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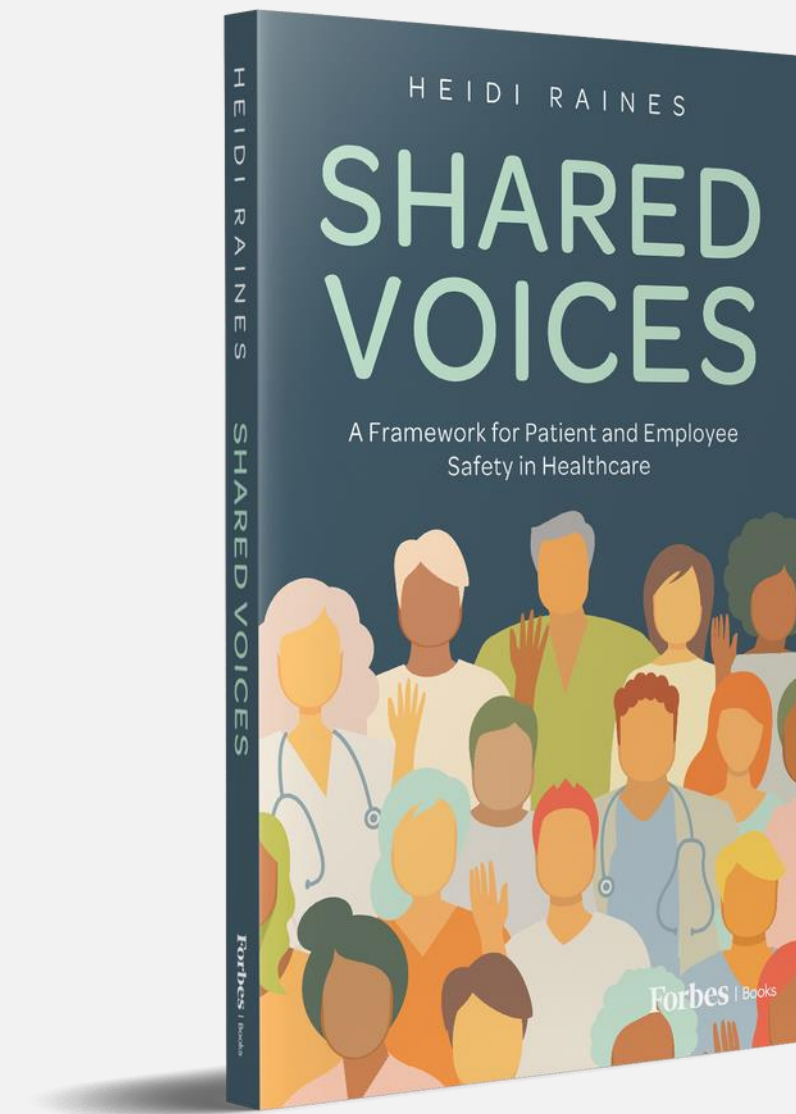
How to Implement a Near Miss Program





... and author of **Forbes & Amazon** best-seller, “Shared Voices: A Framework for Patient and Employee Safety in Healthcare”

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Partners



Forbes

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RUN OF SHOW

- 1 A Modern Approach to Safety
- 2 What is a Near Miss?
- 3 How to Implement a Program
- 4 Questions



