



Avoid Root Cause Analysis déjà vu Events

On the Radar webinar series

June 2026

MONTHLY INSIGHTS

Webinar schedule & topics

THE 3RD THURSDAY OF EVERY MONTH:

10AM Pacific, 1PM Eastern

JUNE

Avoid Root Cause Analysis déjà vu

JULY

Restraint simplified: Practical
approaches to a persistent
compliance challenge

Past webinars available for streaming





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Greeley

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On the Radar

Chartis and Greeley explore practical and future-focused topics in quality, regulatory & medical staff.





UPCOMING WEBINAR

Seconds to contaminate, years to recover

Apr 09, 2026

Navigating the Zoom interface

Handouts:

Check the chat function for copies of the slides for note taking and any other handouts.

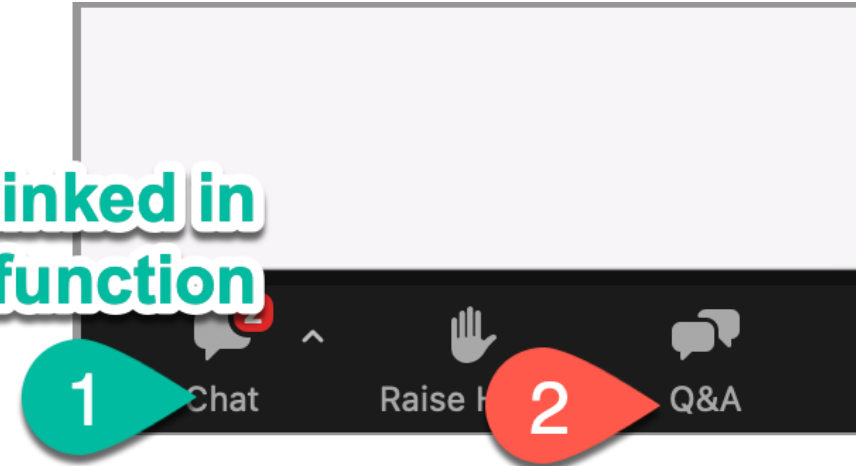
Questions and comments:

Please participate in the discussion by asking question through the Q&A function during the webinar.

There will also be a survey you will receive immediately after the webinar that will give you an opportunity to ask additional questions or make comments.

Any questions not answered during the webinar will be addressed in a follow-up email or posting.

Handouts are linked in the “chat” function

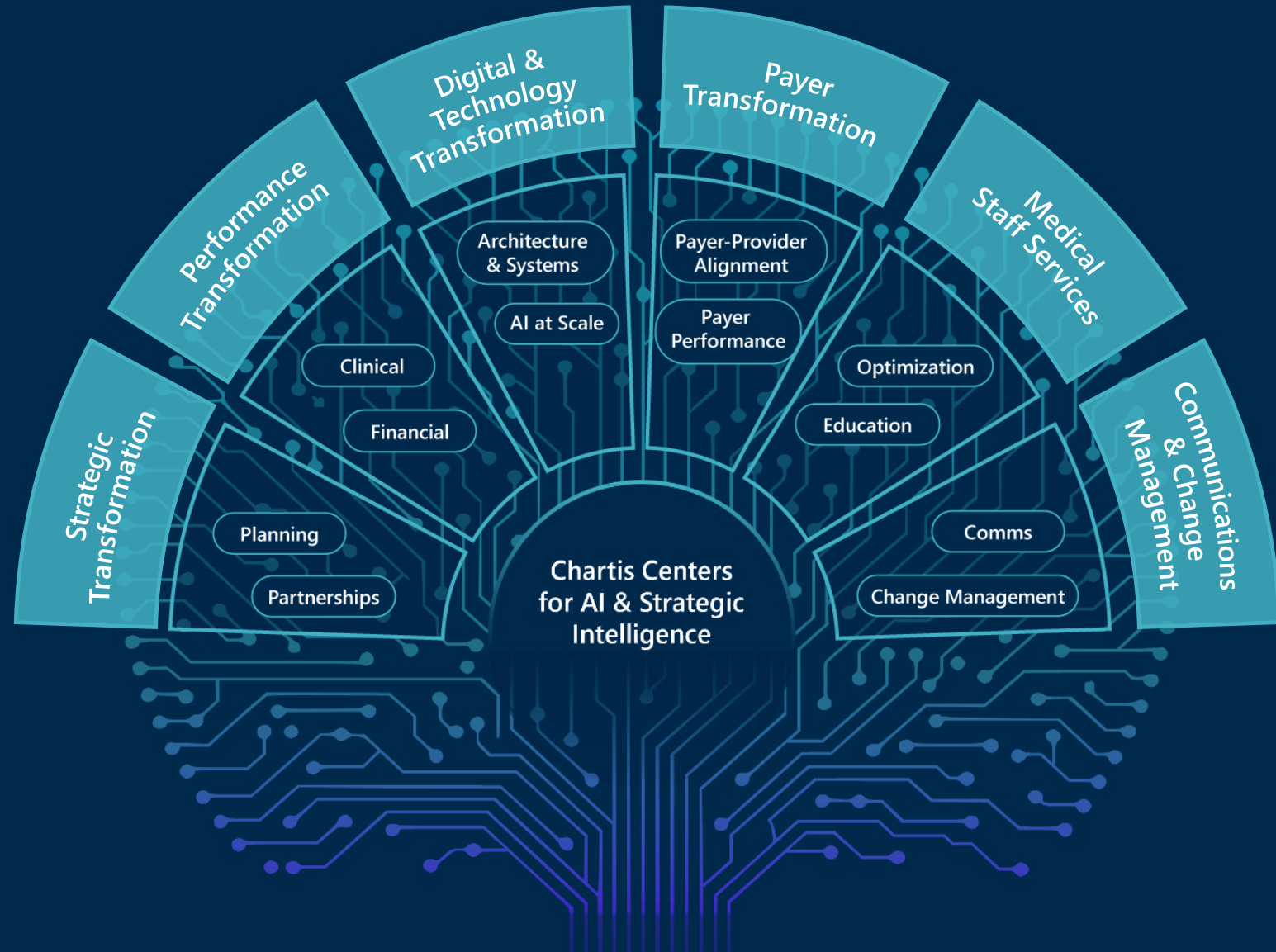


Please ask questions by clicking on “Q&A”

Chartis is uniquely built to *deliver the last mile*.

Our **integrated lines of business** work alongside the Chartis Centers for AI & Strategic Intelligence to deliver against the last mile necessary to **transform healthcare delivery**.

