

**An Innovative Approach to ‘Near Miss’ Capture for Improvement of Patient Safety**

**A Canadian Patient Safety Institute  
Studentship Project**

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## **An Innovative Approach to ‘Near Miss’ Capture for Improvement of Patient Safety**

### **Abstract**

*The odds are greater that a person will be injured or die as a result of medical error than as a consequence of driving or flying (Leape 1991). The Canadian Adverse Events Study by Ross Baker et al. (2004) estimated that 7.5% of patients admitted to acute care hospitals in Canada in 2000 experienced 1 or more adverse events. He found that 36.9% of these patients had experienced highly preventable adverse events.*

*A review of the literature confirmed that health care professionals do not report near misses for a number of reasons: lack of understanding; fear; blame; belief that reporting may not result in improvement; and complaints about available reporting methods (Leape 1991; Cohen 1999; Mahlmeister 2006; Coyle 2005; Richardson 2006; Hughes 2004; Jamieson 2006; Symon et al 2006; Kellog & Havens 2006; Shaw et al 2005; Rudman et al 2002).*

*The reporting and evaluation of near misses provides data for development of strategies for patient safety improvement. This report will summarize a new approach which used a 3 month prevalence study to evaluate different strategies of capturing near misses. It will review the extensive education program delivered to all hospital staff, innovative reporting strategies and the incentives to encourage reporting. Over the 3 month collection period, 335 near misses were reported (5% by paper, 23% by web and 72% by phone). In the previous reporting year (2005) 2 near miss reports were filed. Reports fell into the following categories: documentation; medication; transcription; equipment; environment; procedural; identification; filing; communication; privacy; and miscellaneous. The results have been disseminated to all stakeholders in order to*

*enable discussions about identified patient safety concerns and the development of strategies for safety improvement.*

*This project has demonstrated that these innovative approaches are sustainable in our current environment. An infrastructure exists to support the management of the paper incident reporting system and the phone and web based methods do not increase the resources used by this system, but do increase reporting frequency. Furthermore, this project has taught us that by providing, user friendly, anonymous reporting methods as well as education about near miss reporting, the safety culture of our organization can be improved.*

## **Purpose of Project**

In hospitals and health care systems, incident reporting is the primary means through which adverse drug events and other risks are identified. The purposes of reporting are to: improve the management of an individual patient; identify and correct systems failures; prevent recurrent adverse events; aid in creating databases for risk management and quality improvement purposes; assist in providing a safe environment for patient care; provide records of the events; and if necessary, obtain immediate medical advice and legal counsel (Cohen 1999).

According to the Canadian Council on Health Services Accreditation (CCHSA) reference guide on near misses, a near miss is an event or circumstance which has the potential to cause serious physical or psychological injury, unexpected death, or significant property damage, but did not actualize due to chance, corrective action, and/or timely intervention. A near miss is a free lesson in proactive risk management and error prevention (Berntsen 2004). Near misses are challenging to capture and yet they may be one of the most crucial areas to study. Evaluating the data collected would identify and address strategies for improving patient safety such as system failures, preventing incident occurrence, and as identifying areas for quality improvement. The successful collection and analysis of near miss data is instrumental in the improvement of patient safety.

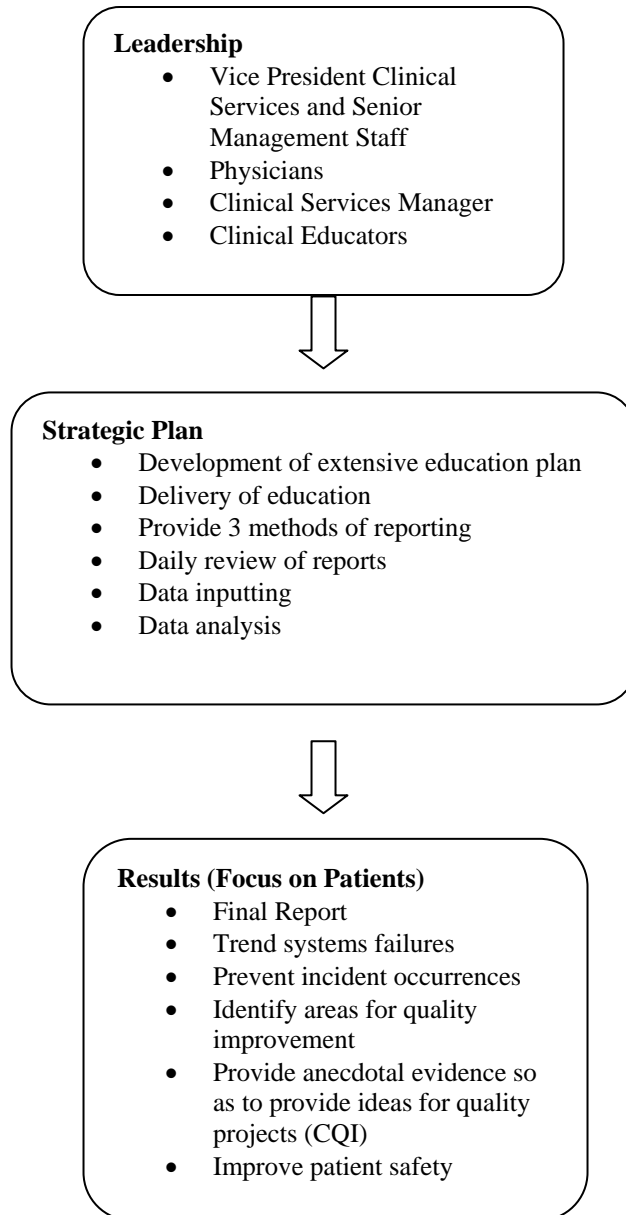
The purpose of this project is to determine if a focused approach will increase the number of near misses reported in a publicly funded hospital.

