Julian is a nurse manager of the medical surgical unit at a mid-sized metropolitan hospital. In the past quarter, there have been 38 reports of patient falls compared to the 30 incidents in the quarter before that. Many of these incidents happened in hospital-based facilities. Julian has been assigned to review the incident reports in order to decide whether a root cause analysis is needed and then to follow up to find solutions.

Root cause analysis is a structured method used to analyze adverse events where patient harm or undesired outcomes occurred. The goal is to look beyond human error to identify and address the root causes and contributing factors.

Based on the findings, an actionable plan can be developed to prevent the event from happening again. In other words, root cause analysis focuses on finding out what happened, why it happened, and how to prevent it from recurring rather than who did it.

The process of root cause analysis typically consists of nine steps. For step one, departments should encourage honest reporting of incidents by the frontline personnel. Incidents should then be reviewed in order to determine whether a root cause analysis is required.

Step two is assigning the incident to a team of individuals who have fundamental knowledge of the specific area of interest and are not directly involved with the case. Step three is developing an initial flow diagram that describes the processes leading to the event.

Step four is creating an event story map that covers the significant details of the events. This can be done by interviewing everyone involved in the incident and using triggering questions to guide further investigation.

Step five is to develop a cause and effect diagram. This includes a problem statement as well as the actions and conditions that caused it. Step six is identifying the root cause contributing factors. These describe how a cause led to an effect and increase the likelihood of an adverse event.

Step seven is developing corrective actions that prevent the event from recurring. Step eight is measuring the outcome to ensure these actions are implemented correctly. And finally, step nine is communicating the results of root cause analysis to the staff.

So coming back to Julian, he carefully reviewed the reports of patient falls in the past three months and initiated a root cause analysis. Following the nine steps, he identified and analyzed the problem,

which is the increased number of patient falls. He then defined the root causes including educational issues, organizational factors, and reduced supervision.

Finally, he implemented preventative measures like education of the nursing staff in order to identify high-risk patients, performing frequent safety rounds, and providing safety companions.