Connected capabilities.
Real healthcare transformation.



High Reliability Care

UNPARALLELED BREADTH AND DEPTH

Our clients are all striving toward the same goal of providing safe, high-quality care—something that's becoming even more important with the many distractions and disruptions in healthcare today. We help clients achieve their organizational reliability, quality, and safety goals, leading to results in areas that matter most—improved care outcomes, staff engagement, operational stability, and total cost of care, enhanced reputation, and better patient experience.

High Reliability Organization (HRO)

- High reliability organizational design and infrastructure
- Quality, Value, and Performance Improvement
- Quality ratings and rankings optimization
- Patient safety / harm reduction / safety and reliability culture
- Adverse event response and remediation / RCA
- High fidelity measurement / Clinical Documentation Integrity (CDI)
- Care facilitation

Clinical Compliance, Regulatory, and Physical Environment Solutions

- Adverse event response
- Adverse action regulatory response and remediation
- Accrediting body readiness assessment
- Regulatory readiness rehearsal / mock surveys
- Life safety and environment of care assessment
- Policy simplification
- Infection prevention program

Bylaws, Rules and Regulations, and Peer Review

- Bylaws and rules and regulations assessment and redesign
- Peer review assessment and redesign
- Medical staff / medical director structure and governance
- Credentialing, OPPE

External Peer Review

- Physician/advanced practice professional external peer review
- Focused Professional Practice Evaluation (FPPE)
- Ongoing case review in support of OPPE/FPPE
- Medical necessity reviews
- Patient safety/carequality case reviews

MEMBERSHIP AND PROFESSIONAL EDUCATION SERVICES

INTRODUCTIONS

Who is here today...



Steve Mrozowski,
MHA, CPPS, CPHRH, FACHE
Partner

25+ YEARS

healthcare experience

EXPERTISE

Clinical quality, patient safety, performance improvement and lean management, patient experience, education and mentorship, and high reliability transformation



Stephanie Boyd,
DNP, RN, CPHQ
Associate Partner

25+ YEARS

healthcare experience

EXPERTISE

Clinical quality, patient safety, performance improvement, patient experience, strategic planning, clinical operations, project management, publicly reported pay-for-performance/ pay-for-reporting ratings and rankings modeling and optimization, education and mentorship, and high reliability transformation

Objectives for today's meeting



1

Define cause analysis process and methods to optimize the impact in healthcare organizations.

2

Outline harm event types and best practice action plan responses.

3

Describe a root cause analysis team structure, team member roles and responsibilities, and the impact of an action plan oversight committee.

CAUSE ANALYSIS – WHY IS IT IMPORTANT?

A method used to *identify* and *understand* the root causes of specific events, behaviors, or problems, rather than just treating their symptoms.

As leaders, we have an *imperative to prevent and detect problems* that can lead to an event.

Yet we have a *more profound obligation to correct causes* once an event has occurred.

Improving safety & reliability: Three critical components

PREVENT

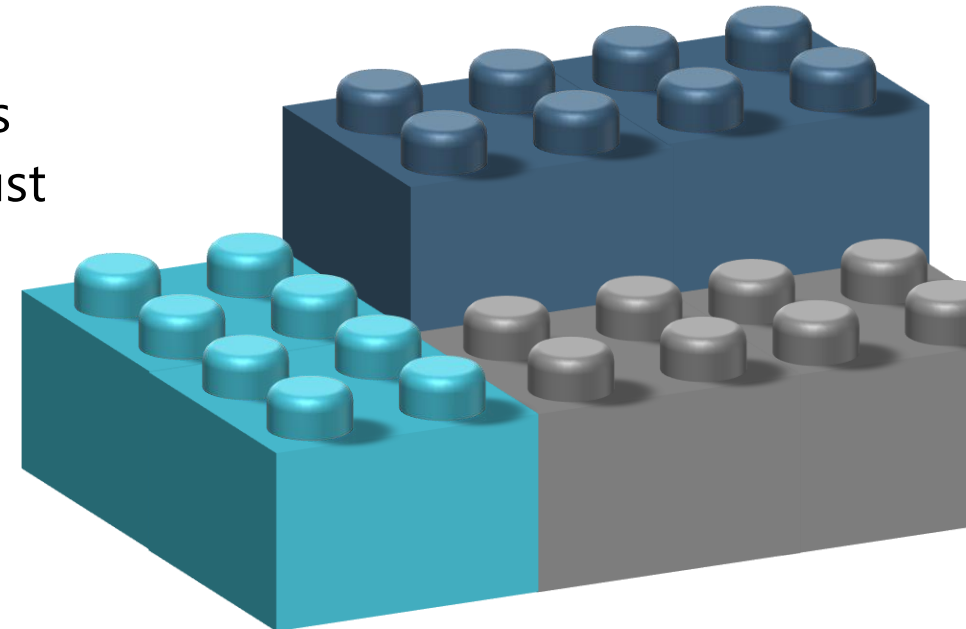
Initiating errors by implementing universal skills and behaviors for error reduction

DETECT

System weaknesses through optimized Cause Analysis

CORRECT

Implement root-solutions for root-causes with robust accountability structure



Déjà vu: Why events recur

Serious events

- Real root causes were not identified
 - Corrective actions to prevent recurrence did not effectively address the root causes or generic implications of the root causes
-

Precursor or near miss events

- Avoid studying them
 - Don't take the time to understand why and aggregate the lessons.
-

All events

- Failure to implement corrective actions
- Corrective actions not effective or sustained
- Failure to share lessons learned

LET'S CHAT

Has your organization
experienced déjà vu events?

Any theories about the
reason(s) for recurrence?