THE GROWING IMPORTANCE OF PATIENT AND EMPLOYEE SAFETY

INFECTIONS

\$28.4 Billion

Add 10.4 days to patient's hospital stay on average



MEDICAL ERRORS

\$20 Billion

100,000 deaths per year



FALLS

\$14 Billion

Adds 6+ days to stay



\$131B

+

STAFFING SHORTAGES

1 in 5 healthcare workers have left medicine since the start of the pandemic



WORKPLACE VIOLENCE

\$852 Million

112.8 hours/year of sick, disability, and leave time



MALPRACTICE

\$55.6 Billion

2.4% total healthcare spending



WORKPLACE INJURIES

\$13 Billion

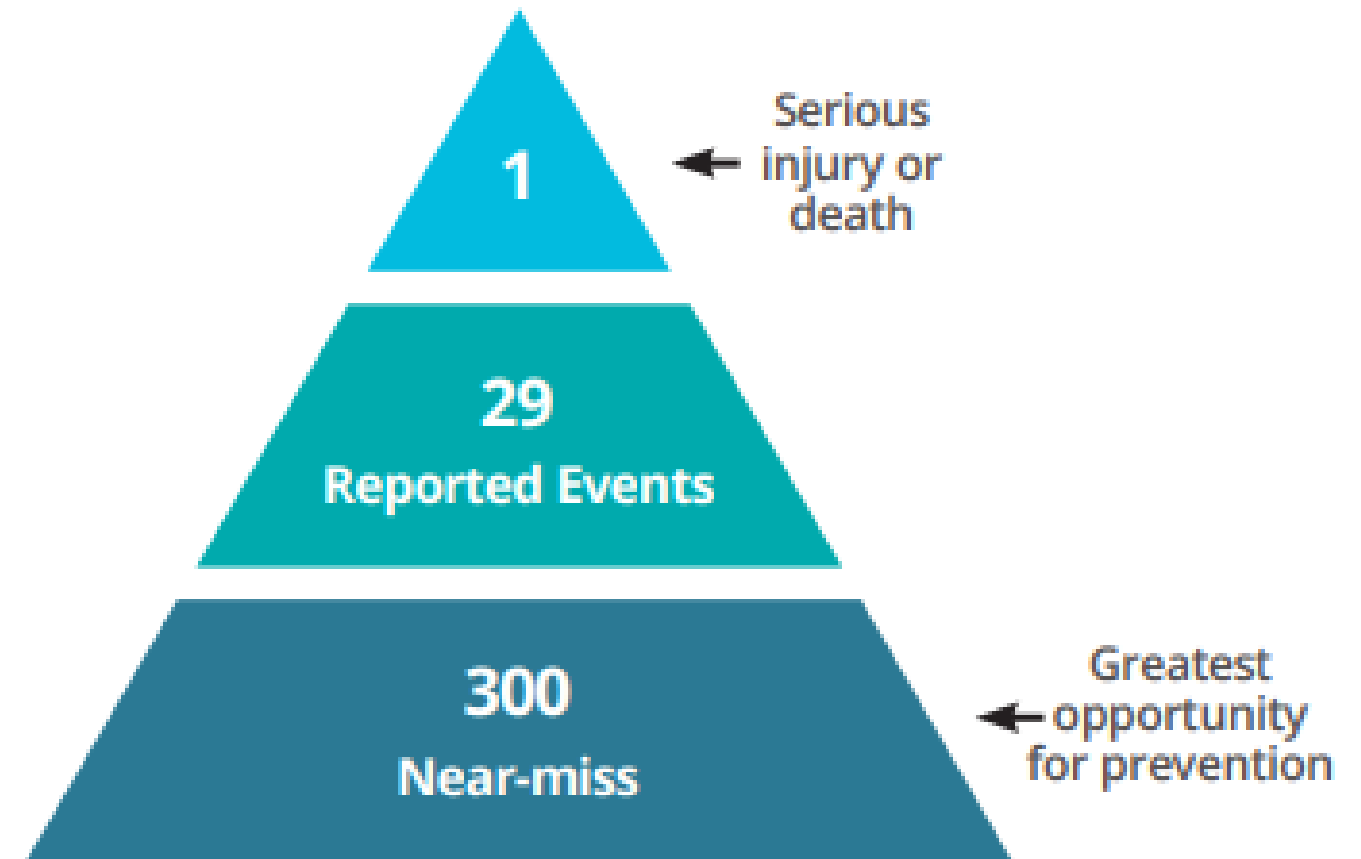
253K injuries/year



IDENTIFY UNSAFE CONDITIONS BEFORE HARM OCCURS

For every incident with serious injury, there are over **300** opportunities to identify unsafe conditions and implement prevention measures.

INCIDENT RATIO MODEL Adapted from Heinrich's Theory



*CBS is the CRICO Strategies National Comparative Benchmarking System, a database of 400,000+ claims representing 30% of all US medical malpractice claims.





WHAT IS A NEAR MISS?