## **Theoretical Framework**

Near miss reporting in healthcare organizations can be examined using an adaptation of the Baldrige Framework (Stepnick et al. 2006). The purpose of the framework is to help organizations improve performance practices, capabilities and results and it facilitates communication and sharing of best practices information within organizations of all types. Furthermore, the framework serves as a working tool for understanding and improving performance and for guiding planning opportunities for learning; the ultimate goal is continuous improvement aimed at getting the results that are important to an organization (Baldrige 2006).

Within this framework there are 3 drivers of success (Figure 1): strategic planning, leadership and a focus on patients (results) (Stepnick et al. 2006). In order for Near Miss reporting to be successful in healthcare organizations, leadership must be effective. Leaders must understand the project and its goals and effectively communicate this to their staff. Leaders also need to understand the system and realize that it is their responsibility to share knowledge and set direction. Strategic planning is critical to the effectiveness of this framework. Every person in the organization must know the strategic plan and be able to describe how he or she contributes to achieving the plan's goals and objectives. Finally, the results driver focuses on improving patient safety and maintaining improvements over time (Baldrige 2006).

**Figure 1**



**Figure 1. Adapted Baldrige Healthcare Criteria for Performance Excellence Framework (2007)**

## **Research Hypothesis**

There will be 2 research hypotheses addressed by this project.

***Hypothesis #1:** By providing staff with a user friendly method of reporting near misses (via 3 methods), the number of near misses reported will be higher as compared to that with the current near miss reporting system (paper based only).*

***Hypothesis #2:** Of the 3 methodologies for reporting near misses, it is expected that the phone method of reporting will be used most frequently.*

While the proposed project will examine the hypotheses outlined above, there are additional research questions that warrant future investigation by researchers interested in this subject, such as:

1. What are the types and numbers of near misses reported with this methodology?
2. Are near misses described in sufficient numbers and clarity to allow for detailed analysis and trending of the data?
3. Is one reporting method preferred by staff for a particular type of near miss?

## **Definition of terms**

A **near miss** is an event or circumstance which has the potential to cause serious physical or psychological injury, unexpected death or significant property damage, but did not actualize due to chance, corrective action and/or timely intervention (Richardson 2006). Alternate terms for near misses are: near error; near hit; potential adverse event; close call; and good catch (Richardson 2006; Mahlmeister 2006; Coyle 2005; Berntsen 2004; Hughes 2004). Near misses are daily occurrences in the health care sector simply because health care professionals are human. Hughes (2004) identifies human factors,

such as lack of experience, skill or motivation as factors that inhibit a person's ability to perform well and as a result, errors and near misses become inevitable. Furthermore, Hughes (2004) states, that the impact of these factors is magnified when the person is fatigued, stressed or distracted, all of which tend to be magnified during a crisis. As a result of this, many safety researchers have applied human factors engineering and industrial engineering to improve safety in many non-health care industries (Hughes 2004).

Near miss reporting has been used in several industries over the last 40 years: aviation; nuclear power; petrochemical processing; steel production; military operations; mining; and avalanche research (Barach & Small 2000; Jamieson 2006, Shaw et al. 2005). The reporting of near misses in the above industries has been successful and instrumental in ensuring the safety of those in the industry as well as those affected by potential errors (Barrach & Small 2000). An examination of these various industries and their near miss reporting systems is essential in the development of a successful reporting system (Rudman et al. 2002). The lessons learned from these industries can be directly applied to the health care sector and implemented because, as the literature suggests, near misses within this sector are still not adequately reported. Furthermore, it is important to assess and identify potential barriers prior to implementation.

## **Literature Review**

There are many reasons for not reporting near misses. Leape (1991) identifies 2 barriers to reporting: fear and lack of belief that reporting results in improvement. Historically, error reporting has been viewed as a means for assigning blame and doling out punishment (Cohen 1999). Staff may think if no harm occurred, there is no need to report the incident. Error reporting of any kind, be it near miss reporting, incident reporting or adverse event reporting is always encouraged by management and administrators, yet they remain underreported (Mahlmeister 2006). Perhaps the largest barrier in reporting near misses is that it is so closely associated with error. Mahlmeister (2006) reports that in the past, health care professionals usually relied on evidence of actual patient harm to report an incident or error and presently many health care professionals view an error as a deviation from written standards of practice. This presents the first barrier in near miss reporting: lack of understanding. Although it is hoped that health care professionals understand errors and near misses from a system perspective, as well as appreciate the benefits of organizational learning and feel empowered to report near misses, many of these professionals using systems within health care organizations are unable to describe the related components of this system as well as their role within this system (Richardson 2006). Richardson (2006) elaborates on this point by stating that it is imperative to obtain the viewpoint of the health care professional on how they perceive near misses and then build on this in the education of the staff.

Another barrier for near miss reporting is blame. The current culture in many organizations is one of blame (Coyle 2005). In order to change this patient safety culture,

staff at all levels of the organization must understand that “near miss” reporting is non-punitive. For a report of a near miss to effectively reveal the ideas that might help prevent similar and potentially more serious incidents, the reporter needs to know, understand and believe that they are beyond blame (Jamieson 2006). Rather than assigning blame, the organization needs to acknowledge that everyone makes mistakes and focus instead on understanding the root causes (Hughes 2004).

Symon, et al. (2006) conducted a two-stage pilot study investigating midwives’ understanding and recollections of clinical near misses through a questionnaire. Although response to the questionnaire was quite low, respondents cited the blame culture in their work environment as one of the barriers to reporting near misses. They felt that this blame culture was less prevalent when things actually went wrong, but was very prevalent when mistakes were averted. Culture change is essential to improve patient safety. In an effort to have this shift in culture, the health care system must move from focusing on people as unreliable components, to a place where people, both individually and as a group or organization make patient safety happen (Coyle 2005). This change in culture requires all members of the health care organization to move toward openness and accountability, where the reporting of near misses (as well as errors) are clearly valued and rewarded (Coyle 2005). Furthermore, this shift in culture must occur at all levels: from the top of the organizational chart to the grass roots employee.

