PSNet
PATIENT SAFETY NETWORK

Analysis and prioritization of near-miss adverse events in a radiology department.

March 4, 2015
Thornton RH, Miransky J, Killen A, et al. Analysis and prioritization of near-miss adverse events in a radiology department. AJR Am J Roentgenol. 2011;196(5):1120-4. doi:10.2214/AJR.10.5373.
https://psnet.ahrq.gov/issue/analysis-and-prioritization-near-miss-adverse-events-radiology-department

This study developed a scoring system and a systematic approach to identify learning opportunities from near miss adverse events. Electronic order entry errors posed the greatest threat, suggesting vulnerability at the human–technology interface.