Root Cause Analysis and Action (RCAA) Learning Series, Part 2: From Good to Better to Best

KHA Quality Team
July 30, 2026

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Objectives

1. Identify common pitfalls or ineffective habits that can compromise the integrity of the RCAA process
2. List alternative approaches for circumventing practices that can derail the RCAA process
3. Define new strategies to ensure a just and effective approach to reconditioning an RCAA process in the event of interference or threat of failure.

Objectives – Put Another Way

1. Identify common pitfalls or ineffective habits that can compromise the integrity of the RCAA process

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“What can mess this up?”

Objectives – Put Another Way

2. List alternative approaches for circumventing practices that can derail the RCAA process

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“How can we dodge around those potential pitfalls that we’ve identified?”

Objectives – Put Another Way

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3. Define new strategies to ensure a just and effective approach to reconditioning an RCAA process in the event of interference or threat of failure.

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“Once the process is broken, how can we get it back online without too much disruption?”

A Few Quick (Crucial!) Notes

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Always, always, ALWAYS follow your organization's policy/ protocol for RCAA and event response.

If you are uncertain of your notification process in the wake of an event, please make it your business to find out!

If you are unfamiliar with your overarching policy/protocol around RCAA, this is a great time to learn about that as well.

Step 1: Safety First

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The Task: In the wake of an event, the first priority is the patient.

Common Pitfall: Rampant Emotions

- Involved staff
- Leaders

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Step 1: Safety First

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Emotional Upset of Involved Staff

- Likely best to assess on a case-by-case basis whether an involved party can continue in patient care following event.
- When appropriate, allow the party some autonomy
- Focus (and re-focus, if needed) on your priority: What is best for the patient?
- If dissent occurs between preference of involved party and leaders regarding discontinuation of work, focus your reasoning on wellbeing and not fear of incompetence.
- Deal with what's in front of you only. Remember: YOU DON'T HAVE A ROOT CAUSE YET.

Step 1: Safety First

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Emotional Upset of Leaders

- Not-so-fun fact: An RCAA can be **absolutely, completely, 100% destroyed** by emotional responses from leadership in the first hours following a safety event.
- If a leader feels they need to be recused from a situation's immediate response, allow that.
- If a leader needs to be overruled in regards to their involvement in an immediate response, be prepared to do what is needed in accordance with your organizational policy.
- Staff will look to leaders in times of crisis. It is more crucial than ever that a leader is calm and in control of their own emotions in these moments.

Step 2: Internal Reporting

The Task: Beyond the immediate care team, follow your organization's policy to determine who else needs to be notified.

Common Pitfall: That was NOT the right list.

- Who'd you leave out?
- Who'd you include?
- What's happening outside of the Conference Room?

Step 2: Internal Reporting

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Included (for events)…following your organizational policy

- Quality*
- Human Resources*
- Senior Leadership*
- Appropriate medical staff if needed for follow up patient care
- Risk/ Legal if indicated
- Departmental leadership if indicated
- Patient Advocate if indicated
- Chaplaincy if indicated
- Security if indicated

**Non-negotiables*

Step 2: Internal Reporting

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Excluded (for events)…following your organizational policy

Where possible, avoid engagement with individuals who:

- Have a negative past with involved parties or the involved department
- Have an ultra-close relationship with involved parties
- Do not have a very clear role in the recovery and RCAA process moving forward.

Step 2: Internal Reporting

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Outside of the Conference Room

This is a great time to talk about the word “transparency.”

- We’re working on a need-to-know basis here.
- Remember: YOU DON’T HAVE A ROOT CAUSE YET.
- Be very clear in your expectations for individuals who may be privy to the event.
  - Explain why you’re asking for discretion.
  - Focus on **safety** and **professional integrity**
  - Be clear in the explanation that compromising the confidentiality of what has occurred can be detrimental to determining the root cause.

Step 3: Family/Caregivers

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The Task: Once again, you will follow your organization's policy to determine how an event will be communicated to a family/ caregivers of an individual who has been involved.

Common Pitfall: Rampant Emotions. (Again.)

- Your patient has a right to know what has occurred.
- All responses are valid.

Step 3: Family/Caregivers

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Emotional Upset of Patients/ Families

- Be authentic.
- Anticipate absolutely every possible emotion: Fear, anger, shock, betrayal
- Be honest while protecting the professional dignity of those involved. **This can be incredibly delicate.**
- Do NOT send a lamb into the lion's den. (Train, train, TRAIN your staff for these responses!)
  - Consider carefully who you put into the room, especially if they were an involved party.
- Consider what a patient is really asking. It is likely:
  - Am I going to be OK?
  - What do I need to do to be OK?
  - What happens next?

