Root Cause Analysis

A Root Cause Analysis investigates factors surrounding the incident in order that any learning can reduce the risk of a similar incident in the future. Complete after each dispensing incident when there has been harm caused to the patient, when the incident involves a Controlled Drug, at the request of the PST or the Responsible Pharmacist or when the accuracy check was completed by an ACT.

Step 1: Information Gathering	Patient Safety Incident Reference No:	Patient Name:
	Date:	Pharmacy Name/ Number:
	Colleagues present completing the RCA:	
Step 2: Incident Data collection	Time of incident:	Date of incident:
	Pharmacists on duty:	Colleagues on duty and their role:
	Colleagues involved in the incident and their role:	
	No. Script items dispensed on the day:	Ave. Script items dispensed per day:
	Other Information:	
Step 3: Outline of incident		
Step 4: Contributing Factors **Why** did this incident occur? Keep asking **why** until there is no longer a "**why**". answer- the final answer may be the root cause. **(See the attached example of 5 whys)**	E.g. Location of stock on the shelves, training/capabilities, lack of knowledge, LASA, SOPs/Best in Class, dispenser's check, final accuracy check **Why did this incident occur? (Please use an extra sheet if necessary)**	
Step 5: Identify the root cause. This may be the answer to your final **why** question in Step 4 and the key factor that caused the incident.		
Step 6: Identify any improvement. What is the action plan **with timescales** to prevent a similar incident from happening again?		
Date of **Patient Safety Huddle** to discuss the learning of this incident: Colleagues present:		
Review date:		Review completed and date:

Example:

What is "5 Whys?"

"5 whys" is a repetitive question asking technique which is used to examine and analyse the cause and effect relationships behind a specific issue or problem. By repeatedly asking "why" you can peel back the layers and determine the root cause of a problem. The answer to a problem can often lead to another question so it may be necessary to ask "why?" a number of times before you can identify the root cause of a problem

How to use the "5 Whys"

1. Write the problem down. This helps you and your team to identify the specific issue.
2. Think about why the problem occurred and write the answer down
3. If this doesn't thoroughly answer the initial question, ask "Why" again and write the answer down
4. Continue to ask "Why" until you have the answer. This could mean you asking "Why?" more or less times than 5
5. Once you have the answer (or root cause) to your problem, agree as a team what action you will take to prevent it from happening again.

Example of "5 Whys

Problem Mrs S was admitted to hospital because she did not receive her antibiotics and her condition worsened

Why did she not get her antibiotics on time?
Because we didn't send them out on delivery

Why did we not send them out on delivery?
Because we did not realise it was an urgent prescription and needed to go out that day

Why did we not know that it was urgent?
Because the doctor hadn't let us know he had done a home visit and Mrs S needed the antibiotics that day and it was an EPS Rx which doesn't flag if urgent

Why did the doctor not let us know they were needed that day?
Because we don't have a process set up with the surgery to notify us when urgent deliveries are needed

Actions – arrange a surgery visit to talk through the incident and to agree a way of working together so that we are always informed when urgent deliveries are required. Review the BIC process for Rx management to ensure that we are following the process in full