Cultural Shift: Starting a Near Miss Reporting System in a Major Correctional Facility

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NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

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Educational Objectives

- Define a near miss reporting system
- Describe the steps to implementing a near miss reporting system
- Outline the benefits of a near miss reporting system

Why I Started

- An incident when HS personnel tried to move a morbidly obese patient alone
  - No one was harmed (neither patient nor employee)
  - Potential harm to the patient and/or nurse
  - This was witnessed and discussed with the nurse, but no reporting system
- Avoid near misses in the future
  - Could not find a near miss reporting system in HS.
  - Started research and development of a near miss reporting system (NMRS) at WSP.

Just Culture

IS

Patient Safety

IS

Employee Empowerment

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Discussion

- What is a near miss
- History
- Definitions
- Implementation
- What was not reported (exclusions)
- Results
- Future
- Closing
- Questions

What is a Near Miss Reporting System

- OSHA Definition:
  - A near-miss is a potential hazard or incident in which no property was damaged, no personal injury was sustained, but where, given a slight shift in time or position, damage or injury easily could have occurred.
- Institute of Medicine:
  - Act of commission or omission that could have harmed the patient but did not cause harm as a result of chance, prevention, or mitigation.
  - AKA
    - “close call”
    - “near accidents”
    - “accident precursor”
    - “injury-free events”

History

- Started in the aviation industry in ~1976 to avoid the potential mishaps
  - Aviation Safety Reporting System (ASRS)
- Studies in several industries demonstrate 50-100 near misses for every accident
  - Includes the US health care system
- Developed in the hospital setting
  - Sentinel paper “To Err is Human: Building a Safer Health System”
    - ~ 98,000 US deaths due to medical errors (IOM 2000)
    - ~ 490,000 to 980,000 near misses

Definitions

- Near Miss: discussed above
- Near Miss Reporting System:
  - TRANSPARENT process of reporting and communicating near misses as they happen.
  - Report is sent to management
    - Root cause analysis
    - Create changes,
    - Study the results
    - report the changes to the organization.

Definintions

- Just Culture:
  - Encourages reporting of errors in order to identify and correct vulnerabilities within the institution.
  - Everyone is held accountable for their actions.
  - Environment is nonpunitive.
    - Encourages self-reporting of medication errors
    - Near-misses
    - Potential vulnerabilities
    - Ultimately improving safety

Implementation

- Identified stake holders:
  - Facility Medical Director
  - Sr. Health Services Manager
  - Director of Nursing
  - Administrative staff
  - Nurse Manager
  - Provider Lead
    - Yours Truly ☺

Implementation

- The “Why”
  - Improve safety
    - Patients and Staff
  - Improved patient outcomes
  - Improved patient confidence
  - Improved access to care
  - Decreased delay in care
  - Decreased legal actions
    - Still needs to be reviewed

Implementation

- Identify your leadership stakeholders
  - The concept did not initially include custody
    - Brought in later
    - Captains used the system
- Plan
  - Near miss reporting system developed
    - Form created
      - Used OSHA format with some changes
      - Anonymous (opt in name if chosen)
      - Requested input for possible corrections (ownership)
      - Open to all Washington State Penitentiary HS staff
    - Reporting
      - Email
      - Internal Mail
  - Tracking system implemented
    - Simple Excel spread sheet
    - Transparent in Health Services Share drive – Read only

