People

Environment

Input causes here.

Input causes here.

Materials

Methods

Equipment

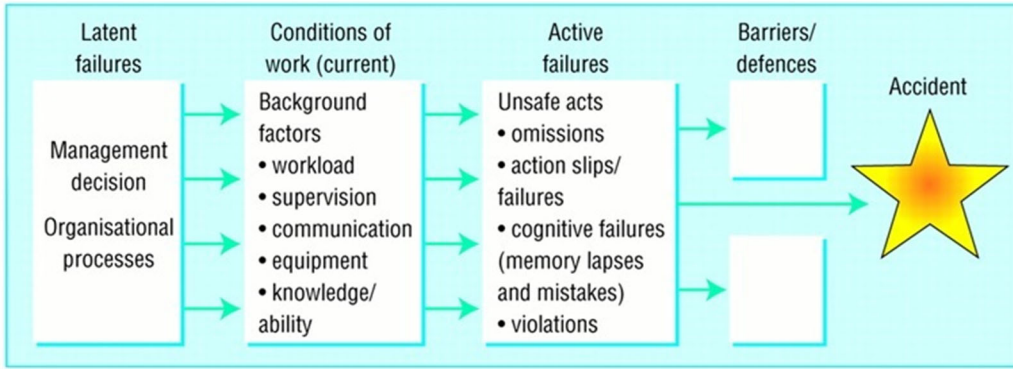**https://www.ihi.org/education/WebTraining/Pages/default.aspx**
You can sign up for free classes through the Institute for Healthcare Improvement (IHI) with your .mil email address.
They have online classes on QI and Patient Safety that are really helpful if you're interested in getting started with QI/PS projects

Five Rules of Causation
Focus on system issues (not human error)
1. Clearly show the cause-and-effect relationship
2. Use specific and accurate descriptors for what occurred
3. Human error must have a preceding cause
4. Violations of procedure are not a cause and must have a preceding cause
5. Failure to act is only causal when there is a pre-existing duty to act

"What circumstances led a reasonable person to make reasonable decisions that resulted in an undesirable outcome?"

Latent failures	Conditions of work (current)	Active failures	Barriers/ defences	Accident
Management decision Organisational processes	Background factors • workload • supervision • communication • equipment • knowledge/ ability	Unsafe acts • omissions • action slips/ failures • cognitive failures (memory lapses and mistakes) • violations		

BMJ

EVENT. What happened? Define the problem as an *event*:

PATTERN. What's been happening? Define the problem as a *pattern* by selecting a poor performance factor:

STRUCTURE. Why is it happening? What are the tangible and intangible structures determining the results we see?

1. ⬅ Why is that?

2. ⬅ Why is that?

3. ⬅ Why is that?

4. ⬅ Why is that?

5.

ACTION. What are the implications for action? What can you do to change the results?