

## INTRODUCTION:

Creating a safety culture is always a top priority for hospitals. The current Risk Management System (RMS) was not suitable in reporting near miss cases as there were no option for near miss category. Hence, many near misses which happened were not reported and tracked.

## AIM:

To build a safety culture among nurses and provide an environment where staff is confident to be open and frank in reporting

## Methodology:

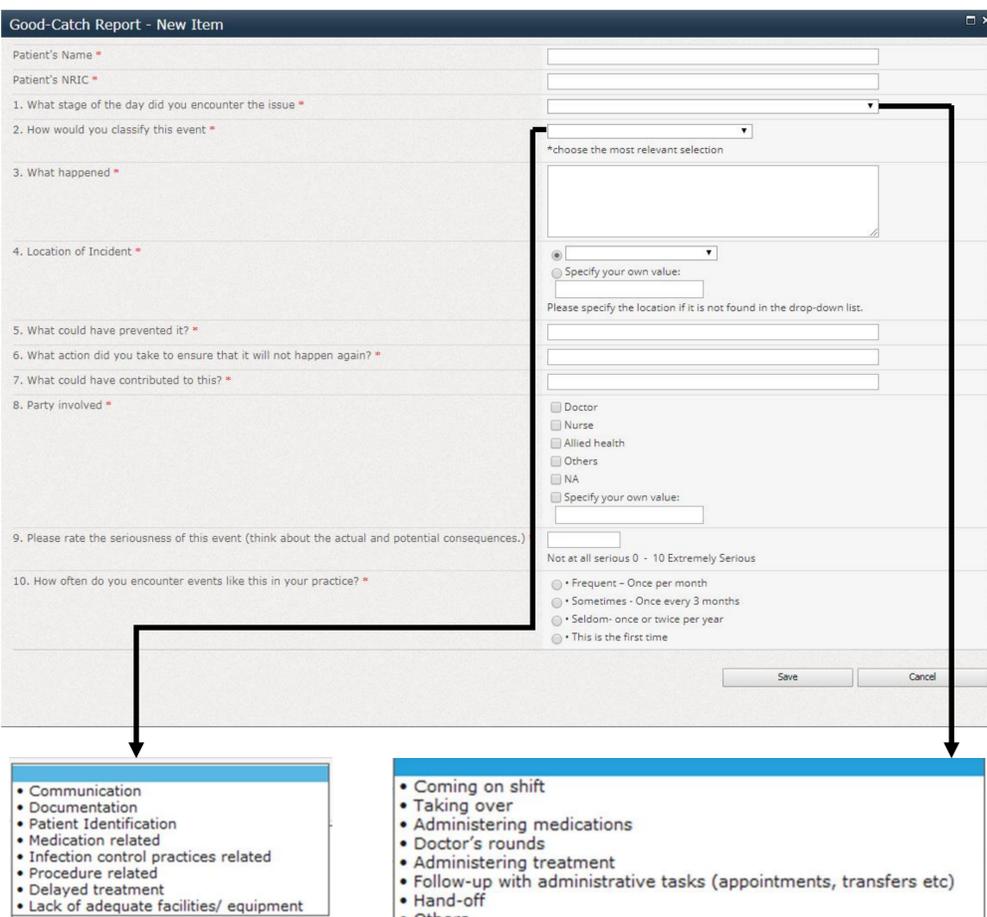
The team brainstormed on ways for nurses to report any near misses with no investigation or root cause analysis needed after reporting.



- ✓ **No follow up actions required** from the reporting staff or supervisors after near miss reporting
- ✓ Staff is not required to submit their name when reporting near miss
- ✓ Time taken is lesser

The electronic form for near miss reporting was designed with few triggered questions for easy reporting and analyzing the data into the specific categories. E.g. stage of the day, classification of the incidents, and etc. Hence, reporting staff do not required to spend much time in writing the details.

### Sample of the e-form on Nursing Safety & Quality Infopedia page:



**Good-Catch Report - New Item**

1. What stage of the day did you encounter the issue? \*

2. How would you classify this event? \*

3. What happened? \*

4. Location of Incident? \*

5. What could have prevented it? \*

6. What action did you take to ensure that it will not happen again? \*

7. What could have contributed to this? \*

8. Party involved? \*

9. Please rate the seriousness of this event (think about the actual and potential consequences.) \*

10. How often do you encounter events like this in your practice? \*

Not at all serious 0 - 10 Extremely Serious

- Frequent - Once per month
- Sometimes - Once every 3 months
- Seldom- once or twice per year
- This is the first time

Save Cancel

**Contributing Factors:**

- Communication
- Documentation
- Patient Identification
- Medication related
- Infection control practices related
- Procedure related
- Delayed treatment
- Lack of adequate facilities/ equipment
- Coming on shift
- Taking over
- Administering medications
- Doctor's rounds
- Administering treatment
- Follow-up with administrative tasks (appointments, transfers etc)
- Hand-off
- Others

## Results:

The Nursing Safety & Quality Infopedia page was enhanced to create a platform to report near misses. Near miss data will be used by Nursing Safety & Quality team for opportunities to prevent future incidents and explore corrective measures to promote patient safety.



There were a total of **319** cases raised in year 2017.

## Conclusion:

This platform of reporting near misses provide accessibility and simplicity for nurses.