

Anesthesia adverse events voluntarily reported in the Veterans Health Administration and lessons learned.

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<https://psnet.ahrq.gov/issue/anesthesia-adverse-events-voluntarily-reported-veterans-health-administration-and-lessons>

This study examined [root cause analyses](#) performed by the Veterans Health Administration to identify and characterize anesthesia-related safety events. Although a relatively small number of events were found, the authors identified several [human factors](#) solutions that, if implemented, could prevent common types of errors.