

Reporting on 'near miss' incidents

Most general practice nurses (GPNs) will have encountered 'near miss' situations at some time in the course of their career. These are the heart-sinking situations when you realise, just in time, that a significant mistake almost occurred that could have adversely affected patient care. Rather than blaming people, health care professionals should accept that these situations happen to everyone. An example of a 'near miss' incident is provided below:

Example: a GPN who experienced a 'near miss' situation

Sue is an experienced GPN, but has recently moved practices. She has been at the new practice for about 6 weeks and is just getting to know some of the patients. She is almost at the end of running a flu clinic. She has already vaccinated 15 patients – mainly elderly, but with a few younger asthmatic patients in between. She calls through her final patient, Mary Smith. Mary is 25 years old and comes in saying 'I'm here for my injection. The receptionist said you'd fit me in at the end of the clinic.' Sue draws up the flu injection and has a quick glance at Mary's notes. She notes that she is on repeat medication for a salbutamol inhaler, so assumes that she is attending for the flu injection because of her vulnerability as an asthmatic.

Sue is just about to give the injection when she remembers to check whether Mary is pregnant before proceeding. Mary's answer is 'Well there'd be something wrong with your injections if I was.' This makes Sue stop in her tracks and she asks Mary what she means. Mary explains that the injection is supposed to be almost 100% effective at preventing pregnancy. Sue realises, with horror, that Mary has attended for her regular contraceptive injection (Depo provera) – not the flu injections. The receptionist squeezed her in at the end of the flu clinic because there was a vacant slot and she needed to have the injection today. No harm is done as Sue has not given the injection and is able to remedy the situation.

There is considerable learning to be had from this situation in terms of systems and processes that could be put in place to avoid this 'near miss' occurring again. However, often the individuals involved feel upset or embarrassed by their 'near miss' and therefore do not discuss it widely. Having an anonymous reporting system for such occasions will bring these incidents (which are usually highly understandable) into the open, so that changes can be made to prevent future risks.

A simple way of reporting incidents is as follows:

- *Set up 1-hour meetings every 6 weeks or so for the whole practice team to discuss the 'near miss' incidents that have occurred – invite GPs, GPNs and reception staff – they will all have something to contribute*
- *Send out a circular to all practice staff explaining what you are trying to achieve and how learning from mistakes (or near mistakes) will enhance future patient safety. Explain the system you are setting up will be anonymous so that no single individual can be identified*
- *Save Form A (below) on your PC and send it out electronically to all practice staff. Explain that if they complete it electronically their handwriting will not be identifiable*
- *Set up a 'near misses' incidents box somewhere private within the practice (eg staff room) and ask for all completed forms to be placed within this*
- *Collect the forms on the day of the planned meeting and discuss them with all staff*
- *Complete Form B at the meeting when you are analysing how you could prevent a sticky situation from occurring again*
- *At the next meeting start by checking that the things you agreed at the last meeting have now been put in place*
- *Keep these meetings going as a regular occurrence; you may want to complete a form yourself relating to a past incident, at least for the first meeting, to make sure that the process takes off. Once people get used to this idea, they will also contribute, as they see the learning that can be gained and the culture within the practice gradually become more open.*

Form A. Recording 'near misses' or adverse incidents

Complete the following form as fully as possible so that the practice can learn about how to minimise future risks to patients. It should be completely anonymous, when referring to a patient please do not name them, but simply refer to them as Mr or Ms A; similarly, when referring to practice staff, refer to them as Nurse X , Dr Y or Receptionist Z etc.

What was the situation that worried you or almost resulted in a big mistake?

What did you do about it (if anything)?

Is there anything you can think of that could prevent this happening again?

Form B. Analysis of adverse incidents

Summary of events

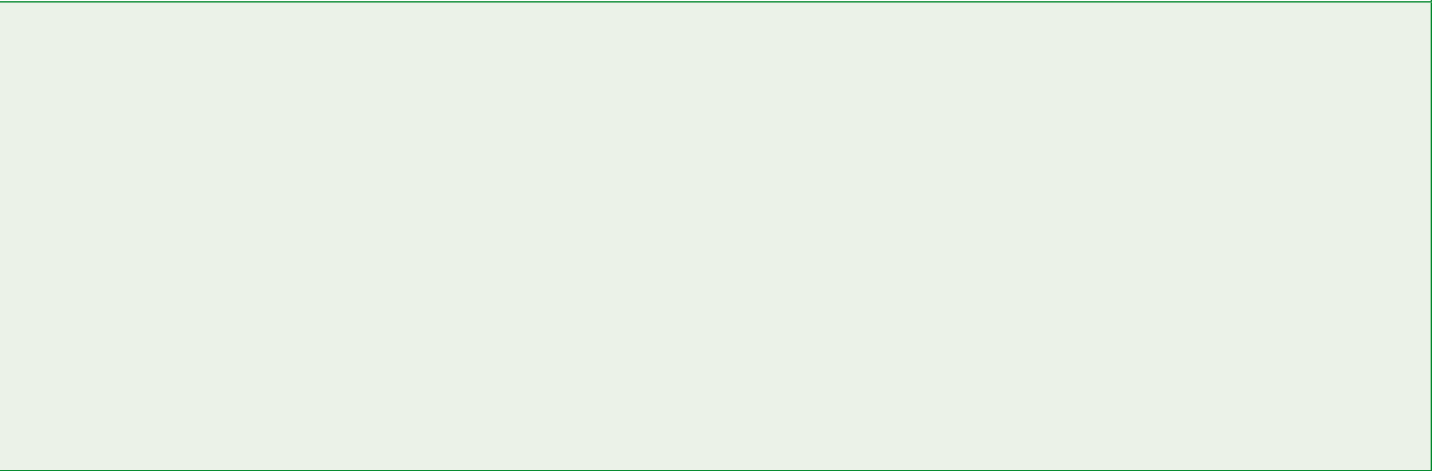
(eg wrong injection almost given during flu clinic)

Ways to stop this happening again

(eg processes to be in place – such as adding 'reason for consultation' next to every patient's name)

Who needs to be involved in implementing these changes?

(This needs to include specific names of people who will alter the system, eg Jo Bloggs, Practice Manager)



Date changes are to be implemented

(A specific date will ensure that there is a defined change-over to a new system, rather than leaving it vague)