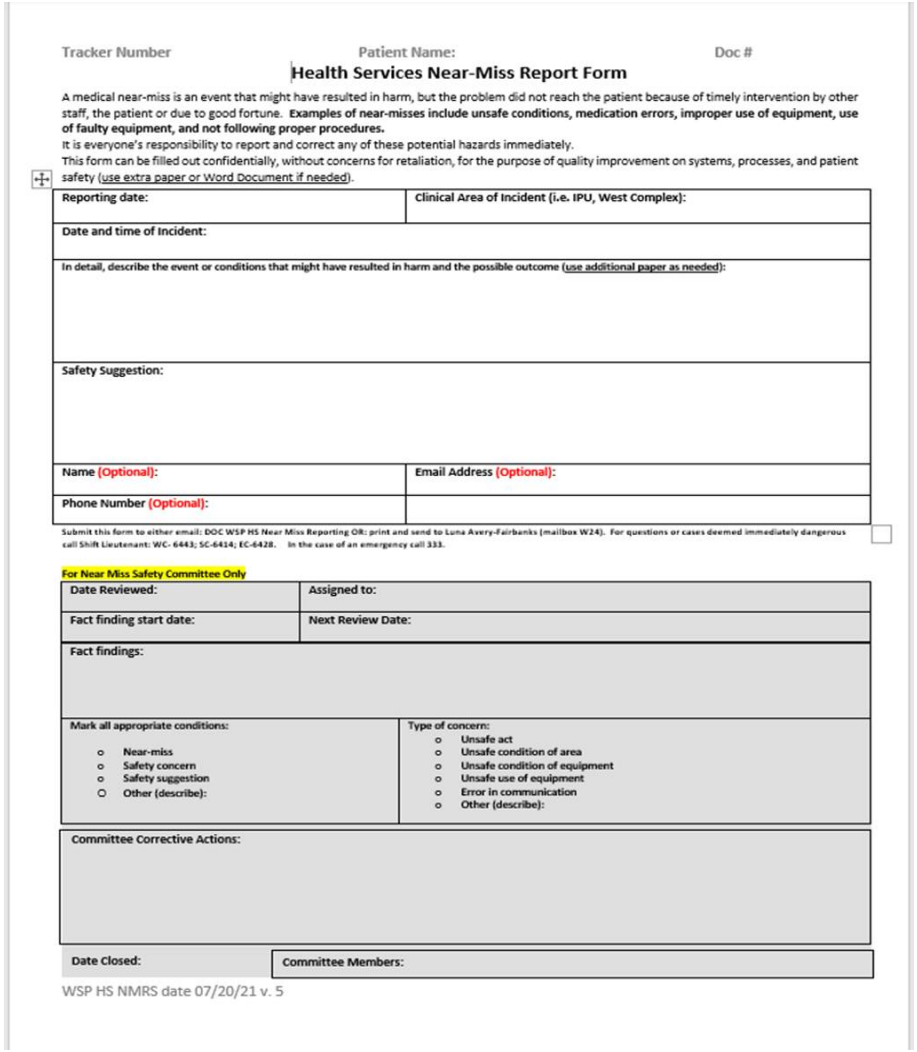
Implemented

- Trained Health Services Staff
  - Trained on the form and reporting
    - Emphasized was anonymous
    - Emphasized transparency
  - Very receptive
    - Decrease hazards
    - Increase safety
      - Patients and staff
    - Increase patient access
    - Empowers employees to act and make improvements
      - Cultural shift
        - Just Culture
        - Increase teamwork
        - Increase ownership
        - Provides Esprit De Corps

Implementation

- Create Near Miss Committee
  - Open to all to health services staff attend
    - Must have
      - FMD (or designee), Health Services Manager, Director of Nursing (or representative), medical provider, a nurse manager, administrative help (recorder)
    - Committee identify
      - Was this a near miss or actual negative impact
      - Assign staff to perform root cause analysis
      - Receive RCA
      - Discuss potential changes
      - Implement changes
      - Analysis if changes caused positive outcomes
      - Implement permanent changes

Implementation



Tracker Number Patient Name: Doc #

Health Services Near-Miss Report Form

A medical near-miss is an event that might have resulted in harm, but the problem did not reach the patient because of timely intervention by other staff, the patient or due to good fortune. **Examples of near-misses include unsafe conditions, medication errors, improper use of equipment, use of faulty equipment, and not following proper procedures.**
It is everyone's responsibility to report and correct any of these potential hazards immediately.
This form can be filled out confidentially, without concerns for retaliation, for the purpose of quality improvement on systems, processes, and patient safety (use extra paper or Word Document if needed).

Reporting date:	**Clinical Area of Incident (i.e. IPU, West Complex):**
Date and time of Incident:	
In detail, describe the event or conditions that might have resulted in harm and the possible outcome (use additional paper as needed):	
Safety Suggestion:	
Name (Optional):	**Email Address (Optional):**
Phone Number (Optional):	

Submit this form to either email: DOC WSP HS Near Miss Reporting OR: print and send to Luna Avery-Fairbanks (mailbox W24). For questions or cases deemed immediately dangerous call Shift Lieutenant: WC- 6443; SC-6414; EC-6428. In the case of an emergency call 333.