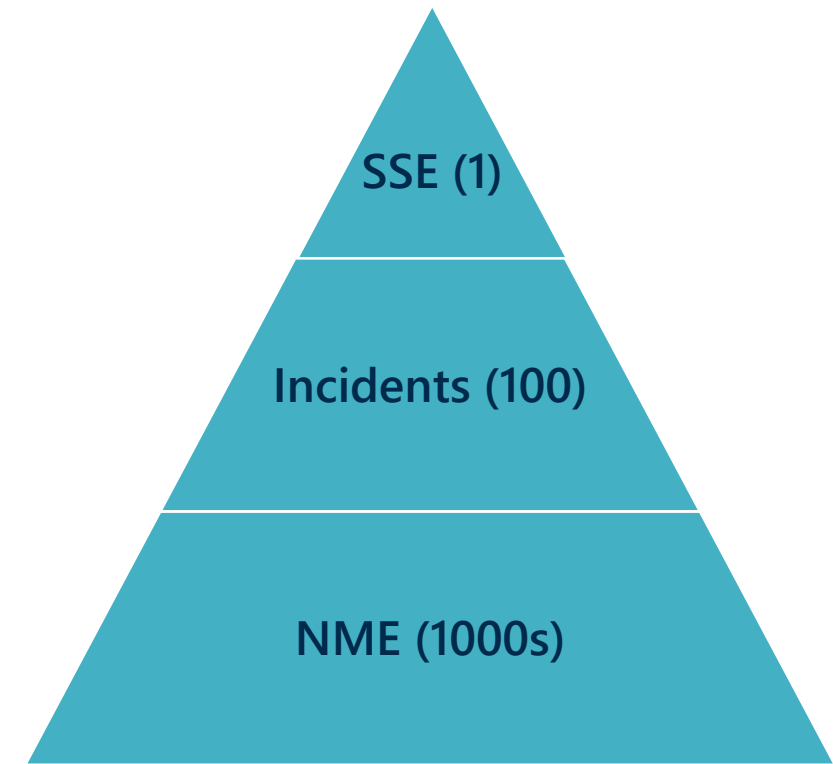
Optimized cause analysis in HROs

- Facilitators trained in cause analysis techniques
- Huddle + 2 (or 3) model
- Executive Owner owns; Operational Leader leads; Quality/Safety/Risk supports
- Event investigation is formerly chartered
- 1:1 fact finding interviews
- Use of appropriate analytical tools
- Knowledge of human performance in complex systems and human error applied in analyzing events and developing root causes
- Robust safety alert and lessons learned program
- Corrective actions with single person accountability and operational ownership
- Governance and oversight structure for optimized accountability

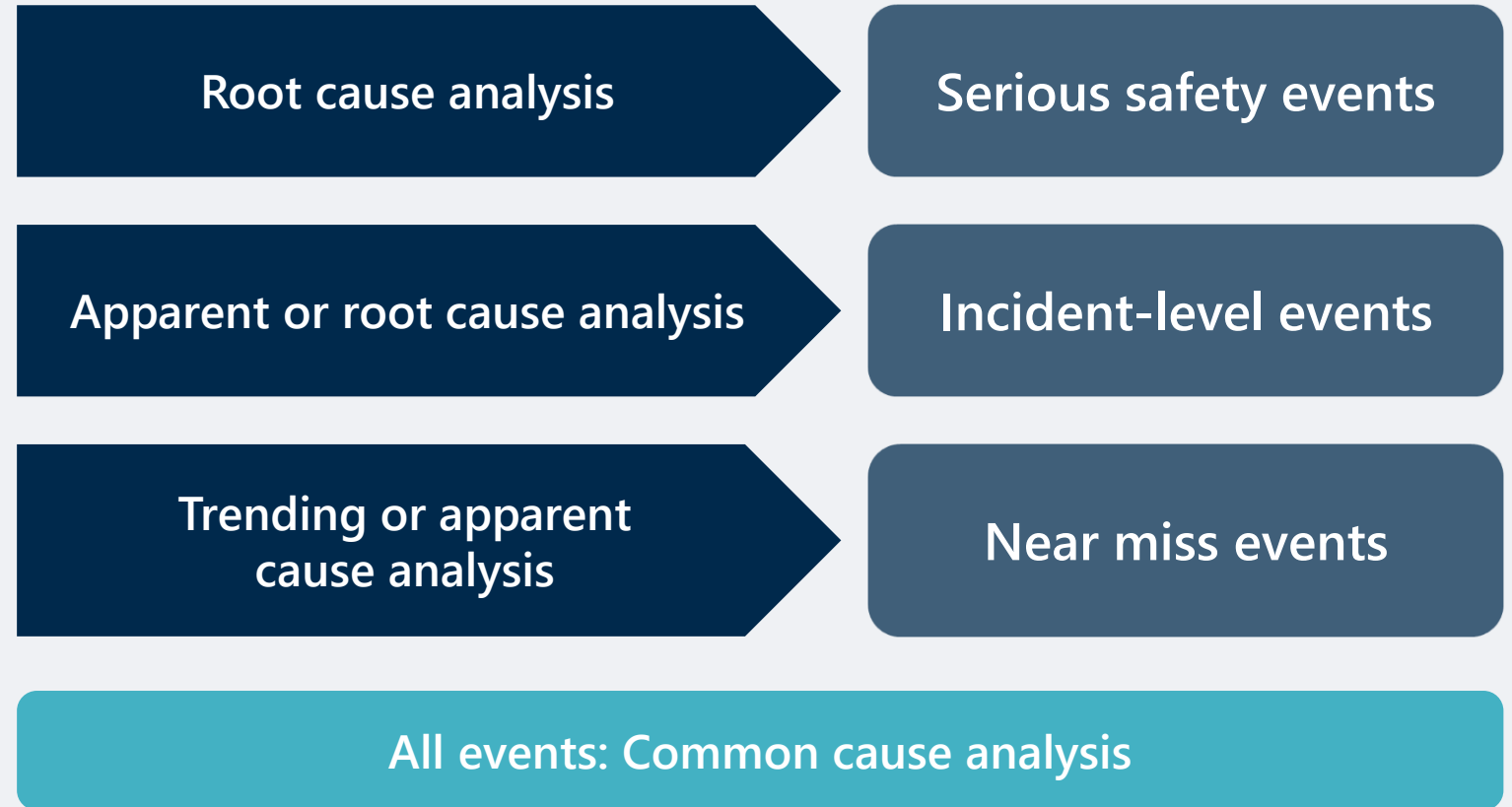
Intake & classification of events

Severity*	Description
A	Circumstances or events that have the capacity to cause harm (unsafe conditions)
B1 – Design	An error occurred but the error did not reach the patient (an “error of omission” does reach the patient**) because of being caught by a barrier build into the system
B2 – Chance	An error occurred but the error did not reach the patient (an “error of omission” does reach the patient) because it is caught by chance or incidentally by a barrier not built into the system
C	An error occurred that reached the patient but did not cause patient harm
D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm
E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention
F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization
G	An error occurred that may have contributed to or resulted in permanent patient harm
H	An error occurred that required intervention necessary to sustain life
I	An error occurred that may have contributed to, or resulted in, death
Non-Event	A non-preventable event not related to deviations from policies, procedures, or best practices

