

# Strengthening Food Safety through Root Cause Analysis

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Iowa Food Safety Task Force Meeting

March 14, 2019 [pewtrusts.org](http://pewtrusts.org)

# Pew's Mission

- Foster unbiased, evidence-based public policy
- Public Charity
  - Established by four children of Sun Oil Company founder J.N. Pew Sr.
- Topics
  - **Health**; Governing; Trends; Conservation; Communities; Finance & Economy

# Safe Food Project

- Approved in 2011
- FSMA implementation and research on meat and poultry safety
- Goal: reduce public health risks from foodborne pathogens



# Pew's Role in Food Safety Policy

- **Facilitate dialogue** among stakeholders
- **Build relationships** through outreach
- **Foster research** to inform recommendations
- **Advocate for changes** in laws & regulations



# Presentation Outline

- Pew's Root Cause Analysis (RCA) Initiative
- Approach to RCA guide
- Guide content and some lessons learned about RCA

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# RCA project history

## Collaborative Food Safety Forum

- RCA intrinsic to enhancing food safety

## Convenings

- First meeting in 2016
- Bring together diverse stakeholders, discuss opportunities and barriers

## Guide development

- Gather lessons learned and approaches for RCA
- Look at guidance and models in different industries

# Why is RCA a priority for Pew

- Foundation of a prevention-based food system
- Underutilized, ineffectively shared, lost opportunities
  - “Unfortunately, there does not seem to be a safe place for businesses to share such insights with each other” - B. Baker, Mars, Inc.
- Improvements require collaborative approach
- Alignment among FDA, CDC, FSIS, state & local gov, industry



# Presentation Outline

- Pew's RCA Initiative
- Approach to RCA guide
- Guide content and some lessons learned about RCA

# Guide information sources

## 1. Convenings

- Key topics from discussion
  - I. What is a RCA
  - II. Considerations before conducting an RCA
  - III. How should an RCA be conducted
  - IV. How should findings be communicated

## 2. Initial research

## 3. Input from working groups

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# Initial research questions

- How are other organizations conducting RCA?
  - How do they decide when to conduct a RCA?
  - How do they perform the RCA?
- How are the key findings disseminated and used?
- What is working & what is not?

# Audience

- Food industry; federal, state, local food safety agencies; trade and professional associations; academia; consulting companies
  - Practitioners
  - Managers/Resource allocators
- Varying backgrounds, experience, food settings

# What's in the guide

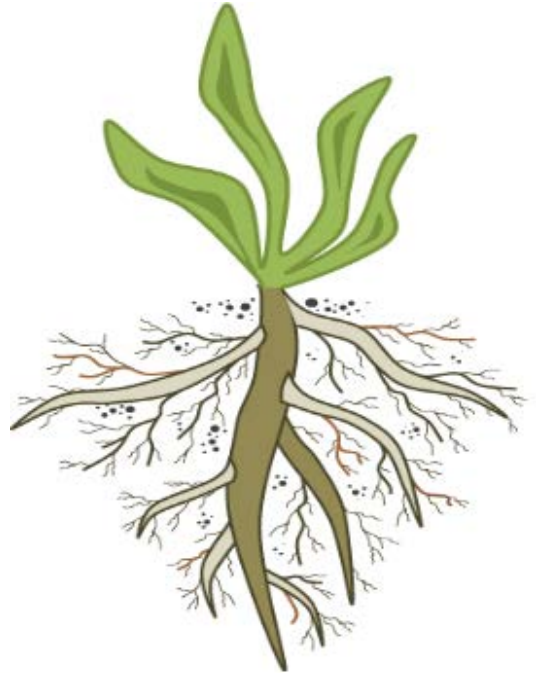
- Approaches for effective RCAs
  - To prepare for and conduct RCA
  - To report findings and conclusions
  - To use RCA findings for process improvement

# Presentation Outline

- Pew's RCA Initiative
- Approach to RCA guide
- **Guide content and some lessons learned about RCA**

# I. What is a root cause analysis?

- Definition: Retrospective investigation used to identify why a problem occurred
- Contributing factor vs. root cause
  - Don't stop at contributing factor!
- When, where, who: Different food settings
  - Safety AND Quality



# Example: Processed Food

Hypothetical: Item is re-contaminated after heat treatment and enters the market

- Contributing factors:
  - Machine corrosion from improper cleaning
  - Product not monitored post-processing
- Root causes:
  - Lack of defined maintenance SOPs
  - Unable to hire adequately trained staff



# II. What should be considered before conducting an RCA?

- How should the scale be determined?
- Is sufficient capacity available?
- How long should it take?

