Adverse Event – Root Cause Analysis – Who to Include

Do we include those involved in creating the hospital error to participate in root cause analysis or Not?!

I have gotten so many conflicting messages when it comes to this question so I did some research on the determination of team members for RCAs.

As with anything, I wish the logic was black or white, but in the case of team members, it is not. Some organizations state "at **no time** are the people that were **involved** in the event **to be part of the RCA**" and others state "you **must always** invite the people who were **involved** in the event."

I believe they are both wrong. We must make educated conclusions based on each event and person(s) involved to determine if they should be at the table during the RCA. It is always appropriate to interview and get information from those directly involved in the event on a one-on-one bases prior to the RCA event, but having them at the table during the event is not a black or white decision.

Below is CMS's recommendations as part of their guidance for performing root cause analysis.

- Team members should be selected for their ability to discuss and review what happened during the event in an objective and unbiased manner. In some situations, staff members personally involved in the event are the best people to serve as team members. In other situations, staff members not personally involved in the event are the best people to serve as team members with the people personally involved asked to share their experience during interviews. This may be appropriate if the people directly involved in the event are dealing with emotions and are not able to be objective. However, if this is the case, it is a good idea to provide those staff persons directly involved with counseling and support so that they are able to participate in the RCA process. Participating in the RCA process and hearing other's objective viewpoints can help them to deal with the situation in a positive manner.
- Keep the number of management or supervisory level individuals on the team to a minimum. Staff members may be inhibited from speaking up or being completely candid during discussions about what happened if their direct supervisor is in the room. If this is not possible, the facilitator should explain the need for members to be free to discuss the process honestly, as it is actually carried out in the facility.
- Make it clear to everyone involved that the RCA process is confidential. This reassurance helps people feel safer discussing the process and system breakdowns that may have caused an inadvertent mistake.

Source: https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf

An ideal situation is one where organizations are well undergoing the path for Just Culture and High Reliable Organizations. Their culture supports an environment where front line staff feel safe to share their concerns and fully understand the purpose and role of the Patient Safety Organization (PSO). The reality is each organization needs to consider their culture before initiating what could be thought of as a intimidation session with their director and c-level leaders in the room.

What I have learned by talking with employees is this: **Any interaction involving more than one person (especially leadership) to those involved in an adverse event could easily be considered an interrogation.**

As organizations continue to do RCAs and slowly introduce front line folks involved in the events, they can establish a culture of *trust* and *understanding* that will lead them to the path of more front line engagement. Jumping into this without that trust will only introduce a cultural time bomb.