The science of safety

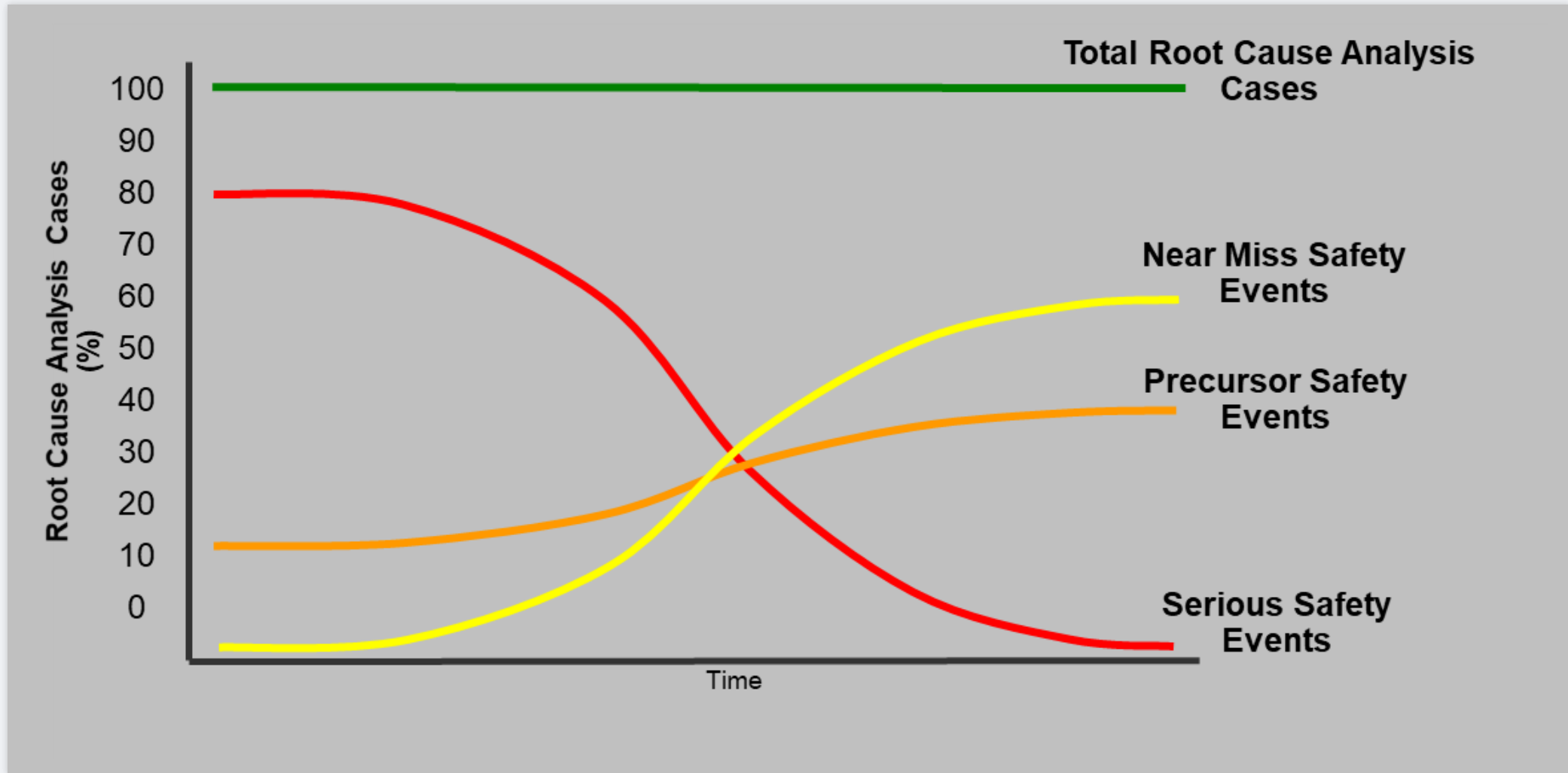


Event response plan



Cause analysis case mix

As serious safety events decrease, we can shift more resources to the investigation of incidents and near miss events – your organization's RCA volume shouldn't ever decrease



Human error classification

	Skill based	Rule based	Knowledge based		
Activity type	Familiar, routine acts that can be carried out smoothly in an automatic fashion	Problem solving in a known situation according to set of stored "rules," or learned principles	Problem solving in new, unfamiliar situation where the individual doesn't know the rules – requires a plan of action to be formulated	Skill based error	"I was busy and I just forgot" "My cell phone rang just as I was about to..." "I had to work 4 hours over my 12-hour shift..."
Error types	- Slips - Lapses - Fumbles	- Wrong rule - Misapplication of a rule - Non-compliance with rule	Formulation of incorrect response	Knowledge based error	"I didn't know there was a policy/protocol." "This was the first time I was doing this task and..." "My leader said we didn't need to worry about this rule..."
Error prevention themes	Self checking – stop and think before acting	- Educate if wrong rule - Think a second time if misapplication - Non-compliance – reduce burden, increase risk awareness, improve coaching culture	Stop and find an expert	Rule based error	"The policy is too hard to follow" "I thought something was wrong, but I didn't want to upset the doctor..." "I've done this so many times, so I didn't do a double check."
Error probability	1:1000	1:100	3:10 to 6:10		

Based on the Skill/Rule/Knowledge classification of Jens Rasmussen and the Generic Error Modeling System of James Reason

HUMAN ERROR – A SYMPTOM, NOT A CAUSE

Human error is not the cause of failure,
but a *symptom of failure*

Human error – by any other name or by
any other human – should be the *starting point*
of our investigations, not the conclusion

Source: Fitts, P. M., & Jones, R. E. (1947). "Analysis of factors contributing to 460 'pilot error' experiences in operating aircraft controls." *Memorandum Report TSEAA-694-12*, Aero Medical Laboratory, Air Material Command, Wright-Patterson Air Force Base, Dayton, Ohio.