# Example: National Transportation Safety Board

What can we learn from NTSB on scaling an investigation?

1. Accident notification
2. “Go Team” composed
  - Number of injuries & fatalities
  - Location
  - Public interest
  - Magnitude of tasks
  - Previous accidents of same type



NTSB 2002

# III. How is an RCA conducted?

- What happens before the investigation begins?
- Steps for conducting RCA
- How do you know you've found a root cause?
- How can changes be maintained?
- What if I can't find a root cause?

# Effective RCAs reconstruct events

## Before the accident

What was the general situation before the event?

What specific events led up to it?



## During the accident

What went wrong and why?

What went right?

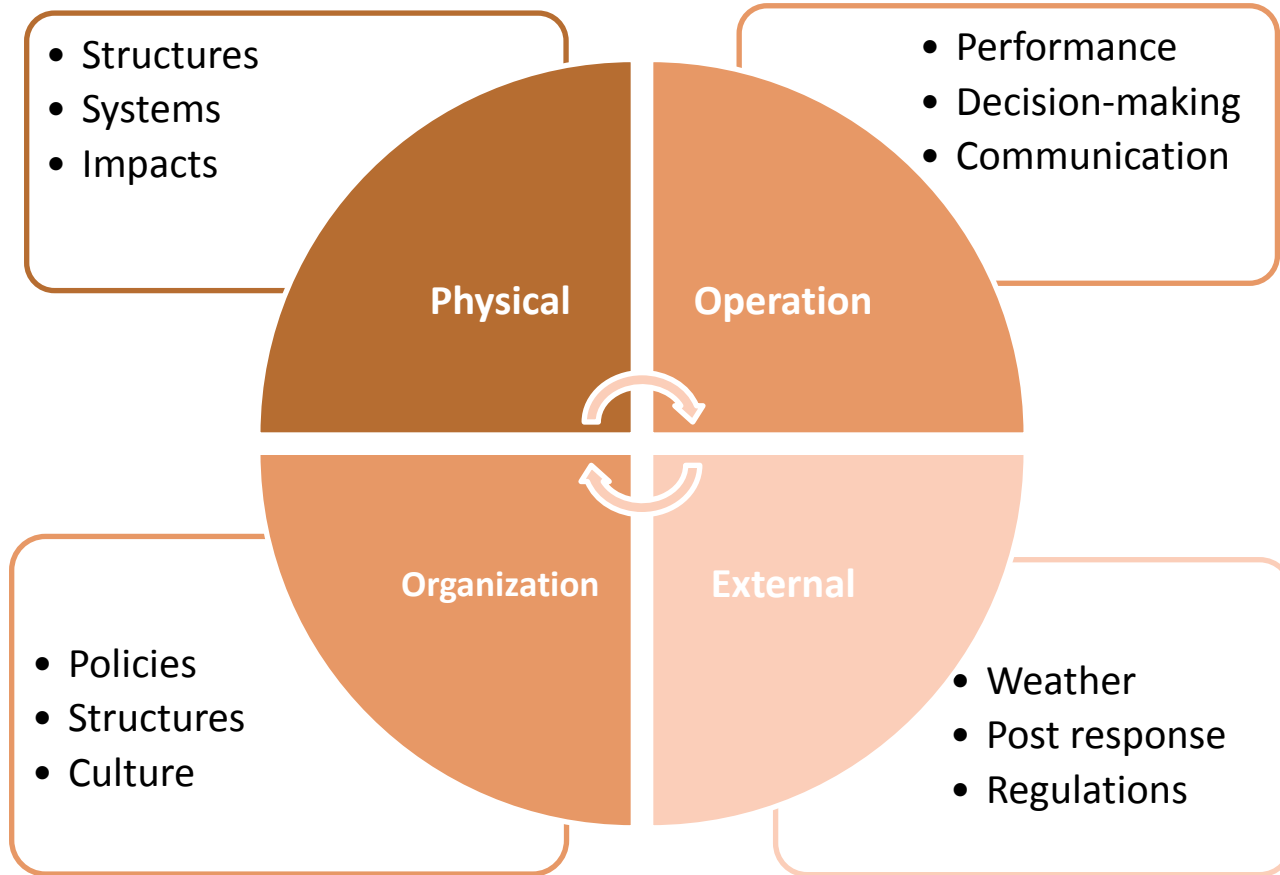


## After the accident

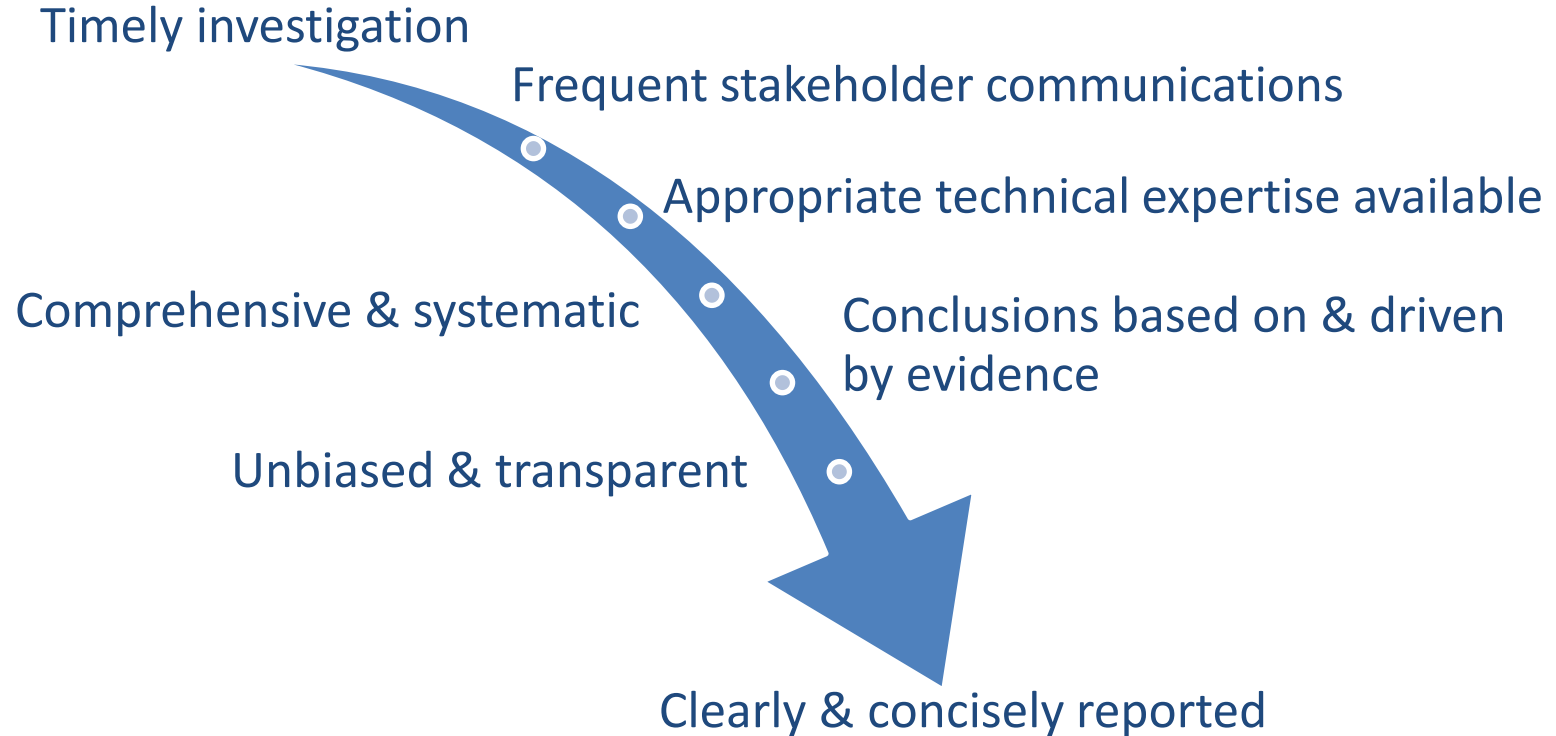
How well did the post-event response work?

