Making Near Misses Count:

Turning Mistakes into Teachable Moments

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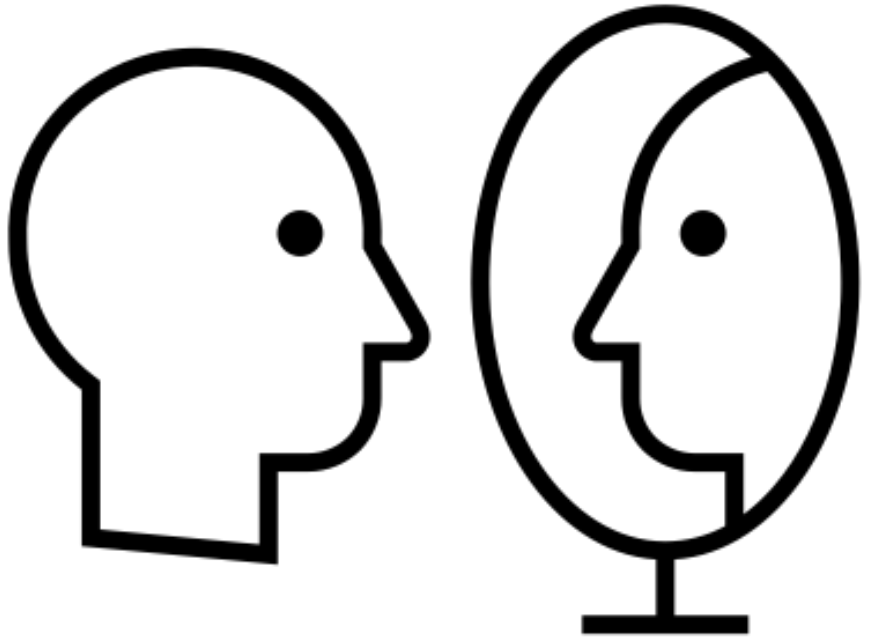
Objectives

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

Respond at **PollEv.com/mededucation**

Text **MEDEDUCATION** to **22333** once to join, then text your message

Why is it difficult to talk about errors and/or learn from them?

No responses received yet. They will appear here...

Why Is It Difficult to Discuss & Learn From Mistakes?

- Emotional barriers

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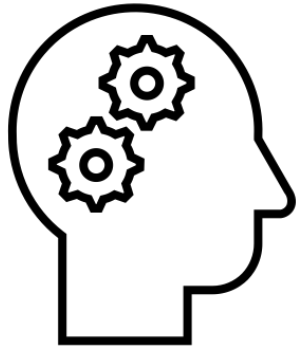
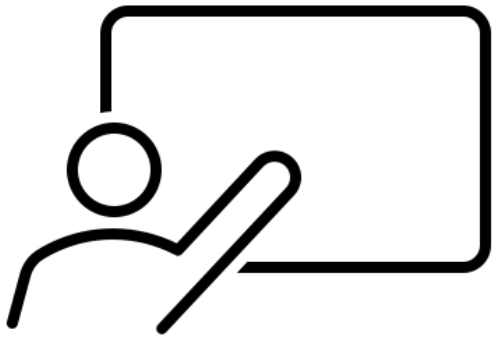
- Cognitive barriers



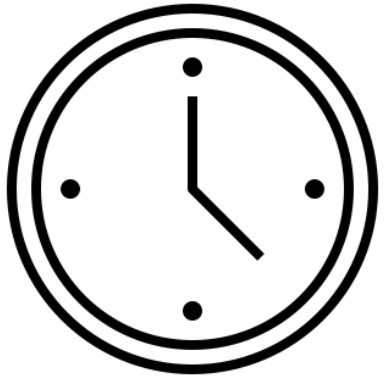
Why Is It Difficult to Discuss & Learn From Mistakes?

- Emotional barriers
- Cognitive barriers
- Lack of training



Why Is It Difficult to Discuss & Learn From Mistakes?

- Emotional barriers
- Cognitive barriers
- Lack of training
- Logistics: time, space, awareness



Why Is It Difficult to Discuss & Learn From Mistakes?

