



Florida Patient Safety Corporation
Near-Miss Reporting System
Advisory for June, 2008

Introduction

As most of our readership knows, the Florida Patient Safety Corporation was established in response to the IOM report series. Shortly following the IOM's initial report, formal calls for the creation of a Florida patient safety organization began to emerge. As a result of studies, consortiums and other deliberations involving authorities in the field of patient safety, the Florida legislature established the Florida Patient Safety Corporation (FPSC) in August 2004.

In May, 2005, funding for a voluntary Near Miss Reporting System (NMRS) as authorized by the Florida Legislature through the FPSC was made available. The grant was awarded to the University of Miami/Jackson Memorial Hospital Center for Patient Safety (UM-CPS). Consultation from Marsh, USA was sought to assist with program set up, in-servicing, data collection and analysis of near miss data reported by hospitals, ambulatory surgery centers and birthing centers across the state. The objective was to establish a program that would develop into a system for near miss reporting throughout the state.

At the onset of this program it was determined that in order to be successful, we needed to identify and overcome as many barriers to near-miss reporting system as possible. Our objective was to develop a system that contained the following attributes;

- immunity from legal penalties or regulatory sanction
- de-identification/anonymous reporting (data is untraceable to care givers, patients, institutions)
- timely and meaningful feedback to reporters and other interested parties
- ease of reporting
- standardization of terms
- sustained public, political, and regulatory support

Unfortunately immunity from legal penalties, resulting, in part from Florida's Amendment 7, was an impediment we have not yet been able to effectively overcome. Florida's Amendment 7 eliminates the confidentiality of peer review and makes adverse incident reports and other documents associated with peer review, risk management, and quality assurance subject to public scrutiny and discoverability.

Clearly, reluctance to submit near-miss reports emanated from facility concern that related deliberations and notes would be subject to discovery potentially placing them in a medico-legally compromised position. This reluctance and concern persisted despite the NMRS' de-identification of all reports within 72 hours of receipt. To date, neither NMRS information nor data have been subpoenaed or, to the best of our knowledge, garnered any attention from plaintiff counsel. As such, it appears that these concerns of non-participants may be unfounded.

As our Florida readership may know, funding for FPSC for fiscal year 2008-2009 was withdrawn by the legislature during this past Session. This precludes continuation with the Near Miss Reporting System at this time. However, our hope and belief is that this will be a temporary hiatus. We believe we can become a federally certified PSO in the near term, at which point we will be able to offer the protections and confidentiality currently missing from our NMRS.

We would like to extend our sincere appreciation to the participants in this voluntary program. It has been our pleasure to work with a group of providers truly dedicated to the advancement of patient safety. As the program is now on indefinite hold, we ask that Near-Miss Reports Not Be Submitted Until Further Notice.

Why Did We Focus on Near Misses?

The FPSC was one of the early organizations to focus on near-misses from a patient safety perspective. The FPSC identified several important advantages of the reporting of near misses:

- The underlying causation factors and system failures leading to near misses are assumed to be similar to those of incidents that reach the patient. Thus, lessons learned from analysis of near misses should be equivalent to those of adverse incidents that reach the patient.
- Analysis of near misses offers the opportunity to explore factors that could lead to error, unhampered by the pressures and emotions that are often present following a serious event.
- There is less risk to the reporter as no harm has come to the patient
- The examination of near misses contributes to a culture of safety by clearly demonstrating the organization's commitment to creating a safe environment for patients and staff
- Where a near miss report suggests the potential for a serious event, root cause analysis may produce significant learning. Similarly, near miss

reports can help in identifying the need for a proactive risk assessment such as failure mode and effects analysis of processes

Clearly, near misses indicate problems in the system that might someday lead to serious harm. According to James Bagian, MD, Chief Patient Safety Officer for the Veterans Health Administration, near-misses occur from 10 to 200 times more frequently than the event of which they are the precursor. Thus we extrapolate that for every wrong procedure performed, incorrect medication administered or laboratory error, there are anywhere from 10 to 200 that almost happened. We can learn from those.

The FPSC is proud to have been one of the “pioneers” in recognizing the importance of near-miss reporting. We are by no means the only system of this type. Other prominent organizations that have launched near-miss reporting systems include:

- The New York State Health Department and the New York chapter of the American College of Physicians agreed to analyze "near-misses" in New York hospitals – events that could have harmed a patient, but did not – to help prevent medical errors. Go to:
<http://www.nyacp.org/i4a/pages/index.cfm?pageid=3391>
- The University of Texas Close Call Reporting System (UTCCRS) is a voluntary and anonymous tool designed to gather valuable information about close calls. For additional information, go to :
<https://www.utccrs.org/ccrs/>

FPSC Near-Miss Reporting System Archived Articles

Our intent in establishing a system for reporting of near-misses was to identify areas for improvement in the delivery of healthcare, provide participating institutions with evidenced-based “best practices” for addressing identified deficiencies, disseminate “lessons learned” from near-miss data analysis, enhance patient outcomes and potentially bring about a reduction in the frequency and severity of medical errors.

