Catch a Near Miss and Prevent a Harmful Error

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L E H I G H V A L L E Y H E A L T H N E T W O R K

Catch a Near Miss and Prevent a Harmful Error

Lehigh Valley Health Network, Allentown, Pennsylvania

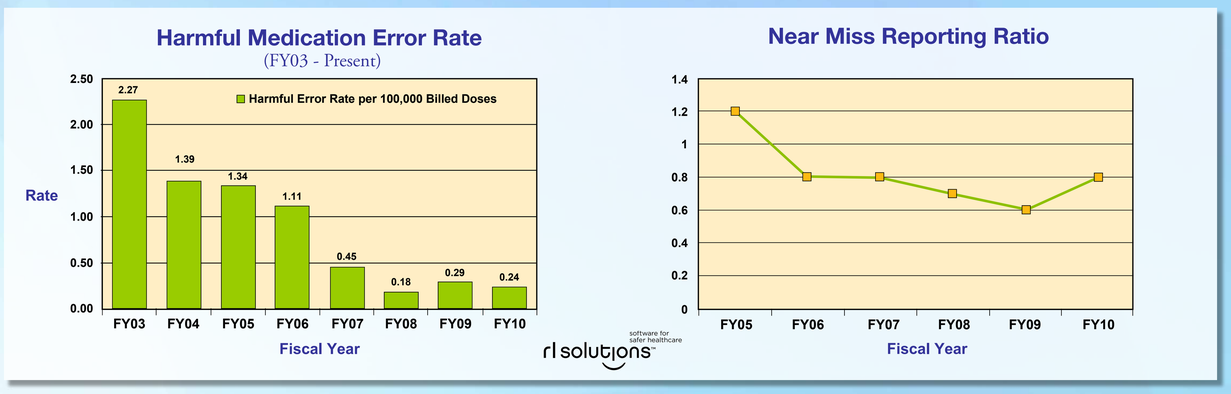
Aim Statement:

In an effort to promote a Culture of Patient Safety, the aim of this project was to increase near miss reporting, with a focus on medication errors. Initial implementation of an on-line patient safety reporting system indicated a near miss reporting of a 1.2 ratio, but we then experienced a downward decline for near miss reporting ratio to 0.6. The goal was to increase near miss reporting to its initial status and higher.

Strategy for Change:

We identified that in order to promote near miss reporting, we needed:

- To provide education about near-miss reporting
  - Near misses occur 3-300 times more often than adverse events,
- To acknowledge staff for reporting and find ways to encourage them to continue to report.
- To recognize barriers to near miss reporting - lack of time.
- To show that these reports made a difference for our patients.



Measurement of Improvement Results:

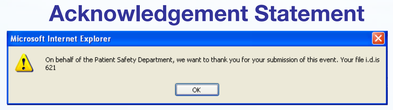
We identified that in order to promote near miss reporting, we needed:

- Significant increase in reporting since moving from paper to on-line reporting.
  - Ease of reporting on-line, education and reinforcement of previously established non-punitive culture which allows staff to submit with comfort and assurance.
- Near Miss reporting ratio rising in FY 10
- Harmful Medication Error rate remains low
- Culture of safety survey results overwhelmingly positive for organization's commitment to patient safety

Changes Made to Achieve Improvements:

Patient Safety Reporting

Acknowledgement Statement



Poster

Mug

Recognition

- Each time a near miss is submitted, the staff receive a pop up with a acknowledgement statement thanking them for their submission.
- At the end of the month, all staff that submitted a near miss report are sent an electronic message thanking them for their dedication to patient safety.
- Posters were designed for display on the clinical units reminding staff to report near misses.
- Staff preventing a serious event are rewarded with a letter and certificate signed by the CEO and are given a coffee mug that says "Great Catch"
- Provided education to "super users" of online reporting system to re-enforce the importance that staff are aware of the need to report near misses.

Lessons Learned:

- It's the PEOPLE…NOT the technology
- Change in focus from errors and adverse events to recovery processes
  - Recovery equals resilience
  - Emphasis on successful recovery as a learning opportunity…A Great catch
- Define data markers and measure it
- Commit to acting upon results that do not reach your goals
- Share learnings…they are powerful messages

Multi-disciplinary team

- Kristie Lowery, RN, BS, CPHQ, CPHRM (Patient Safety Officer)
- Leroy Kromis, Pharm D. (Medication Safety Officer)
- Unit "Super Users"
- Information Services
- Georgene Saliba, RN, BSN, MBA, CPHRM, FASHRM (Administrator, Risk Management/ Patient Safety
- Anthony Ardire, MD, MPH, CPE (Sr. V.P. Quality and Patient Safety)

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