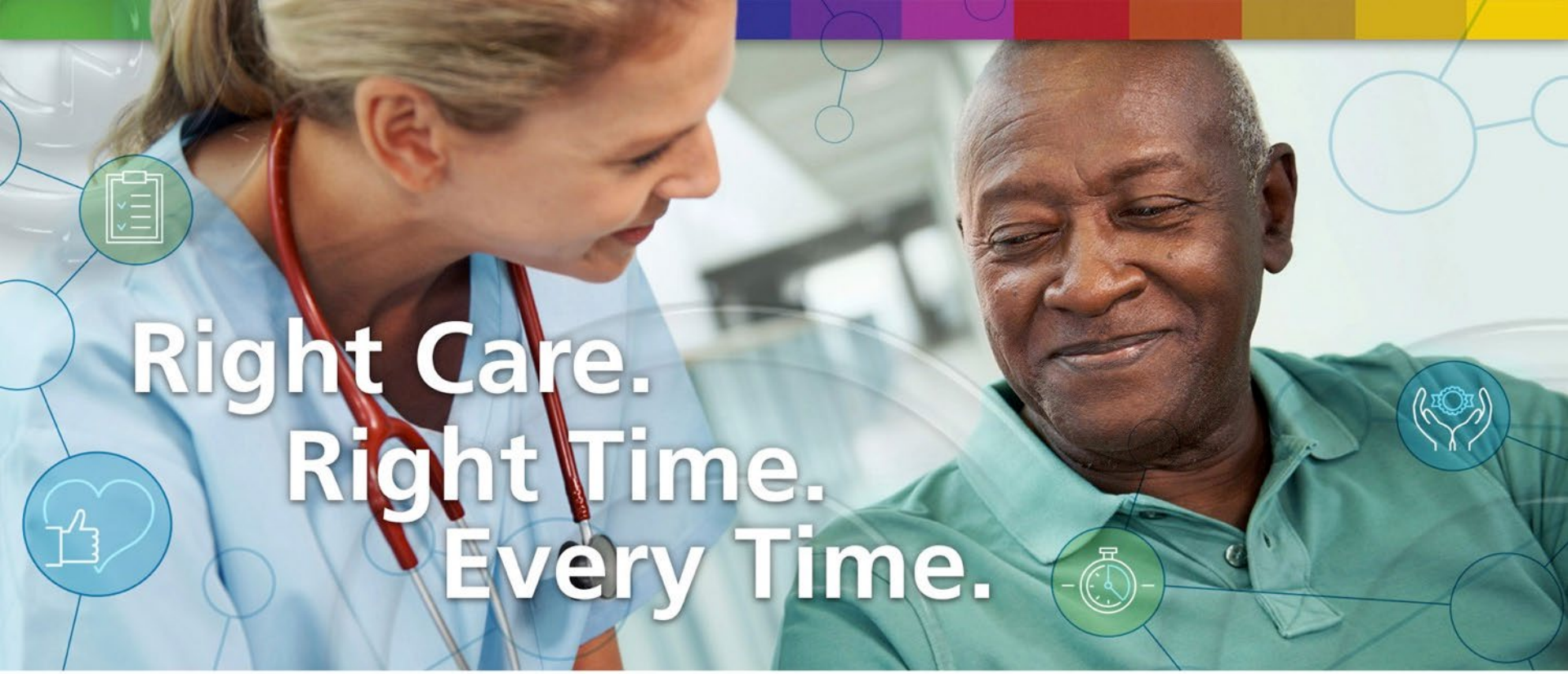

Root Cause Analysis: 5 Whys

Heartland Kidney Network Quality Improvement Team

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Introduction

The purpose of this PowerPoint presentation is to assist you in your efforts to identify the root cause of a problem in order to improvement the care provided at your dialysis facility

In this presentation you'll learn…

- What is Root Cause Analysis
- How does the 5 Whys system work
- Example of a 5 Whys Root Cause Analysis
- Resources Available