Step 4: External Reporting

The Task: Follow your organization's policy to determine who else needs to be notified.

Common Pitfalls: Inconsistency or Delays

- Strive for consistency in who you report which events to. What is your algorithm?
- Make sure your report is then consistent with the facts.
- Do NOT delay reporting in the wake of an event any more than necessary.

Step 5: Immediate Review

The Task: Conduct an immediate review of the event, including the physical space where appropriate, and also the involved and adjacent parties to the event.

Common Pitfall: Neglecting Just Culture Principles

- We need people, not clams.
- We really should be aiming for the 85/15 theory to be proved, not disproved.
- This may be the greatest learning opportunity you will ever have.

Step 5: Immediate Review

- Strike while the iron is hot. Immediate means just that.
- Define the goal when interviewing. Rinse and repeat as needed.
- Remember: All emotions are valid. (For a little while.)
- Watch your words.
  - A Just Culture does not necessarily equate the eradication of punitive responses… sometimes they are still indicated.
  - Don’t make promises you can’t keep.
  - Think about what an employee really needs to hear in order to build trust.
  - Emphasize (with vim and vigor!) the absolute, irrefutable value the person you are interviewing brings to the table with their perspective.

Step 6: Build a Team

The Task: Select the individuals you will directly involve in the Root Cause Analysis process from this point forth.

Common Pitfall: Creating a Bad Guest List

- Traditional hierarchy
- Knowledge deficits
- Conflicts of Interest
- Unilateral disciplinary perspective
- Weak or inexperienced facilitation
- The entire bench is on the field

Step 6: Build a Team

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Traditional Hierarchy

- Executive or Senior Leadership engagement is crucial.
  - Authority to effect change
  - Alignment of word and deed (“Safety First!”)
  - Transparency for quality improvement
- Blend front-line teams and leaders where possible
  - Front-liners have no illusions about the capabilities of their peers. They see the work as it actually exists.
  - Leaders have more in-depth understanding of policies, expectations, and holistic approaches to quality improvement.
  - Uniting front-line teams and leaders creates a united front.

Step 6: Build a Team

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Knowledge Deficit

- Pull in external consultants where indicated if possible.
- Remember: The greatest knowledge may not always provided by the highest-ranking individual in the room.
- Counsel must be provided by someone with equal or greater degree of training, education, or experience for balanced point of view.

Conflicts of Interest

- Too close
- Not close enough
- Directly involved in event
- Overseer of involved department

Step 6: Build a Team

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Unilateral Disciplinary Perspective

- Name an event where only one department could feasibly provide all needed input to conduct a thorough and complete RCAA. (Go ahead. I'll wait.)
- *MOST* events involve a process that many different perspectives can lend creative and diverse approaches to.
- Bringing only one department to the table can feed into the "only one person to blame" mentality, and detract from the "systems improvement" 85/15 perspective.

Weak or Inexperienced Facilitation

- Know when to hold 'em
- Know when to fold 'em
- Know when to walk away
- Know when to run
- Emotional intelligence

Step 6: Build a Team

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The Entire Bench is on the Field

- Too many people can stall progress
- Consider emotional hit of walking back through a significant event with all your friends there. (Now make it worse… you've gotta work with these people!)

Step 7: Select Your Tools/ Gather Your Findings

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The Task: Using all that you have gathered during your initial assessment/discovery process, select the tools you will bring to the table for the team to use during the execution of the RCAA.

Common Pitfall: Skipping this step *entirely.*

- Gemba
- Process Map (aka Flow Map)
- Fishbone
- 5 Whys
- Goal-setting tools (more on this in Session 3!)

