RCA TEMPLATES AND PROCESS

2023

Agenda

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

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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"

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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 DETAILED VERSION

Date

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

Same as before

Same as before

Same as befor

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:"

Action:

Action:

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	More analysis questions	More analysis questions
• Trigger examples from investigation/findings		

Safety Event Title:					
RL Events #:		Lead Facilitator:		Executive Sponsor:	
Event Date:		Date of Analysis Meeting:		Event Location:	
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

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CONCLUSION

- Wrap up
- Questions
- Gratitude
- Next Steps