Service Priorities and Programmes

Electronic Presentations

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From Miss to Near Miss and Beyond, a Paradigm Shift.

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Introduction

A reactive rather than proactive approach to errors is often the norm. When patient safety is at stake, learning from actual incidences is a high price to pay. So, medication safety cannot be left to chance, we must grasp all opportunities to learn and prevent error. It is important to alter our mindset and attitude towards medication safety. A change in culture is imminent. A near miss is an unplanned event that has the potential to cause, but does not actually result in harm. Very often, it is being forgone. However, near misses provide a wealth of information from which preventive strategies can be devised to avoid the potential incident from occurring. Openly sharing near misses in a no blame environment is our challenge ahead to begin our quest to achieve a paradigm shift in reporting culture.

Objectives

To raise the awareness of near miss and promote its reporting

Methodology

To gain hospital support for near miss reporting. To equip Medication Safety Subcommittee members to cultivate change through near miss. To set criteria for capturing near miss data. To enter all near miss into AIRS 3, and group errors according to category. To explore contributive factors and discuss measures to tackle near misses. To disseminate results and measures to wards and departments via link doctors, pharmacists & nurses.

Result

To promulgate the idea of near miss and encourage the reporting in various discipline.

To monitor the trend of near miss. To analyze the contributive factors to near miss. To devise the improvement strategies.

Since promotion of near miss reporting, there has been an average of 13 cases reported monthly versus <10 cases reported annually in the past. Reported cases in the first 8 months were analysed. The contributory factors were largely non-system related, so a soft approach was adopted for improvement measures. Two major Medication Safety programs were developed to raise awareness towards local near miss issues. 1. Medication Safety Education Program for doctors (commenced June 2017). 2. Medication Safety Promotion Month on Drug Allergy. After which the following trends were observed: Near misses by doctors are on a downward trend, 41 cases (2Q17), 34 cases (3Q17), 22 cases (4Q17). Less than intended duration for long term prophylactic antimicrobials reduced from 5 cases (2Q17) to 1 case (3Q17) to 0 case (4Q17). Other prescribing near misses e.g. wrong drug, unspecified administration site, wrong/unclear instructions and wrong dosage reduced by 75%, 50%, 38% and 33%, respectively.