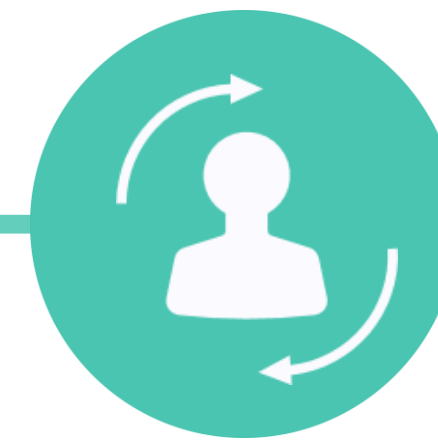
An interception of a potential safety event before a patient or employee is harmed



Sometimes referred to as a "good/great catch"



Opportunities for learning to reduce harmful events



Create a culture based on reporting



NEAR MISS EXAMPLES

Listing the incorrect patient weight

Suicide precautions were not set in place due to no verbal notification from CCU nurse. The patient's chart was reviewed, it was noticed that suicide precautions were needed, and the hospitalist was informed. The room was prepped for suicide precautions

Operator puts wristband on mother instead of patient

A regular tray with thin liquids is brought to a patient's room who is on moderately thick liquids. Patient was working with PT so the tray was not consumed and placed out of reach

Upon arrival, a manager was informed that all transport oxygen bottles were empty. Upon inspection, 6 full bottles were found in crash carts, brought into the facility, and more bottles were ordered

Infants drawer was restocked with incorrect formula

The doctor marked the wrong part of the patient. Consent was double checked, and the nurse alerted the doctor of the mistake, which was then corrected before the procedure.

Chemotherapy drugs were labeled wrong. The nurse finds error prior to administration and alerts pharmacy.

A large needle was found on the floor where a patient was standing during PT. The sharps container was on the floor, hidden behind the nightstand

200 mg of Thiamine scans as 100 mg. If rights of admin weren't checked, a double dose would have occurred



WHAT IS A NEAR MISS CAMPAIGN?

An **incentives-based** program that fosters a culture of safety.

User-friendly

- ✓ Anyone must be able to report
- ✓ Intuitive reporting system available 24 hours a day
- ✓ Accessible and responsive on any mobile device (QR code)

Well-communicated

- ✓ Clearly define what a near miss is
- Employees are assured that
- ✓ information collected will never result in reprimand
- Positive language “good/great
- ✓ catch”

Takes corrective actions

- ✓ Employees are motivated by visible progress and feedback
- ✓ Take deliberate action on reported items
- ✓ Communicate actions to the workplace

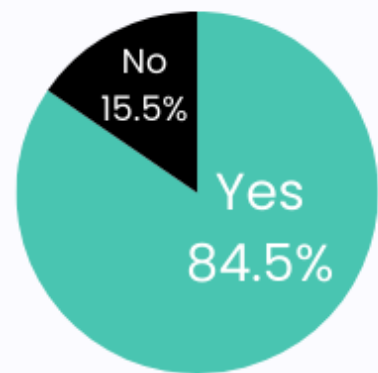


ANONYMOUS REPORTING



Over the past decade, anonymous reporting levels were trending downward, dropping to **50% in 2021** as more employees were willing to put their names behind reports. However in **2022**, **levels rose to 56%**, consistent with historic levels.

If you could report completely anonymously, would you be more likely to report issues?



Results based on a survey of 822 full-time American employees



decrease in retention rates for employees that do not feel comfortable giving upward feedback

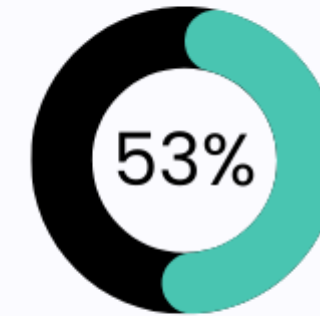
54% more medical errors were reported with an anonymous reporting system when compared to a non-anonymous incident reporting system

80-85% incidence of errors and near-misses are reported in anonymous surveys

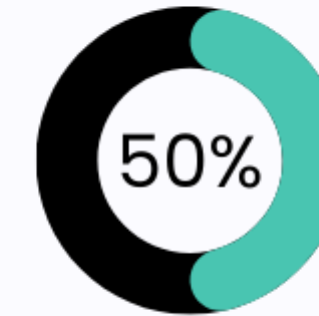
74% of employees say that they'd be more inclined to give feedback if it was truly anonymous

