Baseline satisfaction data were obtained via retrospective survey of 55 participants from 7 events during Quarters 2-4 of 2016. The survey posed the question: "Overall, how would you rate your level of satisfaction with the RCA process?" A 5-point average scores fall below the goal.

**Implications:**
- **RCA Satisfaction Scores:** The team continues to monitor opportunities for improvement.
- **PDSA Cycle Tested Solution Tested During Events**
  - Department of Radiology at Mayo Clinic Rochester, a patient safety team facilitates a Root Cause Analysis (RCA) with frontline and work area leaders to learn from the event and improve processes to increase patient safety. An improved process map was developed (Figure 4) to outline a more concise, efficient process.

**Lessons Learned**
- **5 RCA meetings shortened from 60 to 45 minutes due to standardization of steps:**
  - Data were subdivided and reviewed by role: participant and institutional personnel.
  - Root causes of dissatisfaction, reduce waste, and define standard work.
  - Solutions to prevent recurrence are not robust.
  - Inconsistent and unclear process for coordinating and facilitation of RCA.

**Goal met:** Average satisfaction scores for participants and facilitators were 4.4, above the goal, by the 5th event review.

**Figure 1: Initial Process Map**

**Figure 2: Satisfactory Levels**

**Figure 3: Root Cause Analysis**

**Figure 4: Improved Process Map**