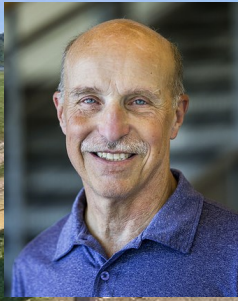


James P. Bagian, MD, PE



Going Beyond RCA to Effect Real Improvement and Impact Safety Culture

Monday
December 14, 2015
4:30PM

Root cause analysis (RCA) is a process widely used by health professionals to learn how and why errors occurred, but there have been inconsistencies in the success of these initiatives. With a grant from The Doctors Company Foundation, NPSF convened a panel of subject matter experts and stakeholders to examine best practices around RCAs and develop guidelines to help health professionals standardize the process and improve the way they investigate medical errors, adverse events, and near misses.

Traditionally, the process employed to accomplish this learning has been called root cause analysis (RCA), but it has had inconsistent success. To improve the effectiveness and utility of these efforts, we have concentrated on the ultimate objective: preventing future harm.

Prevention requires actions to be taken, and so we have renamed the process Root Cause Analysis and Action, RCA2 (RCA “squared”) to emphasize this point. This document, RCA2: Improving Root Cause Analyses and Actions to Prevent Harm, describes methodologies and techniques that an organization or individuals involved in performing an RCA2 can credibly and effectively use to prioritize the events, hazards, and vulnerabilities in their systems of care to accomplish the real objective, which is to understand what happened, why it happened, and then take positive action to prevent it from happening again.

It cannot be over-emphasized that if actions resulting from an RCA2 are not implemented and measured to demonstrate their success in preventing or reducing the risk of patient harm in an effective and sustainable way, then the entire RCA2 activity will have been a waste of time and resources.

Dr. James P. Bagian is the Director of the Center for Healthcare Engineering and Patient Safety and is a Professor in the Department of Anesthesiology in the Medical School and in the Department of Industrial and Operations Engineering in the College of Engineering at the University of Michigan. Previously, he served as the first Director of the VA National Center for Patient Safety (NCPS) and the first Chief Patient Safety Officer for the Department of Veterans Affairs from 1999 to 2010 where he developed numerous patient safety related tools and programs that have been adopted nationally and internationally. Dr. Bagian served as a NASA astronaut and is a veteran of two Space Shuttle missions and was an investigator of both the Challenger and Columbia Space Shuttle mishaps. Presently, he is applying systems engineering approaches to the analysis of medical adverse events and the development and implementation of systems-based corrective actions that will enhance patient safety primarily through preventive means. He received his B.S. in mechanical engineering from Drexel University and his M.D. from Jefferson Medical College at Thomas Jefferson University. He is a Fellow of the Aerospace Medical Association, a member of the National Academy of Engineering, the Institute of Medicine, and has received numerous awards for his work in the field of patient safety and aerospace medicine.

The seminar series “Providing Better Healthcare through Systems Engineering” is presented by the U-M Center for Healthcare Engineering and Patient Safety: Our mission is to improve the safety and quality of healthcare delivery through a multi-disciplinary, systems-engineering approach.

For additional information and to be added to the weekly e-mail for the series, please contact genehkim@umich.edu



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