WHY IS IT IMPORTANT TO GET THE MOST OUT OF ROOT-CAUSE ANALYSES?

- Reactive analyses, which include but are not limited to root-cause analysis (RCA), aim to identify and address deeper organizational issues (systems issues) that contribute to adverse events or near misses in an attempt to prevent future events.
- Unfortunately, many reactive analyses fail because they do not uncover systems issues that contributed to the event; thus measures cannot be enacted to address those issues.
- The work and resources spent on an investigation and reactive analysis are wasted if systems issues are not unearthed or if the actions taken as a result do not address them.
- Systems issues that go unaddressed can lead to future events, harm to additional patients, and other organizational problems.

DID YOU ASK?

- Does our approach to reactive analysis reflect a deep-seated commitment to learning?
- In investigating an event, do we seek to understand the perspectives of the people who were involved as the event unfolded?
- Do we focus on work as staff actually perform it, rather than evaluating staff members’ actions against formal policies and procedures?
- Do leaders wholeheartedly support efforts to seek and address organizational, managerial, and systems issues?
- Do we provide necessary resources and time to implement corrective strategies?
- Do we use leading indicators to evaluate safety continuously and proactively, while continuing to track adverse events and near misses?

Need More Information?

As a member of ECRI Institute’s risk and patient safety program, you and your staff can access guidance outlining strategies for conducting effective root-cause analyses:

- Guidance: Getting the Most out of Root-Cause Analyses
- Tool: Root-Cause Analysis: Questions for Discussion and Self-Assessment
- Tool: Root-Cause Analysis: Common Pitfalls and Strategies to Avoid Them

ECRI Institute can help you with all of your patient safety, quality, and risk management projects. Email us at hrc@ecri.org.