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Valuing the ‘near miss’ - an opportunity to learn from hospital complaints

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Caring Expert Quality

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Aim of the Study

- To provide a clear understanding of complaints made by hospital transfusion staff to NHSBT, their frequency, causes, impact, potential impact and need for resolution.
- Review of complaints made to NHSBT during 2016 (n746). Scope involved supply of blood components and services to hospital Transfusion Laboratories.
- Review conducted by Hospital Customer Services.
- Complaints categorised by service area and type of issue raised in the complaint.

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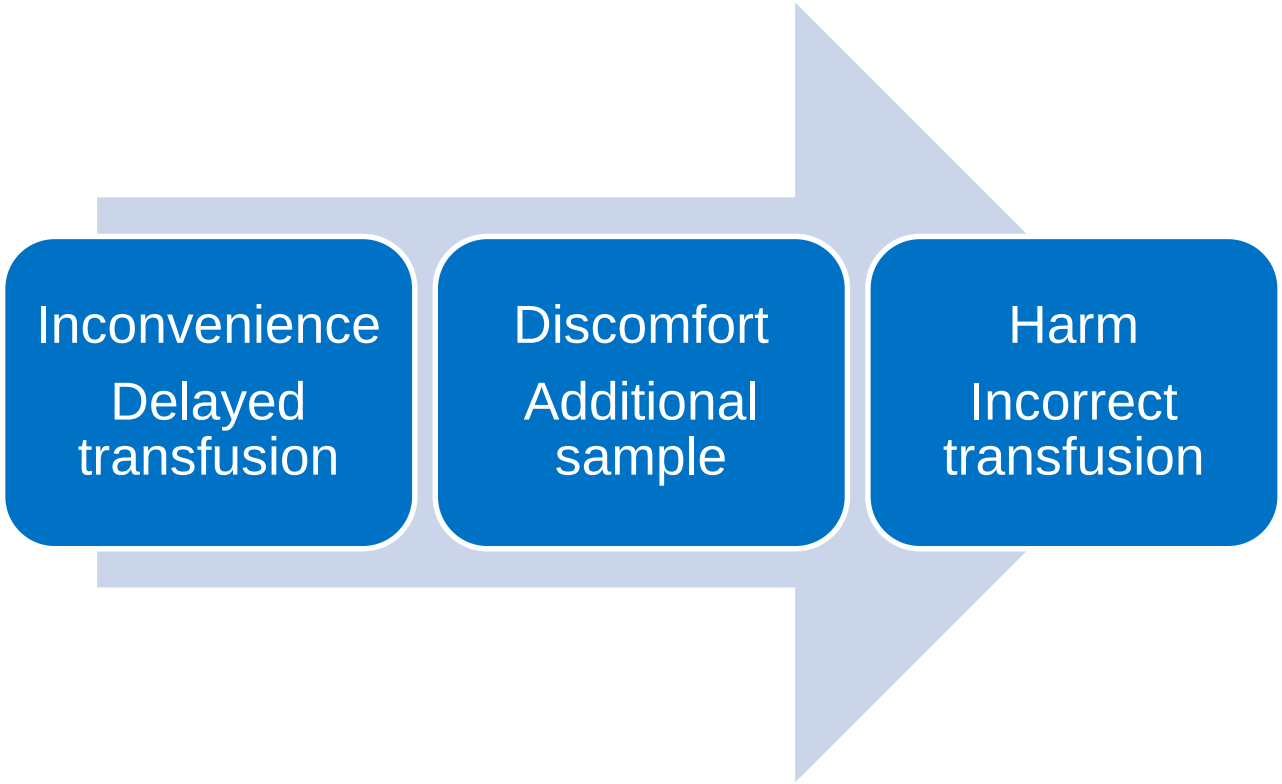
SHOT Annual Report 2016

A ‘near miss’ event refers to any error which if undetected, could result in the determination of a wrong blood group or transfusion of an incorrect component, but was recognised before the transfusion took place.

