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Near Miss Project Newsletter

▪ Volume I

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New York State Internal Medicine Interns and Residents Making History!

Greetings and Welcome

By Ethan Fried, MD

This is the first edition of the New York State Near Miss Registry Project Newsletter. The Near Miss Registry is an anonymous, risk free reporting system for near miss medical errors. It is directed and administered by the New York Chapter of the American College of Physicians, with funding and support by the New York State Department of Health. The project is also co- sponsored by the Association of Program Directors, New York Special Interest Group. The Registry can be found at www.nearmiss.org. Residents in Internal Medicine Training Programs across the state are encouraged to login and make anonymous and de-identified reports of "near misses". The login numbers, given to medical interns and residents are randomly distributed and cannot be traced to you or your hospital. The reason logins were created was to insure that only Internal Medicine residents had access to the registry and to assure the validity of the data collected.

Did You Know:

Online Investigator Training in Protection of Human Research Subject Course available @ www.citiprogram.org.

AHRQ Patient Safety Tools Kits are available by setting and user at http:www.ahrq.gov/qual/pips

Near Miss Project Newsletters will feature Interns and Residents Quotes on their Near Miss Entry Experience. Contact: mdonnelly@nyacp if you are interested in submitting feeback.

Important Facts

• The Near Miss Project was open for reports on 9/1/07. 64 training kits were distributed to IM teaching institutions in August, 2007. Resident training is underway across New York State.

• The Near Miss tool is located on a secure Web based site, owned by the Near York Chapter of the American College of Physicians @ www.nearmiss.org

• The Near Miss Registry has received IRB approvals from the New York State Department of Health and St. Lukes Roosevelt Hospital.

• The Near Miss Registry is an anonymous, risk free reporting system for near miss medical errors. The data it is designed to collect would have never otherwise been collected. The New York State Department of Health has issued a research waiver that protects anyone that submits de-identified data to the near miss registry.

• Random login #s are available from the IM Program Directors or from the Near Miss project staff @ 1-800-446-9746.

• Upon survey completion, the submitter can receive a certificate that qualifies as documentation for "Systems Based Practice" training requirements. The certificates do not identify the nature of the submission, but merely documents that a report was filed and that by identifying and reporting a near miss, the resident is recognizing the "systems based" aspects of patient care.

Rationale: Near misses include medical errors and other serious adverse events that could have resulted in patient harm but were identified and prevented from occurring before the patient was actually affected in any way. These reports will collectively help us to understand the underpinnings of medical errors and also show us how to strengthen the barriers that keep errors from reaching patients. An effective Near Miss reporting system should be anonymous in order to increase the likelihood of residents Reporting into the system.

The benefit to residents and their training programs, particularly in this project is that in making reports, residents can gain experience and document the fact that they have contributed (without revealing the nature of the report) to the systematic improvement in patient safety. This is an integral part of the Systems Based Practice competency which is now part of all accreditation and credentialing for physicians.

Errors reported so far: In its first few months the Registry has collected several reports of near misses involving medications. We have received reports of sound - alike medications being ordered (eg: quinine for quinidine). An antibiotic was ordered to which the patient was known to have a cross allergy. In another report an antibiotic to which the target bacteria was known to have resistance was ordered. Antibiotics were ordered for one patient that was nearly dispensed to another. There was also a report of an oral hypoglycemic agent ordered for a non-diabetic patient but meant for another patient. Finally, an anticoagulant was ordered in a standing dose when daily dosing was more appropriate.

In each case, the error was detected and reversed by another member of the health care team. These reports all serve to illustrate that careful reconciliation of medications may need to be done for every patient at multiple stages of the admission. Physicians and nurses need to be able to assess every medication and the purpose for its use. In some teaching programs, "running the med-ex" is a standard part of the daily routine. In others, the medication record is still kept on paper and often contained in multiple books; one for each nursing zone and is thus not as available as it should be.

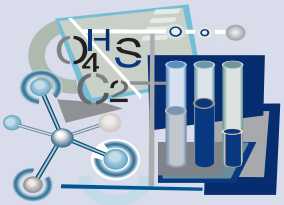
Prevention Advice and Potential Solutions: Computerized physician order entry systems have managed to eliminate handwriting errors and they identify potential allergies, cross allergies and medication interactions, but it is still up to humans to read, understand and react to such warnings. Could it be that we are in "warning overload" and that we have become so inured to ignoring superfluous warnings that we wind up ignoring important warnings as well?

Furthermore default doses and administration schedules may contribute to inadvertent dosing errors. Multitasking on the part of residents may contribute to wrong patient or wrong medication errors. Residents not only need to be reminded that prescribing is serious business but hospitals must create systems to reduce distractions for prescribing house officers.

Perhaps, orders should not be written at busy nursing stations but in a more protected area with relatively fewer distractions. Perhaps when overriding the safety warnings given by CPOE systems, the program should require more explanations as to why they do not apply rather than the flick of a button by an overloaded or distracted resident.

As more data is collected, we may be able to determine the environment that most predisposes health care workers from making these errors. We will also be able to say more about the most successful barriers that stop these near misses from becoming errors.

Additional Resource Materials



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- To Err is Human: Building a Safer Health Systems. IOM Report Executive Summary @ http://www.nap.edu/catalog/9728.html
- NYSDOH Voluntary Near Miss Hospital Event Reporting System Announcement Press Release @ http://www.health.state.ny.us/press/releases/2007/2007-11-13 near-miss hospital reporting system.htm
- Wachter, Robert M. **Understanding Patient Safety**. Columbus: McGraw-Hill Companies. 2008.
- Singh, Hardeep, et al. **"Medical Errors Involving Trainees."** Archives Internal Medicine. 167.19 (October 22, 2007) :2030-2036
- Volp, Grande. "Residents' Suggestions for Reducing Errors in Teaching Hospitals." New England Journal of Medicine. (February 27, 2003): 348:9,851-855."