

What Can We Learn from No-Harm Events and Near Misses in Pathology? A Review of 244 Cases.

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Introduction/Problem

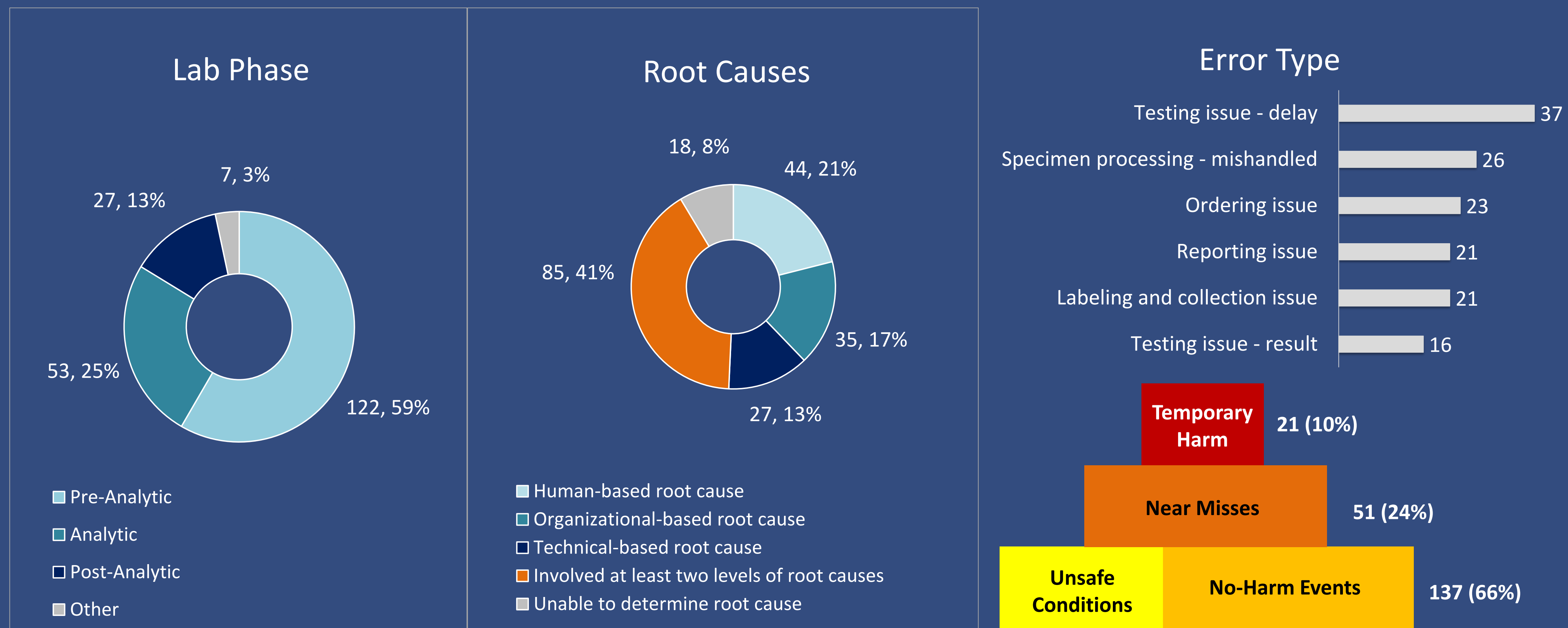
Harmful pathology errors typically undergo systematic review for root causes in order to seek out opportunities for improvement. However, non-harmful events including minor errors, near misses, and unsafe conditions are far more frequent and undergo minimal to no systematic review. Harmful errors and near misses often share root causes and the difference between the two can be due to chance alone.

Despite this, non-harmful events and near misses rarely get reported and do not undergo review. If studied, these events offer an opportunity for learning and risk reduction for pathologists before serious patient harm occurs.

Design

- A hospital-wide Outlook mailbox was created to solicit information on laboratory incidents not submitted to the hospital incident reporting system.
- A multidisciplinary team was established including quality, operations, clinical, and educational leadership to review and manage incidents weekly.
- Incidents were classified by:
 - Eindhoven error classification model by severity
 - Error type
 - Laboratory and testing phase
 - Root cause
- A VBA-programed Excel spreadsheet dashboard served as a hub for documentation and to track resolution progress.

Results



- 244 incidents were reported hospital-wide from May 2016 to August 2017. 35 incidents were excluded as they were not considered patient safety incidents following review.
- In response to these findings, we have initiated 32 changes in procedures, workflows, and information systems to prevent similar incidents from recurring.
- By August 2017, 200 (96%) cases were investigated and addressed with an average turnaround time of 3 weeks.

Conclusion

Non-harmful pathology errors and near misses offer critical opportunities for risk reduction and learning. By establishing a user-friendly reporting mechanism and regular local review and tracking, we were able to understand and address systems vulnerabilities before patient harm ensued.

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