PSNet
PATIENT SAFETY NETWORK

Reporting and using near-miss events to improve patient safety in diverse primary care practices: a collaborative approach to learning from our mistakes.

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Crane S, Sloane PD, Elder NC, et al. Reporting and Using Near-miss Events to Improve Patient Safety in Diverse Primary Care Practices: A Collaborative Approach to Learning from Our Mistakes. J Am Board Fam Med. 2015;28(4):452-60. doi:10.3122/jabfm.2015.04.140050.
https://psnet.ahrq.gov/issue/reporting-and-using-near-miss-events-improve-patient-safety-diverse-primary-care-practices

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This study describes the successful implementation of a Web-based reporting system for near-miss events in primary care practices. The most prevalent reports were breakdowns in office processes, with varying risk for adverse events, as found in prior studies of incident reporting. Although near-miss reporting can stimulate improvement efforts, it is not a precise method for detecting safety problems.