Top 3 Barriers of Error Reporting for Nurses

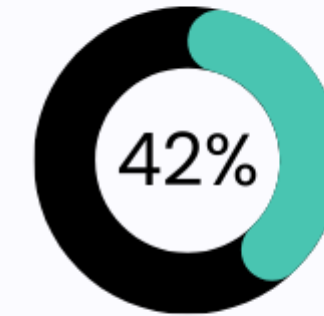
Results based on a study of nurses



fear of potential blaming



fear of losing credibility



fear of disciplinary proceedings

1/3

of those that report concerns are willing to come forward and provide additional information during the investigation that follows when companies offer anonymous reporting



55%

of 2023 Global Compliance Risk Benchmarking survey respondents identify fear of retaliation as a reason for reluctance to report

46%

of respondents to HR Acuity's Workplace Harassment and Misconduct survey do not report due to fear of retaliation

After a company with 1,000 employees introduced an anonymous reporting system:

70% of reports were anonymous

but

decreased over time to 30% since employees did not feel the need to hide behind anonymity once seeing management's response to reports



The Transformative Power of Near Miss Campaigns

To increase near miss reporting, hospitals across Arkansas participated in the American Data Network PSO's 2017 Good Catch Campaign



45

hospitals participated

47%

saw an increase in near miss reporting over baseline



246

more near misses per organization per month on average during the campaign



100%

have continued to support and monitor near miss reporting



68%

of hospitals acknowledge rewarding staff as a key strategy to improving or sustaining near miss reporting



63%

saw decrease in overall patient safety incidents related to near miss corrective actions



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How to Implement a Near Miss Program at Your Organization



Step 1: Review Baseline Performance

- Collect patient and employee incident event data from previous year or 12 months
- Know near miss data by month from previous year or 12 months
- Establish goal for increased near miss reporting
 - % increase from baseline
 - 3 near misses per employee
 - 3 near misses per event

Evaluate baseline near misses to understand:



What kind(s) of near misses (medication errors, fall hazards, etc.) are reported most frequently?



Are the same near misses reported repeatedly by single staff member(s)?



Are most near miss reports coming from a few departments?

