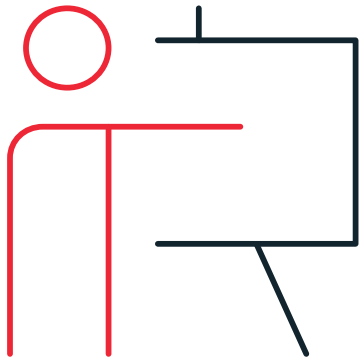
Root Cause Analysis in Aging Services – Improvement Recommendations

Jean Harpel, MSN, RN, GCNS, CPASRM – PSRQ
Aging Services Operations Manager, *ECRI*

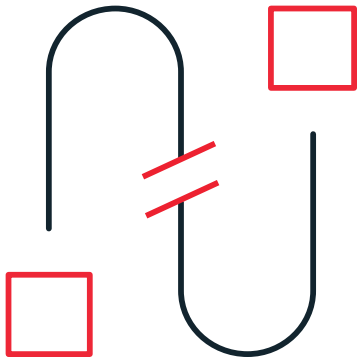
Victor Rose, MBA, NHA, FCPP, CPASRM –
Director of Aging Services, *ECRI*

RCAs in Aging Services | Learning Objectives



- To discuss best practices and processes for formulating a corrective action plan
- To develop corrective actions that are linked to identified root causes
- To develop immediate-, short-, and long-term actions
- To identify the strength of improvement actions

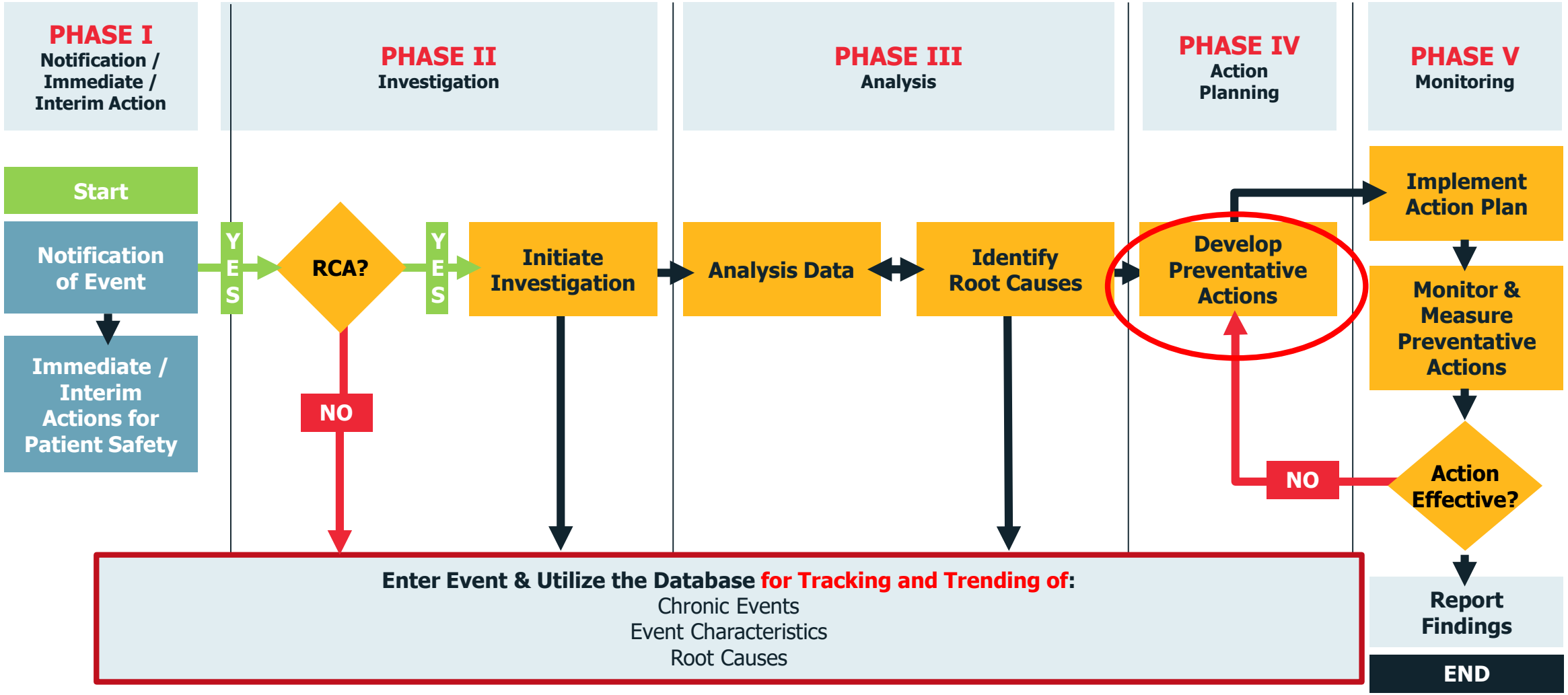
RCAs in Aging Services | Common Pitfalls