- Emotional barriers
- Cognitive barriers
- Lack of training
- Logistics: time, space, awareness
- "Fix and forget"


Original research

Learning from near misses: from quick fixes to closing off the Swiss-cheese holes

Lianne Jeffs,[1,2,3] Whitney Berta,[4] Lorelei Lingard,[5,6] G Ross Baker[4]


ORIGINAL RESEARCH

Fix and forget or fix and report: a qualitative study of tensions at the front line of incident reporting

Tanya Anne Hewitt,[1] Samia Chreim[2]

Error Discussion, Feedback, & Learning

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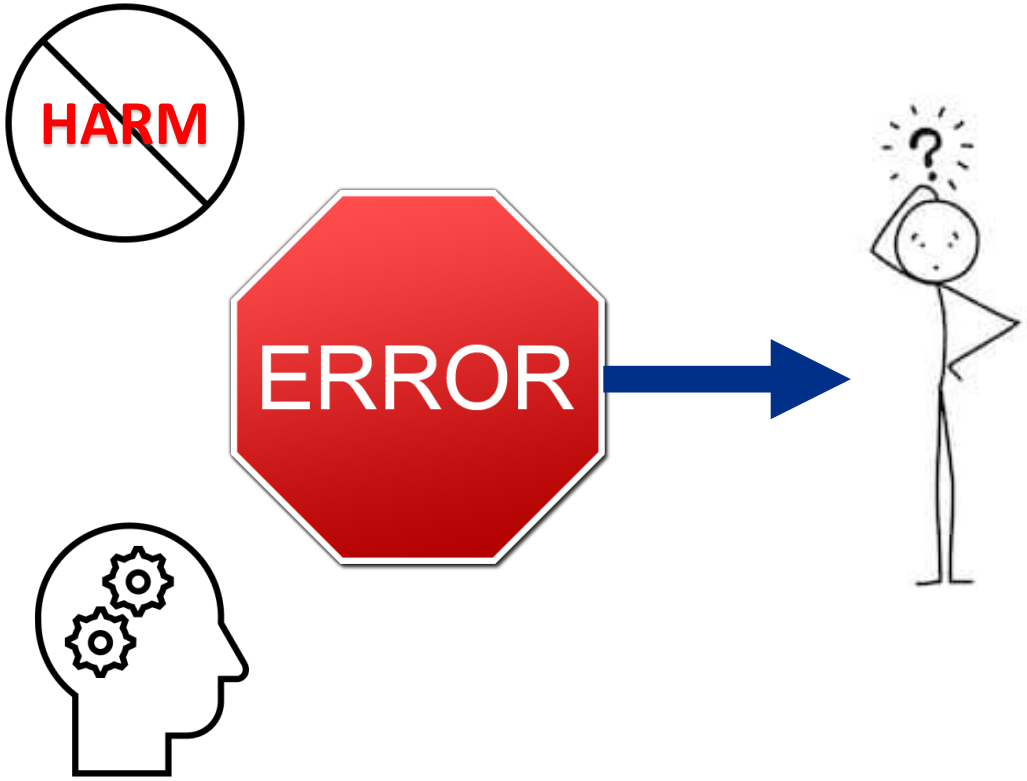
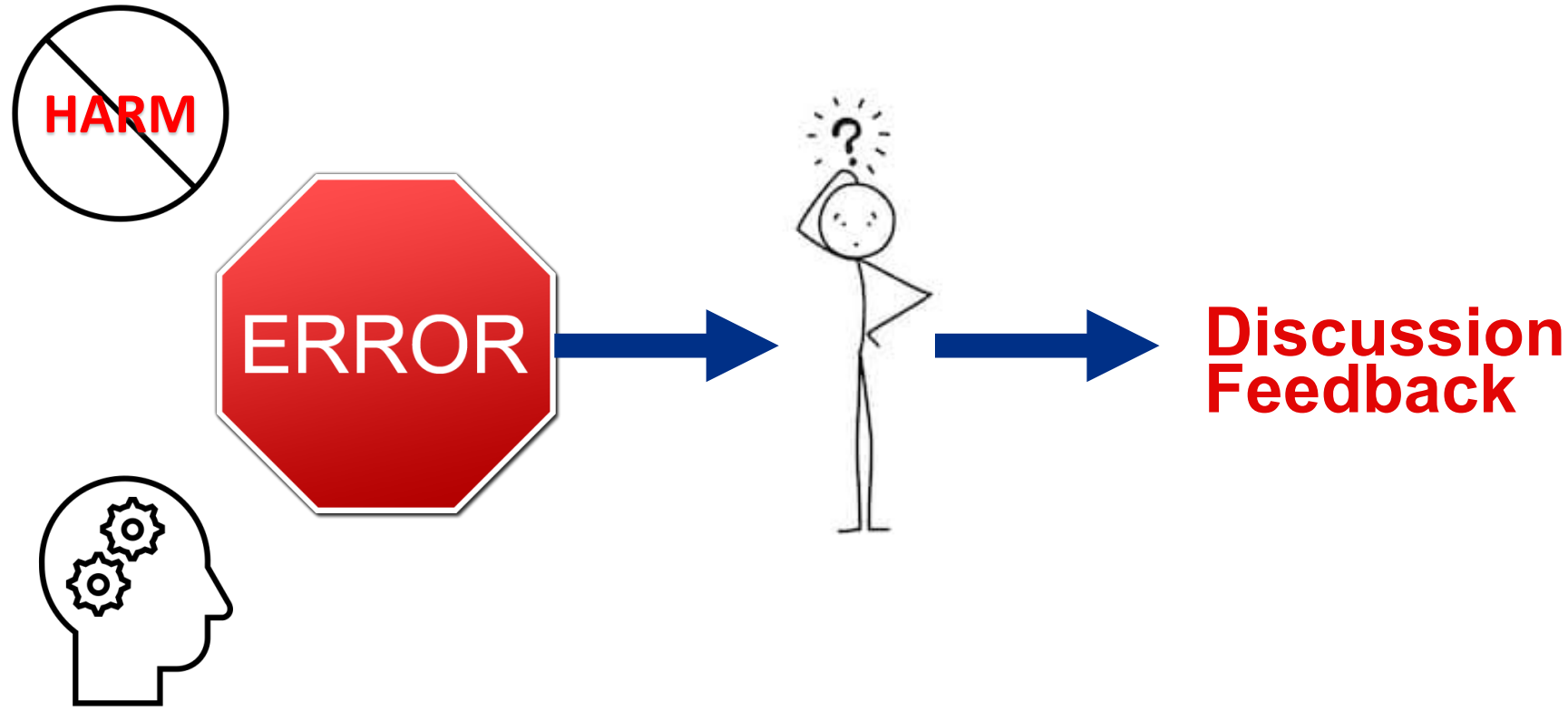
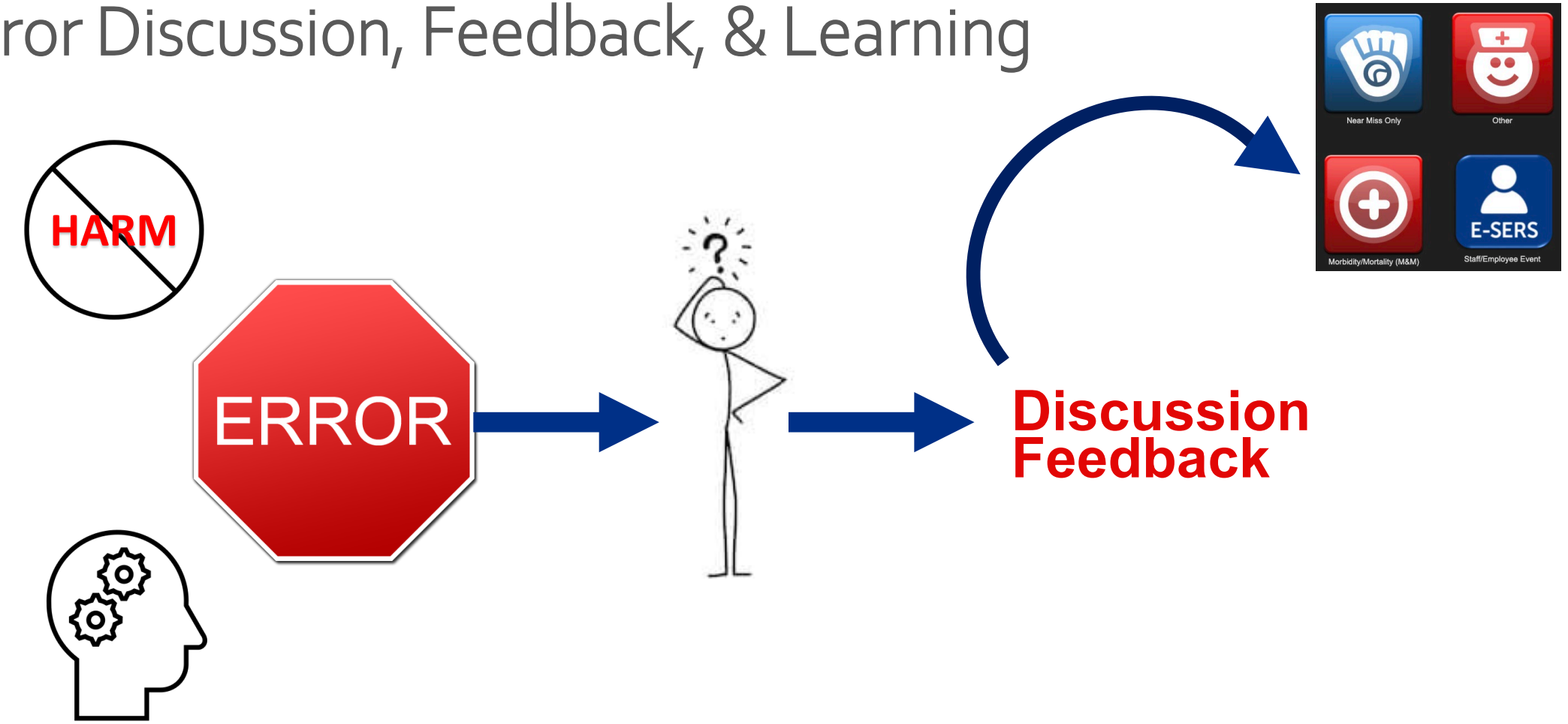


