



Patient Safety Essentials Toolkit:

5 Whys: Finding the Root Cause of a Problem

The key to solving a problem is to first truly understand it. Often, our focus shifts too quickly from the problem to the solution, and we try to solve a problem before comprehending its root cause. What we think is the cause, however, is sometimes just another symptom.

One way to identify the root cause of a problem is to ask “Why?” five times. When a problem presents itself, ask “Why did this happen?” Then, don’t stop at the answer to this first question. Ask “Why?” again and again until you reach the root cause.

This simple tool can be surprisingly insightful in helping you figure out what is really going on and can help you avoid quick fixes. It is especially useful for tackling chronic problems that show up over and over again in a complex system.

The technique is attributed to Taiichi Ohno, father of the Toyota Production System, which revolutionized automobile manufacturing with methods now known as Lean. It’s important to note that there may be multiple root causes of a problem, and that different people who see different parts of the system may answer the questions differently. For a more comprehensive tool, please see [RCA²: Improving Root Cause Analyses and Actions to Prevent Harm](#).

IHI’s Patient Safety Essentials Toolkit is a helpful companion for you and your organization on the journey to delivering safe, reliable care every time, for every patient. Each of the nine tools in the toolkit includes a short description, instructions, an example, and a blank template. NOTE: Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

- Action Hierarchy (part of RCA²)
- Ask Me 3[®]
- Cause & Effect
- Developing Reliable Processes
- **Five Whys**
- Flowchart
- FMEA
- Huddles
- SBAR

Instructions

- 1) Gather a group of interprofessional stakeholders who are familiar with the problem or event you are exploring.
- 2) Define the problem or event in clear, plain language.
- 3) Define the problem as a pattern and not just as an isolated event.
- 4) Ask “why” five times (at least) until you get to the root cause of the problem.
- 5) Explore the best way to solve the problem and make the subsequent changes to the system to ensure it doesn’t happen again.

Example: 5 Whys

A patient received the wrong medication.

- 1) **Why** did the patient receive the wrong medication?

The nurse did not complete patient identification.

- 2) **Why** did the nurse not complete patient identification?

The patient did not have a wristband.

- 3) **Why** did the patient not have a wristband?

The wristband had been removed for a procedure and not replaced.

- 4) **Why** was the wristband not replaced?

The printer for the wristbands was not working.

- 5) **Why** was the printer not working?

The staff needed to support IT had been reduced and was overworked.

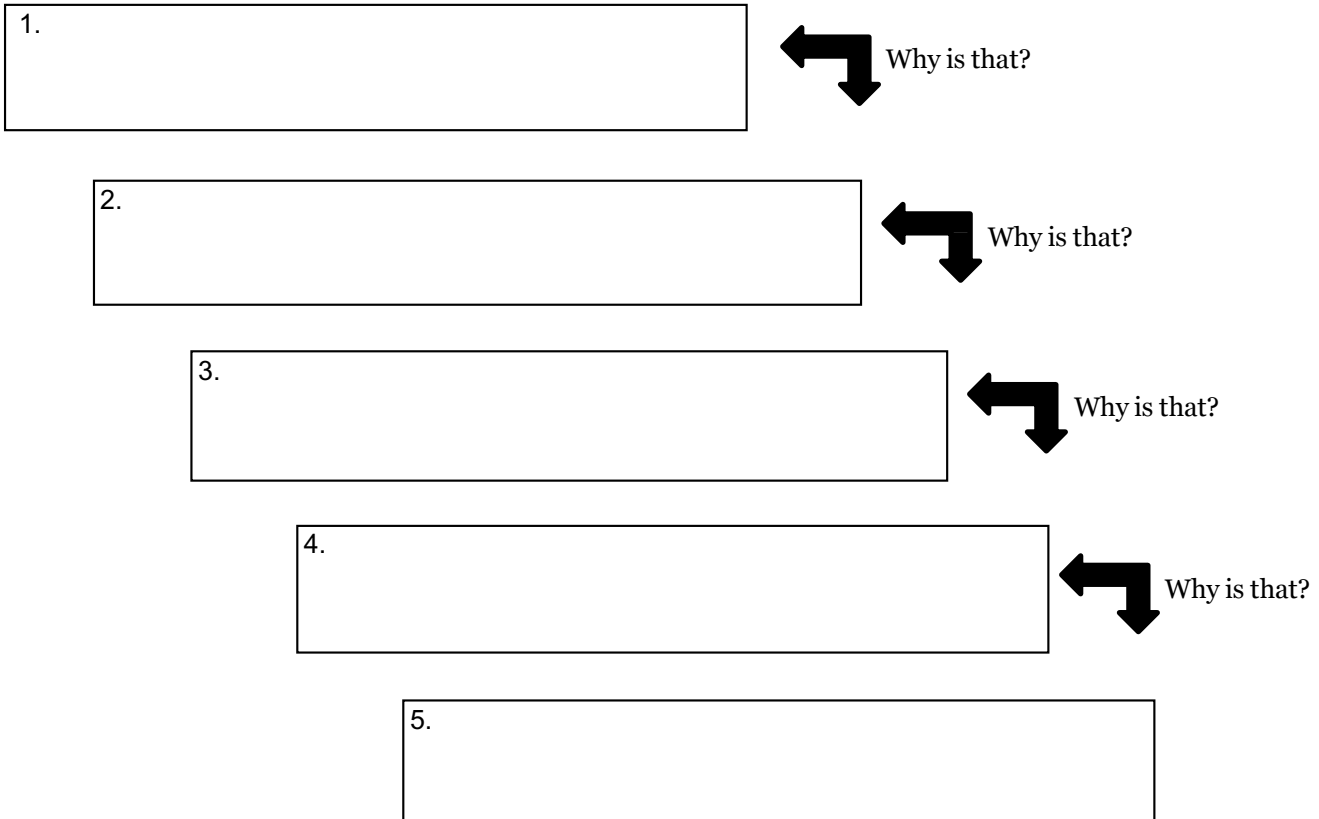
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Template: 5 Whys

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?



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