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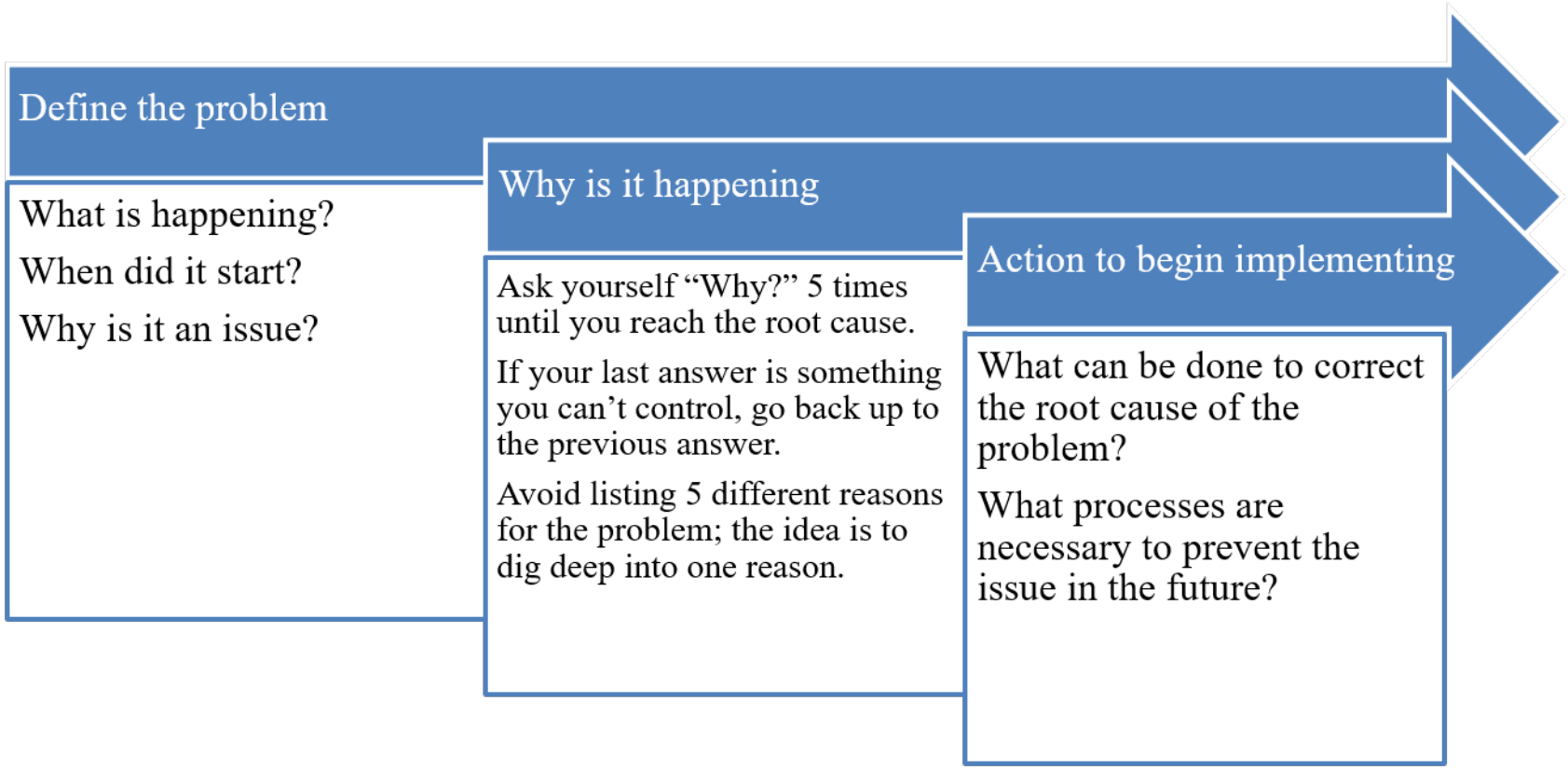
What is Root Cause Analysis

The **key** to **solving** a problem is to first **truly understand** it.

The role of the Network is to serve as partners in quality improvement with patients, practitioners, healthcare providers, and stakeholders

Institute for Healthcare Improvement *5 Whys: Finding the Root Cause*

Root Cause Analysis: 5 Whys



Let's review the various parts for this model

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Define the Problem

- You must **FIRST** identify the problem **BEFORE** jumping to a solution
- We often jump to what we **THINK** is the problem and develop a "quick fix"
- If you fail to identify the **ROOT CAUSE**, the problem will continue or reoccur
- Determining **WHEN** it started may help you identify a change in practice that lead to the issue

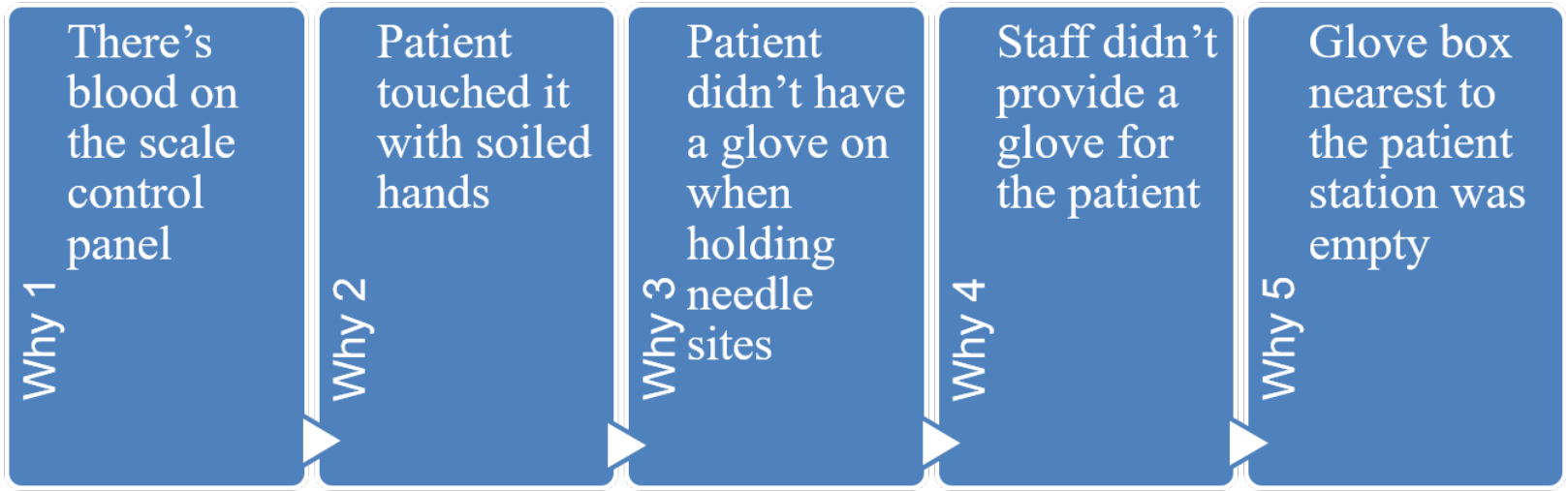
Why ask Why?