Finally, a third barrier to near miss reporting is the method of reporting itself. Health care professionals are inundated with a myriad of papers, forms and reports. Therefore, it stands to reason that when asking health care professionals to report near misses, there will be resistance as many will view it as more work, another form to

complete and file. The health care provider must have a user friendly, accessible, quick method of reporting so as not discourage reporting, but to facilitate it (Kellog & Havens 2006). The reporting system must also be one that can be easily monitored and supported by the organization, so that data collected can be disseminated to the appropriate stake holders and systems analyzed so that all areas of concern are dealt with accordingly (Shaw et al 2005).

Many health care organizations acknowledge that near misses are rarely reported. Anecdotally, as health care professionals, we are aware of conversations within our organizations in which health care professionals discuss the pros and cons of whether or not to report the occurrence of a particular incident or a near miss. Health care organizations need to recognize that in order to implement patient safety strategies, they must develop and implement innovative ways of reporting near misses. The organization must capture the interest of all staff and use this momentum to improve the patient safety culture in their institution. Reporting methods should foster an environment where compliance with reporting and proactive monitoring of near miss events makes patient safety the focus of staff efforts. Anonymous self-report methods provide a means by which the person committing or witnessing an error can report the mistake without being associated with it (Cohen 1999). The advantages of this method are its low cost and the ability of staff to avoid the fear of disciplinary action. However, anonymous reporting may not be feasible in all institutions, but is a great alternative to improving reporting as near miss reports can not be assigned blame to any one individual. Whether or not near miss reports are anonymous, a user friendly and sustainable system needs to be implemented in order to have successful reporting (Cohen 1999).

Coyle (2005) describes in her article that in designing a near miss reporting system, one must move beyond the punitive approach of placing blame on individuals and focus on the faulty processes inherent in the health care delivery system. The reporting system designed by Coyle (2005) provided 3 methods of reporting: traditional form marked near misses; email; or phone. Designated staff collected the information and took appropriate initial action to control or mitigate the situation and once the executives in the organization had a chance to evaluate the reports, the medical center director recognized and awarded the employee (Coyle 2005). In this reporting system, reporters were required to identify themselves and in turn were rewarded by the organization, not blamed. Response from participants in Coyle's (2005) reporting system was universally positive from both employees and management. Coyle (2005) reports that at the institution where this was implemented, a win-win environment for patient safety was created, while simultaneously raising the bar for quality patient care. This article successfully describes the use of incentives for near miss reporting in an effort to enhance patient safety, however it lacks any statistical validity as it simply presents a narration of the implementation of these various reporting methods.

A study conducted by Kellogg and Havens (2006) examined an alternative method to reporting adverse events in the hospital setting by using shift coupons developed by the researchers. The researchers felt that these shift coupons that were completed by all the Registered Nurses at the end of their shift would provide them with a reporting method that would accurately measure the occurrence of adverse events while protecting their anonymity and the reporting method centers on why the adverse event occurred and how the healthcare system can be redesigned to prevent the same event from

happening again. This method of reporting focuses on the adverse event as related to the healthcare system, not the individual health care professional. Kellogg and Havens (2006) reported that the shift coupons did yield more adverse events data than the traditional incident report, however they did note in their findings that the data collected from these shift coupons need to be compared to the data collected from the traditional incident reports filed in order to determine which method provided the most accurate data. The limitations of this method are that these coupons are only appropriate to specific areas, therefore if an organization were to use this method of reporting, shift coupons would have to be designed for each specialty area in the health care organization.

Shaw et al. (2005) conducted a multicentre study on adverse events and near miss reporting in the National Health Service (NHS) in England to explore the feasibility of creating a national system for collecting this data. Hospitals with information technology (IT) departments able to support the electronic reporting method were only eligible to participate, however among these 18 centers the number of adverse events and near misses reported totaled 28, 998. Of these reports, less than 2 % were associated with catastrophic or major adverse outcomes for the patient. The collection of data was plagued with technical and IT interconnectivity problems, however, users did comment favourably on the ease of using the electronic reporting method. Although the participating hospitals in this study were predominantly acute care facilities, it does successfully demonstrate that an electronic method of reporting near misses yields many reports and from these patient safety issues can be identified (Shaw et al. 2005).

Rudman et al. (2002) conducted a retrospective study where they employed data mining techniques to identify adverse drug events and near misses with respect to medication. The limitations of this study are that it only examined reported adverse events and near misses with respect to medications; therefore it relied solely on what was reported on the existing incident report form. Data from this study provided unique insights into the processes and structures related to medication errors and medication near misses. Furthermore, results from this study confirmed that if the medication error did not result in an adverse drug event, it was not reported. Therefore, as a result of this underreporting, a true incident rate of medication errors may never be known, thus not providing the data required for interpretation. This method of near miss data collection is not likely to yield the information required to identify patient safety and quality concerns.

Mahlmeister (2006), reports that no matter what the method of reporting near misses, all members of the health care team need to be aware that through reporting they are making a positive contribution to the creation of a high reliability environment. Furthermore, Mahlmeister (2006) states that a formal program of recognition and reward not only encourages reporting, but reduces the fear of punishment, especially when the near miss is apparently a result of an error or lapse by the individual who initiates the report. Timely feedback after reports of near misses is crucial so that the reporter is aware that his/her report has been received and will be addressed (Mahlmeister 2006).

Instituting and running a near miss system should not burden the health care organization. Since near misses occur more frequently than incidents and adverse events (Shaw et al 2005), an organization could become overwhelmed by the number of near misses that might warrant further analysis. Once a near miss reporting system has been

functioning for a while, it is crucial to establish selection criteria that can identify a manageable number of reported events with enough learning potential to warrant full root-cause analysis (eds, Aspden *et al.* 2004).

