

Processes for identifying and reviewing adverse events and near misses at an academic medical center.

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<https://psnet.ahrq.gov/issue/processes-identifying-and-reviewing-adverse-events-and-near-misses-academic-medical-center>

This survey of operational leaders at a single academic medical center identified multiple conferences, meetings, and processes in which adverse events or near misses were routinely discussed. Investigators found significant variation regarding whether these events were reviewed at a [morbidity and mortality conference](#), educational conference, or operational review process. Some clinical programs had no designated forum to discuss adverse events and near misses. The authors recommend developing and implementing a consistent [event analysis](#) process across clinical programs.