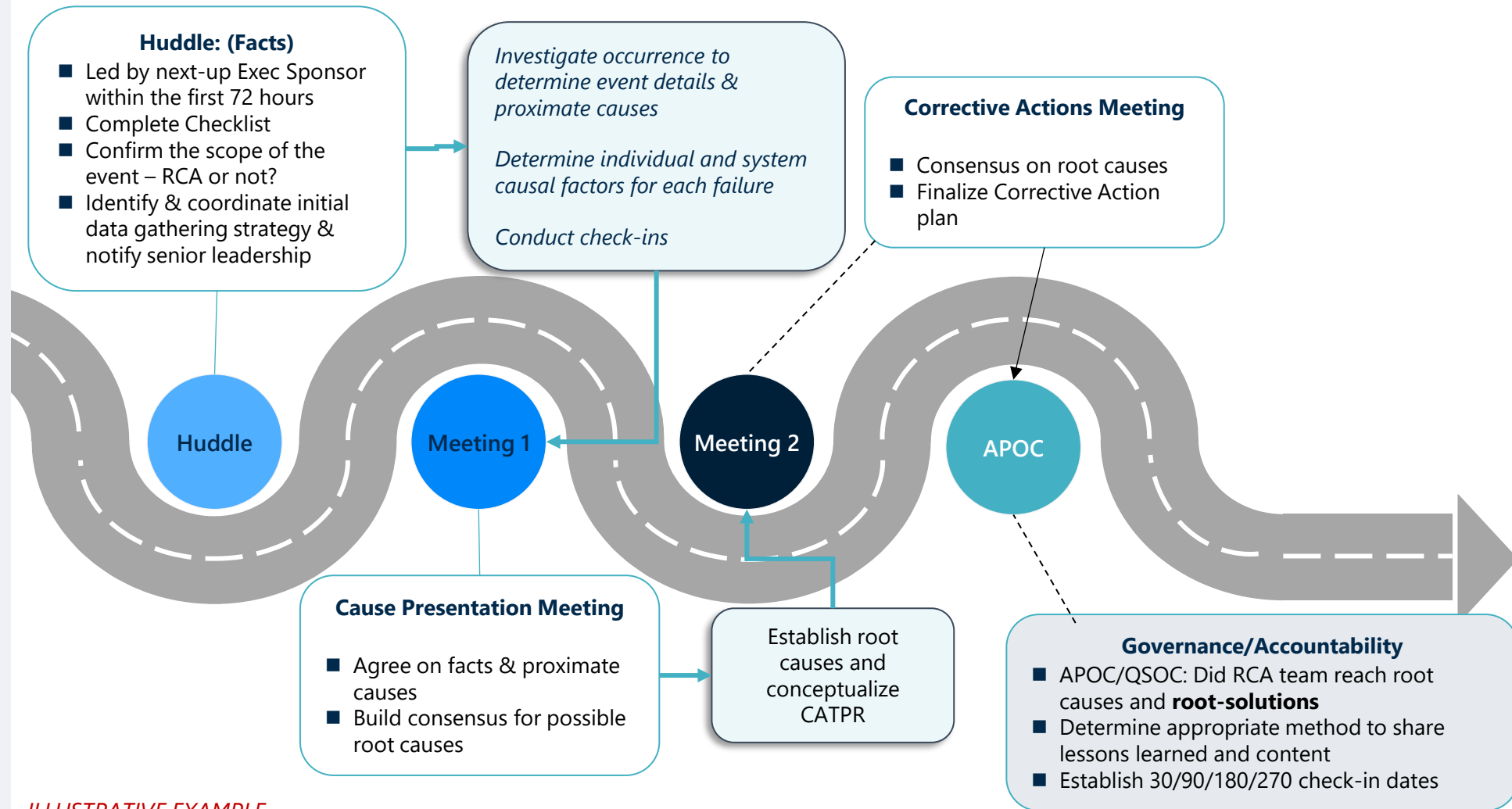
Chartis' RCA Model

RCA approach

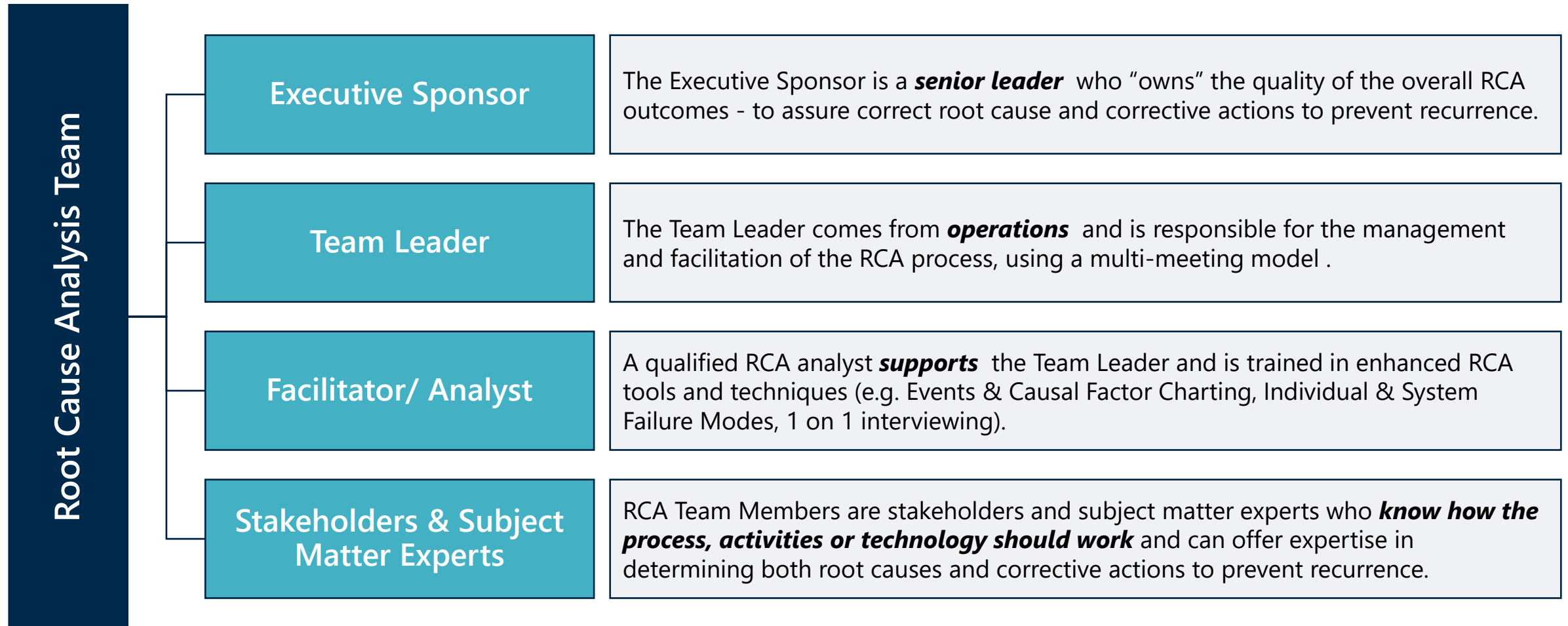
The RCA (Root Cause Analysis) process will include an initial huddle plus three formal meetings – one to present analysis findings, and a second separate meeting to formulate a corrective action plan and a third for action plan accountability.