## **Methodology**

This project spanned a 3 month period and involved a number of activities. First, the appropriate IT and audiovisual staff were contacted to set up the phone line (x16677) on the existing phone line in the clinical services office and the IT department placed an icon on the homepage of the intranet with a link to an electronic near miss reporting form. Second, a corporate education plan and educational material for staff was developed based upon a literature review on near misses, including common definitions and data capture tools. Finally, the education plan was delivered by the Clinical Nurse Educator (the researcher) to all clinical and non clinical staff in the Heart Institute, 1 month prior to the commencement of the reporting period.

Once all of the methods of reporting were implemented and the staff education completed, the researcher performed a review of the near misses reported each day to ensure that patient safety issues requiring immediate attention were addressed. All near misses reported were entered into an existing incident database (excel spreadsheet). The time required for data entry was minimal as the existing incident reporting system was used as a template for the collection of this data.

### *Participants*

In an effort to change the safety culture at the UOHI, the participants for this project consisted of all staff members (nurses, allied health professionals, physicians, non clinical personnel and clerical staff) at the UOHI. Education (Appendix I) was delivered to all personnel along with email information, and posters (Appendix II) were posted in all areas of the hospital providing instructions about the project and how to report. In addition to this, laminated cards (Appendix III) were prepared and distributed to staff so that they could wear them on their ID lanyards. These cards contained information about the project, including how to report and the definition of a near miss.

#### *Data Collection*

Near miss reports were collected daily from the 3 methods of reporting, over the 3 month collection period (Feb. 12/07- May 31/07). All reports included a description of the near miss, the date, time and location. Reporters were instructed that reporting is anonymous and confidential, however if they chose to identify themselves, they became eligible for a prize to be drawn at the end of the project.

The first method of reporting was the paper-based, incident report form that is currently used within UOHI. The form includes a near miss reporting section and staff were instructed to complete the form as outlined in the UOHI policy and procedure manual. Forms were submitted to the clinical manager as per current protocol, who then submitted the forms to the manager of quality. The quality manager submitted all forms to the researcher who then entered the data into the database.

Web reporting (via the UOHI intranet) was the second method that was made available to staff. An icon was added to the homepage for staff to click on, which opened up an electronic reporting form. The reporter typed all the information required and then

clicked submit. All submitted forms were sent electronically via email to the researcher, who then entered the data into the database.

The third method of reporting was via the designated phone line/voicemail (1-OOPS, x16677). This voicemail was available 24 hours a day, 7 days per week, and callers were prompted to leave the details of the near misses. The messages were reviewed on a daily basis and entered into the database.

## **Data Analysis**

### *Sample Size*

Traditional power calculations to determine sample size were not appropriate given the nature of the study design and hypotheses. Given that consent to participate was not necessary, it was not possible in advance to determine the number of staff who would submit reports. Furthermore, it was not possible to predetermine the number of near misses that would be reported by potential staff participants.

### *Analytic Strategies*

Both qualitative and quantitative methods were used in analyzing the near miss data collected during the course of the project. A qualitative, thematic content analysis was utilized to identify different categories of near misses. The themes identified were: documentation, medication, procedure, transcription, equipment, environment, identification, filing, communication, privacy, and miscellaneous.

Descriptive statistics, specifically, frequency counts were run to obtain: 1) the number of near misses reported across all 3 reporting methods; 2) the number of near misses reported by each method; and 3) the number of near misses per category.

## **Incentives**

In an effort to encourage staff to report and to demonstrate that reporting is non-punitive, incentives were provided. Individuals who chose to identify themselves when reporting had their names put into a draw which was to take place at the end of the collection period; the prize being the cash equivalent to onsite parking for 6 months. In addition to this incentive there was a prize (pizza lunch once a month for a year) awarded to the unit with the most near misses reported (ratio of the number of staff divided by the number of near misses reported). Finally Tim Horton's gift certificates were awarded to the unit who simply had the highest number (volume) of near misses reported.