Common RCA Pitfalls Include…

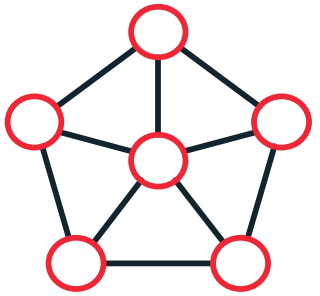
- Stopping short of root causes
- Not using a broad enough RCA Team
- Not including a timeline and sequence of events
- Bias
- Not clearly defining the problem
- Blaming actors instead of the system
- Ineffective Improvement Recommendations and/or Implementation
- Trying to Conduct an RCA for Every Incident

Event Investigation & Analysis Methodology



Systems Thinking

- Root causes identify systemic problems.
  - These causes go deep enough to reveal the system issues underneath the apparent causes.
  - Once root causes are known, they point to fixes at a systems level.
  - Fixes at the systems level can prevent recurrences.
- A thorough systems analysis is fruitless without effective improvement strategies.



Performance Improvement Actions

Improvement actions are the ultimate goal and most important step in performance improvement.

- Each action should:
  - Link to an identified root cause and potentially to contributing factor(s)
  - Achieve the desired performance improvement goals
  - Reduce the likelihood or prevent a recurrence of similar events

McGaffigan 2016

Key Features of Performance Improvement Actions:

- Address the risks associated with findings identified in the analysis
- Target the elimination of the root causes
- Use the most effective solution that is reasonable or possible given the circumstances
- Offer the long-term solution to the problem
- Target the actions at the right level of the system
- Assign responsibility at the appropriate level in the organization

McGaffigan 2016

Key Features of Effective Performance Improvement Actions

- S.M.A.R.T.E.R.
  - Specific—tackle a clearly defined issue, have a clear scope
  - Measurable—can show impact on process and outcomes
  - Attainable—achieved with available resources
  - Realistic—will be acceptable and implemented, practical and feasible
  - Timely—set a time frame for implementation and completion
  - Evaluate—are the actions doing what you intended
  - Re-do—if you are not achieving the desired effect

Minnesota Department of Health

Successful Performance Improvement Actions:

- Are based on conclusions from data collected during the RCA
- Clearly state the intended implementation strategy
- Address options for reducing the occurrence or frequency (prevention) and/or reducing the consequences (mitigation) of one or more causes
- Eliminate or control the known causal factors and the underlying root causes of the event
- Do not pose other unacceptable risks

McGaffigan 2016

Action Strength: Hierarchy of Improvement Recommendations

High

- The best at removing the dependence on the human to "get it right" (they are physical and permanent, rather than procedural and temporary)

Medium

- Reduce the reliance on the human to get it right, but do not fully control for human error

Low

- Support/clarify the process, but rely solely on the human; these actions do not necessarily prevent the event/cause from occurring

Strength of Action: Low-Impact

- Reeducate, training for individuals/staff
- Counseling staff: “Be more careful,” “Remember next time,” “Don’t forget that again”
- Implementing new policies, revising existing policies, new rules
- Sending an email
- Posting reminders or signs throughout the department
- Double checks

Strength of Action: Medium-Impact

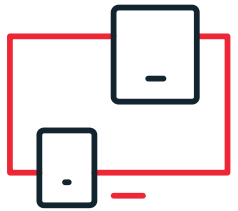
- Computerized warning messages/alarms on equipment
- Separate look-alike and sound-alike drugs
- Checklist
- Cognitive aids

- Reduce duplication
- Reduce variability
- What are some processes in your organization you could standardize?
- Reduce/eliminate distractions
- Increase detectability
- Read back

Strength of Action: High-Impact

- Computer hard stops—Reduce the potential for incorrect dosing of medications
- Security—Require badge swiping and passcode to enter facility
- Clinical alarms—Require manual response
- Dose-error reduction system—Require manual override with two electronic signatures for high-risk medication
- Physical plant changes—Safe rooms for suicidal patients, lock out medical gas valves

Performance Improvement Actions

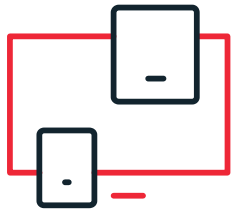


Problem #1: There was not a fall risk sign outside of the resident's room.

- **Root cause:** The policy was not developed or written with frontline staff input because policies are developed by a leadership practice committee that does not have frontline staff in its membership.

- **Actions:**
  - High: Add frontline staff to the policy committee membership to simplify the process.
  - Medium: Revise the policy with frontline staff input.
  - Low: During all upcoming staff meetings, remind staff of the proper location for placement of the fall risk sign.

Performance Improvement Actions



Problem #2: The grab bars on the wall were not secure.

- **Root cause**: Routine inspections and maintenance of grab bars were not performed because there is not a unified and integrated preventative maintenance inspection program.
- **Actions**:
  - High: Implement a software application program that tracks, schedules and assign routine preventative maintenance inspections.
  - Medium: Develop a policy and procedure for conducting preventative maintenance and safety inspections in residents rooms that is approved and supported by senior leadership, and approved through the risk management committee.
  - Low: Post signs to remind staff to report hazardous conditions involving broken or malfunctioning equipment.

