# Hardin Medical Center: Hitting the Target by Focusing on the Near Misses

While a *miss* is definitely better than a *mis*take, the leadership at Hardin Medical Center has worked hard to change the collective mindset about the importance of analyzing near misses.

Cindy Jeter, director of Quality and Patient Safety at Hardin Medical Center, said all misses are not created equal. Without studying the underlying processes and safety nets, it's far too easy for a close call to become a major concern down the road. "We want to fix things before they become issues. Correcting a near miss can prevent the real event," she stated.

A 26-year veteran nurse, Jeter accepted her current role with the 58-bed West Tennessee hospital in December 2013. "We actually had a policy in place that said if the event didn't reach the patient, it didn't have to be reported," she recalled. "We've changed that policy," she added with emphasis. Since re-thinking the way near misses are viewed, the hospital has enjoyed measurable improvement across a number of key areas.

Not long after she took the reins for quality and patient safety, Jeter began focusing on inpatient fall rates. "In 2014, we had 38 falls … and looking back, half could have been prevented," she said. And, Jeter added, the numbers didn't capture the full scope of the problem because of reporting methodologies. Jeter said the hospital's figures didn't include assisted falls where a staff member intervened and carefully helped a patient to the ground so they wouldn't be hurt. "It still was an unplanned descent to the floor," she pointed out.


Quality and Patient Safety Director Cindy Jeter (center) is flanked by Laressa Vega, RN, Medical-Surgical Nursing Director, and Shane McGee, RN, Telemetry Nursing Director, who played an integral role in the successful team effort to reduce inpatient falls.

The hospital has since applied PDCA (Plan, Do, Check, Act) continuous improvement model to fall prevention and other improvement projects, which incorporates near misses and a root cause analysis to see what is working … and what isn't. "In 2014, we had 38 inpatient falls. We've had 10 so far in 2016," she said of the difference since putting near misses on the radar. Additionally, Jeter said implementing electronic event reporting through the KB Core system has facilitated the process of tracking, trending, and reporting events in line with AHRQ Common Format.

The success in reducing falls led Jeter to start looking at other areas where close calls weren't being tabulated or analyzed. "We want to know … even if a safety net caught it, we want to know. It might be we see that we're using the safety net too much so we need to add another step in the process," Jeter explained.

A recent near miss underscored a gap in the hospital's dietary program. A patient, who had an allergy to pork, received a lunch tray with chicken cordon bleu. "She wasn't allergic to the chicken but to the ham. It shouldn't have been on the patient's menu for selection, and it should have never gotten to her even if it was an item on her menu," Jeter pointed out. Fortunately, a nurse recognized the dish included a pork element and stopped the patient before the lunch was eaten.

That near miss, though, has led to a new process where the dietician prints an allergy report for every patient and compares it to each ingredient in every dish before it's released for distribution. "Right now it's a manual process, but Nutritional Services is researching software to automate the process and load all the menu ingredients to screen for allergens," Jeter said.

Jeter credits the Tennessee Hospital Association's Hospital Engagement Network with helping ignite Hardin Medical Center's passion for measuring everything. Jeter said the THA HEN has helped drive home the point that "any kind of action you can take to promote the reporting of events decreases the likelihood that event is going to happen again."

She continued, "Being involved with the HEN and having to report these metrics propelled me to take a look at how we were reporting and how we were classifying events." Jeter added, "Getting a near miss report is like a golden nugget to me because it's a head's up … you can't fix problems you don't know about."

Now the hospital uses the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) Index to rate and assess incidents. "It's primarily applied to medication events, but we've found it works really well for all events," Jeter said of adapting the scale hospital-wide.

That outside-the-box thinking also led Jeter to think of new and different ways to drive home safety messages and help change the mindset for all staff members. One fun, easy idea that really resonated with staff was a 'goody bag' campaign that used clever phrases to tie different candies to safety messages. Life-Savers reminded staff that reporting a near miss could truly save a life, Jeter shared of one example.

Today, the safety messages are so ingrained, they have become standard operating procedure, beginning with new employee orientation. "They get the message from the first day they walk in the door," Jeter said of introducing new staff to the hospital's culture of safety.

By searching for the root causes behind near misses and analyzing the thought processes that created policies, Jeter said Hardin Medical Center has moved the needle on patient safety. While everyone on staff has always worked hard to provide quality care, measuring everything has underscored what works and what doesn't.

"We had a lot of homegrown monster tools that weren't doing the job," Jeter said. "Now we try, wherever possible, to use evidence-based tools. We've come a long way, but there is always room for improvement."

*The Tennessee Center for Patient Safety, a department of the Tennessee Hospital Association, develops and shares hospital and health system success stories and promotes best practices.*

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