Workshop Details

**Root Cause Analysis (RCA) 2015 - 2016**

**Workshop Outcomes**

Learning Objectives:
- Understand importance of system and human factors in the development of incidents
- Understand the purpose of root cause analysis (RCA)
- Understand when to undertake an RCA
- Have a practical understanding of the steps of the RCA process
- Be familiar with the tools available to support RCA
- Have developed sufficient knowledge in order to actively participate and contribute to an RCA team, if lead by an experienced practitioner

**Who Should Attend?**

This program is suitable for all health care professionals who are involved in root cause analysis (RCA). From public and private hospitals, primary and community healthcare organisations and mental health organisations.

**Workshop Presenter**

Peter Hibbert: Program Manager, Australian Institute of Health Innovation, at Macquarie University. Peter has delivered interactive incident management/root cause analysis training to diverse organisations such as public acute, mental health, private hospitals, community care, and Medicare Locals. Peter was previously the Associate Director of Patient Safety at the National Patient Safety Agency (NPSA), London, United Kingdom.

Prior to his current role, he was the Associate Director of Patient Safety at the National Patient Safety Agency (NPSA), London, United Kingdom. He led and managed teams to reduce preventable patient harm in health care in England and Wales. He was the Program Director for Matching Michigan, at the time, the largest central line bloodstream infection reduction program in the world comprising over 200 intensive care units across England. The accompanying editorial to this paper states that "Matching Michigan will remain a model in the years ahead of how large, well-designed studies advance the science of patient safety." He chaired a national and multi-disciplinary incident response process to 300 serious and death incidents per week; he also directed the modification, release and spread of the World Health Organisation’s Safe Surgery Checklist to ensure that it was fit for NHS service.

**Program**

“Patient Safety, Human factors”

“Overview of the RCA Process”
- Objectives /Characteristics
- Process / Flow Diagram
- RCA steps
- When to conduct a RCA/ RCA not indicated
- Confirmation of a RCA and selecting a team

“What, Why, How”?
- Team meeting /Scenario
- Initial flow diagram 1
- Contributing factors /Gather information
- Interviews / Contributing factors
- Initial flow diagram 2 /Source Documents

“So What”?
- Review additional information,
- Final flow diagram
- Brainstorm barriers
- Cause and effect diagrams
- Causation statements

“Recommendations”
- Recommendations,
- Measures
- Human factors discussion

“Closure”
- Final report

**NOTE:** This is a 4 hour program. Start and finish times can be adjusted to suit your organisation’s needs

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This workshop is available to run onsite at your organisation.

For further details please contact ACHS education: educate@achs.org.au