For Near Miss Safety Committee Only

Date Reviewed:	**Assigned to:**
Fact finding start date:	**Next Review Date:**
Fact findings:	
Mark all appropriate conditions: o Near-miss o Safety concern o Safety suggestion o Other (describe):	**Type of concern:** o Unsafe act o Unsafe condition of area o Unsafe condition of equipment o Unsafe use of equipment o Error in communication o Other (describe):
Committee Corrective Actions:	
Date Closed:	**Committee Members:**

WSP HS NMRS date 07/20/21 v. 5

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Implementation

Tracking # (# = Date i.e. 001-092120)	Status	Dept.	Patient involved Y/N?	Name of patient	Type of concern	Descripton	Corrective Action Plan (CAP)	CAP Owner	Due	Results
035-092821	In work					There are no wedge elevation devices for our patients with lower extremity edema. There are no HSRs for this and I believe this is a WADOC issue. Currently the wedges we have are on back order. I can think of 4 patients just off the top of my head that need these. The have been on back order for	1. Create HSR criteria for HSR for lower extremity elevation wedge 2. In the meantime, create these wedges in SPL for these patients.	Jim Duncan		09/28/21: Nursing said wedges are back-ordered. Jim will create HSR criteria to be submitted to FMD committee. Will report back in 4 weeks.
										12/7/21: Did receive leg elevation wedges, Duncan did find evidence based medicine to support but still needs to develop a protocol to present. Will need to be sent to FMD through Dr. Curl.
										12/14/21: Duncan is writing a "SS" type protocol for use of bed wedges. This will then go to FMD/HQ Medical for review/approval
										12/28/21: Duncan done with protocol. Will have available at next near miss meeting.
										1/11/22: PA Duncan will submit protocol for review and submission to FMD group next week
036-120721	New	South Clini	Yes	Unknown	Unsafe Act	Patient was returned to Adams Unit afer a stay in CDA (E-tier) with KOP medications. As there is no policy that I know of that would prohibit me from reissuing these medications. He then overdosed on these medications when he returned to	LPN has proposed that meds be put on PLN on discharge from E-tier (CDA) until such time that provider can review for safety and can convert to KOP	MaryAnn Curl, MD		12/14/21: Providers and Nursing need to be educated on desired change in protocol - that patients discharged from CDA/E tier are on pill line until provider reviews and assures their safety. Dr. Curl will put out the proposal and ask for feedback. Target for implementation: January 3, 2022.
										12/28/21: Personnel on vacation at this time. Will follow up next near miss.
										1/11/22: Decision of Near Miss Committee is that all meds (medical and mental health) should be PILL LINE after discharge from CDA. Primary care will review and discuss with Mental Health, then they will make a team decision regarding the safety of changing the status to KOP as appropriate. The timeline for this review to occur is within 30 days of discharge from CDA. Dr. Curl will put out for feedback to all of medical prior to

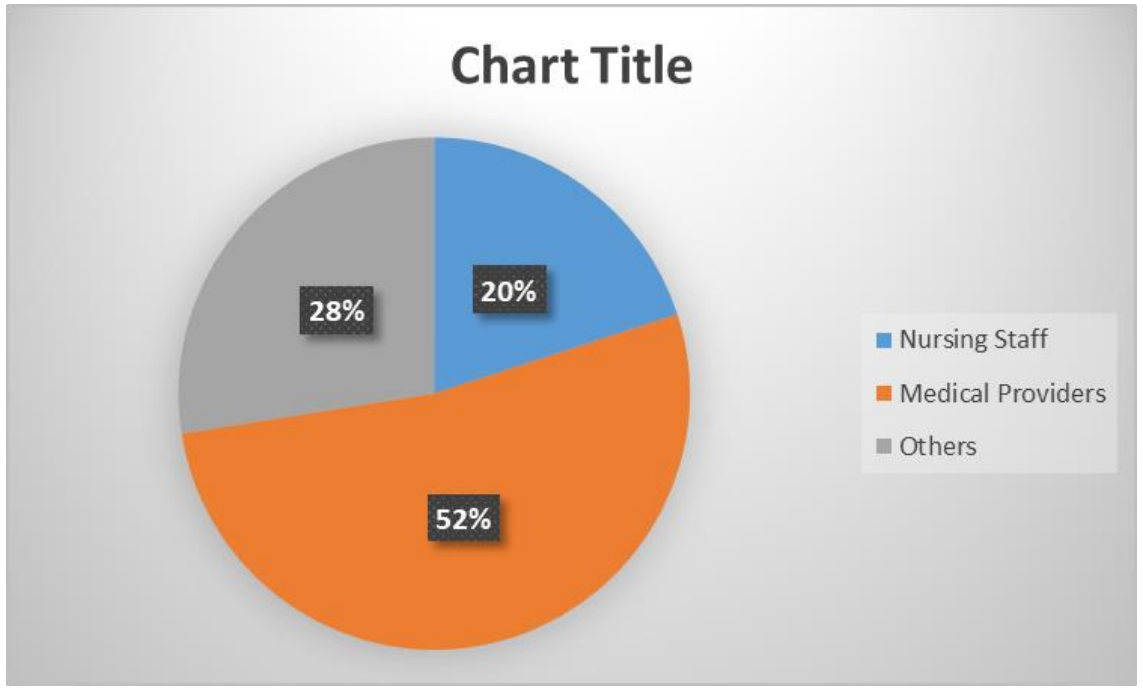
Not reportable (exclusion criteria)

