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In response to “Getting to the Root of the Matter” (June 2005)

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Letter

To the editors:

In Drs. Flanders and Saint's otherwise superb summary and review of the use of root cause analysis to identify systems' vulnerabilities and improve overall patient care delivery, I was surprised by their statement that RCAs are "performed by a team with expertise in the area of investigation whose members were NOT directly involved with the error." While they do mention conducting "interviews with key staff involved in the error," they do not propose including these staff on the RCA team. This is contrary to my experience and interpretation of others recommendations.

The VA National Center for Patient Safety suggests the "involving of those who are the most familiar with the situation" in the RCA. My interpretation is that this includes those directly involved in the error. I believe they have the most to teach us as they directly experienced the system failures.

I fear that excluding those staff most affected by the actual incident implicitly perpetuates a culture of blame. Encouraging participation by those who "made the mistake" strongly reinforces promotion of a culture of patient safety through demonstration of the efficacy of the RCA approach. In the RCAs in which I have participated, these individuals often have contributed the most, and participating in the process may also help them cope with any feelings of guilt. The end result is that they feel supported by the system and become vocal advocates of patient safety.

Mark V. Williams, MD Emory University School of Medicine

In reply:

Dr. Williams suggests that individuals directly involved in an error should participate in the root cause analysis (RCA), both as interviewees and as members of the RCA team. While we agree that such individuals should participate in the RCA process, we don't believe that they should be members of the RCA team, for the following reasons: (1) such individuals often feel guilt over their role in the error and can be overly defensive; (2) their presence may prevent other team members from speaking freely about all the factors involved in the error, especially in the case of a rule infraction in which the individual's behavior may have been an important contributing factor; and (3) we have observed that individuals involved in the error can have a hard time separating themselves from the error and focusing on systems solutions.

At our institution, we do include members who are familiar with the role of the individual involved in the error. If a respiratory therapist is involved in an error in the intensive care unit (ICU), not only would we want a respiratory therapist who works in the ICU to be on the RCA team, but we would seek one who works on the same shift and in the same ICU. This allows the RCA team to appreciate the barriers and obstacles faced by the individuals involved with the error.

The viewpoint of the health care provider involved in an error, however, is critical. We ask such individuals to describe the incident and to suggest improvements in care delivery that could prevent recurrent errors. This is done in a formal "debriefing" meeting, in a blame-free environment. When the RCA team develops potential solutions, they are "reality tested" prior to implementation by soliciting the opinions of those involved with the error. This task is accomplished during the "wrap up" meeting. Finally, when changes are finalized, we describe them to both the involved units and the individual involved in the error prior to final implementation.

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