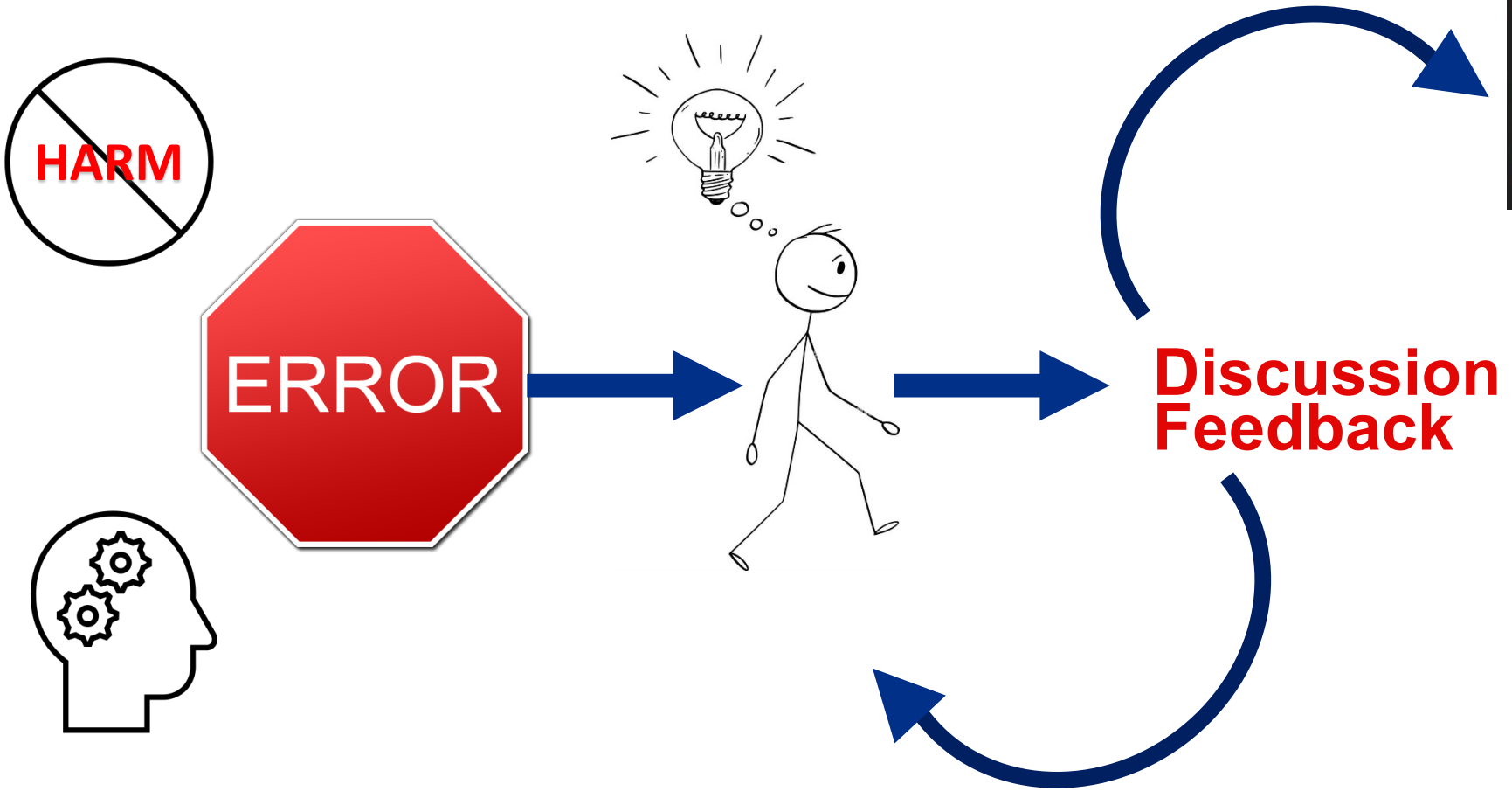
Error Discussion, Feedback, & Learning

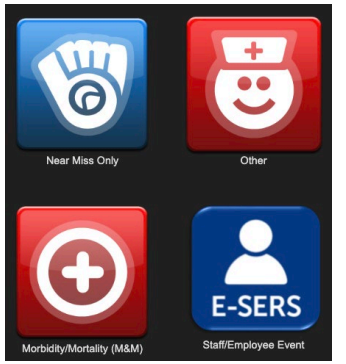


Error Discussion, Feedback, & Learning



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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COMMON

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COMMON

FIXED & FORGOTTEN

Why Near Misses?

Comparison of Responses to Near Misses vs. Adverse Events

Scale	Severity of Error	Near Miss	Adverse Event	P-value
Importance Rating*, mean (±SD)	Mild Moderate	4.00 (0.97) 4.61 (0.60)	4.61 (0.60) 4.87 (0.33)	<.001 <.001
Effort to Notify Rating^, mean (±SD)	Mild Moderate	2.55 (0.64) 2.58 (0.60)	2.58 (0.60) 2.64 (0.56)	<.001 <.001

***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.

Study Participant Responses:

*…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.*

*I worry significantly about contributing to **burn out and/or shame** surrounding errors and learning.*

***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**.*

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

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NORMALIZING

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

Value

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.