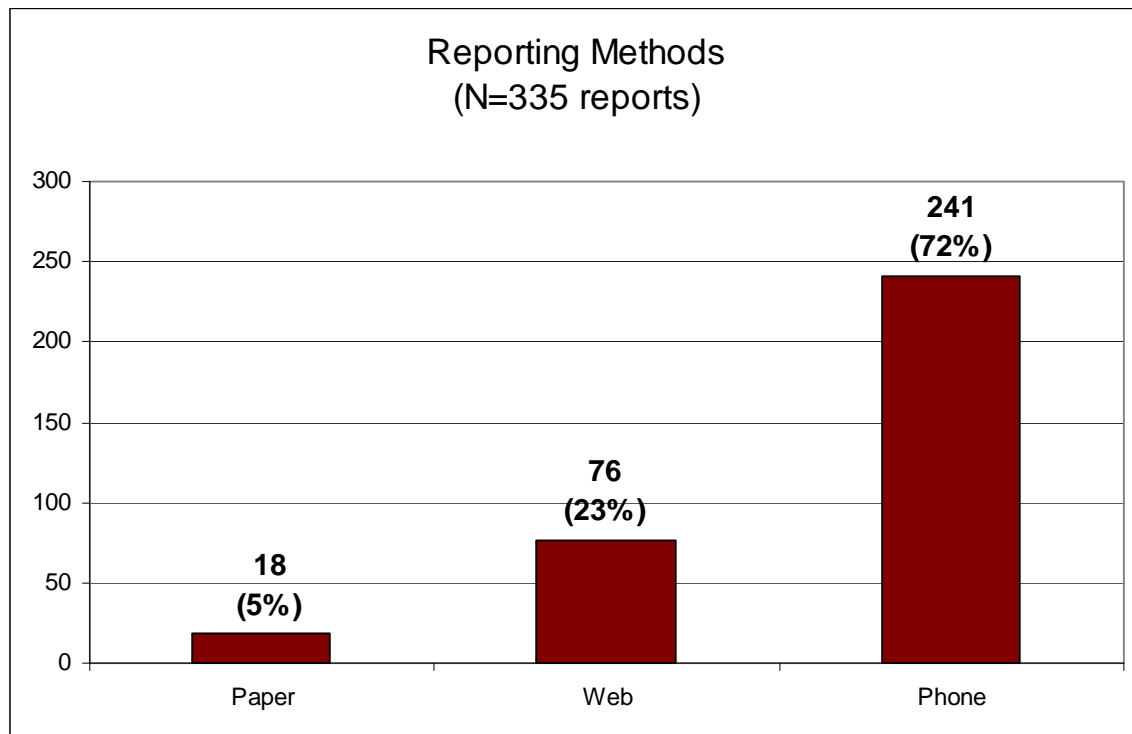
## **Results**

Results of this project were striking (See Figure 2). 335 near misses were reported from February 12, 2007 to May 31, 2007. The phone proved to be the reporting method of choice with 72% (N=241) of the reports being submitted via this method. A point of interest regarding the phone reports were that when staff started leaving a message, there always seemed to be a sense of panic and secrecy, however as the message continued, there was a noticeable change in their voice: relief. The phone seemed to provide callers with a means of verbalizing a near miss in a non-threatening, non-punitive manner. Some telephone reports also ended with the caller stating 'thank-you for listening'.

The web contributed to 23% (N=76) of the reports, while only 5% (N=18) reports were submitted using the current paper based method. It is important to note that the

UOHI had 2 near miss reports submitted in the last reporting year (2005-2006), while The Ottawa Hospital (Civic Campus, General Campus, Riverside Campus and Heart Institute) had 31 near misses reported in that same year.

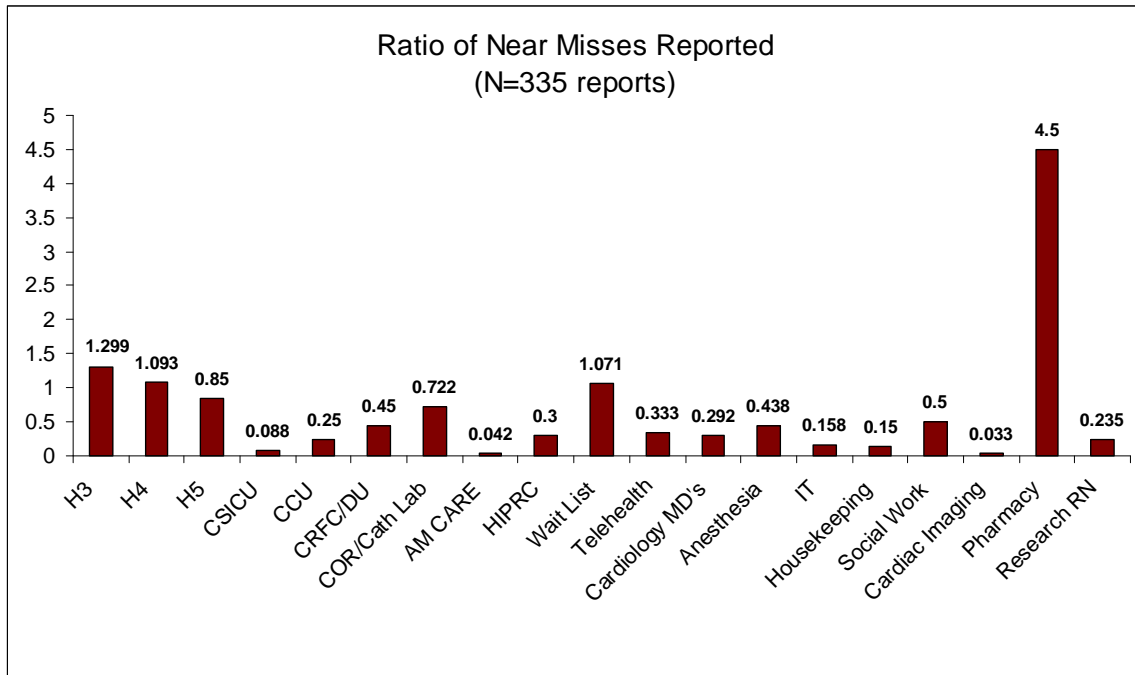
**Figure 2**



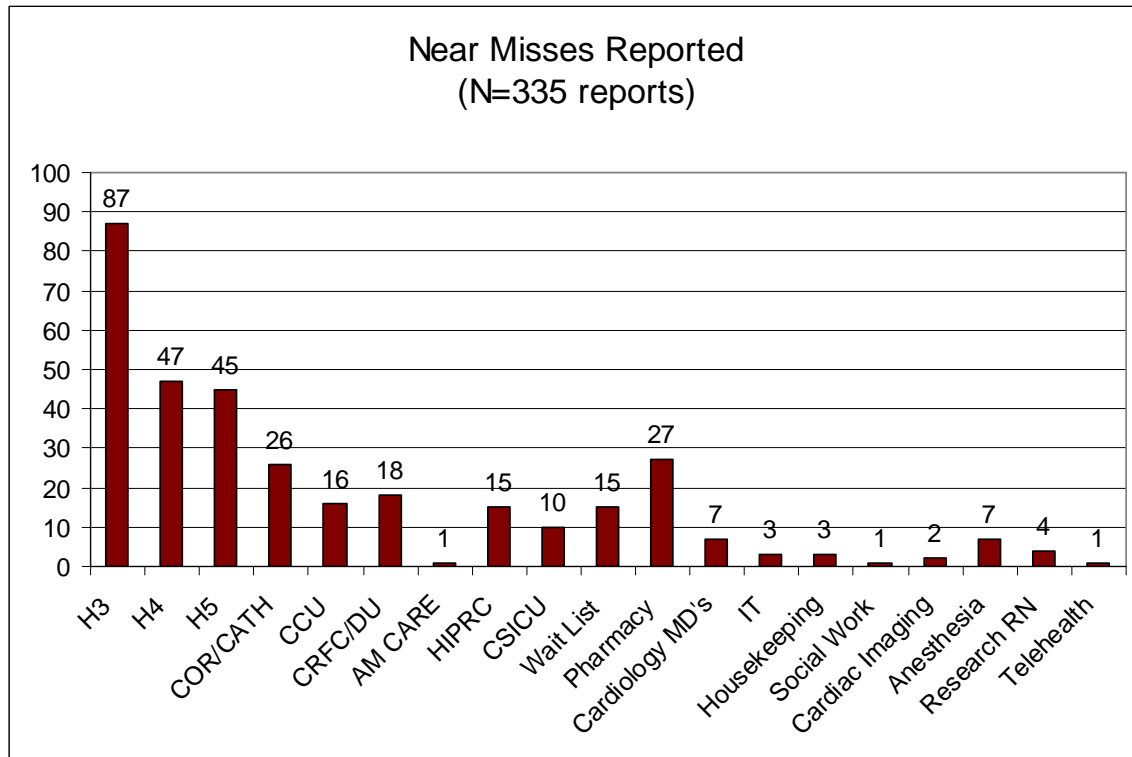
Education (Appendix I) was delivered to all clinical and non clinical staff prior to the beginning of the collection of the near misses. These educational sessions provided not only information about the near miss reporting project, but information about the incentives provided during this project, as well as a forum for discussion about near misses. Many discussions ensued during these sessions and it was evident that the patient safety culture was one of blame. The researcher used these sessions to dispel these misconceptions in an effort to promote a positive, non-punitive environment. To this end, staff in all areas of the Heart Institute were encouraged by these discussions and proceeded to report. The area with the highest ratio (4.5) of near misses reported was the

