**VA National Center for Patient Safety – Backgrounder**

The Department of Veterans Affairs (VA) National Center for Patient Safety (NCPS) was established in 1999 to lead the VA's patient safety efforts and to develop and nurture a culture of safety throughout the Veterans Health Administration (VHA). NCPS' primary goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care.

Our program is unique in health care because we use a "systems approach" to develop health care solutions based on prevention, not punishment. We use Human Factors Engineering methods – the study of designs that are "human-centered" and support or enhance human performance – and apply ideas of "high reliability" organizations, such as aviation and nuclear power, to target and eliminate system vulnerabilities. The success and importance of this approach to health care earned NCPS the prestigious Innovations in American Government Award, 2001.

NCPS uses a multi-disciplinary team approach, known as Root Cause Analysis (RCA), to study adverse events and near adverse events, know as close calls. The goal of each RCA is to find out what happened, why it happened, and determine how it can be prevented from happening again. Training programs, cognitive aids, and companion software have been developed by NCPS to support facility RCA teams.

Along similar lines, NCPS developed and implemented the Healthcare Failure Modes and Effect Analysis ™ training program and tools for health care facilities to use in proactive risk assessment and prevention.

Another key tool in our systems approach to health care solutions is the innovative Patient Safety Reporting System (PSRS). PSRS functions as an external "safety valve" for all VA employees, and was jointly developed by the VHA and the National Aeronautics and Space Administration (NASA). PSRS is modeled after NASA's very successful Aviation Safety Reporting System, in operation for more than 25 years.

The Ensuring Correct Surgery Directive is NCPS' most recent safety initiative. Wrong site, wrong patient and wrong implant procedures are relatively uncommon adverse events but often devastating when they occur. The new program offers a straight-forward, five-step procedure to identify the correct patient, mark the correct site and ensure the correct procedure or implant.

Our multi-disciplinary headquarters staff offers expertise on an array of patient safety and related health care issues and initiatives. All 163 VA hospitals actively participate in the program and it is support by dedicated patient safety managers.

For more detailed information on the NCPS program, visit our Web site: www.patientsafety.gov