The RCA facilitator(s) will conduct routine check-ins with quality/safety leaders at least weekly through the process.

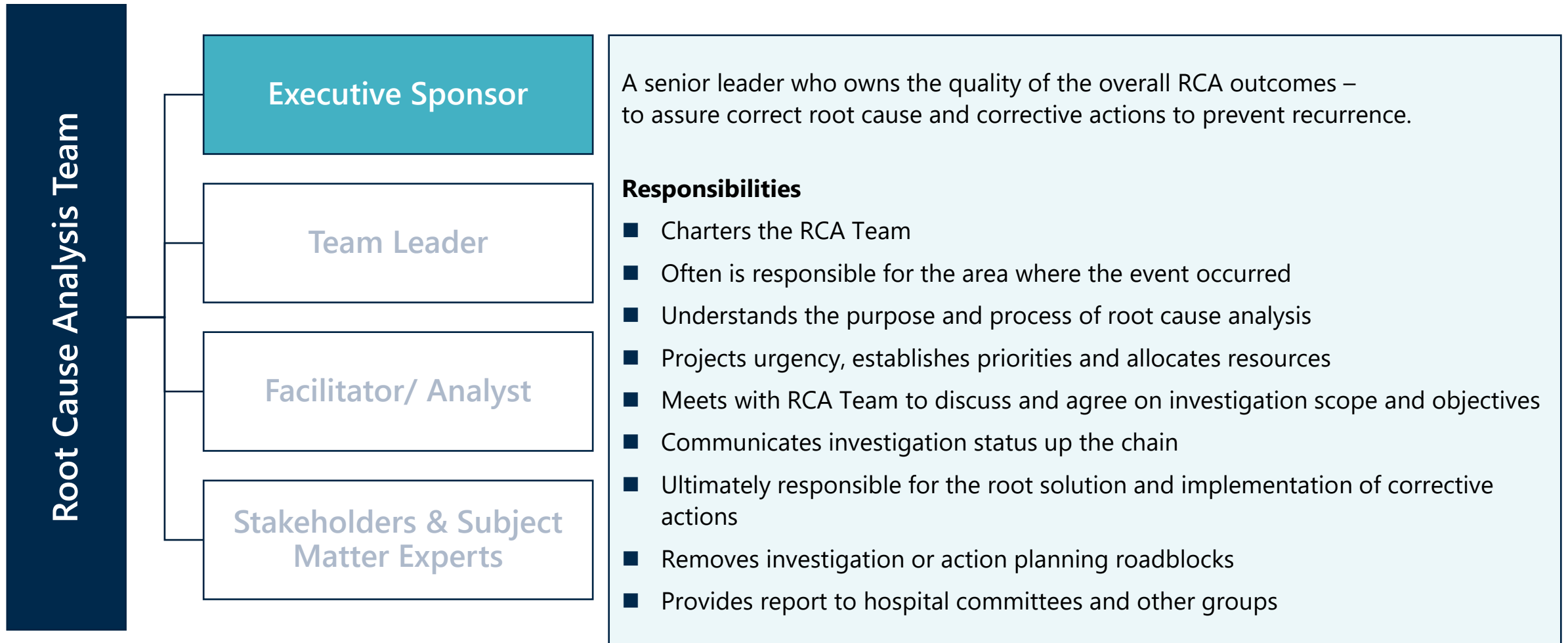
Structures like Quality Safety Oversight Committee/Action Plan Oversight Committee (QSOC/APOC) will ensure a close-out memo is sent to participants and a substantive, transparent, case overview is produced to broadly share relatable lessons learned and a link back to HRO skills and tools.



RCA team structure



RCA team structure



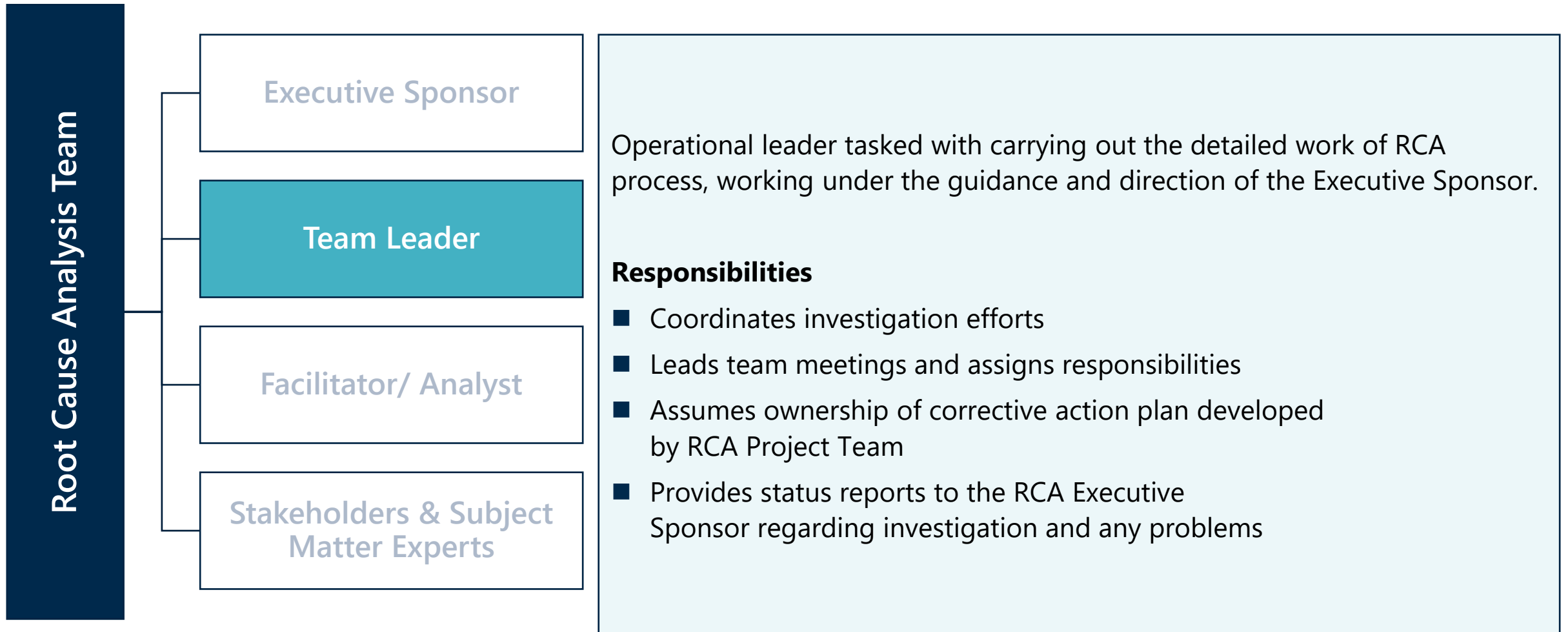
Effective executive sponsorship

- General education on responsibilities is helpful, but education alone does not change behaviors.
- Leaders may be used to being a Sponsor “in name only” (happy to turf off responsibility for the RCA to Safety/ Quality/ Risk).
- Best practice: Include a standing item on the periodic senior leadership team meeting to discuss RCAs in progress (each senior leader reports out on the RCAs they are sponsoring).
- Other considerations:
 - Hold a quick pre-job brief with the executive sponsor before each RCA meeting or event
 - Create a written job aide or supporting document