Step 7: Select Your Tools

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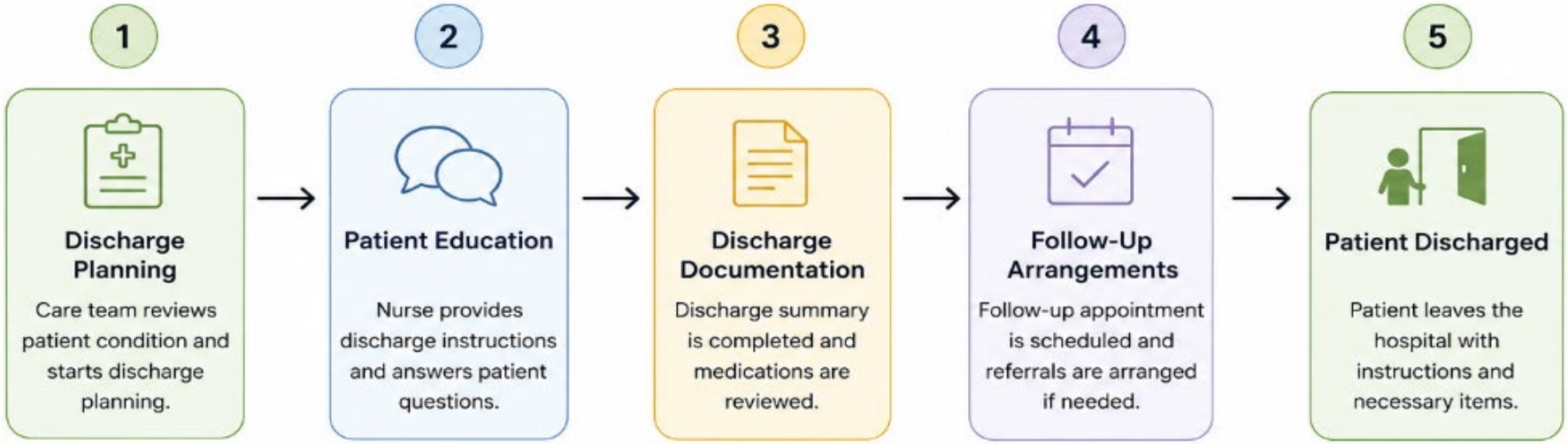
PROCESS MAP EXAMPLE

Hospital-Based Scenario: Patient Discharge Process

Purpose: To safely discharge a patient from hospital and provide follow-up information.



