PSNet
PATIENT SAFETY NETWORK

Using near-miss events to improve MRI safety in a large academic centre.

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https://psnet.ahrq.gov/issue/using-near-miss-events-improve-mri-safety-large-academic-centre

Near misses can uncover process weaknesses and motivate improvement to prevent similar incidents. This commentary outlines how one hospital used Plan–Do–Study–Act cycles to improve their MRI screening process, including developing and implementing a safety checklist in the electronic medical record and building in a hard stop to prompt checking for contraindications.