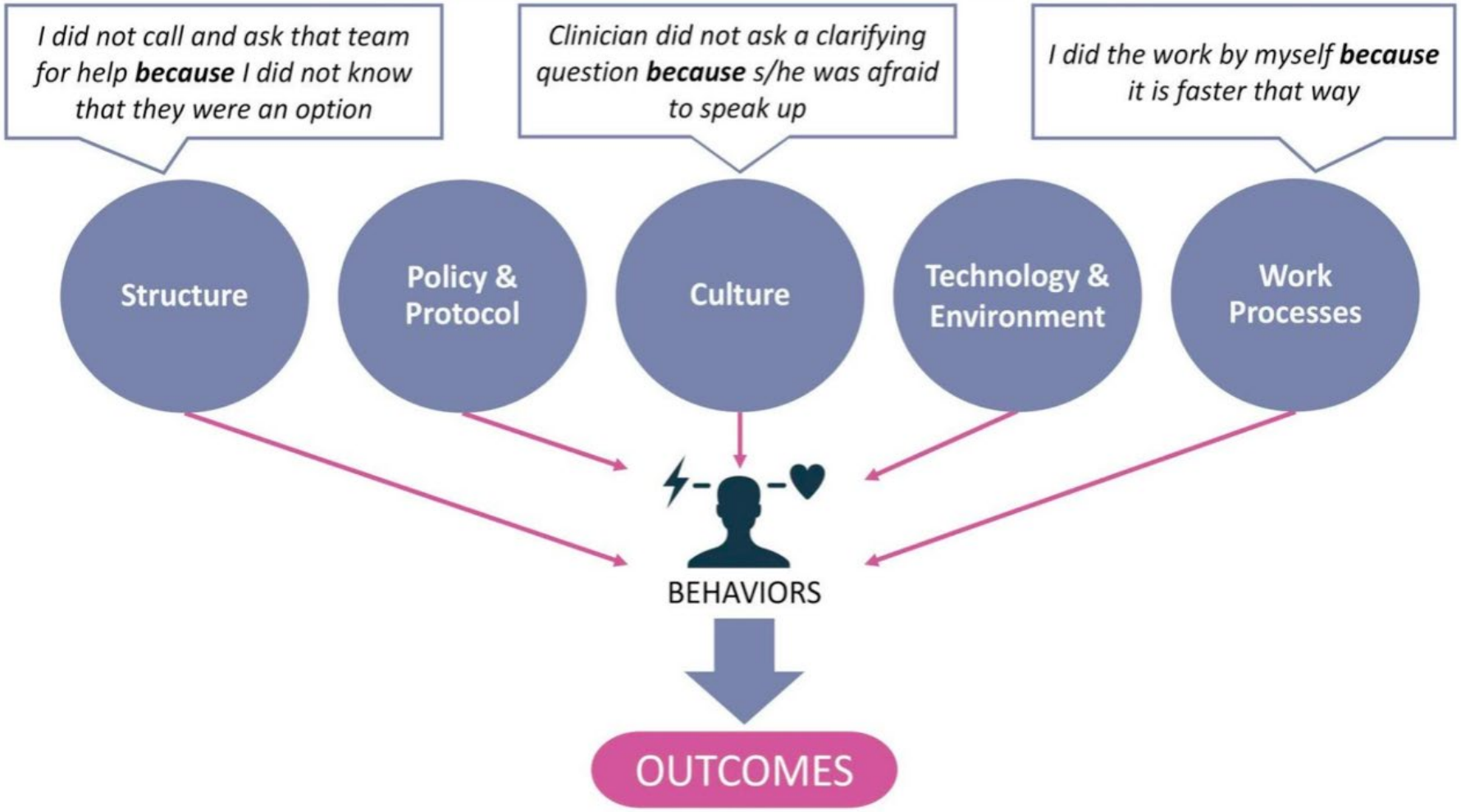
Unmindful
Who cares as long as we're not caught *chronically complacent.*

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*



Adapted from HBI

Safety Story for Shared Learning

What Happened:

A nasogastric tube was replaced by the bedside nurse in a patient status post major sinus surgery

Severity: What is a ***reasonable*** "worst case" scenario for this event?
Select severity level:

Catastrophic	Death or permanent loss of function
Major	Permanent lessening of bodily functions, disfigurement or surgical intervention required
Moderate	Increased length of stay or increased level of care
Minor	No injury, increased length of stay, or level of care

Frequency: What is the frequency of this potentially occurring?
Select the frequency:

Frequent	Likely to occur immediately or within a short period (may happen several times in 1 year)
Occasional	Probably will occur (may happen several times in 1-2 years)
Uncommon	Possible to occur (may happen sometime in 2-5 years)
Remote	Unlikely to occur (may happen sometime in 5-30 years)

ACA Guide	**Potential Severity**: Worst case scenario for this event				
		Catastrophic	*Major*	*Moderate*	*Minor*
Frequency of event occurring	*Frequent*				
	Occasional				
	Uncommon				
	Remote				

Safety Story for Shared Learning

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:

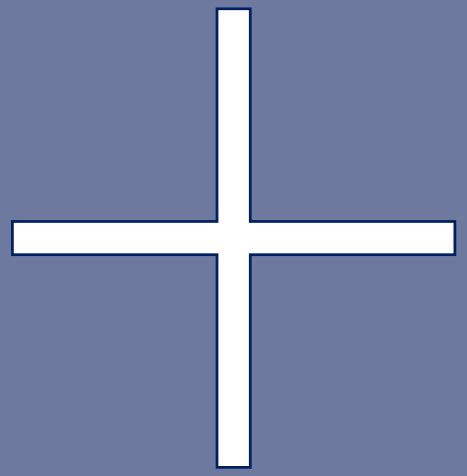
Presented at an inpatient M & M

Action Item Strength and Reliability	Action Item Plan	Assigned Point Value
Most Reliable	• Forcing functions • Physical stops and constraints • Computerized automation • Redundancy • Simplification, removal of unnecessary steps	1
Somewhat Reliable	• Checklists, cognitive aids, decision support • Reduce distractions • Standardization • Forced pauses, self-check, double-checks	2
Least Reliable	• Education and training • Rules, policies, procedures	3