- Medication errors
  - Reported on Medication Incident Reports
    - Went directly to pharmacy
- Actual Negative Outcomes
  - Events that reached the patient or staff
  - Reported on Incident Report
    - Went directly to appropriate manager

Results

- Implemented from 9/29/2020 to 03/01/2022
  - 18 months of reports
    - Total of 40 near miss's report
      - 30 reports from 09/29/2020 to 09/28/2021
        - 2.5 reports a month
          - Report every 2 to 3 weeks
        - Causes for decrease
          - COVID 19 pandemic hit WSP
            - Decreased staffing
            - Staffing over worked
            - Decrease in training of new staff

Results by Staff



- Nursing staff: 8
  - RNs
  - LPNs
  - MAs and CNAs
- Medical Providers: 21
  - Medical
  - Dental
  - Mental Health
- Other: 11
  - Custody
  - Administrative Staff

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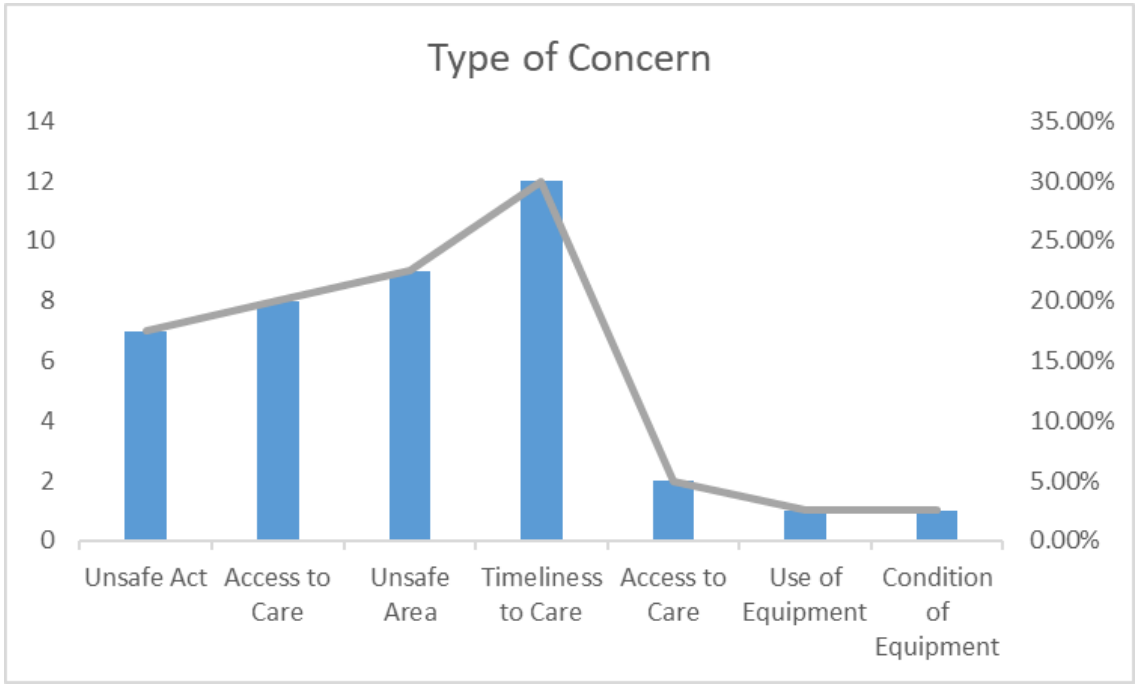
Results Type of Near Miss

- Reported Events:
  - Unsafe Act: 7
  - Access to Care: 8
  - Unsafe Area: 9
  - Timeliness to Care: 12
  - Use of Equipment: 1
  - Condition of Equipment: 1



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Improvements

- Patient accessibility
- Transitioning patients
- Safer patient environment
- Record keeping
- Communications
- Staff safety
- Fixed sidewalks
- Improvements in medical staff training

Lessons Learned

- Need for ongoing training
  - New Employee Orientation
  - Annual in-service
- Near Miss reminders
  - Newsletter
  - Email
- Involve all personnel
  - More eyes = more improvements
- Positively acknowledge the reporter
  - Unless anonymous reporter

Conclusion

- Improved patient
  - Safety
  - Access to care
  - Staff safety
- Near miss is a proactive process
  - Find it before it happens
- Empowerment of staff
  - Sense of ownership
  - Proactive process

Questions

- And thank you!!!

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