Near Miss

Mallory Kremer, MD

A near miss is defined as a healthcare error or mistake that narrowly avoids patient harm. Colloquially referred to as a "good catch" or "close call," an error is identified early enough to avoid impacting the patient completely, or the patient incurs minimal impact.[1] As described in culture of safety, healthcare workers should be encouraged to report and discuss near misses openly, without fear of punishment. After identifying near miss common themes, action can be taken to improve systems to prevent recurrent events.[2] Discovery and remedy of systemic problems identified by a near miss should be disseminated throughout the system and the personnel involved applauded. When all members of the healthcare team are involved in reporting, it empowers them to feel engaged in the mission of delivering excellent patient care.

High impact near misses are frequently cited in the inpatient setting, however the ambulatory environment contains a higher volume of events. Minor errors in the ambulatory setting can have varying degrees of impact, and yet can have a deleterious effect on patient trust of the facility. As such, efforts to improve detection and error prevention are necessary.

Examples:

1. The post-operative CBC resulted in a critical hemoglobin of 5.1.

This was unexpected, given an uncomplicated cesarean section without hemorrhage. The resident quickly ordered 2 units of packed red blood cells, and then went to assess the patient. The patient was stable and asymptomatic but had received Benadryl and Tylenol in preparation for the transfusion. At this time, the team realized that the labs had been drawn above the IV site. The blood transfusion orders were cancelled, and a repeat blood draw showed an appropriate post-operative hemoglobin of 10.9. The team debriefed on this event.

2. During a routine clinic visit, a suspicious genital lesion was swabbed for HSV testing by a clinician. The lead medical assistant recognized that the incorrect specimen tube was used and informed the clinician immediately. The patient was informed, and the specimen was recollected with the correct specimen tube. This 'good catch' ensured the patient received the right test at the right time.

Reference Materials

1. Implementing Near-Miss Reporting and Improvement Tracking in Primary Care Practices: Lessons Learned by Crane et al.
   https://www.ahrq.gov/patient-safety/reports/liability/crane.html

2. Patient safety network primer on Near Miss
   https://psnet.ahrq.gov/primer/adverse-events-near-misses-and-errors