

Investigation of urology intraoperative events leading to root cause analysis at national VA medical centers.

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<https://psnet.ahrq.gov/issue/investigation-urology-intraoperative-events-leading-root-cause-analysis-national-va-medical>

[Root cause analysis](#) (RCA) is one tool commonly used to identify factors contributing to adverse events. Using RCA data from the Veterans Health Administration (VHA), this study characterized adverse events occurring during [urologic procedures](#). The most common causes of adverse events were improperly functioning equipment (e.g., broken scopes or smoking light cords), [wrong site surgeries](#), and retained surgical items.