Root Cause Analysis and Action (RCA2) in Preventing Patient Harm

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Millions of patients are harmed every year as a result of the care they receive. This presentation discusses methodologies and techniques that an organization can utilize to prioritize the adverse events and vulnerabilities in their systems. The goal is to understand what happened, why it happened, and then take positive action to prevent it from happening again. This presentation will discuss processes to prevent or reduce the risk of patient harm in an effective and sustainable action plan. This presentation discusses a system-based investigatory approach after a healthcare-related adverse event or near-miss. It will provide steps on performing a root cause analysis and action that results in the implementation of sustainable action plans and improvements that make patient care safer in settings across the continuum of care. It will identify methodologies and techniques that will lead to more effective and efficient root cause analysis and action. It will also mention the system vulnerabilities so that they can be mitigated with the focus on processes instead disciplinary actions.

Keywords: patient harm, root cause analysis, action plan, investigatory approach, improvement, system-based