-101 et seq.

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CONCLUSION

- Wrap up
- Questions
- Gratitude
- Next Steps

