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www.nearmiss.org

Near Miss Project Newsletter

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Registry Results Included in this Newsletter!

Near Miss Project Update

By Ethan Fried, MD

Overview

In August, 2007, the Near Miss Registry located at www.nearmiss.org was officially opened for the collection of Near Miss reports. Since this time, we have learned lessons on "best practices" for obtaining Near Miss reports from busy interns and residents in practice. We have made several modifications to the survey tool to enhance the speed and efficiency of the report entry process and have introduced additional methods of obtaining Near Miss reports in order to meet the participants' reporting needs. As part of our continuing project refinement efforts to enhance reporting, we have created a "universal login" in addition to using individual logins for IM interns and residents to access the Near Miss registry. We are looking forward to completing educational training in the majority of Internal Medicine teaching programs in New York State by the second quarter of 2009.

This current issue details information regarding the project's first year of experience, current survey statistics, stated value of project by stakeholders, identification of project champions and "best practice" lessons learned.

Current Survey Statistics

As of February 13, 2009, 42 Internal Medicine Training Programs have completed the initial Near Miss education; with an additional 4 programs (73%) committed to provide the training in the near future. Two hundred seventeen IM interns or residents have activated their confidential personal information numbers with their randomly selected anonymous login identification numbers; 244 surveys were initiated and 185 were completed.

New Methodology

Offering IM Interns and Residents the option of completing hard copies of reports of Near Miss events has resulted in a significant increase in reports. The information on the hard copies is submitted, entered into the registry and then shredded by one point person who is an employee of NYACP (a Registered Nurse and Manager of Quality). The survey collection methodology remains anonymous, confidential, voluntary and risk free.

Important Facts

The Near Miss Project was open for reports on 9/1/07. 64 training kits were distributed to IM teaching institutions in August, 2007. Resident training continues across New York State.

The Near Miss tool is located on a secure Web site, under the auspices of the New York Chapter of the American College of Physicians @ www.nearmiss.org

The Near Miss Registry has received IRB approvals from the New York State Department of Health and St. Lukes Roosevelt Hospital.

The Near Miss Registry is an anonymous, risk free reporting system for near miss medical errors. The data it is designed to collect would have never otherwise been collected. The New York State Department of Health has issued a research waiver that protects anyone that submits de-identified data to the near miss registry.

Random login #s are available from the IM Program Directors or from the Near Miss project staff @ 1-800-446-9746.

Upon survey completion, the submitter can receive a certificate that qualifies as documentation for "Systems Based Practice" training requirements. The certificates do not identify the nature of the submission, but merely documents that a report was filed and that by identifying and reporting a near miss, the resident is recognizing the "systems based" aspects of patient care.

Registry Report Statistics:

Preliminary results of the data show the majority of the cases reported exhibit the following characteristics:

- Supervising Residents as submitting the reports
- Work in large institutions (> 250 beds)
- Near Misses are occurring on the Regular Floor of Hospital
- Use night floats to cover patients at night
- Do not use Computerized Physician Order Entry (CPOE) Systems
- Utilize Electronic Medical Records (EMR)
- Use paper hand offs as a communication method for the transfer of patient information
- Report that the Near Miss event involves a patient
- Near Miss event was discovered immediately or within 3 hours
- Drug administration and communication are the most common elements involved in the event
- Near Miss are communicated to program directors, supervisors or hospital administrators
- The primary team is identified as the most effective protective barrier that prevented the event from reaching the patient
- Reported ease of using the survey
- Reported the importance of using an anonymous survey

Near Miss Champions

The Near Miss Project wishes to congratulate the following individuals who have been identified as project champions:

James Hellerman, MD
(St. Barnabas Hospital)
His training program submitted twenty three (23) Near Miss Events (**highest number of near miss events recorded in one day**)!

Larry Phillips, MD
(North Shore University Hospital & Long Island Jewish Medical Center)
As the faculty chair, he has established Near Miss Reporting as a standard item on the NYACP Associate Member meeting agenda. Nineteen (19) new Near Miss events were submitted by the associate members during the NYACP Upstate Scientific Meeting on November 13, 2008 in Rochester, NY.

Dr. William LeCates
(Bassett Healthcare Program)
Coordinated Grand Round training resulting in 11 new reports.

Dr. Shiraz Sandhu
(Nassau Medical University)
Coordinated Near Miss Grand Round training resulting in 11 new reports.

Robin Dibner, MD
(Lenox Hill Hospital)
for providing training to the IM interns & residents @ Lenox Hill, St. Johns and St. Barnabas Programs.

What People are Saying About the Value of the Near Miss Project

It is easy…by Interns

"It is an easy and safe way to contribute to efforts made to improve safety for our patients. I am now more acutely aware of the importance of our contribution to the knowledge regarding the errors to which we are susceptible. I could clearly see that all efforts were made to attain a high level of security for the respondents in protecting their anonymity" - **Cecelia Mirant-Borde, PGY 2, St. Luke's-Roosevelt Hospital New York City**

This is a Voluntary Quote; the contributor agreed to have her name used!

