Making Near Misses Count:
Turning Mistakes into Teachable Moments

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Objectives

By the end of the session, participants will be able to:

1. Define "near misses" and their impact
2. Identify the opportunities and challenges related to discussing near misses
3. Introduce the NEAR MISS framework for turning near misses into teachable moments with learners
Reflecting on Our Experiences
Instructions for PollEverywhere

Please text “MEDEdUCATION” to the number 22333 or sign on to Pollev.com
Why is it difficult to talk about errors and/or learn from them?
Why Is It Difficult to Discuss & Learn From Mistakes?

- Emotional barriers
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- Emotional barriers
- Cognitive barriers
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- Logistics: time, space, awareness
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- “Fix and forget”
Error Discussion, Feedback, & Learning
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Discussion
Feedback
Error Discussion, Feedback, & Learning
Why Near Misses?

- **Near miss** = an error that *does not cause injury* to a patient, either by chance or because it is *intercepted* before being administered or provided to the patient.
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### Why Near Misses?

#### Comparison of Responses to Near Misses vs. Adverse Events

<table>
<thead>
<tr>
<th>Scale</th>
<th>Severity of Error</th>
<th>Near Miss</th>
<th>Adverse Event</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance Rating*, mean (±SD)</td>
<td>Mild Moderate</td>
<td>4.00 (0.97)</td>
<td>4.61 (0.60)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.61 (0.60)</td>
<td>4.87 (0.33)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Effort to Notify Rating*, mean (±SD)</td>
<td>Mild Moderate</td>
<td>2.55 (0.64)</td>
<td>2.58 (0.60)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.58 (0.60)</td>
<td>2.64 (0.56)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*Importance was rated on 5-point Likert scale (1 = not at all, 2 = slightly, 3 = moderately, 4 = very, 5 = extremely).

^Effort was calculated from two multiple-choice questions pertaining to actions the respondent would take in response to an error. Minimum = 0; maximum = 3.
...we’re all already working so hard and trying our best, and it would feel unnecessarily punitive and accusatory or elicit shame or guilt. Also, some errors are quite minor and not necessarily worth bringing up if they won’t lead to any meaningful change.

The major factor is whether there was significant risk to the patient or if harm occurred. Things that have little or no consequence are sometimes not worth bringing up to avoid making peers feel judged/criticized/condescended to.

I worry significantly about contributing to burn out and/or shame surrounding errors and learning.
Why Near Misses?

- **Near miss** = an error that does not cause injury to the patient, either by chance or because it is intercepted before being administered or provided to the patient.
Laying the Foundation
Psychological Safety

- Perception that you can engage in interpersonally risky behaviors in the work environment, such as asking questions, reporting mistakes, and seeking feedback, without negative consequence (Edmondson, 1999)

- Shifts focus to shared goals

- Facilitates clinical learning
Growth Mindset

- The belief that intelligence and ability can be **developed** (Dweck, 2015)

- Compared to fixed mindset

- Facilitates motivation and receptiveness to feedback
System Level Learning
How Do Hospitals Learn from Near Misses?

A structured process for near miss and lower-level safety events

Support Event Review:

Safety Culture:

Enterprise-wide Sharing and Learning
Apparent Cause Analysis

- A *limited* investigation of adverse events that:
  - reach the patient resulting in minimal or no harm (often called *precursor events*) OR
  - do not reach the patient and are caught by detection barrier or chance (*near miss*)

* Emphasis on identifying *immediate local changes* to prevent recurrence
Safe & Reliable Culture Maturity Model

Tipping Point = Psychological Safety

Generative
Safety is how we do business around here constantly vigilant and transparent.

Proactive
Anticipating and preventing problems before they occur; Comfort speaking up.

Systematic
We have systems in place to manage all hazards.

Reactive
Safety is important. We do a lot every time we have an accident.

Unmindful
Who cares as long as we’re not caught chronically complacent.

Cultural shift from reactive to proactive
An Apparent Cause Analysis is a 5-Step Process

1. Identify criteria to initiate
2. Investigate the event and identify immediate actions
3. Create an apparent cause statement
4. Identify corrective actions
5. Develop solutions and recommendations for organizational learning
The Power of *Because*

- **I did not call and ask that team for help because I did not know that they were an option**
- **Clinician did not ask a clarifying question because s/he was afraid to speak up**
- **I did the work by myself because it is faster that way**

Diagram:
- Structure
- Policy & Protocol
- Culture
- Technology & Environment
- Work Processes

**BEHAVIORS**

**OUTCOMES**

Adapted from HPI

Where the world comes for answers
Safety Story for Shared Learning

What Happened:
A nasogastric tube was replaced by the bedside nurse in a patient status post major sinus surgery.
ACA Statement:
The bedside nurse replaced the tube BECAUSE this is a routine bedside task for nurses and BECAUSE a system alert did not identify risk.

