

Radiologic safety events within a pediatric emergency medicine network.

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<https://psnet.ahrq.gov/issue/radiologic-safety-events-within-pediatric-emergency-medicine-network>

This study analyzed a database of [voluntarily reported errors](#) to determine the types of [radiologic errors](#) encountered in a regional pediatric emergency medicine network. Radiologic errors accounted for 7% of all incident reports, of which the most common were incorrect or changed interpretations of studies. Individual errors—including clinical judgment or failure to follow established safety procedures—were judged to be more common than system factors, though only half of the incident reports described contributing causes.