It is Safe …by Committee of Interns & Residents (CIR)

"CIR strongly supports this project. The CIR interns & residents have tested the process multiple times; the login ID #s are not traceable back to your program or institution."

-Anne Mitchell, CIR Representative

It improves Patient Safety by adding to the body of "error science" knowledge… by "Near Miss Champions"

A champion is an individual who agrees to serve as a leader in creating a patient safety culture in their institutions by coordinating near miss event activities within their program.

Contact Mary Donnelly RN, NYACP Quality Manager @ mdonnelly@nyacp.org or 1-800-446-9746 if you are interested in scheduling a Near Miss Event training or reporting opportunity for your program or facility.

NYACP hosted NYS Near Miss Reporting Roundtable Discussion

Over the past year, we have recognized that some healthcare systems are developing or in the process of implementing their own internal Near Miss reporting system.

On October 31, 2008 NYACP hosted a Round Table discussion of those maintaining or developing Near Miss systems within their institution. Representatives from New York City Health and Hospital Corporation, New York Presbyterian Hospital, North Shore Long Island Jewish HealthCare System, Krasnoff Quality Institute, Mount Sinai – Elmhurst Hospital, New York Medical College at Westchester Medical Center and the University Health System Consortium participated in the call. There was consensus on the value of collecting and tabulating Near Miss events as a method to **1) learn more about medical errors, 2) to prevent them and to 3) increase patient safety.** There were significant differences identified in the way each of these programs collect report and use Near Miss data.

The group agreed that the "next step" was to begin to work collaboratively

The group agreed that the "next step" might be to begin to work collaboratively on using similar Near Miss nomenclature in order to decrease confusion and increase the value of the data being collected.

Lessons Learned

Best Practices

- Providing Interns & residents the ability to submit Near Miss reports as part of noon conference or grand rounds with a reward for survey completion and submission.
- Integrating the Near Miss event reporting into the annual patient safety training of Interns & Residents
- Citing actual non-identified clinical examples of Near Misses during training sessions for discussion
- Proposing a Near Miss champion "model" that relays any Near Miss events communicated during "handoffs" into the Near Miss Registry.
- Recommending Near Miss reporting be introduced into Hospital M&M conferences.

Congratulations to the following IM training programs that have completed a Near Miss Project Training session in 4th quarter of 2008!

- Bassett Health Center
- Brooklyn Hospital Center
- Coney Island Hospital
- Lutheran Medical Center
- Nassau University Medical Center
- North General Hospital
- Mount Vernon Hospital
- St. Barnabas Hospital
- SUNY Upstate Medical University
- Unity Health System
- Wilson Regional Medical Center
- Woodhull Medical and Mental Health Center

To Err is Human: Building a Safer Health System (2000) - Building a Culture of Safety

Institute of Medicine (IOM) "A Case for Voluntary Confidential Reporting Systems"

- The committee believes there is a role for both the mandatory, public reporting systems and voluntary, confidential systems. However , because of their distinct purposes, such s**ystems should be operated and maintained separately.** (pg. 86)

- **Reporting systems can be designed to meet two purposes.** They can be designed as part of the public system for holding health organizations accountable for performance. In this instance, reporting is often mandatory, usually focuses on specific cases that involve serious harm or death, may result in fines or penalties to the specific case, and information about the event may become known to the public. Such systems ensure a response to specific reports of serious injury, hold organizations and providers accountable for maintaining safety respond the public's right to know, and provide incentives to health care organizations to implement internal safety systems that reduce the likelihood of such events occurring. (pg.86)

- A second type of reporting system can be voluntary. Voluntary confidential reporting systems can also be part of overall program for improving safety and be designed to **complement the mandatory reporting system.** Voluntary reporting systems, which generally focus on errors that resulted in no harm, sometimes referred to as "near misses" or very minimal patient harm. Reports are usually submitted in confidence outside the public arena and no penalties or fines are issued. When voluntary systems focus on the analysis of "near misses", their aim is to identify and remedy vulnerabilities in systems before the occurrence of harm. **Voluntary reporting systems are particularly useful for identifying types of errors that occur too infrequently for an individual health care organization to readily detect based on their own data, and patterns of errors that point to systemic issues affecting all health care organizations.** Voluntary reporting systems that examine a much broader set of events and strive to detect system weaknesses before the occurrence of serious harm can provide rich information to healthcare organizations in support of their quality improvement efforts. (pg. 87)

- ***For either purpose, the goal of reporting systems is not data collection or to count the number of reports. The volume of reports does not indicate the success of the program. The goal is to analyze and use the information they provide to identify ways to prevent future errors from occurrence.(pg.100)***

- Patient Safety programs should implement **non-punitive systems** for **reporting and analyzing** errors within their organizations.

- The committee believes that voluntary reporting systems have a very important role to play in enhancing the understanding of the factors that contribute to errors. (pg. 106)

- The reports and analyses in these reporting systems should be protected from disclosure for legal liability purposes. (pg. 102)


NYACP
New York Chapter
American College of Physicians

New York State
Department of Health

APDIM NYSIG
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