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An overview of Near Miss Reporting in Prince of Wales Hospital (PWH) in 2014-2017
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Introduction
A Near Miss is an unplanned event that did not result in any injury, illness or damage, but had the potential to do so. Heinrich's study of workplace accidents observed that for every accident that results in a major injury, there would be 29 accidents with minor injuries, and 300 near misses (i.e., in a ratio of 1:29:300). On the other hand, it is important to establish a strong reporting culture of Near Misses while we should act on every opportunity to identify and control risks, reduce risks and prevent harmful incidents. Creating corresponding policy and communicating it to all staff by management is vital. Besides, training on near miss reporting for new staff as part of their orientation should be established. Moreover, an anonymous reporting system may increase the number of near misses reported. Advance Incident Reporting System 3 (AIRS 3) was launched within NTEC including PWH on the 1st January 2014 with templates for Clinical Near Miss Reporting incorporated. Besides the "Policy on reporting and management of Near Miss" was released on 17th August 2015 in NTEC which aims to promote reporting of near-miss especially for those with learning points in either identifying the potential system pit-falls and/or establishing useful protective mechanism. It also provides guidance for reporting and management of near miss.

Objectives
The purpose of the study is to review the Near Miss reporting culture in Prince of Wales Hospital after the launching of AIRS 3 that with templates for Clinical Near Miss Reporting incorporated.

Methodology
A retrospective review of all near miss cases reported through AIRS 3 by PWH from year 2014 to 2017.

Result
From Jan 2014 to Dec 2017, there were total 241 (4.72% of the total no. of cases reported) Near Miss Cases reported by PWH through AIRS 3. `The cases were reported by Nurse (62.5%), Allied-Health (16.3%), Doctor (11.3%), Pharmacist (8.8%) and others (1.3%). The top five reporting departments were M&T (19%), DIIR (15%),

O&G (11%), PAED (9%) and PHARM (9%). The top five related errors of the cases were Incorrect Patient's Identification (16%), Radiological & Imaging- Contraindication (13%), Wrong Drug Dispensing (11%), Wrong Dosage Prescription (6%) and Wrong Patient Prescription (5%). Besides, 77.1% of the reports were about spotting out the errors committed by other parties while 22.9% of the reports were concerning spotting out errors committed by themselves. It is clear that a risk of error can manifest its presence through near misses. Organizations should recognize that Near Misses provide the opportunity to identify potential risk of the system. Incidents can be prevented once risks are known and prompt your organization to take action to eliminate or mitigate the risk. Maintaining a positive attitude towards Near Misses reporting should be one of the main focuses for organizational risk management.Near miss reporting can be a means to engage and empower all staff that everyone shares and contributes in a responsible manner to improve patient's safety.