- Asking **WHY** will lead you to the **ROOT** of the issue
- Identify **ONE** reason and dive deeper to identify the **ROOT CAUSE**
- If you identify multiple reasons, **PLAN** to implement change on only **ONE** reason at a time
- If you fail to find a resolution, move on to the **NEXT** reason you identified

Action to begin implementing

- Understanding **WHY** it happened will help you identify a solution
- Identify a **PROCESS**, not an **INDIVIDUAL**
- Avoid covering the problem with a **BANDAID**
- Developing a **PLAN** to implement a change leads you to begin the **Plan – Do – Study – Act (PDSA)** cycle
  - Additional resources about the PDSA cycle are available in our Quality Improvement Toolkit on the Heartland Kidney Network website www.heartlandkidney.org

Problem: Contamination of the Scale Control Panel



Action: Begin adding gloves for patient into the take-off pack

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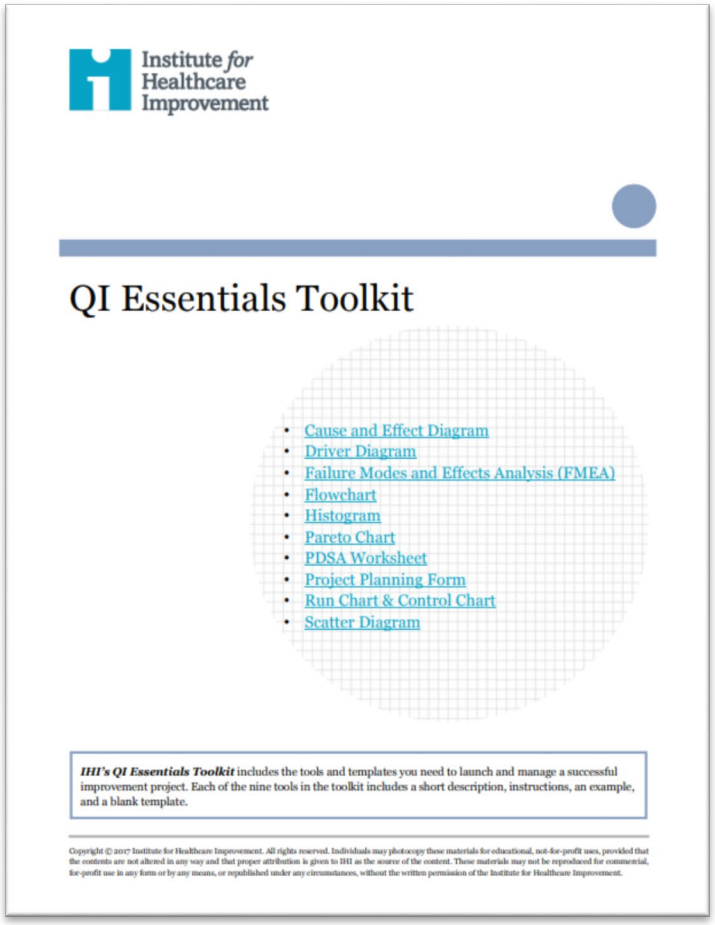
Additional RCA Exercises

Institute for Healthcare Improvement (IHI) QI Essentials Toolkit

- Cause and Effect Diagram
- Driver Diagram
- Failure Modes and Effects Analysis



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Network Quality Improvement Team

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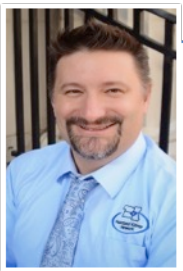
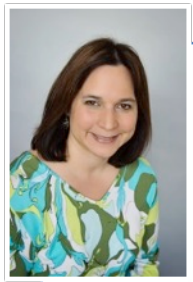
Quality Improvement Manager



Shane Perry
Quality Improvement Analytic Manager



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This resource was developed while under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contract #HHSM-500-2016-00012C. The contents presented do not necessarily reflect CMS policy. 18.Q-ESRD12.118

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