SHOT Bite No.17:
Learning from Near Misses (NM)

SHOT Serious Hazards of Transfusion

July 2021

Introduction

A near miss is an error or deviation from standard procedures or policies that is discovered before the start of the transfusion that could have led to a wrong or unsafe transfusion, or a reaction in a recipient if the transfusion had taken place

Reporting and investigating near misses helps identify and control risks before actual harm results, providing valuable opportunities to improve transfusion safety

Investigations into the causes of near misses will enable a more proactive approach to safety. Potential system failures and hazards can be identified and corrected before harm or injury occurs

Near miss reporting to SHOT

Number of reports received

NM consistently account for the largest proportion (>30%) of the events/reactions reported to SHOT. Reporting criteria can be found in the SHOT Defintiions document which is updated annually

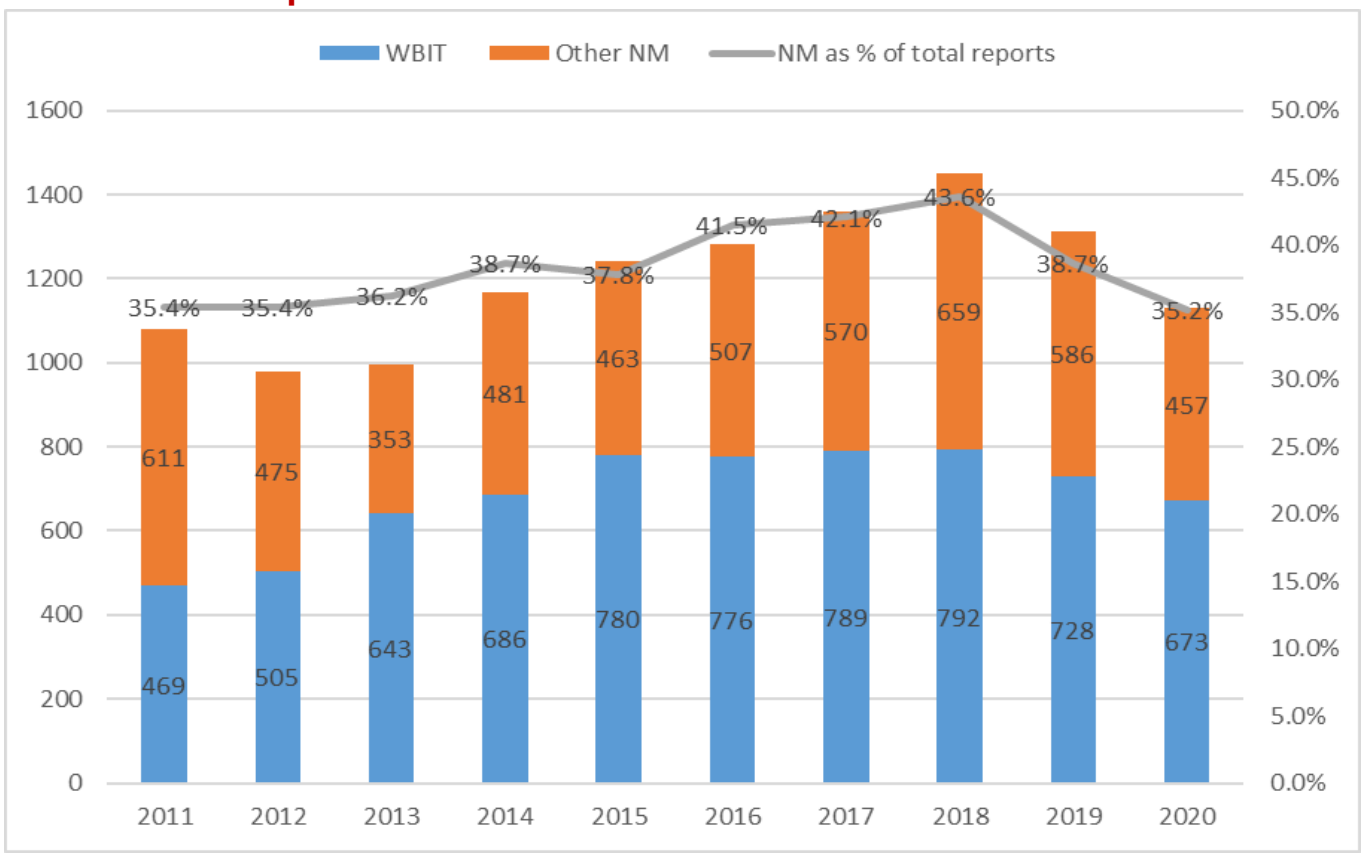
Near miss- Wrong blood in tube events

Wrong blood in tube (WBIT) incidents are the largest subset of near miss cases. Greater than 50% of all near miss events reported to SHOT are WBIT

Near miss- ABO incomaptible (ABOi) events

NM are far more common than serious events. There were 1495 ABO incompatible NM events reported to SHOT 2016-2020 with 19 ABOi red cell transfusions reported

Trends in NM reported to SHOT 2011-2020



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Near Misses reporting is all about learning: See one, Report one

- Have a clear definition of a near miss
- Report the identified near miss
- Prioritise reports and classify information for future actions
- Analyse the causes of the problem
- Distribute information to the people involved in the near miss
- Trend incidents/near misses
- Identify solutions
- Disseminate the solutions to the people impacted
- Resolve all actions and check any changes needed. Share lessons learnt

NM provide valuable opportunities to learn and improve systems. They occur much more frequently and afford more opportunities to learn than the rarer serious adverse events. When they are not identified or investigated, they are missed opportunities that can contribute to future risks

Elements of a good NM reporting system

- **Should be thorough and ask the right questions with meaningful reports**
- **Help identify safety concerns- reporting should not be perceived negatively or a hassle**
- **Staff should see evidence that reporting NM helps improve safety**
- **Educational- the learning from NM is shared widely**
- **Teams work together to address safety concerns, co-create solutions**
- **There should be no fear of repercussion from reporting NM**

Key messages

To improve safety, it is important to implement a NM reporting system and have clear reporting criteria

Importance of reporting and investigating NM must be understood by all staff. Just because patient harm was avoided, it does not mean the event should not be investigated

NM should be investigated, and corrective actions taken as appropriate to prevent reoccurrence and/or prevent serious events

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