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Perspective

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Near-Misses in Patient Safety: The Need for an Integrated Reporting System at the National Level

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Breakthrough in science has led us into a new era of medicine. This era, on the one hand ensures medical advancements at an accelerated pace and on the other hand focuses on quality of care by improving standards of patient safety. To this day, a lot of work has been done to document errors, enhance accountability, and improve standard of care. Nevertheless, according to Kohn., *et al.* the results of two different studies (1999) suggest that between 44,000 and 98,000 Americans die from medical errors each year [1]. Subsequently, the World Health Assembly (2002) called for the need to reduce the magnitude of harm and preventable deaths resulting from unsafe care [2]. A strategy widely used over the last decade has been the use of incident reporting systems [3]. For example, in the United Kingdom, the British Government established a multicenter national data collecting system with the objective to collect data on patient safety incidents and to implement solutions to improve safety within the National Health Service (NHS) in England and Wales [4]. The standardized nature of this system and the mandatory nature of reporting in the British example is missing from the US, where the focus of such systems has been at the organizational and state levels, and the systems have been characterized by variable design and non-mandatory reporting [5]. We believe that there is, therefore, a need for a standardized reporting system that encompasses mandatory reporting for 'near-misses' in patient safety at a national level in the United States.

The World Health Organization (WHO) defines a near-miss as a "serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or because it is intercepted" [6]. It reflects an initial, relatively benign event that may even go unnoticed but has the potential to evolve into a more serious incident that can be life-threatening. According to some statistics, for every 600 near-misses, there are 30 incidents that result in minor injury, 10 that lead to serious injuries, and 1 that results in a fatality [7]. The fundamentals of an ethical medical practice include autonomy, justice, beneficence and non-maleficence [8]. Therefore, as responsible operators in the healthcare system, it is our moral obligation to stand by these principles and stay vigilant to near-misses at the unit level in order to improve outcomes at an organizational level, thereby ensuring standardized patient care.

Hospitals across the United States have implemented reporting systems at the organizational level to grade near misses, but due to variation in infrastructure, it is nearly impossible to compare incidences and data among organizations. Furthermore, the non-mandatory nature of reporting in these systems results in the number of near misses being under-reported. An article by Shaw and colleagues notes that US physicians and patients lacked a sense of urgency in reporting adverse events [9]. An ideal reporting system should include quantitative, as well as qualitative, analysis that should be done by taking into account near-misses. However, there are certain barriers to the reporting of near-misses. Among these barriers are the fear of repercussion or punishment [10]. Such an individualized impression has the potential to yield deadly consequences. In addition, according to a study published in the British Medical Journal, further barriers in reporting near-misses include the nonhazardous nature of the incident, lack of reporters' awareness to gravity of situation, fear of blame, and the lack of a role model [9]. Other factors that serve as barriers to reporting are

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feelings of guilt or pressure, the nonmandatory nature of reporting, the absence of a review process, workload pressures related to the reporting system, and the stigma associated with having experienced a near-miss [11]. Overcoming these fears and pressures and designing a structurally sound review system is essential to preventing this from happening in the future.

Experts in patient safety argue that, because the root causes of near-misses are similar to those of adverse events, determining the root causes of near misses can allow us to address those root causes and prevent adverse events from occurring in the future [12]. Near misses reflect low-risk, error-prone situations that should be immediately reported and analyzed to prevent further progression to incidents with irreversible consequences and medicolegal liability. Reporting near-misses also alerts providers to possible vulnerabilities and helps bridge gaps in training.

Hospitals around the country are striving to develop comprehensive healthcare delivery systems that encompass near-miss reporting systems and greater accountability on the part of physicians in order to minimize the margin of error in the provision of healthcare services. Although these efforts have resulted in reporting systems flourishing at the organizational level, there is a greater need for a standardized reporting system at the national level. A homogenized reporting system will provide deeper insights into the circumstances leading to near-misses and their potential consequences. Such a system will further allow for comparing the findings to national benchmarks and will help hospitals to devise strategies to minimize the occurrence of near-misses in the future.

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