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VA Health Care: Actions Needed to Assess Decrease in Root Cause Analyses of Adverse Events.

September 9, 2015
Washington, DC: United States Government Accountability Office; July 29, 2015. Publication GAO-15-643.
https://psnet.ahrq.gov/issue/va-health-care-actions-needed-assess-decrease-root-cause-analyses-adverse-events

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The National Center for Patient Safety (NCPS) has contributed to patient safety improvement initiatives in the Department of Veterans Affairs (VA) since its inception. This investigation explored VA medical centers' application of root cause analysis after adverse events and how findings from these analyses were used to make system-wide improvements. This report found that the number of root cause analyses performed has decreased and the NCPS has not yet sought to determine why, but factors such as use of other incident analysis methods may have contributed. The Government Accountability Office recommends that the VA assess reasons behind the decline in use of root cause analysis and the extent to which alternative strategies are being utilized.