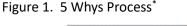
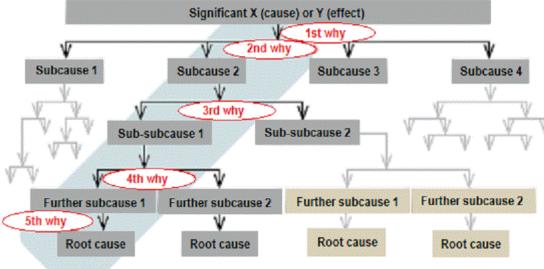
## <u>The 5 Whys</u>

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The "5 Whys" is a problem-solving technique to identify the root cause of a problem. The 5 Whys helps teams to drill down into problems, and is often used in improving patient care, safety, and operational efficiency. Taiichi Ohno, the father of the Toyota Production System, is credited with the technique. The concept is to ask "Why" five times, such that the deeper reasons for the problem are revealed (Figure 1). Finding the root of the problem allows solutions to be developed that are more likely to be effective and lasting. The initial "Whys" may be superficial symptoms of the problem, and solutions crafted to address them may not completely address the issue. Different individuals, or people in different healthcare roles, because of their important, different perspectives, may answer the "Whys" differently.





## \*ASQ. "Five Whys and Five Hows." <u>https://asq.org/quality-resources/five-whys</u>. Accessed 4.6.25.

The process starts with defining the problem. For example, it is noted that the patients served by one obstetric practice group have higher rates of anemia upon admission for labor than patients of all other practice groups delivering in the same hospital. One can ask, "When presenting for labor, why do patients in obstetric practice group "X" have a higher rate of anemia than other practice groups' patients?" The answer may be that there was a decline in the use of standard protocols for management of anemia. Then, the second "Why": Why was there a decline in standard protocol use? The second answer: because nurses are no longer reliably resulting the CBC to the patient with the instructions for anemia management? The third answer: because an electronic medical record (EMR) update limited some nurse's access to the result note functionality. The fourth "Why": Why were only some nurses affected by the EMR update? The fourth answer: Only nurses hired in 2025 lost access. The fifth





"Why": Why were only nurses hired in 2025 affected? The fifth answer: Because the IT individual responsible for correcting the issue went out on medical leave unexpectedly. While the same thing happened to all nurses, everybody else's access was corrected before the leave.

Of note, it is important to have stakeholders from all roles involved in the brainstorming. In this case, nurses and IT specialists were key to identifying the root cause. Discussions with other groups may reveal additional subcauses (Figure 1). Pharmacists may have also identified issues related to efficacy and compliance surrounding various iron formulations. A group of social workers may answer that patients' socioeconomics are different across provider groups and nutritional deficiencies are more common in certain zip codes, leading to higher rates of anemia. These ideas could be helpful in future improvement cycles.

When diverse teams apply this technique, they can identify and address root causes. This can enhance the effectiveness of the chosen interventions, leading to sustainable improvements in patient care and outcomes.

## **Further Reading**

- Centers for Medicare and Medicaid Services. "Five Whys Tool for Root Cause Analysis." <u>www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/FiveWhys.pdf</u>. Accessed 3.12.25.
- Institute for Healthcare Improvement. "5 Whys: Finding the Root Cause." <u>https://www.ihi.org/resources/tools/5-whys-finding-root-cause</u>. Accessed 3.12.25.