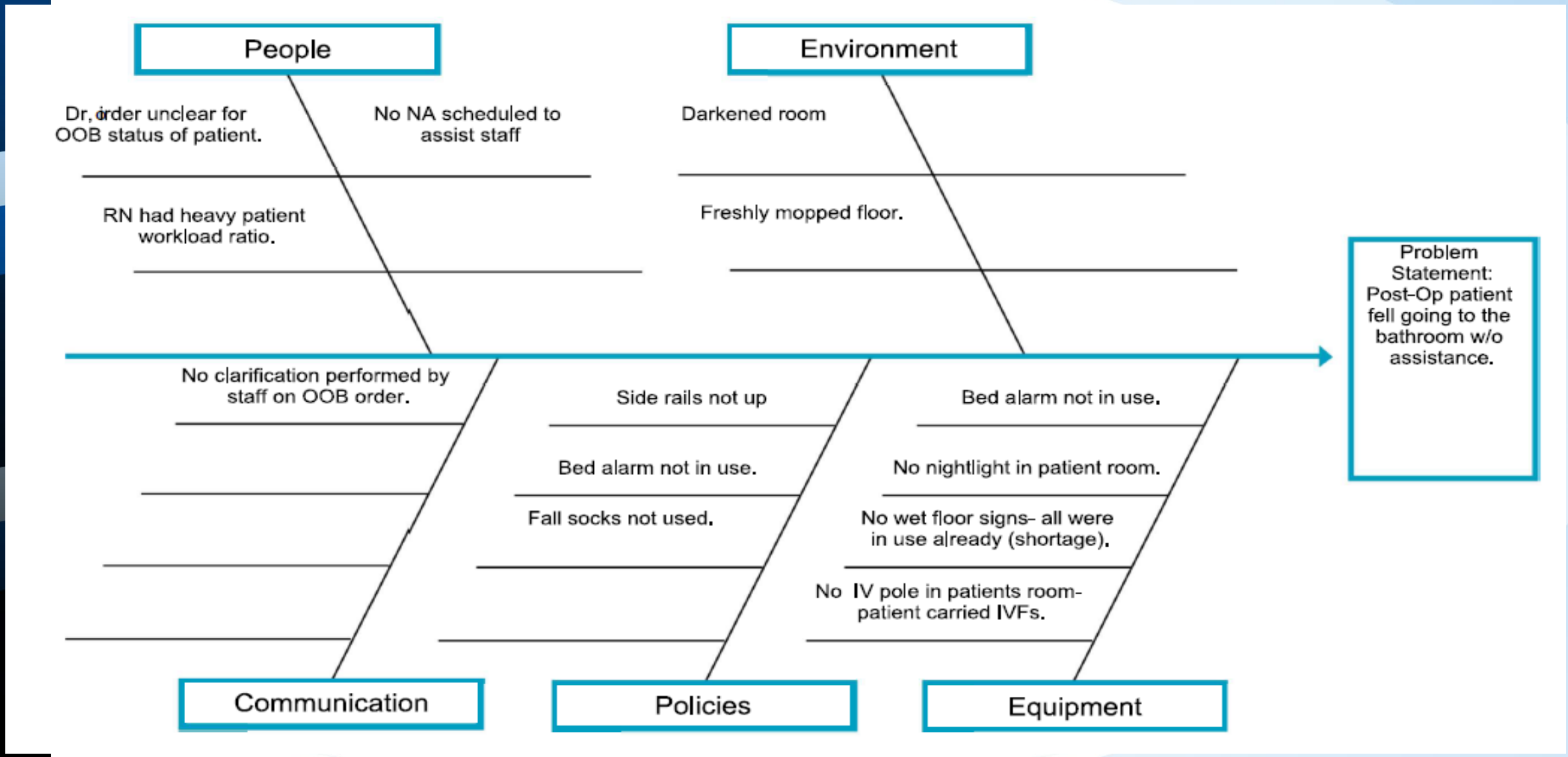
LEGEND

- Start / End
- Process Step
- Flow / Sequence

Notes for Beginners:

- Each box represents a step in the process.
- Arrows show the order of the steps.
- The process starts at Step 1 and ends at Step 5.

Step 7: Select Your Tools



Step 7: Select Your Tools

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Why #1: Why did the patient fall? *(Because they slipped on the wet floor.)*

Why #2: Why did they slip on the wet floor? *(Because they did not see it.)*

Why #3: Why did they not see it? *(Because there was no warning "Wet floor" sign.)*

Why #4: Why was there no "wet floor" sign? *(Because the floor tech had to leave the wet floor to go fetch one.)*

Why #5: Why did they have to leave to get what they needed? *(Because between the mop, bucket, and cleaning supplies, they didn't have a way to pack a sign along with them.)*

Step 8: Come Together

The Task: Work **slowly** and **methodically** through the RCAA process to recreate the situation and identify root causes.

Common Pitfall: Misidentifying key factors

Know the difference between:

- Symptoms, Contributing Factors, and Root Causes
- Facts, Opinions, Assumptions, Speculation

Step 8: Come Together

Recognizing what you see. Appreciate the difference *(and it is a significant one)* between:

1. **A symptom:** Something that indicates a problem exists.
2. **A contributing factor:** Something that may have made an event more likely to occur, but not necessarily the primary reason it did.
3. **A root cause:** A failing or deficit that contributed clearly and directly to the event or unsafe circumstance.

Step 8: Come Together

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Let's Practice: **A patient is given the wrong IV medication.**

Are the following **SYMPTOMS**, **CONTRIBUTING FACTORS**, or **ROOT CAUSES**?

- The medication that was given has a very similar white pharmacy label to the one that the nurse meant to administer.
- The unit had experienced three previous near misses involving look-alike IV bags during the past year, but no formal review had been conducted.
- The nurse had already worked 14 consecutive hours because of staffing shortages.
- Several nurses stated they had nearly selected the wrong IV bag before but never filed safety reports because "nothing ever changes."
- During orientation, new nurses were taught to retrieve IV medications from the refrigerator but were never instructed to verify the patient's name before leaving the medication room.

Step 8: Come Together

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1. **Facts:** Verifiable through reliable evidence.

2. **Opinions:** A belief or interpretation about something.

3. **Assumptions:** Something that is accepted as true without sufficient verification.

4. **Speculation:** A possible explanation that is offered without irrefutable evidence to support it.

Opinions and Speculation can have (valuable!) places at the table, but take care to only ever accept fact as fact.

Be very, **very** alert and wary of assumptions.

Step 9: Design Corrective Actions*

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The Task: Design and implement corrective actions that will produce an effective and sustainable seal against event reoccurrence.

Common Pitfalls: There are many!*

- Interventions are not directly and effectively related to the actual root cause.
- Actions are treated as "one and done."
- Low-end hierarchy of strength of interventions.
- Inappropriate prioritization of issues
- Tools not utilized for effective change design.

**More on all of this in our third session of this series!*

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Step 10: Stay the Course

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In session 3, we'll talk about the sustainability of our interventions.

Meanwhile:

1. Remember that culture eats strategy for breakfast.
2. Audit where you **can**
3. Hold accountable when you **must**
4. Celebrate when you **should**
5. Create a stable goal (SMART goal strongly recommended) and resist the urge to move the goal post … yet.

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Hope to see you again!

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Root Cause Analysis and Action (RCAA) Learning Series,
Part 3: The Second "A"
Thursday, August 13 | 1:00–2:00 p.m. ET

SEPARATE REGISTRATION:

Root Cause Analysis and Action (RCAA) Learning Series,
Part 4: Tabletop RCAA Simulation
Thursday, August 27 | 10:00 a.m.–12:00 p.m. ET

Important: Part 4 will not be recorded. Live participation is strongly encouraged to maximize learning and engagement.

Register Online for Part 4*

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Questions?

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