Nursing at South Shore Hospital
Weymouth, Massachusetts

Near-Miss(ed) Opportunity: Nurse Perception of Near-Miss Event Reporting

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Research Question: What factors influence nurses' decision to report a near miss event?

Purpose: To explore the phenomenon of reporting of near-miss events using focus group methodology.

Objective: Describe the facilitators and barriers to reporting near miss events among a convenience sample of registered nurses.

ISMP Close Call (Near-Miss) Definition:
"An event, situation, or error that took place but was captured before reaching the patient." [1]

Background

Medical errors account for 44,000 – 98,000 deaths per year according to the Institute of Medicine[2]. The IOM published To Err is Human in 1999 to bring the topic of human error and patient safety in the forefront of patient safety. The IOM also reports that most commonly, errors are caused by faulty systems, processes, and conditions, not individuals.[3,4]

Context : A near-miss happens 300 times more frequently than an actual adverse safety event.

Methods

Design- focus group design

Recruitment – snowball sampling

Sample and Setting - Participants were 17 registered nurses (3 groups) working at the bedside on selected medical surgical units and the emergency department. Groups were facilitated by the researchers, a script was utilized with open ended probes and questions.

Data collection / Data Analysis: Content analysis was performed by researchers thematic analysis /emerging patterns from data analysis

References
1. ISMP survey helps define near miss and close call. (2009, September 24), Retrieved from: https://www.ismp.org/newsletters/acutecare/articles/20090924.asp
2. IOM (Institute of Medicine), 2001. Crossing the Quality Chasm: A New Health System for the 21st Century . Washington, D.C: National Academy Press;.
3. Coyle, G. A. (2005). Designing and implementing a close call reporting system. Nursing Administration Quarterly, 18(21), 57-61.
4. Kohn, L., Corrigan, J. (1999). To err is human; building a safer health system. Washington, DC: National Academy Press.
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THEMES WITH EXEMPLARS

KNOWLEDGE: I Don't Have a Clue

Nurses report knowledge gap regarding near-miss incident reporting guidelines

"Honestly it's not clear to me that it's a policy here that we report near misses."

"I know some people who have never filled one out"

PUNITIVE CULTURE: Say 3 Hail Marys

One nurse compares a disciplinary action plan to a Catholic confession. " You have to say three Hail Marys and two Our Fathers. Now you have to do your penance because you made this mistake; this is what we are going to make you do."

"Nobody wants to be that one that's dragged in the office and belittled."

FEEDBACK LOOP: Black Hole

Nurses have acknowledged that they assume reports are reviewed, but never hear what the outcome was. "They just go somewhere but you don't really know where."

"People might not fill them out because they don't get any feedback"

TECHNOLOGY: How Many Clicks?

Nurses admit that filling out reports is time consuming, and the general feeling is that nurses fill out reports for actual events, not near miss events.

"There's a lot of unnecessary questions, redundancy and questions that aren't pertinent to the particular situation. It's like I have to make up answer to click something so I can go on to the next one."