Lessons learned have been disseminated through the quarterly Patient Safety Advisories. Advisory articles were based on the reports submitted by Florida hospitals and ambulatory surgical facilities. The objective of these articles was to increase awareness of our readership as to an individual near-miss or pattern of near-miss events. Most articles provide analysis of causation factors leading to the near-miss. An important aspect of our analysis afforded by that fact that the event was a near-miss was identification of the aspect most contributory to **preventing** an adverse event. J T Reason once stated, “The most detrimental error is failing to learn from error.” In reviewing

Advisory content, we hoped that readers would ask themselves this simple question, “Could this occur at my facility?”

Following is a list of articles and the date of the Advisory in which it appeared. (All Advisories can be found at; <http://www.floridapatientssafetycorp.com/>):

NEAR-MISS CAUSATION FACTORS (December/2006)

Communication Failures in Healthcare

ANATOMY OF A SERIOUS NEAR-MISS: JAMES REASON’S MODEL (December/2006)

The NMRS Experience: Anatomy of a serious near-miss
Chronology of Events leading up to a wrong site surgery near-miss
The Swiss Cheese Model Illustration of the Above Sequence

PREVENTING PATIENT IDENTIFICATION/ SPECIMEN LABELING ERRORS (December/2006)

- The NMRS Experience
- Contributing Factors
- Process Improvements or Lessons Learned to share with other facilities
- Specimen Mislabeling: A Recurring Problem
- Formalize specimen error definition and reporting
- The NMRS Experience

MISCOMMUNICATION OF OPERATIVE CONSENT FROM THE PHYSICIAN OFFICE TO THE HOSPITAL/ SURGICAL CENTER (December/2006)

- What Might Have Happened In The Above Scenarios?
- What Prevented NMRS Near — Misses From Becoming “Hits”?
- Why Did These Near Misses Occur?
- Lessons Learned & Future Steps

LATEX ALLERGY RELATED NEAR MISS (December/2006)

- Case Synopsis

POOR QUALITY FAX TRANSMISSIONS – A COMMON PROBLEM (December/2006)

NON-ADHERENCE TO HAND HYGIENE (March/2007)

- Another problem for which the solution is well known
- Addressing the problem
- Barriers to compliance
- Success Stories

IDENTIFYING AND REPORTING NEAR-MISS EVENTS (March/2007)

FOLLOW-UP ON WRONG SITE SURGERY (March/2007)

A New Strategy for Addressing the Problem

AUTOMATED DRUG DISPENSING CABINET NEAR-MISS March/2007)

How These Near-Miss Events Occur

Automated Drug Dispensing Cabinet Safety and Staff Complacency

CLOSING THE LOOP ON RECURRING NEAR-MISSES (June/2007)

Implementing an Innovative Hand Hygiene Program to Combat Hospital Acquired Infections

INTRODUCING METALLIC EQUIPMENT INTO THE MRI MAGNETIC FIELD (June/2007)

VA Recommendations for MRI Safety

WRONG SITE SURGERY: RAISING AWARENESS/PROVIDING TOOLS (June/2007)

Correct Site Surgery Tool Kit (June /2007)

Risks Associated with Inappropriate Perioperative Anticoagulant Usage (December/ 2007)

What Went **Wrong** in these Cases

- A. Need for Improved Communication
- B. Provide Additional Education to Address Knowledge Deficit
- C. Absence of Applicable Protocol
- D. Not Following Protocol

Errors Involving DVT Prophylaxis (December/2007)

The Dangers of DVT and Anticoagulants

Develop Monitors to Measure Compliance with Protocols

Failure to Update an EKG of a 90 Year Old Patient Prior to Surgery(December/2007)

What Factors Might Contribute to this Failure?

The Preoperative Checklist

Excerpted Portion of Preoperative Checklist

Radiology Misreads “Caused” by Poor Quality of Images

Radiology Risk (December/2007)

Types of Near-Misses Received

The types of near-misses we received remained constant in terms of percentages throughout the course of our program. We received over 350 near-miss reports. The majority of reports (41.50%) reflected medication errors and treatment/procedure /tests (20.46%). An article on medication near-misses appeared in the NMRS 3/2007 Advisory (*Prevent Automated Drug Dispensing Cabinet Near-Misses*). Two articles relating to anticoagulant near-misses appear in the March 2008 Advisory. Most of the treatment /procedure/tests near-misses relate to laboratory issues. A comprehensive analysis relating to this problem, *Preventing Patient Identification/ Specimen Labeling Errors* appeared in the 12/2006 Advisory