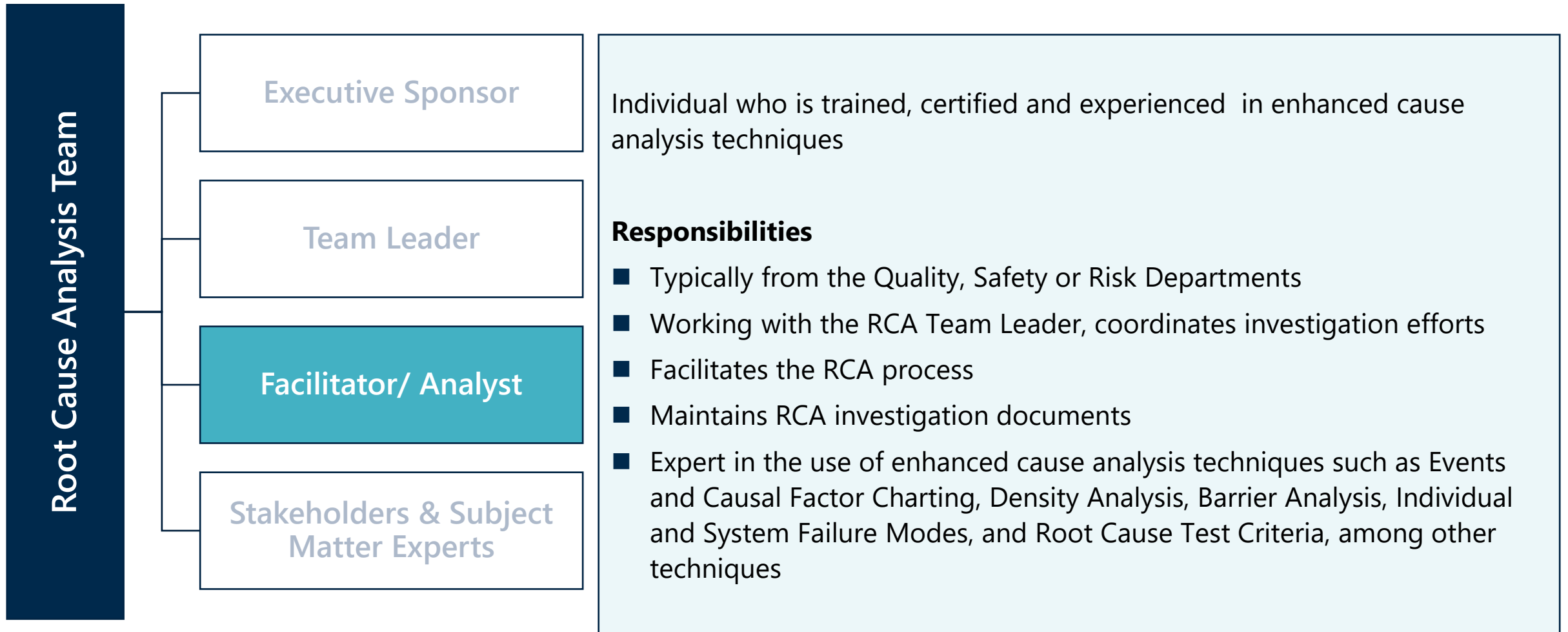
RCA Executive Sponsor guided discussions

1. What must we do now to make our patients safe while we perform the root cause analysis?
2. Where else in our hospital/system might we be at risk for a similar type of event?
3. If we had delivered safe, evidence-based care, what would that have looked like? What did we do that was different – what are the inappropriate acts?
4. What are the system factors contributing to the acts comprising this event? Have we asked WHY enough?
5. Of the system factors that are root causes, what must we change or put in place to prevent recurrence? That is, what are the corrective actions to prevent recurrence?
6. Is this a déjà vu root cause (i.e. have we seen it before in a safety event)? If yes, why were past efforts unsuccessful in fixing the cause?
7. What problems do you anticipate in implementing the corrective actions?
8. What must we do to make our patients safe while we implement these actions?
9. Where else in the hospital/system should we apply these actions? How will we share the lessons learned?
10. How will you know that the corrective actions have been implemented effectively and are working?

RCA team structure



RCA team structure



Five-step RCA process

**Investigate the occurrence (interviews,
document review, visit environment of care)**

Identify the sequence of events and proximate causes

Identify root causes

Identify self-assessment deficiencies
(previous missed opportunities)

Develop correct actions to prevent recurrence

Action plan considerations by error type

Human Error Types	Prevention Strategies	Action Plan Considerations
SKILL	Slip: Stop and think before acting	■ Interruption reduction ■ Self-checks/ Second checks
	Lapse: Check and review	■ Visual cues/reminders ■ Checklists ■ Self-checks/ Second checks
RULE	Wrong Rule: Clarify and educate	■ Policy clarification and standardization ■ Education
	High Burden to Comply: Simplify/reduce burden	■ Checklists/Job Aides/Visuals ■ Process simplification ■ Intuitive design
	Low Risk Awareness: ■ Transparency ■ Communicate consequences	■ Share events ■ Share lessons learned ■ Discuss possible consequences of non-compliance
	Lack of Co-Worker Coaching: ■ Team checking and coaching ■ Safety Coaches	■ Teamwork training ■ Increase safety coaches
KNOWLEDGE	Operating Outside of Expertise: ■ Stop the Line ■ Validate and Verify	■ Teamwork training ■ Communicate Validate and Verify expectations

Linking corrective actions to identified causes

- In a study of 227 healthcare RCAs, 1137 action planning recommendations were made (about 5 per RCA on average).
- Based on the reviewer's criteria, 8% of the action items were 'strong', 44% 'medium' and 48% were 'weak'.
- In 165 (72%) RCAs, no strong recommendations were made.
- The most frequent recommendation types were reviewing or enhancing a policy/ guideline/ documentation, and training or education.