Pharmacy department, while the surgical ward (H3) had the highest number of near misses reported (87) (See Figure 3 for ratios of all areas). While the majority of reports were submitted by clinical staff, a number of the reports were also submitted by non clinical staff/areas (Figure 4).

**Figure 3**



**Figure 4**



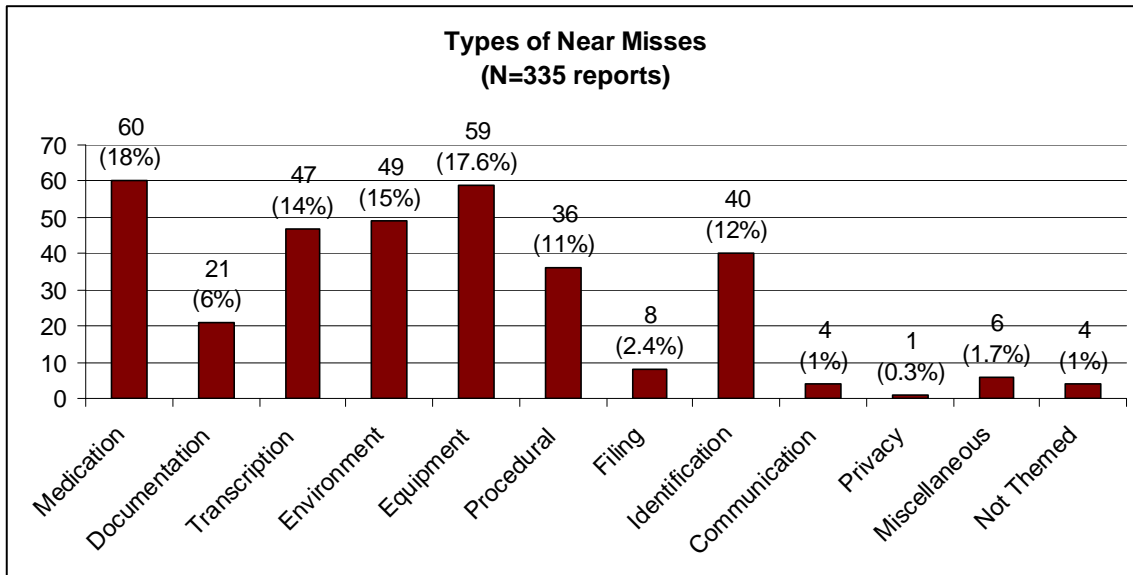
The incentives not only provided rewards for participation, they also provided a spirit of friendly competition and promoted the discussion around near misses, thus promoting a positive patient safety environment. Once staff understood that near misses were not errors, and there was no punishment, they were more likely not only to report these, but to share these events with their colleagues: staff were talking to each other about their “OOPSes”. The hallways of the Heart Institute, were now abuzz with staff sharing experiences and providing one another with support and words of encouragement, as they all worked together to ensure that the patients were being cared for in a safe environment.

Once all the reports were collected, a thematic content analysis was completed using an inter rater evaluation by distributing the reports to five clinicians at the UOHI (Figure 5). These individuals were nurse managers, educators, quality analyst and staff

nurses. Once completed, the themed reports were submitted to the Manager of Quality and Performance Management and she recorded the consensus and ensured that the themes were an accurate reflection of our quality reporting system. The following themes (Appendix IV) emerged from the reports:

1. Medication
2. Equipment
3. Environment
4. Transcription
5. Identification
6. Procedure
7. Documentation
8. Filing
9. Communication
10. Privacy
11. Miscellaneous

**Figure 5**



## **Conclusion**

A review of the literature on near miss reporting provided information about what constitutes a near miss, barriers to reporting near misses, and methods of reporting near misses. In all of the literature reviewed, a common theme emerges: patient safety and quality improvement. It is evident that data collected from near miss reports would identify and address strategies for improving patient safety.

The data collected from this project has allowed the University of Ottawa Heart Institute to: trend systems failures; prevent incident occurrences; identify areas for quality improvement; and provide anecdotal evidence so as to provide ideas for quality improvement projects. Furthermore, in order to improve and promote near miss reporting, this project proved that a user friendly, sustainable method of reporting must be implemented. The method or methods of reporting may be anonymous, however the literature suggested that rewarding the reporters for their near miss reports proved to be a highly effective motivational tool. The provision of incentives to staff did encourage reporting, however now that the reporting period for the project is finished, staff are anxious to continue using the phone line and the web for reporting. The data collected along with this report will be submitted to the Executive committee of the UOHI in order to request that these reporting methods are maintained. The results of this project clearly demonstrated that the provision of user friendly methods yields more near miss reports and that the telephone is preferred for reporting. Results collected from this project will be embedded into the development of next year's safety plan and the themes identified will generate Continuous Quality Improvement (CQI) activities to be undertaken by the University of Ottawa Heart Institute.