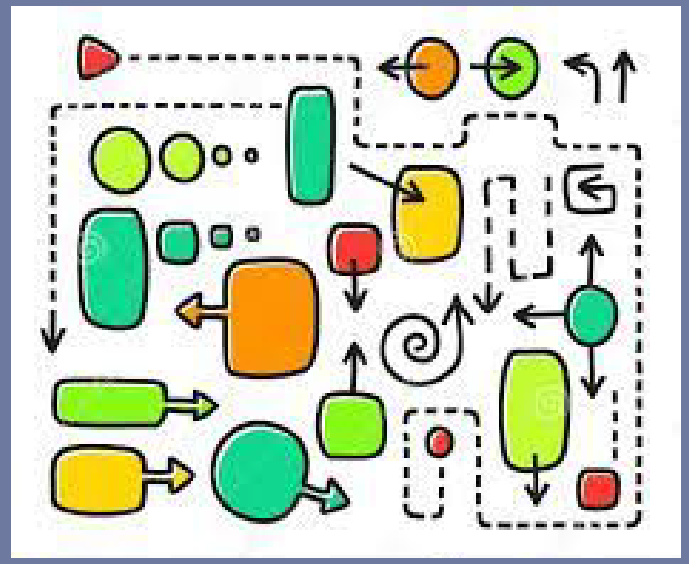
Role Play

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

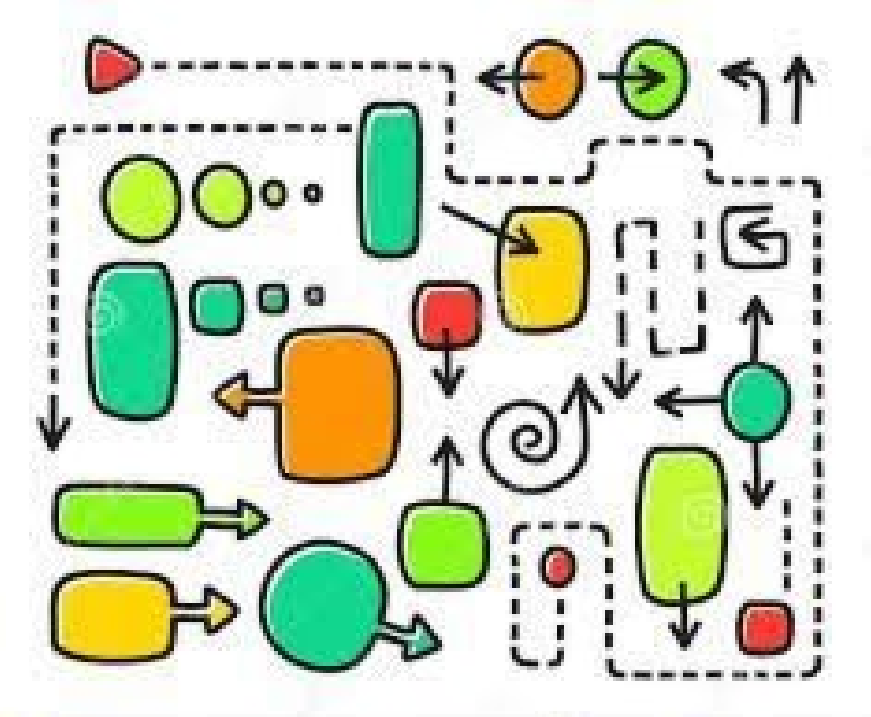
Review error specifically

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

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?*

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

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

Make it a teachable moment

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?*

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

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

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

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"

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

- *What I observed was…*
- *This was a near miss because…*

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

- 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**

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

- 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?*

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

- 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?*

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

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)

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

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.)….*

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NEAR MISS Framework

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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

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