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Root Cause Analysis- not a whodunnit!

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There's been an incident and you have to do a Root Cause Analysis…

Does your heart sink?

Do you know where to start?

Do you feel over whelmed?

Do you wish you'd had some training?

Do you just not get it?

If so, please stay where you are and together we will make this less daunting and more manageable

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RCA – so what is it?

So its easy, right? You just…

- Decide what's the problem?
- Assemble as much data and input as possible
- Locate the causes
- Find solutions
- Create actionable strategies for the changes you seek
- Give yourself time to see if the changes take hold

But in reality its not that easy…. Yet!

Let's take a step back and start at the beginning

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Why investigate and incident and do an RCA?

It's a requirement under the "managing safety incidents in the NHS screening programmes" guidance

It's important as part of an open culture, the public rightly expects NHS screening to be high quality and safe

It supports staff, it aids learning and service improvement

if screening is not up to standard, it can harm individuals and do more harm than good for the population

NHS screening typically involves multiple clinical teams and organisations – screening incidents often affect the whole screening pathway so it all needs to be reviewed

We want to prevent the same incidents happening across the country

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Step by step

Example review

Breakdown of incident and process

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Step by step part 2

- Form the team
- Draw up the timeline
- Gather the background information
- Review the documentation
- Note patient compliance
- Record contributing factors
- Complete the RCA
- Draw up some recommendations

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No blame or punishment – support and learning

Don’t play the blame game – if you think the cause was human factors or fault, ask yourself these 2 questions:-

1. Were the actions intended?
2. Were the consequences intended?

If you can say yes, then you are looking at sabotage, malevolent intent and fault.

Most people come to work wanting to do a good job, to do the right thing and to help the people we screen and work with.

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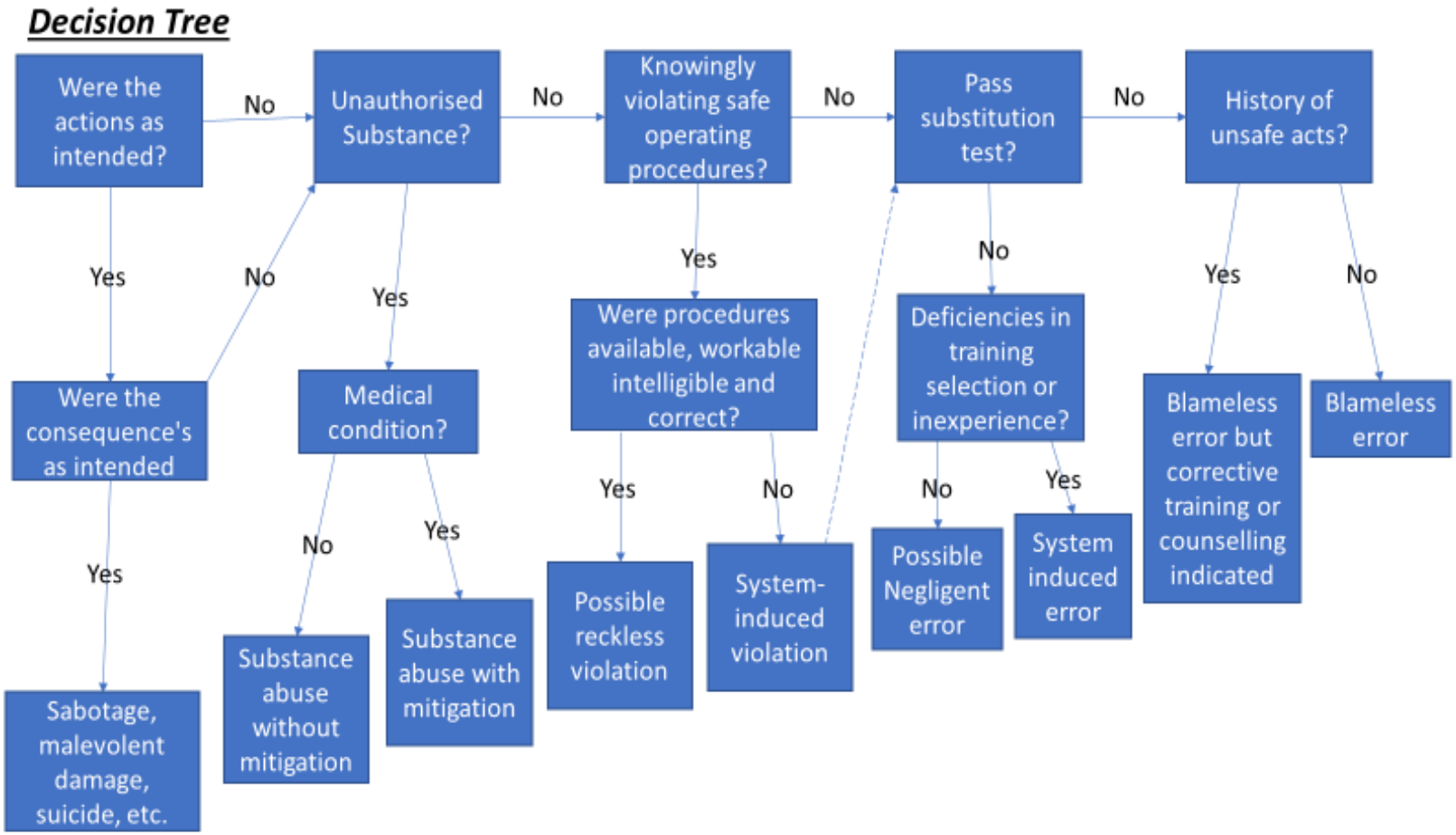
Help to avoid the blame game