Authors: Alison Watt and Katy Cowan

The Near Miss

Those things that go wrong and were it not for an effective quality system in NHSBT, in the hospital, or by chance, the patient would face an adverse impact.



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Complaints in Context

Activity	Activity volume	No. Complaints	Rate per 100,000
Delivery	137,000	258	1.88
Component	2.2m	226	0.10
Reagents	300,000	147	2.04
Diagnostics	70,000	85	0.82
Service	n/a	31	n/a

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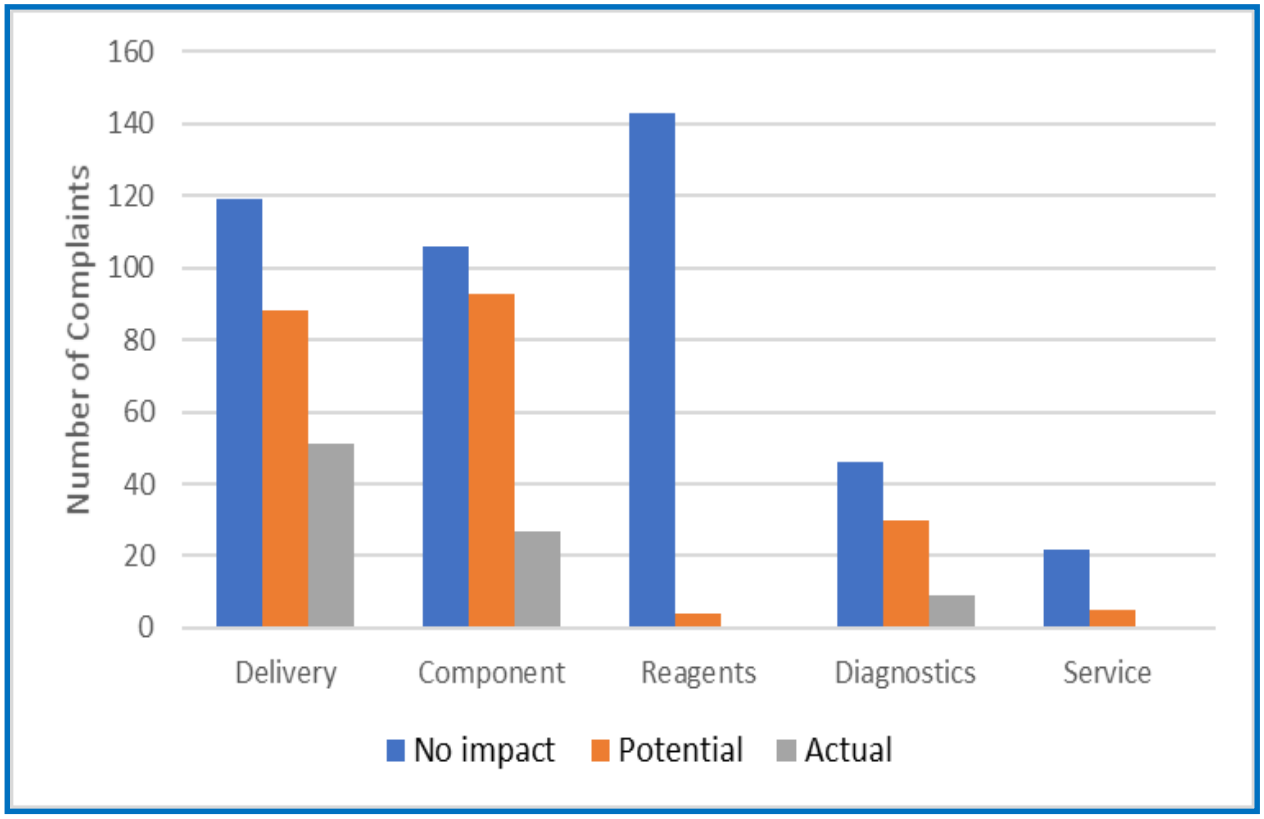
Category and Impact