Local Clinical Action Items:
1. EDUCATION
2. CHECKLISTS
3. COGNITIVE AIDS (signage)
4. DECISION SUPPORT (clinical orders)

Broader Dissemination:
Presented at an inpatient M & M
Role Play

A learner admits a patient with pneumonia. The patient has a severe seizure disorder. The learner does not order the patient’s seizure medication, but a parent at bedside alerts the team that seizure medication is due.
Role Play
NEAR MISS Framework
NEAR MISS Framework

Note the time
Evaluate facts & feelings
Approach with curiosity & kindness
Review error specifically
Make it a teachable moment
Invite reflection
Strategize for change
Support the learner
Note the time

- Not too long after event
- Good time for learner
- Good time for you

Evaluate facts & feelings
Approach with curiosity & kindness
Review error specifically
Make it a teachable moment
Invite reflection
Strategize for change
Support the learner
Note the time

- How long ago did this occur? Do I need to address this immediately?
- Is it sign out time? Is the learner amid time-sensitive tasks?
- Am I emotionally and physically available to discuss this?
Evaluate facts & feelings

- Learn facts of event
- Reflect on your own feelings about the event
- Reflect on any biases you may have

Note the time
Evaluate facts & feelings
Approach with curiosity & kindness
Review error specifically
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Invite reflection
Strategize for change
Support the learner
Evaluate facts & feelings

- What do I know about what actually happened?
- What am I assuming about the learner?
- How am I feeling right now?
Approach with curiosity & kindness

- Try to understand learner’s frames, assumptions, and knowledge that may have guided their actions

- Maintain respect for learner and value their perspectives
Approach with curiosity & kindness

- I’m wondering...
- How were you seeing that situation...
- Can you help me understand...

Note the time
Evaluate facts & feelings
Approach with curiosity & kindness
Review error specifically
Make it a teachable moment
Invite reflection
Strategize for change
Support the learner
Review error specifically

- Discuss the details of the error
- Name the “near miss”
Review error specifically

• *What I observed was…*

• *This was a near miss because…*
Make it a teachable moment

- Instill teaching points into discussion

Note the time
Evaluate facts & feelings
Approach with curiosity & kindness
Review error specifically
Make it a teachable moment
Invite reflection
Strategize for change
Support the learner
Make it a teachable moment

• *It is completely understandable how this error occurred, but I hope we can still learn from it...*

• *This is important because...*

• *Address knowledge gaps or biases specifically*
Invite reflection

- Ask the learner about their thoughts, feelings, and perspectives about the event

Note the time
Evaluate facts & feelings
Approach with curiosity & kindness
Review error specifically
Make it a teachable moment
Invite reflection
Strategize for change
Support the learner
Invite reflection

• What thoughts do you have?

• Did you see things differently?
Strategize for change

- Make a plan with the learner for the next time to avoid a similar error

- Discuss potential system changes
  - Report the error (i.e., SERS)

Note the time
Evaluate facts & feelings
Approach with curiosity & kindness
Review error specifically
Make it a teachable moment
Invite reflection
Strategize for change
Support the learner
Strategize for change

- Do you have any ideas about how you could do things differently next time?
- What can we change for the future?
- I think others can learn from this too... Have you filed a SERS before?
Support the learner

- Normalize and share own experiences
- Listen to the learner’s feelings
- Provide overall evaluation if relevant/helpful
- Refer for outside support if needed (e.g., OCS, other supervisors)
Support the learner

- This is a common mistake that has been made by many other learners...
- I have made the same mistake before...
- I have confidence in your abilities...
- I appreciate your willingness to discuss this and learn from it...
- How can I support you in making that change in the future?
- If it might be helpful to talk to someone else about this (now, next week, next month...), there are other resources (OCS, supervisors, program leaders, etc.)...
NEAR MISS Framework

Note the time
Evaluate facts & feelings
Approach with curiosity & kindness
Review error specifically
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Invite reflection
Strategize for change
Support the learner

Have you tried anything similar or different?

What might you add?

What might make this challenging to implement?
What is one thing you are going to take away or change as a result of this session?
Conclusion

- Near misses are common, no-harm events that are typically “fixed & forgotten”

- Near misses are opportunities to facilitate
  - individual learning
  - system learning
  - culture change

- NEAR MISS can be utilized to approach learners with empathy and kindness in order to turn a mistake into a teachable moment
Q&A
References