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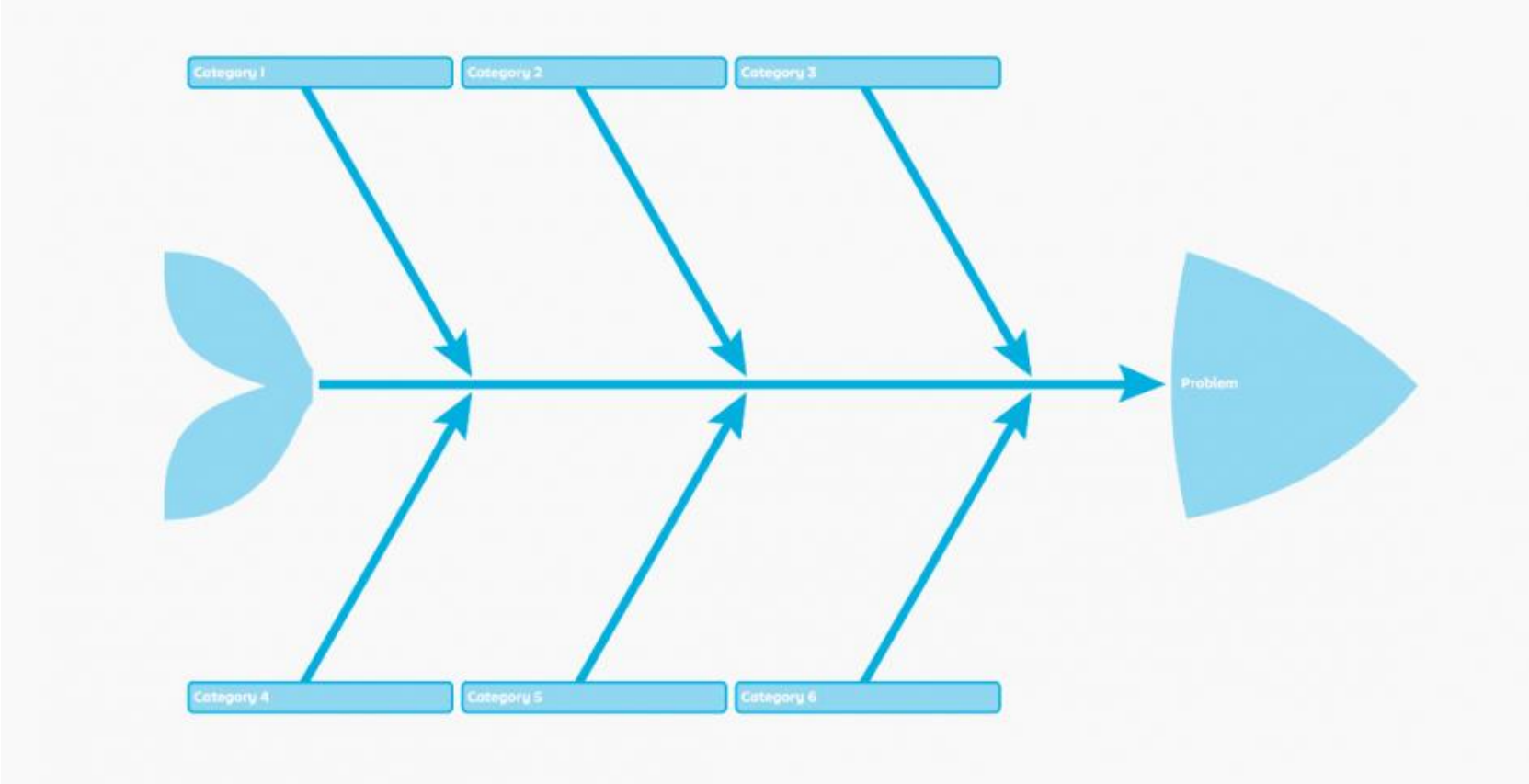
Tool to help to break down the incident



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Time to give it a go for some DES incidents

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RASCI – template for local adaptation

	Key stakeholders									
	Lead provider	Other providers involved	Responsible PHE Screening and Immunisation team	Other PHE Screening and Immunisation team	SQAS (region/sub region)	Responsible commissioner CCG	Centre directors	Regulator (e.g. CQC, Monitor)	Local Authority	Other- please state:
Organisation name										
List agreed Functions for Oversight (RASCI)										
Closure										

RASCI Definitions
Responsible - (Doer) - The team assigned to do the work
Accountable - (Buck stops here) - The team making the final decision with ultimate ownership
Supporting - (Here to help) - who will give support in undertaking the quality assurance functions including ensuring there is timely reporting, investigation and learning and action plan implementation undertaken by the provider in response to the incident
Consulted - (In the Loop) - The team that must be consulted before a decision or action is taken
Informed - (For Your Information) - The team which must be informed that a decision or action has been taken

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SIMPLE ROOT CAUSE ANALYSIS REPORT

ISSUE DETAILS		ISSUE TO REPORT				POSSIBLE ROOT CAUSE			SUGGESTED SOLUTIONS				
DATE ISSUE REPORTED	ID / TITLE / NAME	DESCRIBE ISSUE	EXPLAIN SOURCE	RATE HOW CRITICAL		DESCRIBE CAUSE	PROBABILITY	DETAILS	DESCRIBE SOLUTION SOLUTION	LIST ANY RISKS		DESCRIBE MEASUREMENT OF SUCCESS SUCCESS	
				Rate how critical: Low, Medium, or High	*Justification*		*Rate probability: Low, Medium, or High*	*List testing for clarification*		*Rate likelihood of risks: Low, Medium, or High*	*Modification*	*Describe testing*	*Describe results*

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Take a ways

- Keep it simple
- Follow the steps
- Remember – no blame, just support and learning
- What caused the incident, what can we do to prevent it happening again and how have we put it right for anyone affected?