Near miss

increased opportunity to improve patient safety

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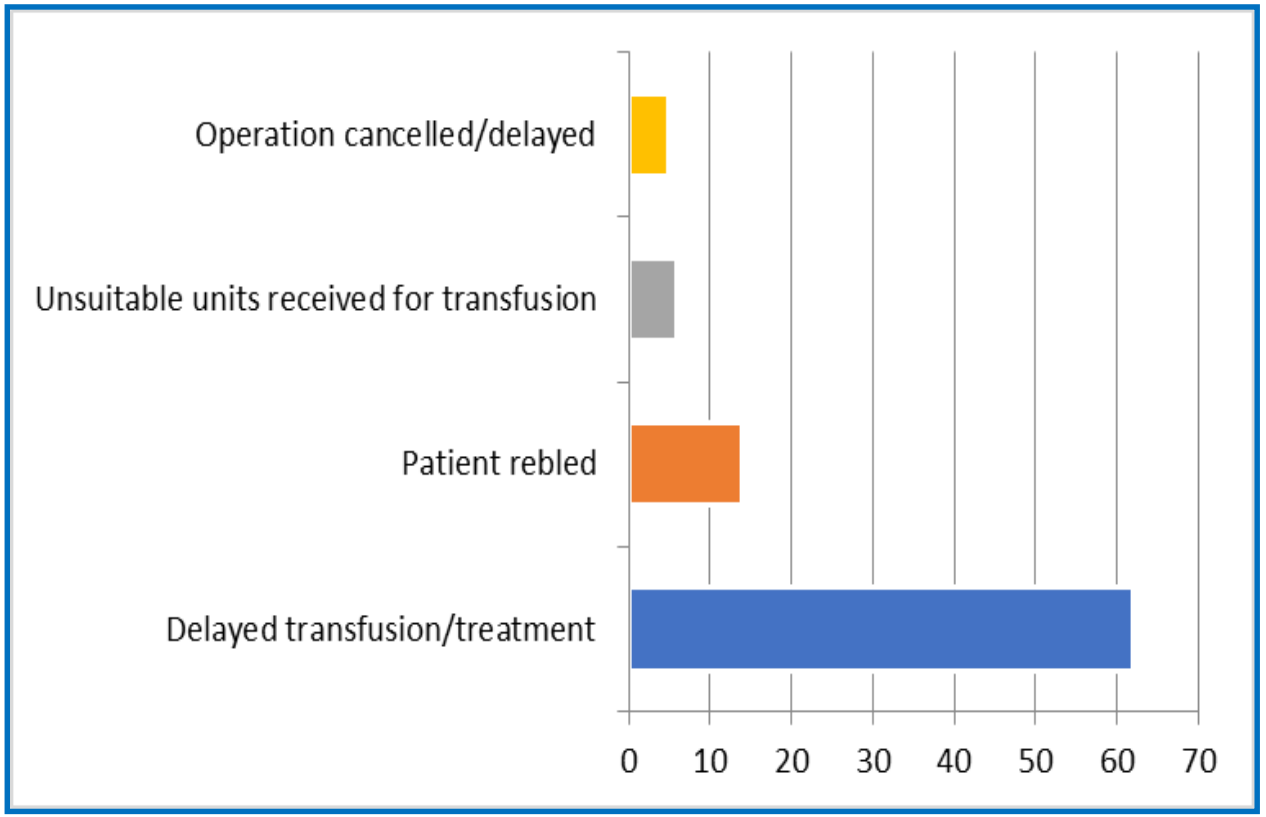
Actual Patient Impact (n87)