Finally, the literature confirmed the common belief among health care professionals that any type of reporting has been viewed as a means for assigning blame. This directly reflects the current culture in most health care organizations as one of blame, therefore, in order to improve patient safety, this culture must change throughout all levels of the organization. Staff need to be engaged in order to change the current hospital culture. By providing them with alternative methods of reporting near misses, incentives, and regular feedback, staff have become active participants in near miss reporting, thus becoming patient safety advocates and ultimately shifting the culture in our health care organization.

# Appendix I

## Education Presentation

Slide 1



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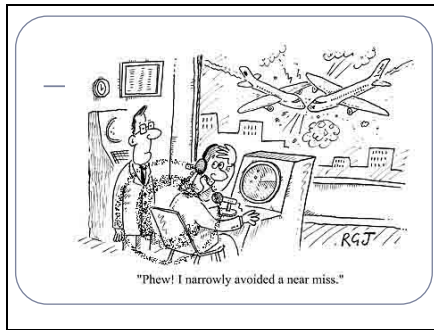
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Slide 2



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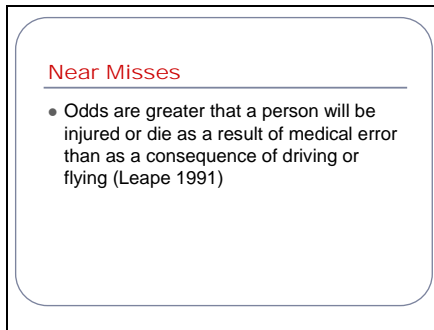
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Slide 3



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Slide 4

**Near Misses**

- Research shows that for every 600 near misses, there are 30 minor incidents, 10 major incidents and 1 critical incident (involving serious property damage, major injury or death)

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Slide 5

**What is a Near Miss?**

- Important to differentiate between incidents, adverse events and near misses.

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Slide 6

**An Incident**

- Unexpected and undesirable event/situation that is not consistent with the routine care of a patient/client
- Example: Patient receiving the incorrect dose of medication (125mg Metoprolol instead of 12.5mg Metoprolol)



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Slide 7

**An Adverse Event**

- Is a negative or unfavourable reaction or result that was unintended, unexpected or unplanned.
- Example: Patient does not have a documented allergy to penicillin, received penicillin, had a terrible allergic reaction.

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Slide 8

**A Near Miss**

- Is an event or circumstance which has the potential to cause serious physical or psychological injury, unexpected death or significant property damage, but did not actualize due to chance, corrective action and/or timely intervention

- "Good Catch"
- "Oops"
- "Whoa"
- "Phew"
- "OMG"



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Slide 9

**Near Misses are...**

- Free lessons in proactive risk management
- Free lessons in error prevention
- Challenging to capture

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Slide 10

**Why Collect Near Miss Data?**

- Data collected would identify and address strategies for improving patient safety
- This allows us to:
  - trend systems failures
  - prevent incident occurrences
  - identify areas for quality improvement
  - provide anecdotal evidence so as to provide ideas for quality projects (CQI)

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Slide 11

**Importance of Near Miss Data**

Until Near Miss data can be successfully collected and analyzed, patient safety is at risk



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Slide 12

**So why don't we report them?**

- Error reporting of any type has been viewed as a means for assigning blame, for doling out punishment
- If no harm has occurred, there is no need to report
- Current culture in hospitals is one of blame

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Slide 13

**How to Remedy this?**

- Must change the patient safety culture in the hospital
- Change must occur at all levels

*Culture change (shift) = Improved patient safety*

Patient Centered.



Patient Safe.  
PS 14830-ALC-01/07

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Slide 14

Near Miss Reporting is Non-Punitive



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Slide 15

**Current state at the University of Ottawa Heart Institute**

- Paper based incident reporting system, which can also be used to report near misses
- Current form not well liked, poorly used, too lengthy, etc...

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Slide 16

**Patient Safety Culture Survey**

- According to the UOHI Patient Safety Culture Survey, this is what you think,  
*"The majority of the healthcare workers in this hospital want to offer the best possible care to all patients. Despite our good will and intentions, we do not have a culture of patient safety in our institution. Many incidents remain unreported and "near misses" are rarely reported, particularly by physicians. The only way to develop a culture of patient safety is to establish a structure with clear objectives and mandatory reporting of events and near misses, and an effective method to disseminate the appropriate information regarding those events (example: incidences and ways to prevent them, etc.) That is our challenge!"*

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Slide 17

**What the UOHI is Doing...**

***Near Miss Project***

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Slide 18

**Near Miss Project**

- Near Miss reporting over a 3 month period (Feb. 12/07- May 31/07)
- 3 methods for reporting
  1. Paper – Complete existing incident report form
  2. Web – Heart Institute Intranet, click on Near Miss icon on homepage to complete form
  3. Phone – Call 10OPS (1-6677) and leave a message

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Slide 19

**Goals of Near Miss Project**

- Improve reporting of Near Misses
  - 3 methods of reporting
- Ultimately this will:
  - Improve Patient Safety
  - Quality Improvement

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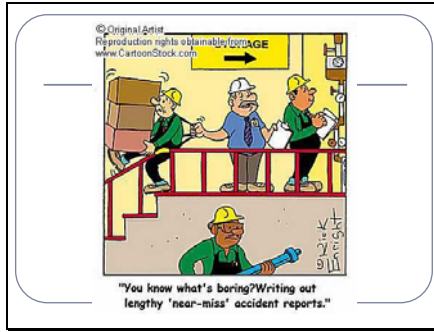
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Slide 20



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Slide 21

**How?**

- Inservice to all Staff of UOHI
  - Provide education about:
    - What is a Near Miss
    - How this will improve Patient Safety
    - Non-punitive Reporting / Anonymous
    - How to report
- Incent Staff to comply/participate

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Slide 22

**Incentives - Individual**

- If the staff member chooses to identify him/herself, these names will be entered in a draw at the end of the 3 month period
- PRIZE: \$Cash\$ Equivalent of 6 month ONSIGHT Parking



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Slide 23

**Incentives - Unit**

- The unit or area that has the most reports of near misses will win .....
- Pizza Lunch once a month for a year.



