

Root cause analysis of ICU adverse events in the Veterans Health Administration.

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Corwin GS, Mills PD, Shanawani H, et al. Root Cause Analysis of ICU Adverse Events in the Veterans Health Administration. Jt Comm J Qual Patient Saf. 2017;43(11):580-590. doi:10.1016/j.jcjq.2017.04.009. <https://psnet.ahrq.gov/issue/root-cause-analysis-icu-adverse-events-veterans-health-administration>

[Root cause analysis](#) is widely utilized in health care to examine [adverse events](#). In this retrospective study, researchers analyzed root cause analysis reports regarding events related to care in [Veterans Health Administration](#) intensive care units over a 2-year period. They found that events frequently had multiple root causes and that action items commonly involved changes to policies, procedures, and processes of care as well as training and education initiatives.