Five Whys Exercise

The Five Whys is a simple, yet powerful, problem-solving technique used for root cause analysis (RCA) in quality improvement (QI). It is particularly useful in the Analyze phase of a project to move beyond symptoms and identify the systemic failure that caused a problem. Here is a template and guide for using the Five Whys tool:

Five Whys Root Cause Analysis Tool

Step 1: Define the Problem (The Symptom)

State the specific problem or event clearly and objectively.

Problem Statement:
Example: The patient received the wrong dosage of medication.

Step 2: Ask "Why?" (Iteratively)

Start with the initial problem and ask "Why did this happen?" Record the answer, and then use that answer to form the basis of the next "Why?" question. The process is typically repeated five times, though you may stop sooner if the root cause is found, or continue if you haven't reached a manageable system issue.

#	Question	Answer (The New "Why?")
Why 1	Why did the patient receive the wrong dosage of medication?	The nurse pulled the wrong concentration of the drug from the Pyxis cabinet.
Why 2	Why did the nurse pull the wrong concentration?	The different concentrations were stored right next to each other, and the labels were visually similar.
Why 3	Why were the different concentrations stored next to each other with similar labels?	The pharmacy staff did not follow the **"Tall Man Lettering"** or **"Look-Alike/Sound-Alike (LASA)"** segregation policy for medication storage.

#	Question	Answer (The New "Why?")
Why 4	Why did the pharmacy staff not follow the LASA segregation policy?	The pharmacy manager had not allocated the time or resources for a full Pyxis reorganization and staff training after a new policy was adopted six months ago.
Why 5	Why hadn't the manager allocated the time and resources?	Senior leadership had not set a clear organizational priority or provided budget for routine system-level safety updates (they prioritized cost savings over capital investment in safety changes).

Step 3: Determine the Root Cause and Action

The final "Why?" answer that points to a process, system, or management failure, rather than a human error, is often the Root Cause.

Root Cause Identified (from Why 5):	Corrective Action (System Fix):
Senior leadership and departmental managers have not consistently prioritized, budgeted, and enforced system-level safety policies (like LASA segregation) across all relevant care areas.	**Action:** Create a formal, interdisciplinary **Medication Safety Task Force** to audit storage and dispensing practices monthly, with direct accountability to the Chief Operating Officer for budget and resource allocation.

Guidelines for Effective Use

1. **Focus on Process, Not People:** The goal is to find the flaw in the system, not the fault of an individual. The question should never be "Why was the nurse careless?" but "Why did the system allow for that error?"
2. **Keep it Factual:** Base your answers on facts and data observed from the event, not on speculation or assumptions.
3. **Go Deeper than Policy:** If the answer is "Staff didn't follow policy," the next "Why?" must ask: "Why didn't staff follow policy?" (e.g., Was the policy impractical? Was training inadequate? Was the policy communicated poorly?).
4. **Use It on the Small Scale:** The Five Whys is excellent for quickly analyzing single, simple adverse events or close calls. For complex, multi-factor failures, a more robust method like Fishbone (Ishikawa) Diagram or a full Failure Modes and Effects Analysis (FMEA) may be required.