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Near Misses

Patient safety isn't just about checklists, it is about making clinical teams aware and interested in patient care improvement, thus changing the culture in healthcare, placing patient safety at the very centre of our daily work.

The concept of medical harm has existed since antiquity, as reported by Hippocrates, and defined as *iatrogenesis*, derived from the Greek for *originating from a physician*. Investigators in the Harvard Medical Practice Study defined an adverse event as 'an injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both.' The Institute for Healthcare Improvement uses a similar definition: 'unintended physical injury resulting from, or contributed to, by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death'.

Patient harm arises due to errors. An error refers to any act of commission (doing something wrong) or omission (failing to do the right thing) that exposes patients to a potential harm. Adverse events refer to harm from medical care rather than an underlying disease, subcategories of adverse events include:

- Preventable adverse events: those that occurred due to error or failure to apply an accepted strategy for prevention;
- Ameliorable adverse events: events that, while not preventable, could have been less harmful if care had been different;
- Adverse events due to negligence: those that occurred due to care that falls below the standards expected of clinicians in the community.

It is recognized that recognition and reporting of adverse events in dentistry is poor[1] and, as a result, compromises opportunities to optimize patient care.[2] This may in part be due to poor education,[2] fear of consequences and the complexity of reporting mechanisms for notifiable events.[3] Publication of the Surgical Safety for invasive procedures (**https://www.rcseng.ac.uk/dental-faculties/fds**) Local Safety Standards for Invasive Procedures (LocSSIPs) for dental extractions toolkit provides an update on Never Events in dentistry and is the first step to improve patient safety culture in dentistry. In my review of serious untoward events in dentistry using the NRLS dataset, wrong site surgery, anaphylaxis due to prescription of antibiotics and missed diagnosis of neoplasia were the most common events reported.[1]

Near Misses are the 'golden nuggets' of patient safety, causing no harm to patients but providing opportunities to identify potential issues that, if addressed, can prevent future patient harm, thus improving patient care. Near Misses provide daily opportunities to recognize potential system and process failure that could lead to patient harm. Recognition and rectification of Near Misses prevents patient harm and medical errors.

A Near Miss is *an unsafe situation that is indistinguishable from a preventable adverse event except for the outcome*. A patient is exposed to a hazardous situation, but does not experience harm either through luck or early detection.[4]

Some examples of near misses

- A patient undergoing root canal treatment in primary dental care practice drinks from one of two white cups on the spittoon. The cup contains sodium hypochrlorite and she spits it out immediately. No harm occurs but obviously this isn't great practice and must be changed to prevent future harm.
- Lack of recognition of oral cancer. Parapharyngeal squamous cell carcinoma is misdiagnosed early on in the presentation, resulting in no harm to the patient but giving rise to a change in patient pathway when a differential diagnosis of glossopharyngeal neuralgia should have been made.
- Prescription of steroids to a patient, with reported history of peptic ulceration, who had recently experienced nerve injury related to dental implants, resulting in near perforation of his peptic ulcer. This could have been avoided if the patient medical history had been checked prior to the prescription.
- A young patient with reported allergy to Penicillin was prescribed Amoxycillin for spreading dental infection, potentially causing Anaphylaxis. The patient's mother identified the problem before the patient took the medication. Medical history checks prior to dispensing medication should ideally be checked by the prescriber and assistant and later by the pharmacist; this did not happen.

These examples illustrate how Near Misses provide opportunities to improve our patient care and minimize harm.

Simple gestures, like keeping a practice or personal log book of Near Misses (and patient safety adverse events/incidents) is essential and provision of evidence that lessons have been learnt from Near Misses or adverse events and showing how practices have been changed which may prevent future events. This demonstrates to peers and the CQC that this shift in concept has been understood. In addition, a patient safety agenda item on monthly practice meetings will avail space and encourage the team to get involved in recognizing, learning from and preventing future events. These simple strategies will demonstrate to the CQC and other stakeholders that the team are intent on changing patient safety culture and improving patient care.

References

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