

# University of Michigan Hospitals and Health Centers Root Cause Analysis Tools For Adverse Events

## Getting Started

### 1. Repetitive “Why?” Analysis Process

Undesirable event or problem occurs
Which was caused by? ....
Which was caused by? ....
Which was caused by? ....

Example:

Critical lab values received, not identified with the correct infant. Infant not treated for low blood glucose.

Which was caused by? ....
Two different patient ID numbers assigned to same infant
Which was caused by? ....
Two different registration cards at the Nurses Station for infant, each with different numbers
Which was caused by? ....
Registration card produced when mother admitted, temporary baby card produced at that time. False labor, mother discharged. Temporary baby card retained (in case of mother’s imminent return). Mother returns. New temporary baby card produced.

### II. Barrier Analysis Worksheet

Undesirable event, adverse outcome or injury: \_\_\_\_\_

Barrier that should have prevented the event (list one/line)	Analysis : Why the barrier failed to prevent the event	Probable reason(s) for the “broken” barrier.

**Sources:**

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