Strong:

- Physical Barriers
- Forcing Functions
- Re-engineered and simplified processes

Medium:

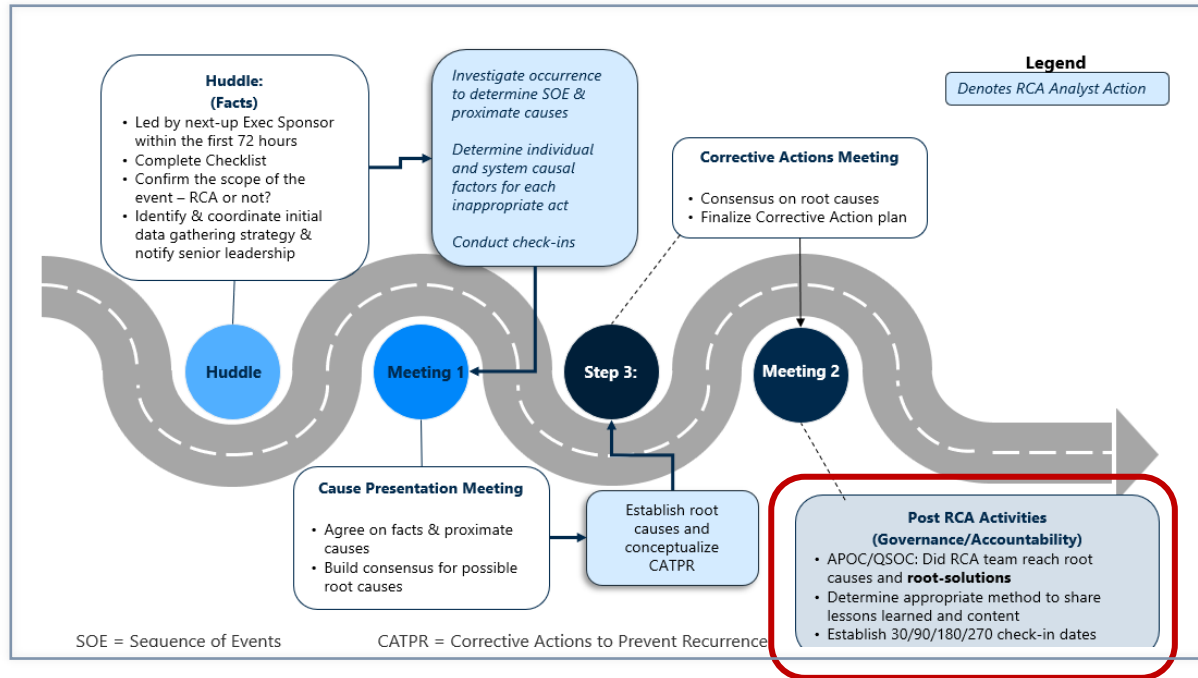
- IT changes
- Checklists
- Other cognitive job aids

Weak:

- Education/ Training
- Warnings
- Policy revision

CAUSE ANALYSIS MONITORING AND OVERSIGHT

“You get what you inspect, not what you expect.”



Targeted and global cause analysis monitoring and oversight helps to ensure:

- Cause analysis improvements (implementation of HRO best practices) are hardwired
- Safety events receive a thorough and credible investigation and analysis
- We minimize the risk of déjà vu events or events due to the same root causes

Remember: As leaders, we have an imperative to prevent and detect problems that can lead to an event. Yet we have a more profound obligation to correct causes once an event has occurred.

Cause Analysis Advisory and Oversight Team

What?

To provide ***oversight and operational ownership*** of the organization's cause analysis program and organizational learning from events.

Who? (Suggested Membership)

- Executive Owner (PSO, CQO, or other senior leader)
- Team Leader (implementation lead for safety such as the Director of Patient Safety)
- Medical Staff representation (CMO or medical staff leader)
- Nursing representation (CNE or other nursing leader)
- Individuals who facilitate cause analyses (typically individuals from safety, quality, or risk management)
- Ad hoc: Executive Sponsors from completed RCAs

Action Plan Oversight Committee

Typical Meeting Agenda

- Action Plan Status Updates/Barriers – Exec. Sponsors of Open RCAs
- Review of newly completed RCA action plans:
 - Were root causes reached?
 - Were the solutions root-solutions
- Review of programmatic metrics & KPIs

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
RCA Name	Event #	Event Date	RCA Huddle Date	Meeting 1 Date	Meeting 2 Date	Meeting 3 date	Executive Sponsor	Operations Leader	Event Details	APOC 30 Day Date	APOC 90 Day Date	APOC 180 Day Date	APOC 270 Day Date	Link to SBAR	Action Item List
RCA 1	123	3/3/2024	3/5/2024	3/20/2024	3/29/2024	4/4/2024	Dr. Ross	Dept Mgr	SE-I	5/4/2024	7/3/2024	10/1/2024	12/30/2024		1. xx 2. xx 3.xx
RCA 2	234	4/1/2024	4/1/2024	4/18/2024	4/25/2024	4/27/2024	Dr. Carter	Dept Mgr	SE-G	5/27/2024	7/26/2024	10/24/2024	1/22/2025		1. xx 2. xx 3.xx
RCA 3	456	4/2/2024	4/4/2024	4/18/2024	4/30/2024	5/3/2024	Dr. Benton	Dept Mgr	SE-I	6/2/2024	8/1/2024	10/30/2024	1/28/2025		1. xx 2. xx 3.xx

Sample Metrics for Oversight Committee

Safety Event Metrics

1. Event Counts
 - # of safety events – near miss, incident, serious
 - # of TJC sentinel events and/ or state reportable events
2. SSER
3. Days Since Last SSE or Average Days Between
 - Point in time days since last
 - Record run (longest days since last stretch)
4. Harm Ratio: serious/non-serious events (indicator of degree of harm); %s of harm levels
5. # of serious events discovered through external means
6. Months with ZERO serious events

Cause Analysis Program Metrics

1. Total Events Reported
2. Cause Analysis Counts
 - # RCA
 - # ACA
3. RCA Quality Indicators
 - RCA Cycle Time (avg days initiation-summary)
 - RCA process quality
4. Corrective Action Plan Status & Effectiveness
 - # action items past due
 - % of measures of success meeting criteria
5. Organizational Learning
 - Lessons Learned communicated
 - % Required Responses (actions taken) received

“

The greatest challenge
in diagnosing problems
is to never stop at the first
answer. Always dig deeper.

— Paul Gibbons



Thank *you*

