



RLI Power Hour

Using Root Cause Analyses to Kickstart QI

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Objectives

- Describe my journey into quality and safety
- Highlight the mistakes and challenges along the way
- Describe how RCA's can kickstart a career in QI

My Journey – Summer 2005



Residency

- ABR Requires PQI Projects – Part IV MOC
- ACR Quality and Safety Meeting
- E. Stephen Amis Fellowship in Quality and Safety
- RSNA Quality Improvement Committee



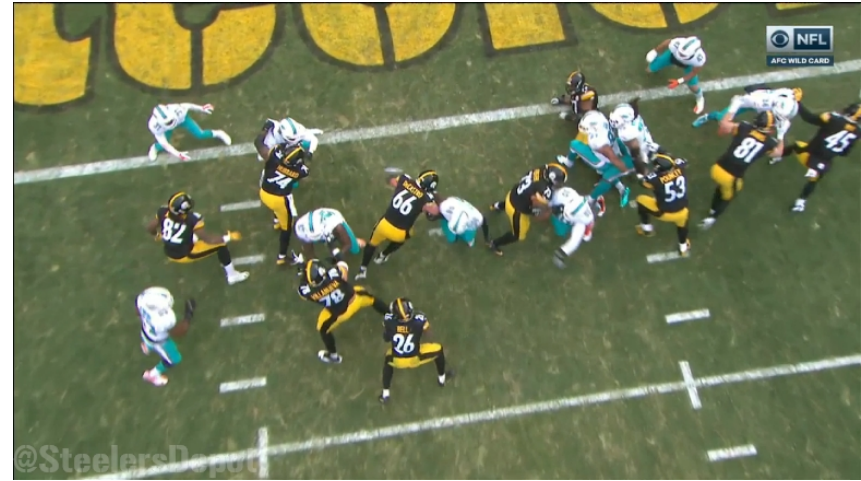
Faculty Experience

- No formal opportunity for local involvement initially
- Failed to build a team
- Peer review replaced need for PQI projects
- Quality as an avenue for academic advancement
- Benefit of network with ACR and radiology colleagues - RSCAN



Second Position

- Formal title and team
 - Extensive institutional know-how
- Proactive institutional risk department
- Concurrent leadership training/coaching



Root Cause Analyses

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David B. Larson, MD, MBA*

Abbreviation: RCA = root cause analysis
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Serious adverse events continue to occur in clinical practice, despite our best preventive efforts. It is essential that radiologists, both as individuals and as a part of organizations, learn from such events and make appropriate changes to decrease the likelihood that such events will recur. Root cause analysis (RCA) is a process to (a) identify factors that underlie variation in performance or that predispose an event toward undesired outcomes and (b) allow for develop-

- Tool used to evaluate sentinel events and other serious patient safety events
- Requires a moderator and “safe space”
 - Physicians, allied health staff, managers, risk, etc
- Generate action items
 - Build the quality team
- Create a culture of pro-active event reviews

Lessons Learned, Opportunities

- Quality Community
- Organic, bottom-up approach
- ACR Resources
- Long term proposition

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**Arizona.
Bold.
Forward.**