Small numbers

But

Inconvenience
Discomfort
Harm

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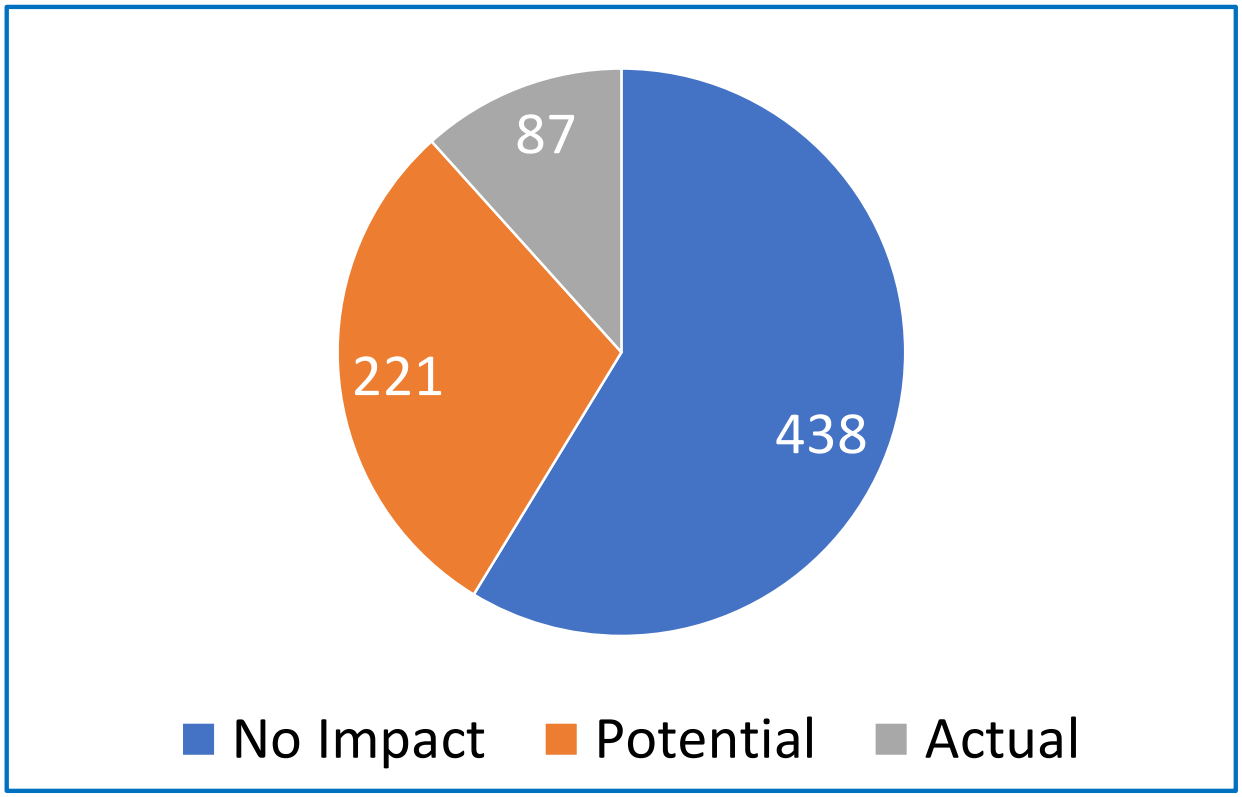
Patient at the Heart



87 *necessities to learn from actual impact*

221 *opportunities to learn from near misses*

438 *chances to improve for next time*

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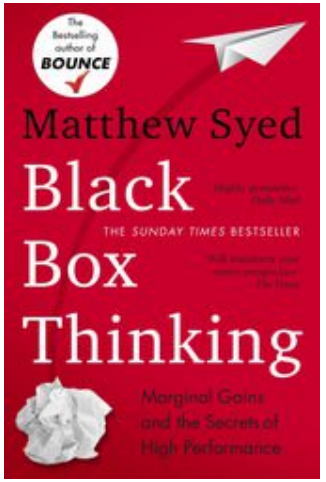
Effective Complaint Management

- Looking beyond the complaint and the event
- Understanding the hospital world
- Understanding our components and services
- What might have happened on another day

“Probe, Alert, Challenge, Emergency”



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Learning into action

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“We take complaints seriously”

Near misses are warnings that something is not working and enables you to learn lessons before a serious incident occurs

Near Miss Reporting
A Missing Link in Safety Culture
NASS Safety Campaign (2013 -2015

It’s safer and more effective to learn from near misses

Greater numbers : better insight

NHSBT provide a safe service