How often did our nurses state they encountered a near miss?
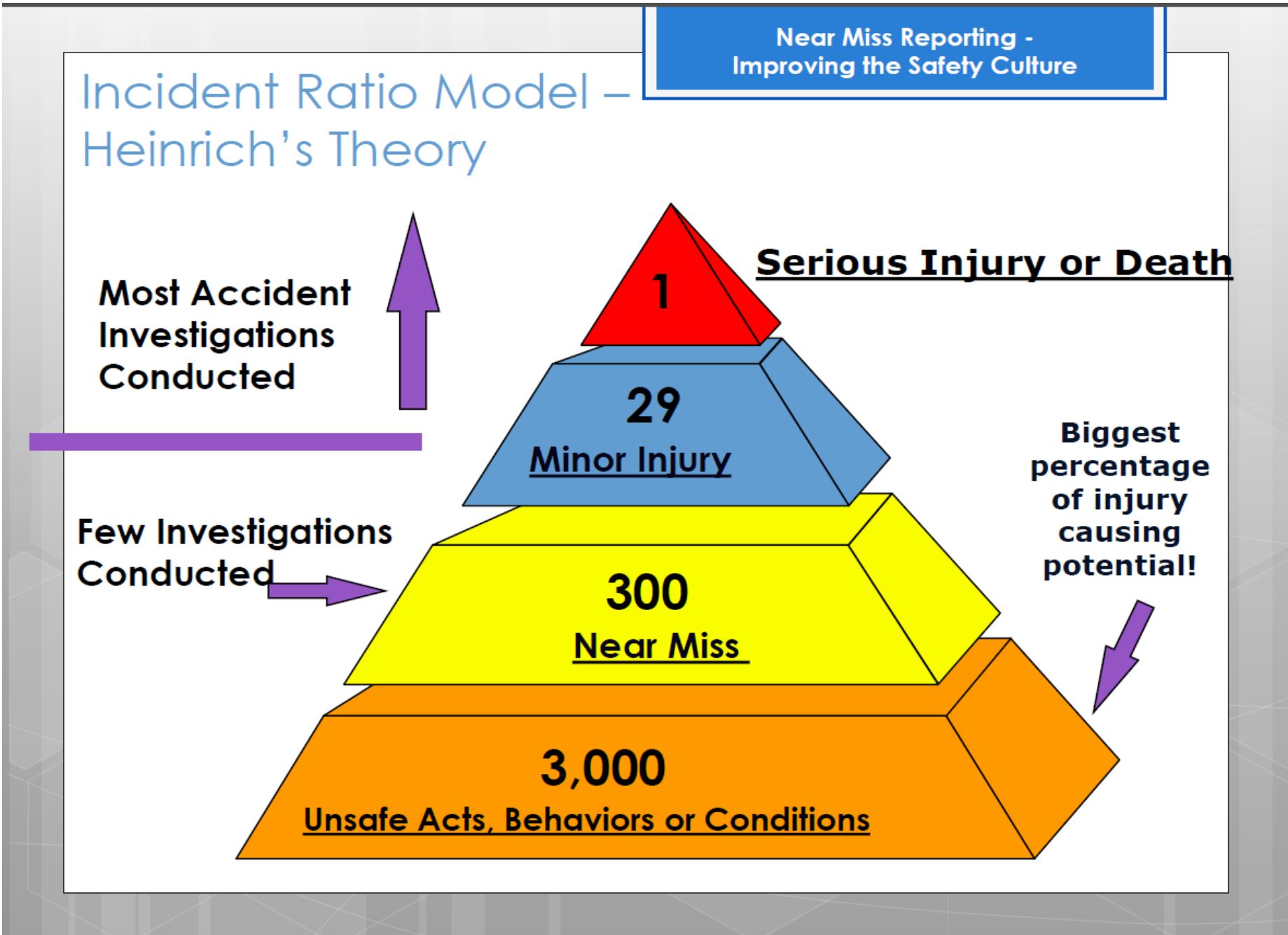
Conclusion

- These findings suggest that bedside nurses agree with the strong need for a transparent feedback loop when near-miss events are reported.
- The development of a just culture which begins with leadership and transcends to all bedside nurses is essential.
- This study talks broadly of its findings as it relates to nurses' perception of near-miss safety events.
- Exploring these findings in detail will help all leaders, nurses, patients and families and ultimately increase the quality of care that we provide

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Practice Implications

- Bedside nurses may benefit from understanding other nurses perceptions about what factors influence reporting of near-miss events.
- Recognizing the value in reporting near-miss events has the potential to increase reporting.
- The development of a policy which clearly defines what a near-miss safety event is as well as the development of a transparent feedback loop will help to demonstrate how sharing impacts our culture.
- Developing a culture that embraces the celebration of near-miss reporting, as well as leadership's strong examples of that sharing in a non punitive manner, will assist in the achievement of a just culture.

Retrieve from: https://mdpublic.files.wordpress.com/2012/11/near-miss-accident.pps

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