Catch a Near Miss and Prevent a Harmful Error

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Aim Statement:
In an effort to promote a Culture of Patient Safety, the aim of this project was to increase near miss reporting, with a focus on medication errors. Initial implementation of an on-line patient safety reporting system indicated a near miss reporting of a 1.2 ratio, but we then experienced a downward decline for near miss reporting ratio to 0.6. The goal was to increase near miss reporting to its initial status and higher.

Strategy for Change:
We identified that in order to promote near miss reporting, we needed:
• To provide education about near-miss reporting
  - Near misses occur 3-300 times more often than adverse events,
• To acknowledge staff for reporting and find ways to encourage them to continue to report.
• To recognize barriers to near miss reporting - lack of time.
• To show that these reports made a difference for our patients.

Changes Made to Achieve Improvements:
• Each time a near miss is submitted, the staff receive a pop up with an acknowledgement statement thanking them for their submission.
• At the end of the month, all staff that submitted a near miss report are sent an electronic message thanking them for their dedication to patient safety.
• Posters were designed for display on the clinical units reminding staff to report near misses.
• Staff preventing a serious event are rewarded with a letter and certificate signed by the CEO and are given a coffee mug that says “Great Catch”
• Provided education to “super users” of online reporting system to re-enforce the importance that staff are aware of the need to report near misses.

Measurement of Improvement Results:
We identified that in order to promote near miss reporting, we needed:
• Significant increase in reporting since moving from paper to on-line reporting.
  - Ease of reporting on-line, education and reinforcement of previously established non-punitive culture which allows staff to submit with comfort and assurance.
• Near Miss reporting ratio rising in FY 10
• Harmful Medication Error rate remains low
• Culture of safety survey results overwhelmingly positive for organization’s commitment to patient safety

Lessons Learned:
• It’s the PEOPLE...NOT the technology
• Change in focus from errors and adverse events to recovery processes
  - Recovery equals resilience
  - Emphasis on successful recovery as a learning opportunity…A Great catch
• Define data markers and measure it
• Commit to acting upon results that do not reach your goals
• Share learnings...they are powerful messages

Multi-disciplinary team
- Kristie Lowery, RN, BS, CPHQ, CPHRM (Patient Safety Officer)
- Leroy Kromis, Pharm D. (Medication Safety Officer)
- Unit “Super Users”
- Information Services
- Georgene Saliba, RN, BSN, MBA, CPHRM, FASHRM (Administrator, Risk Management/ Patient Safety)
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