Organization: Meritus Medical Center

Solution Title: Increase Near-Miss Reporting Initiative

Program/Project Description, including Goals: What was the problem to be solved? How was it identified? What baseline data existed? What were the goals—how would you know if you were successful?

Program Description/Background/Issue:
In October 2014, The Joint Commission released the Patient Safety Systems Chapter that encourages health care organizations to take a proactive approach and make sustainable improvements in patient safety and quality. This involves taking that fundamental step of becoming a learning organization. In a learning organization, every patient safety event, including those that have the potential to reach the patient (also known as near miss, close call or good catch), is reported.

Near misses or “close calls” are potentially under-reported. Reporting near misses is essential to enable leaders and staff opportunities to learn from these events and make improvements before they actually reach the patient and cause an adverse outcome. Increased reporting of near misses also promotes a collaborative mindset that proactively seeks to identify system hazards or underlying system failures before a patient may be harmed.

Goals:
- Increase the number of near-miss events reported by 50 percent.
- Increase awareness of the importance of increased near-miss reporting and promote an organizational-wide safety and learning culture.

The project goals align with The Joint Commission Patient Safety Systems Chapter, Just Culture and our organization’s mission to improve quality and safe care.

Process: What methodology or process was used to develop the Solution?

A Lean A3 project to increase near-miss reporting was initiated with a multi-disciplinary team and supported by senior leadership. The initial team consisted of our chief quality officer, chief nursing officer/chief operating officer, patient safety officer, medication safety officer, accreditation and patient safety coordinator, clinical managers, clinical directors, clinical educators, the risk director and corporate communication staff. During the Lean A3 process, it was discovered that we have variation on how leaders communicate these reported near-miss events to staff and staff knowledge on the importance of reporting near-miss events or close calls.

Solution: What Solution was developed? How was it implemented?

Two main interventions were developed and implemented:

1. Standardize the unit leadership loop back/feedback mechanism of near-miss events to staff as
a standing agenda in the unit monthly meetings. This enables the front-line staff to be aware of patient safety events, including close calls, in their units on a consistent basis and be able to learn and participate in driving improvement in the process.

2. Increase awareness through staff education (clinical and non-clinical staff) on what is the value of reporting near misses (e.g. through staff meetings, email, newsletters, posters and handing guides on how to report through the incident reporting system). The increase near-miss reporting initiative was also campaigned in partnership with other committees: the medication safety committee, nursing quality council, nursing leadership, patient safety subcommittees and support services leadership meetings and at quality forum.

The solutions were initially implemented in three units for three months. Data was monitored and tracked through the incident reporting system. The results demonstrated significant improvement. The initiative was then rolled out house-wide.

Measurable Outcomes: What are the results of implementing the Solution? Provide qualitative and/or quantitative results to data (Please include graphs, charts or tools).
Since the interventions were implemented, the above data demonstrated an 83-percent improvement in the number of reported near-miss events, which shows that we have met or exceeded our improvement goal of 50 percent. This also means that staff members are more knowledgeable on these types of patient safety events and are more comfortable in reporting close calls or near misses.

**Sustainability: What measures are being taken to ensure that results can be sustained and spread?**

Near misses continued to be discussed during unit staff meetings along with the importance of reporting them in order to prevent events from reaching the patient. Staff members are empowered to question events that occur. Typically, these are associated with near misses. Staff members are supported by management to enter an incident report.

Near-miss events are also included in the patient care unit quality dashboards that are shared with staff and reported by unit leaders and staff Quality champions in the monthly nursing quality council meetings.

**Role of Collaboration and Leadership: What role did teamwork and collaboration play in the Solution? What partners and participants were involved? Was the organization’s leadership engaged and did they share the vision for success? How was leadership support demonstrated?**

Education was provided to staff by the clinical educators, unit leaders, the medication safety officer and patient safety staff regarding the meaning of near misses and examples. Handouts and posters were placed on the unit (e.g. patient care and non-patient care areas) along with directions on how to enter an incident report. Resource nurses for the units were also empowered to encourage staff to report near misses. Senior leadership was supportive of this initiative and view reporting of near misses as a positive loopback for the organization. As more near misses were reported, we were able to learn and identify our top opportunities to improve the process. One of our unit’s high near-miss categories is related to NPO status not being entered in a timely manner before the food trays arrive. Based on the number of these events, one of our nurses completed a Lean A3 project that focused on education about how to hold meal trays and increased awareness about the issue. This led to a 65-percent improvement in the process and prevented potential delays in treatment which might occur if the event reached the patient. The results of this project were disseminated to the staff in the unit and the intervention is being implemented in other patient care units.

**Innovation: What makes this Solution innovative? What are its unique attributes?**

In reporting and reviewing near misses and system processes, we are helping to prevent events that could possibly cause harm from reaching a patient. Staff members are able to take their critical thinking and apply it to prevention. This proactive approach with leaders supporting their staff to report near misses and engaging staff in improving the process promotes a culture of
learning and patient safety. In addition, the Lean A3 methodology was utilized to help decrease variation in the process that contributed to staff being more comfortable in reporting near misses with leadership support and a staff-led patient safety initiative using the Lean A3 tool to address the top-opportunity, near-miss event.

Related Tools and Resources

Please see attached “It’s Important to Report Near Misses” poster that was utilized during this initiative and continues to be available and visible in the units and departments.

References:


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