What has been learned and what changes have been made?

# Effective RCAs consider 4 types of factors

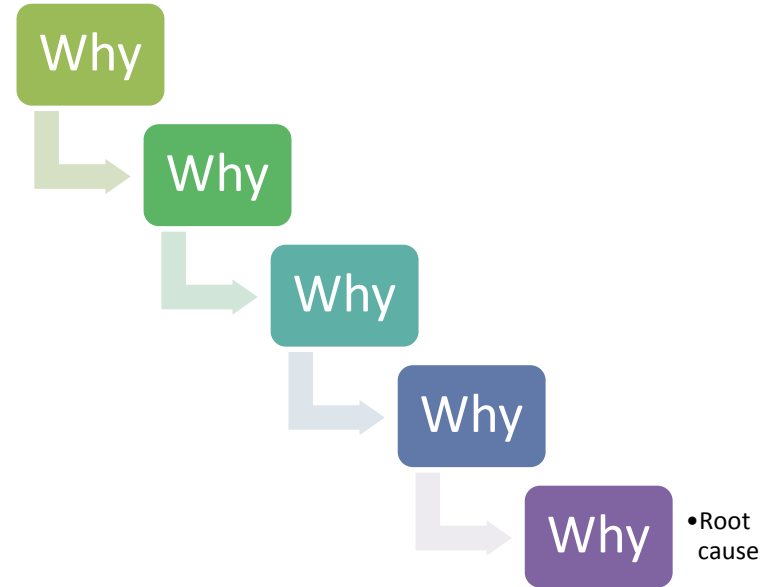


# Properties of effective RCAs



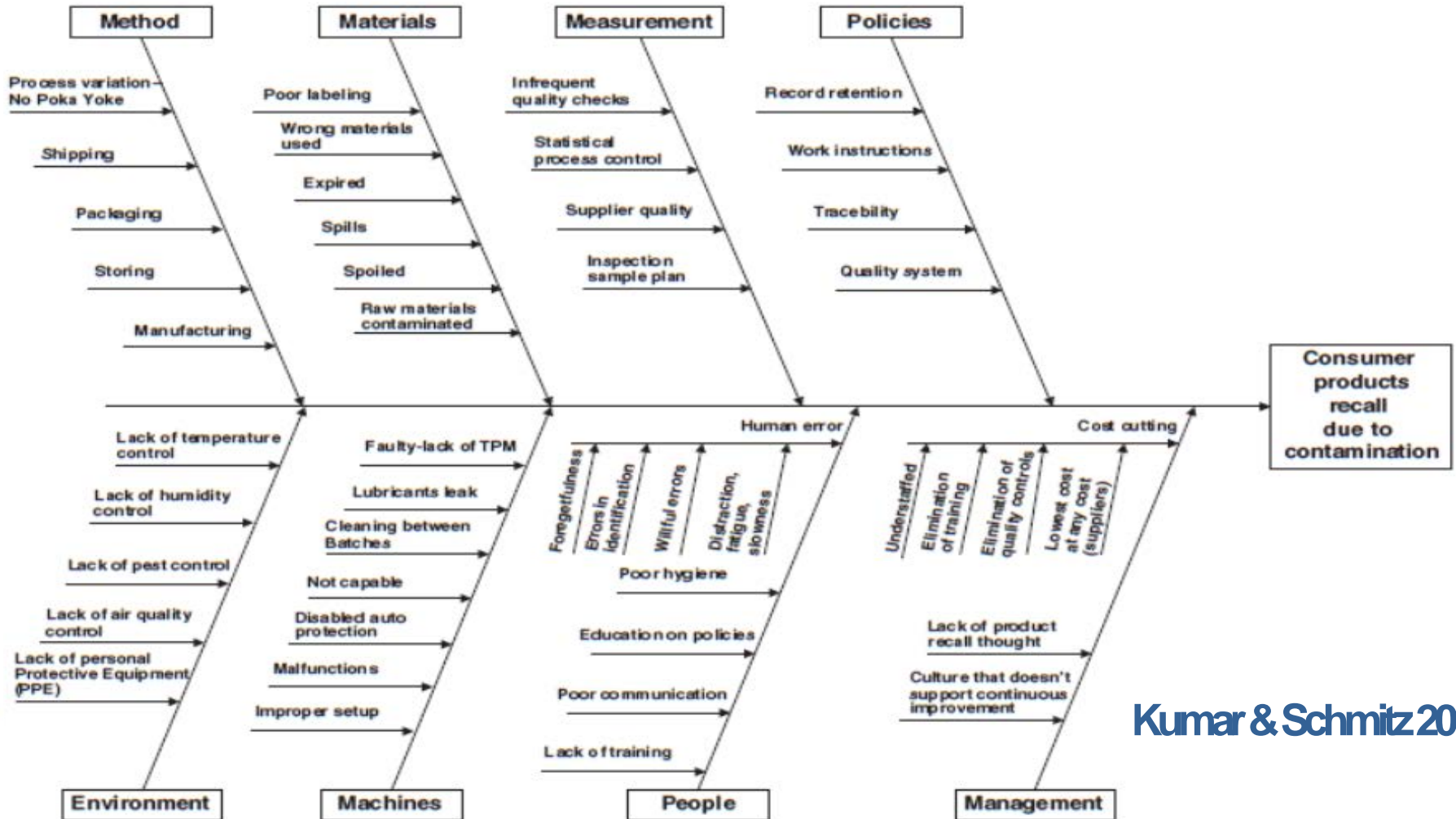
# Tools

- Cause & effect diagrams
  - Fishbone/Ishikawa, Fault tree
- KNOT chart
  - Classify evidence
- 5 whys
  - Very simple, use with other techniques



	<b>Specific Data Item</b>	<b>Know</b>	<b>Need to know</b>	<b>Opinion</b>	<b>Think we know</b>	<b>Action</b>
D1	80% Humidity and Temperature of 84 degrees F at 2:00 PM	<b>X</b>				
D2	Belt Speed on the machine <i>appeared</i> to be slower than usual			<b>X</b>		Locate and interview other witnesses
D3	Operator said she was having a difficult time cleaning the contacts			<b>X</b>		Locate and interview other witnesses
D4	Press Head speed was set at 4500 rpm				<b>X</b>	Verify by review of Press Head logs
D5	Oily Substance on the floor?		<b>X</b>			Interview Cleaning Crew
D6						

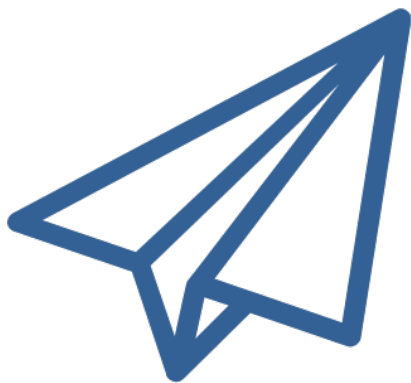




# Example: Changes to Food Policy

- 2006 Spinach & E. coli
  - Contamination from feral swine and cattle
  - Finding: Wildlife intrusion on fields
  - Policy change: emphasize wildlife barriers in good agricultural practices
- Food service & Norovirus
  - Ill workers handling food
  - Finding: Pressure to work
  - Policy change: require workers to report illness, mandating sick leave

# IV. How should findings from an RCA be communicated?



- Report sharing
  - Academic institutions
  - Industry associations
  - Government networks
- Education and training
- Policy action

# Example: Patient Safety

## What can we learn from Patient Safety on sharing results?

- U.S. Department of Veterans Affairs (VA) National Center for Patient Safety
  - Developed and mandated RCA process
  - Maintains database of RCAs for analysis and to drive improvements
- Enables analysis of RCA's impact
  - Study found postoperative complications higher at VA medical centers that performed fewer RCAs



# How we hope the guide will be used

- Promote RCA as part of a food safety professional's training
- Starting point for investigators in any organization with vested interest in food safety
  - Principles, basic tools, resources, rationales
- Template for creating internal standard procedures for root cause analysis

# Next steps

- Work in progress, circulation and review
- Strategy for sharing and communication of RCA findings

# Thank You

## Questions?

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