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Slide 24

**Examples of Near Misses**

1. Wet floor in hallway, no sign to indicate floor is wet
  - Potential for staff, patient or visitor to slip and fall.
  - Housekeeping notified, sign put up, now everyone aware that floor is wet



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Slide 25

**Examples of Near Misses**

2. Patient is in the Cath Lab, getting prepped for angio in the angio suite

- RN does a final check of pt id bracelet, and it is not the correct patient for that suite (the right patient is still in the bed bay).
- Procedure was not yet started, took patient out of the angio suite and brought in the correct patient



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Slide 26

**Example of Near Misses**

3. Pt transferred up to floor at 1600hrs, has PO 5mg Coumadin ordered

- Critical care area administered dose at 1400hrs, however on the floor time for coumadin is 1700hrs
- As the nurse was getting ready to give coumadin, did a final review of orders and noted that coumadin had already been administered, therefore RN did not give the coumadin.

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Slide 27

**Example of Near Misses**

4. Patients chart has Physician order sheets (no orders on it yet) stamped with an incorrect addressograph

- As Ward Clerk is transcribing transfer orders, this is noticed, sheets destroyed and new ones readdressographed.



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Slide 28

**Example of Near Misses**

5. Pharmacy has sent up 2gm of IV Ancef to the unit
  - The nurse is about to administer the medication, checks the orders, the drug and notices that patient is ordered only 1gm of IV Ancef
  - RN does not give the medication, alerts pharmacy, they quickly supply the correct medication and dose, patient receives his/her medications in a timely fashion

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Slide 29

**Report Any Near Misses**

1. **PAPER**
  - Fill out the Incident Report Form
2. **WEB**
  - Go to UOHI Intranet home page and click on Near Miss icon to complete report
3. **PHONE**
  - Call 1-OOPS (1-6677), state date, time, location/unit, description of Near Miss and your name is optional

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Slide 30



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# Near Miss Reporting

3 ways to do it:

## 1. Paper

- Complete current incident report

## 2. Web


- UOHI Intranet homepage, click on Near Miss icon

## 3. Phone

- 1-OOPS
- (16677)



**Appendix III**  
**Laminated Cards**



**1-OOPS**  
**(16677)**

When calling state:

Name (optional)  
Date  
Time  
Location/Unit

**Who:** All staff  
**What:** Near Misses- an event or circumstance which has the potential to cause serious physical or psychological injury, unexpected death, or significant property damage, but did not actualize due to chance, corrective action and/or timely intervention  
**Where:** All areas in UOHI  
**When:** Feb. 12/07 - May 31/07  
**Why:** Improve Reporting  
**How:** Paper Form  
Web -Near Miss Icon  
Phone-1-OOPS(16677)

## Appendix IV

### Examples of Themes of Near Miss Reports

THEME	NEAR MISS
Communication	Dr. ■■■ AVR, CABG LITA, RITA, Consent OR list OR Plan reflect this when patient checked in Bed bay by ■■■, verified by ■■■ ■■■ circulating nurse for room. Dr. ■■■ anesthesia asked if radial to be done before starting lines. Dr. ■■■ arrived at 0830 said he saw Dr. ■■■ office chart which suggested radial. Chart reviewed by RN, found a second OR plan, Dr. ■■■ called Dr. ■■■ no radial only with mammaries.
Equipment	Dr. ■■■ requested a “Regular Ablation” cath. None were in stock. The stock should have been on the shelf. These caths are a form of treatment for the patient. If Dr. ■■■ was unable to finish with a blue cath the pt would have to come back for a second procedure
Medication	<b>Ex. 1:</b> Old stock of medication kept on H ■ and put in another pt drawer, as they pt was ordered the same med, but not yet arrived from pharmacy. The problem is that the label on the med was for a different dose, so potential for error when giving this old stock to a different patient. <b>Ex. 2:</b> RN was giving Digoxin, thought it was IV, drew it up, rechecked the order and it was PO, discarded the IV and administered the PO dig
Identification	Blood work sent to lab for a patient, but the wrong addressograph used (as 2 pts on unit with same last name), discovered this as blood went off in tube, called lab to cancel the blood work, new sample sent with correct addressograph.
Filing	Received pt back from the cath lab and wrong results were placed on the chart
Documentation	Looking for graduated pt lab results, not found anywhere, for whatever reason, checked pts old chart, found results along with a pile of other pt results all paper clipped together on this one pts chart. Removed all of the results and put them on the correct charts, no harm done.
Procedure	Physio witnessed a housekeeper enter a MRSA room with no precautions taken (no gown, gloves, etc) and proceed to try and change sharps container. Physio approached room, informed the worker of the precautions, and the housekeeper, washed hands left room and did the appropriate precautions.
Environment	Housekeeping waxing floor with ride on machine, leaving huge wet streaks on 1 <sup>st</sup> floor, no sign put up...asked them to put a sign up to identify wet floor.
Privacy	A post-it with patient information on it in the stairway from 1 <sup>st</sup> floor to the main floor. The patient is presently an inpatient in the HI, it states his name, his diagnosis as well as previous diagnosis.
Miscellaneous	In basement corridor, coming out of OR Bay, almost got hit by linen cart going by.

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