Raising a Red Flag: Reporting Near Misses in Health Care

Definitions of a Near Miss:

**Health Studies Institute**: “A near miss or close call is an event or situation that could have resulted in an accident or injury, but did not, either by chance or timely intervention.” (Miller, 2004)

**Institute of Medicine**: “A near miss is an event in which unwanted consequences were prevented.” (IOM, 2000)

**Association for Healthcare Research & Quality**: “An event or situation that did not produce patient injury, but only because of chance. This good fortune might reflect robustness of the patient (eg, a patient with penicillin allergy receives penicillin, but has no reaction) or a fortuitous, timely intervention (eg, a nurse happens to realize that a physician wrote an order in the wrong chart). This definition is identical to that for close call.” (AHRQ, 2007)

Form: 1. "Near-miss" medication event reporting form.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Unit</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Ordered: ____________________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Circle One</strong>: Incorrect</td>
<td>Route</td>
<td>Dose</td>
<td>Time</td>
</tr>
</tbody>
</table>

What happened?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How could this be avoided in the future?

________________________________________________________________________
________________________________________________________________________

Congratulations on identifying this patient safety risk. You have helped to make our medication system safer. Keep the cards coming!

your name

*Please return this card to the Safety/Quality Box. Thank You!*

*Delnor Life
dLifelinePatient Safety is #1*

MEDICATION EVENT, CLOSE CALLS OR NEAR-MISS REPORT FORM (2004)
Deltor-Community Hospital, Geneva, IL

Pt. Name: ___________________________
V#: _________________________________
M#: _____________________________ Room# ___________________________

2. Event location: ______________________ 3. Event date & time: ____________________________

4. Was medication obtained from: [ ] Pyxis profile [ ] Pyxis override [ ] Pharmacy [ ] Patient's own meds

5. Type of event: [ ] Incorrect patient [ ] Extra dose given [ ] Infusion pump issue
   [ ] Incorrect dosage [ ] Dispensing issue [ ] IV drug infiltration
   [ ] Incorrect medication [ ] Ordering issue [ ] Medication contraindicated
   [ ] Incorrect time/date [ ] Transcription issue [ ] Failure to draw lab levels
   [ ] Incorrect route [ ] IV infusion too rapid [ ] Failure to act on lab values
   [ ] Incorrect injection site [ ] IV infusion too slow [ ] Med not stopped when ordered
   [ ] Med not given [ ] Other: ____________________________

6. Medication order involved ____________________________ Date of Order ____________________________
   Physician ____________________________

*** Attach supporting documentation, if available ***

7. Objective comments:

_________________________________________________________________________
_________________________________________________________________________

8. Describe effect on patient:

_________________________________________________________________________

9. What do you think contributed to the event? How can this be avoided in the future?

_________________________________________________________________________
_________________________________________________________________________

10. Physician was notified: [ ] Yes [ ] No

11. Signature & Title of Person Completing Form: ____________________________ Date/Time: ____________________________

FOLLOW-UP & ADDITIONAL INFORMATION BY PATIENT UNIT TEAM LEADER:

12. The following event was: [ ] an Adverse Event [ ] Close Call [ ] Near-miss (Definitions on back.)

_________________________________________________________________________
_________________________________________________________________________

14. Feed back was given to the involved staff member: [ ] Yes [ ] No ____________________________

Team Leader Signature: ____________________________ Date/Time: ____________________________

ROUTING INSTRUCTIONS: After completion of the "Follow-up & Additional Information by Team Leader" section, the Patient Unit Team Leader should forward this report to the Quality Management Department. Do not make copies.

THIS REPORT IS FOR INTERNAL QUALITY IMPROVEMENT PURPOSES ONLY:
Pursuant to the Illinois Medical Studies Act (735 ILCS 5/8-2101), this document is confidential and shall be privileged from disclosure in any civil action or claim. No person or committee shall disclose information from this document except as permitted by Hospital policy.
References:


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