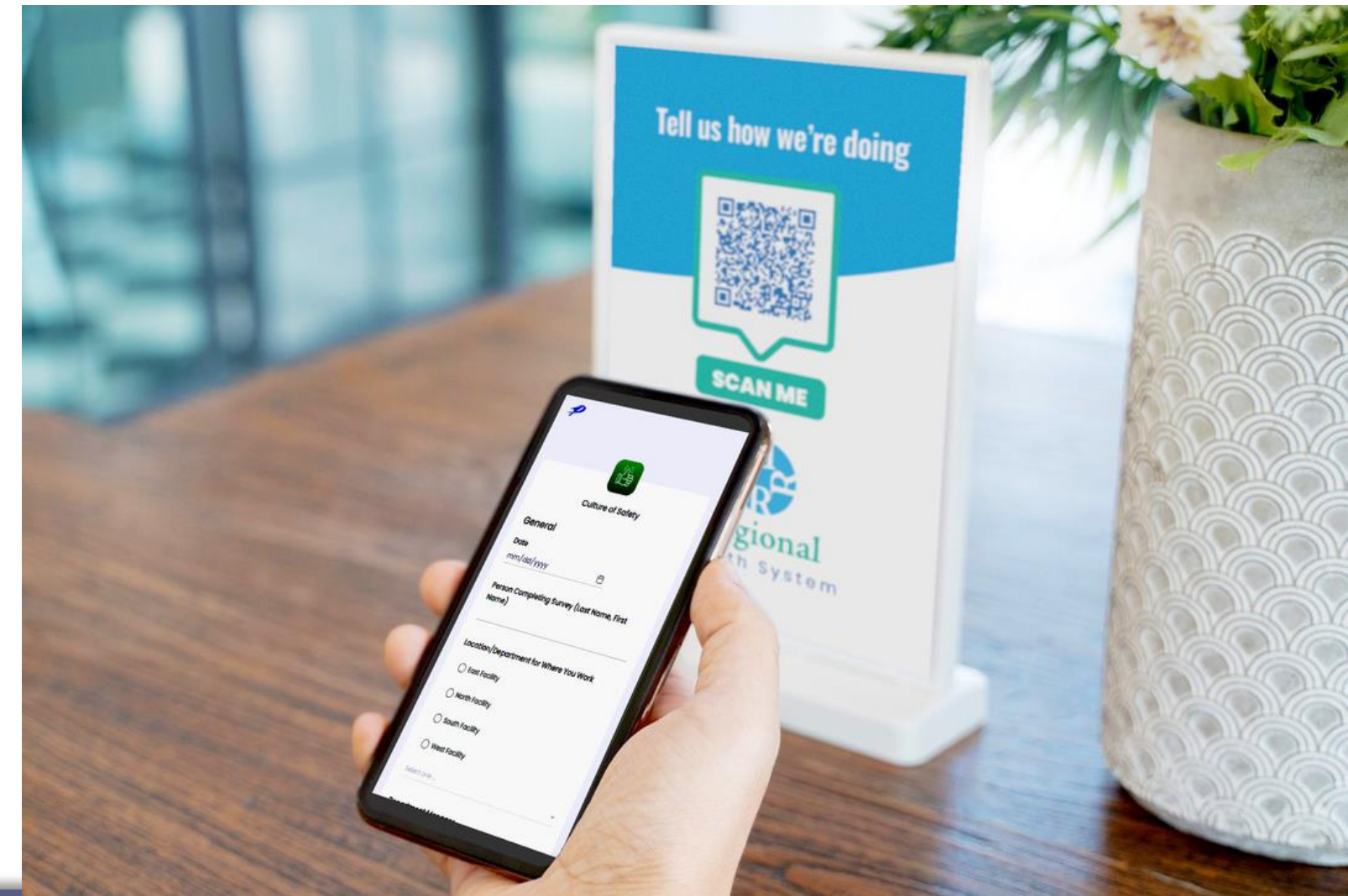


Are there departments/areas with zero reported near misses?



Step 2: Understand Areas for Improvement

- Review existing collection method to determine ease of near miss reporting
 - QR code
- Review organizational definitions, accountability, and feedback processes for near misses
- Identify other strengths and obstacles



Step 3: Obtain Senior Leadership Support

What to talk about?

- Scope of the program
- Benefits of participation
- Baseline data and stretch goals
- Proposed resources
- Award and recognition budget
 - Monthly spotlight
 - ✓ Department
 - ✓ Individual
 - End of year- wowser!



Step 4: Implementation Plan

- Create **a reward and recognition program.**
 - Monthly spotlights with prize.
- Define internal communication channels for generating awareness and enthusiasm.
 - Attend shift huddles, newsletters, leadership rounding, committee meetings, email distribution, etc.
- Develop a schedule for reviewing near misses and goal progression.
 - Focus group

