

**ASHP**  
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**The Art of Delegating**

# Managerial Resources

(in descending order)

- **People**
- **Technology**
- **Money**
- **Time**
- **Material**

# Delegating

- **The individual must have the skills and desire.**
- **You must be clear in what you expect.**
- **You must provide an end-point.**
- **You must have update meetings to monitor progress.**
- **You must provide authority with responsibility.**

# Root Cause Analysis Mining for **Gold**

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# What is Root Cause Analysis (RCA)?

- Retrospective tool to uncover the most fundamental reason(s) why an event has occurred
- Ask “WHY?” Five Times
- Required evaluation for a Sentinel Event
- **Useful to evaluate less severe medication errors**

# RCA Key Steps



# Essential Questions

- Working conditions
- Human factors
- Equipment factors
- Latent errors
- Availability of information
- Human resource considerations
- Leadership

# RCA works best when...

- **Timely**
- **All personnel involved contribute**
  - Multi-disciplinary approach
  - Open communication
- **“Just Culture”**
  - Focus on systems and processes
  - Non-punitive
- **Focus on the “Gold”**

# When to apply RCA?

- ***Actual* serious event**
  - caused patient harm
  - had the potential to cause harm
- ***Potential* event or near miss that if not caught would have lead to patient harm**
- **Recurring errors**
- **An error that “should not have happened”**

# Opportunities for Improvement

- Cephalosporin dose not properly adjusted for patient with renal failure
- High alert medication not properly diluted
- Medication orders not appearing on the medication administration record (MAR)



# Barriers to Improvement

- Thinking that you know why a particular error occurred
- Not asking the right people
- Operating in a “silo”
- Resources
- Leadership support

# Resources



- Framework for Conducting a RCA:  
<http://www.jointcommission.org/>
- Modified Approach to RCA:
  - Pronovost PJ et al. A practical tool to learn from defects in patient care. Jt Comm J Qual Patient Saf 2006;32(2):102-8.
- Other References:
  - Williams P. Techniques for root cause analysis. BUMC Proceedings 2001;14:154-7.
  - Manasse HR, Thompson KK. Medication Safety: A Guide for Health Care Facilities. Bethesda, MD: ASHP, Inc.;2005.