

An important tool for use in of Quality improvement in the state of Virginia's DD programs.



# STARTING WITH "WHY"

When a serious incident happens during the delivery of disability supports, it is important to learn from the event and understand the main reasons it happened in order to take the right steps to prevent similar events.



## GETTING DEEPER, ASKING QUESTIONS

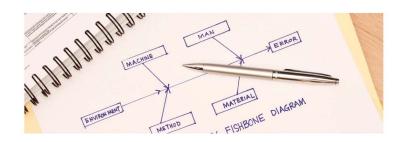
The required investigation will collect information about what happened. Root Cause Analysis helps to understand why it happened. Quality Monitoring teams should focus on asking multiple rounds of "WHY".



## FISHBONE DIAGRAMS



A fishbone ("Ishikawa") diagram provides a structure and a visual way to organize and group causes. It helps teams to break out of ruts in thinking and consider all contributing factors. The resulting event, or "error" as it is described in the example below is at the far right. Teams work together to review available information and to identify and group contributing factors before then agreeing on the main contributing factors and what actions (if any) should be taken to address contributing factors.





# TRAINING: USUALLY ONLY PART OF THE SOLUTION

Often times, human error will be identified as a factor in an incident, resulting in additional staff training. It is important to also consider other system factors which may contribute, such as staffing levels and processes which may contribute to error-prone situations.



# BUILDING QUALITY



Root cause analysis after an significant adverse event, using tools such as a Fishbone Diagram is used to identify actions that will result in enhancements in quality and safety in the delivery of supports to people with disability.

#### References:

- Guidance for Using Root Cause Analysis for Performance Improvement Projects.https://www.cms.gov/medicare/provider-enrollment-and-
- How to Use a Fishbone Diagram for Root Cause Analysis https://www.oms.gov/medicare/provider-enrollment-and-
- certification/qapi/downloads/fishbonerevised.pdf

  How to Create a Cause and Effect Diagram Harvard X: https://www.voutube.com/watch?app=desktop&v=mlvlzyDFLQ