Employee Recognition Examples

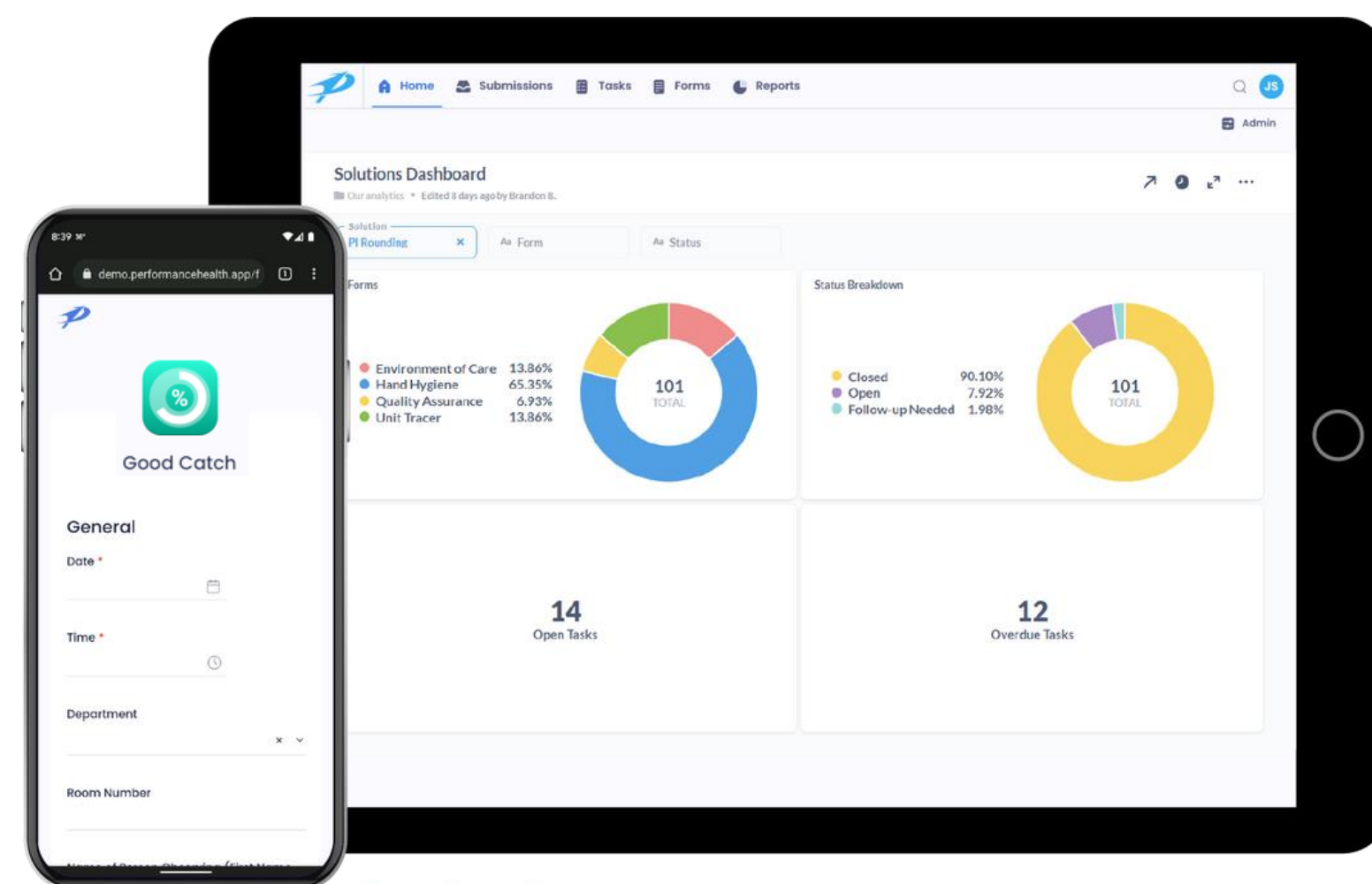
-  Gift card/movie tickets/sports tickets/museum or zoo pass
-  Coffee club membership
-  Mani/pedi gift certificate
-  The best parking spot
-  Lunch with...
-  Take the afternoon off

Drop in the chat other ideas that you have found successful



Step 5: Prepare for Launch

- Educate frontline staff and physicians
 - Repetition is encouraged
- Utilize educational and promotional materials to raise staff engagement
 - Screensavers
 - Posters
 - Intranet banners
 - Email signatures



Step 6: Sustain Momentum

- Recognize frontline staff/physicians/teams via internal reward program
 - **Patient Safety Champion**
- Provide timely, relevant feedback at all organizational levels
 - Patient safety newsletter
- Track monthly near miss volumes and compare to previous year's volumes to monitor program performance. **Share data and trends with managers.**
- Modify action plan as needed



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Step 7: Utilize Data to Make Improvements

- Analyze trends using a focus group and categorize near misses as high, medium, low
- Report results of corrective interventions
- Calculate ROI

Prevent Harm with Near Miss Reporting





Healthcare-Acquired Condition	Average Cost per Event
Medication Errors/ Adverse Drug Events (ADE)	\$1,000–\$9,000
Catheter-Associated Urinary Tract Infections (CAUTI)	\$5,000–\$30,000
C. Difficile Infections (CDI)	\$4,000–\$32,000
Falls	\$3,000–\$15,000
Pressure Ulcers	\$9,000–\$21,000
Surgical Site Infections (SSI)	\$12,000–\$42,000
Ventilator-Associated Pneumonia (VAP)	\$19,000–\$80,000
Venous Thromboembolism (VTE)	\$11,0000–\$32,000