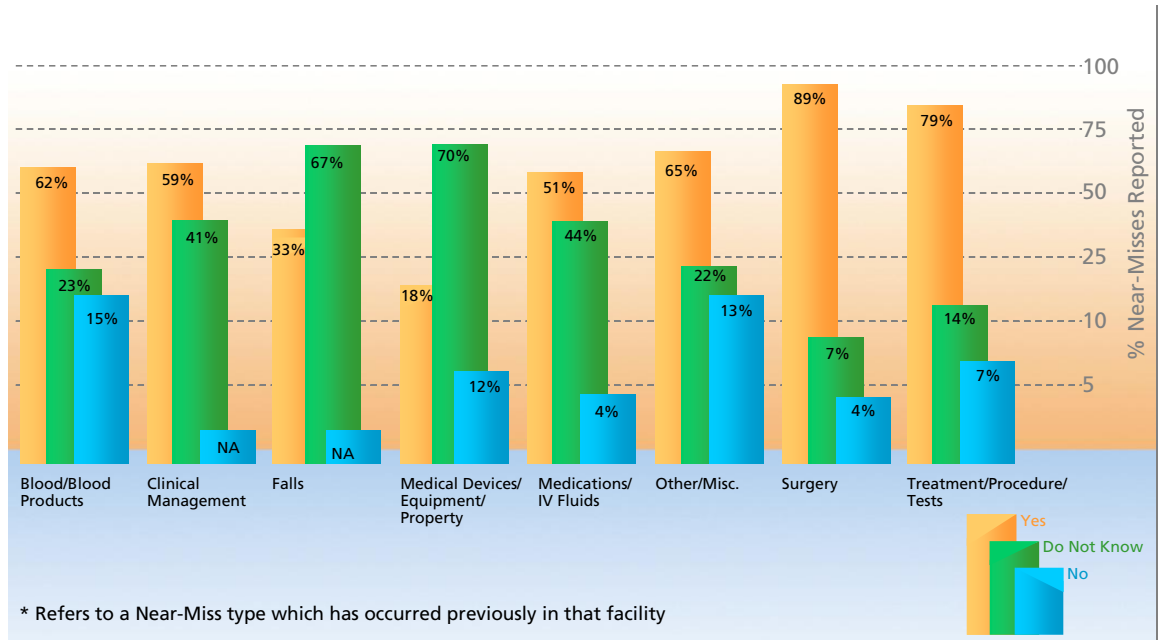
Type of Near Misses – Near Misses to Date	
Near Misses	Percentages
Medications / IV Fluids	41.50%
Treatment / Procedure / Tests	20.46%
Other/ Misc.	15.85%
Surgery	7.78%
Medical Devices / Equipment / Property	4.90%
Clinical Management	4.90%
Blood / Blood Products	3.75%
Falls	0.86%
Total	100.00%

Recurring Near-Misses

Most reported near-misses were reflective of recurring issues. This clearly indicates that preventable errors continue to occur with distressing regularity. In each Advisory, we publish data on “recurring” near-misses. Each near-miss report asks the reporter to respond to the following question; “If this type of event occurred before, why do you think it has occurred again?” Not infrequently, the response to this question indicates “lack of a detailed follow-up or process for change”. In an effort to raise the awareness of program participants that we identified a pattern of the same type of errors were frequently repeated, an article titled “Closing the Loop on Recurring Near-Misses” appeared in the 6/2007 Advisory. Data reflective of recurring near-miss reports is illustrated in the graph below.

Florida Patient Safety Corporation Advisory, June 2008

Recurring* Near-Misses (All Near-Misses)



Conclusion

It has been more than two years since data collection was initiated. Participants ranged from inner city to rural, not-for-profit to investor owned, and small to academic medical centers. This provider mix enhanced our collection efforts resulting in more meaningful data that yielded some important lessons.

As mentioned previously, it was not long into the project before the recurring nature of reported near miss types became apparent. We quickly learned that the same preventable errors continued to occur over time. The patient names change but the near-miss types don't. The fact that the same near-misses continue to be reported from the same group of institutions suggests that hospitals are not effectively addressing these potential "catastrophes in the making". This should be "food for thought" for every patient safety program; especially in view of the fact that third party reimbursement for "never events" will be curtailed later this year.

In order for this program to draw more meaningful conclusions, a larger, more robust data set will be needed. In order to achieve this goal, greater reporting of near misses from additional facilities will be necessary. We are hopeful that the statutory protections and confidentiality currently missing from our NMRS will be fully addressed when we become a federally certified PSO.

The FPSC Advisories co-authors have, to date, remained anonymous. At this time, however, we would like to personally extend our appreciation to those facilities that generously agreed to participate with the NMRS. Their contributions have been significant and have enabled the project to progress. We would also like to recognize the following NMRS team members for their significant contributions:

**University of Miami Center
For Patient Safety**

Ruth Everett-Thomas, RN
Maureen Fitzpatrick, RN
Joshua Lenchus, DO
Igal Nevo, MD

Marsh

Thomas Kerman

CS STARS

Ellen Goldader
David McElroy

A special note of appreciation is extended to the Florida Patient Safety Corporation Leadership and most prominently;

Susan A. Moore, CEO
Robert L Wears, MD, MS

With gratitude and continued optimism, we remain,

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