Timing of Actions

- Immediate / short term
  - Implemented within a few minutes, hours, or days of the incident
- Interim /medium term
  - Implemented for weeks or months while the long-term recommendations are being implemented
- Permanent / long term
  - Implemented actions that result in operationalized change to avoid the next similar incident

Ugwu, Medows, Don-Pedro, 2020 and McDonald, et al 2010

ECRI

Immediate/Short-Term Actions

Risk containment—immediate actions taken to safeguard patients from a repetition of an unwanted occurrence

- Implemented within a few minutes, hours, or days of the incident
- Sometimes referred to as "broke-fix" or quick-fix recommendations
- Consider whether there are quick, safe patient care wins—this empowers the team

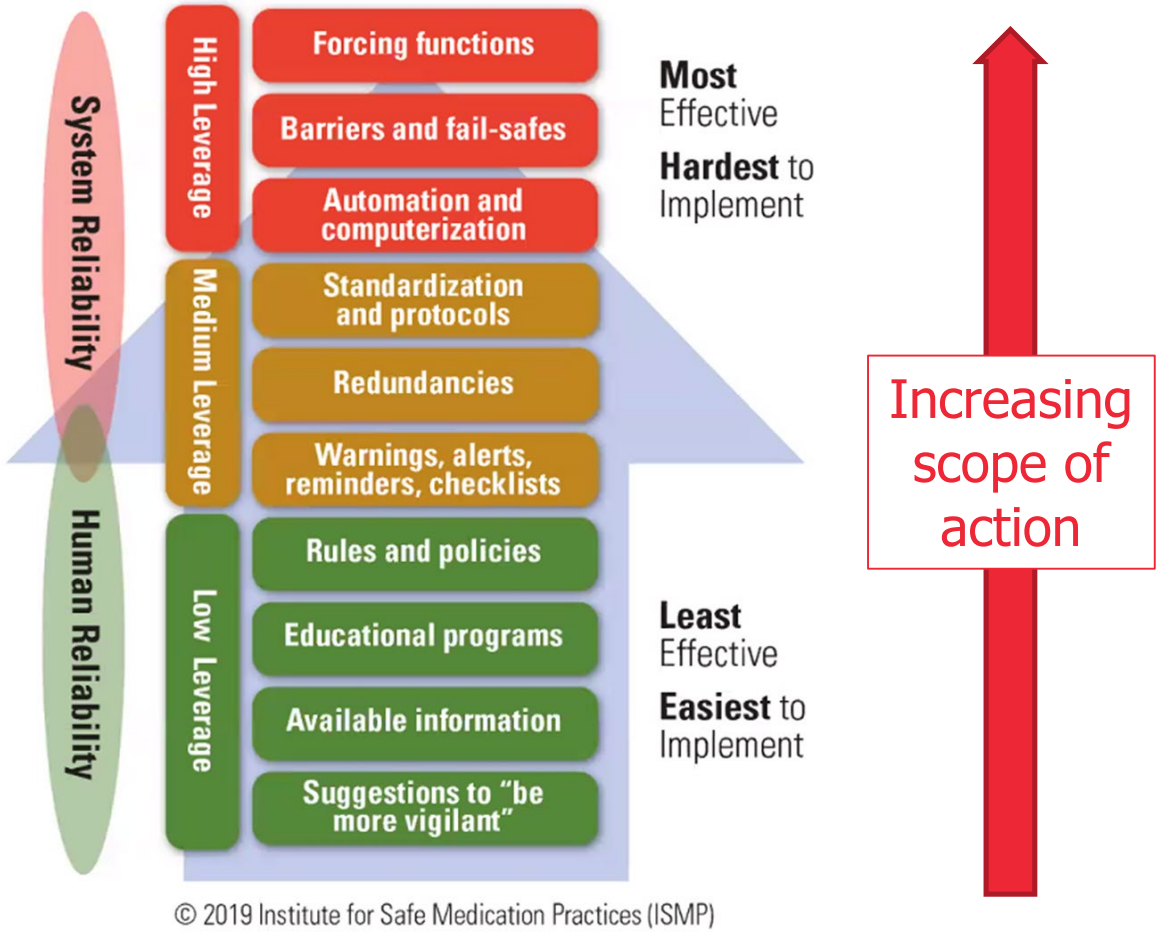
Ugwu, Medows, Don-Pedro, 2020 and McDonald, et al 2010

Interim and Long-term Actions

- Interim/Medium-Term Actions
  - Recommendations implemented until long-term solutions can be set in place
  - They bridge the gap
  - Pilot testing can fall into this category
- Long-Term Actions
  - Permanent, hard-wired, high-impact solutions
  - Ask the question, "Will this action prevent the event from recurring?"

Ugwu, Medows, Don-Pedro, 2020 and McDonald, et al 2010

Performance Improvement Actions Summary



- Link corrective actions to root causes
- Use a combination of low-, medium-, and high-impact/strength corrective actions
- Develop immediate-, short-, and long-term actions

Questions

ECRI's most recent white paper on Root Cause Analysis in Aging Services is available for download to the public by following the link above.