Source: AHRQ



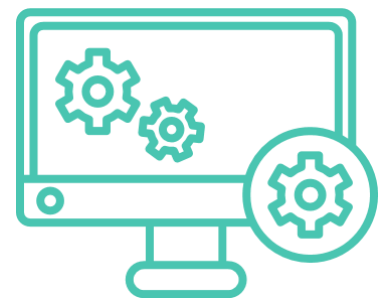
Increase Near Miss Reporting with Incident Management System

Incident and Event Management System



Prevent events with a highly accessible reporting app that securely and instantly manages, monitors, and remediates risk

With PHP's Incident Reporting software, healthcare organizations can easily report, manage, and track near misses to provide safer, high-quality care. With our incident reporting software, your organization can:



**Report near misses
in less than
2 minutes**



**Pinpoint root
cause process
breakdowns**



**Manage follow up
and track
action plans**



**Use real-time data
to gain insights**



Questions?

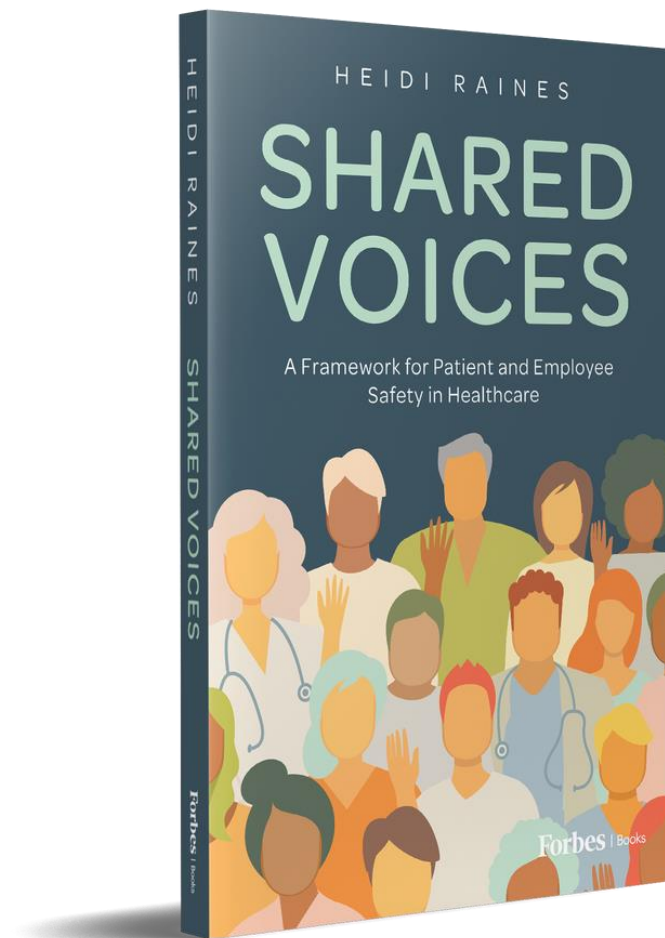


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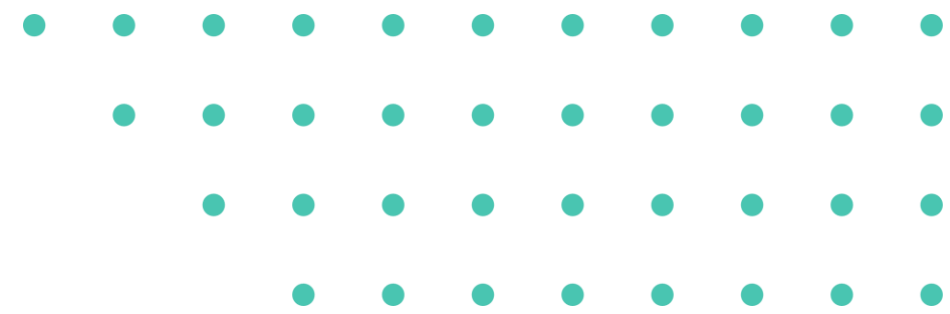


Download PHP's
near miss/
good catch tool kit



Request a copy of
“Shared Voices”





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