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The Veterans Affairs root cause analysis system in action.

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This article focuses on the application of root cause analysis (RCA) and the relationship between the National Center for Patient Safety (NCPS) and Veterans Affairs (VA) facilities in the RCA process. Discussion includes background into VA patient safety programs and the role NCPS plays in providing the structure, tools, and training for facilities to use the RCA with active feedback. The authors review current monitoring efforts and contrast the RCA process with the now-replaced focused review process. The comparison study demonstrated greater efficacy of RCA in providing more lessons and better information than focused review for translation to other facilities. Following detailed presentation of these study findings, two actual cases are reviewed to describe the RCA process in action. The case discussions illustrate how valuable RCA can be in improving quality and safety.