



## Service Priorities and Programmes Electronic Presentations

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### **Risk Reduction Program – Near Miss Management**

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### **Keywords:**

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### **Introduction**

A near miss is an unplanned event that does not result in injury, illness or damage – but has the potential to do so. Recognizing and reporting near miss incidents can make a major difference to the safety of patients / carers / consumers and staff within the organization. Staff are always encouraged to report any near miss or potential risk through Adverse Incident Reporting System (AIRS); but under-reporting is apparently the case. According to the records retrieved from AIRS, only 5 near miss incidents in the Hospital were classified as severity index “0” in 2011.

### **Objectives**

To cultivate a near miss reporting culture and staff awareness on patient safety through establishing a platform on near miss management and sharing

### **Methodology**

To enhance staff awareness on near miss management, OLMH Quality and Safety (Q&S) Committee implemented the following logistics. (1) The Q&S newsletter introduced the definition of “near miss” and encouraged staff to report the near miss or potential risk through AIRS or designated reporting form. (2) Near Miss sharing sessions are conducted regularly. This is a platform for staff to express their experiences on near miss and work with team members to identify preventive measures for near miss during the sessions. Details of sharing sessions are dispatched in the Q&S newsletter or on the hospital webpage. (3) A designated near miss reporting form was designed, providing another option to encourage staff to report the near miss incidents. Data are collected, analyzed and monitored by the Q&S Committee. Results are promulgated through the near missing sharing sessions.

### **Result**

Since May 2012, 2 near miss sharing sessions have been organized. More than 70 participants attended the sharing session. Evaluations were conducted after the sharing session and 97% of participants agreed that the briefing content was practical to their work.