Near Misses

Please fill out this survey as honestly as you can. All responses will be completely anonymous.

1. Have you ever made a mistake that could potentially have compromised patient safety?

2. How did the realisation of making that mistake make you feel?

3. Have you ever made any of the following mistakes? If yes how many times?

A) Anticoagulation error e.g. Clexane, warfarin
B) Insulin error
C) Allergy prescribing error (please specify)
D) Other prescribing error (please specify)
E) Transfusion error
F) Identity error (any error in which wrong patient was identified)

4. What factors contributed to you making those mistakes? e.g. time pressures, lack of senior support....

5. How often do you make mistakes and what impact do they have? See definitions on reverse.

	Error	Near Miss	Adverse Event		
			Low harm	Moderate Harm	Significant Harm
Never					
Once					
Monthly					
Fortnightly					
Weekly					
Twice weekly					
Daily					

6. Do you discuss the mistake's you make with anyone? If yes who?

7. What barriers have stopped you from discussing your mistakes with other doctors?

8. Do you think a near misses session once a month, in which you could discuss mistakes with other junior doctors and one senior doctor, would be helpful? If yes why? If no why not?

Thank you for filling out this survey.

WHO Definitions:

Error:

The failure of a planned action to be completed as intended (i.e. error of execution) or the use of a wrong plan to achieve an aim (i.e. error of planning) (3). Errors may be errors of commission or omission, and usually reflect deficiencies in the systems of care.

Adverse event:

An injury related to medical management, in contrast to complications of disease (4). Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable.

Near-miss:

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. Also called potential adverse event.

Fig 1. Baseline Questionnaire

How did the realisation of making a mistake make you feel?

- Incompetent
- Guilt, like an idiot, sadness, like a bad doctor, worried about how easy it would be to make further mistakes in the future.
- Awful, very upset that I may have injured a patient, and ashamed. Worried I may have disappointed seniors.
- Awful, anxious of what if?
- Dreadful, made me doubt my ability as a doctor.
- Awful, sick, afraid, shame, very upset.
- It was awful I felt really bad.
- Panic, sheer terror until I found out I had a near miss and patient was ok.
- Bad
- Guilty
- Embarrassed, ready to make a big effort so it doesn't happen again.
- Stupid and regretful.
- Terrible
- Really bad
- Awful

Fig 2. Responses to question 2 of baseline questionnaire. 2 FY1s did not answer this question.

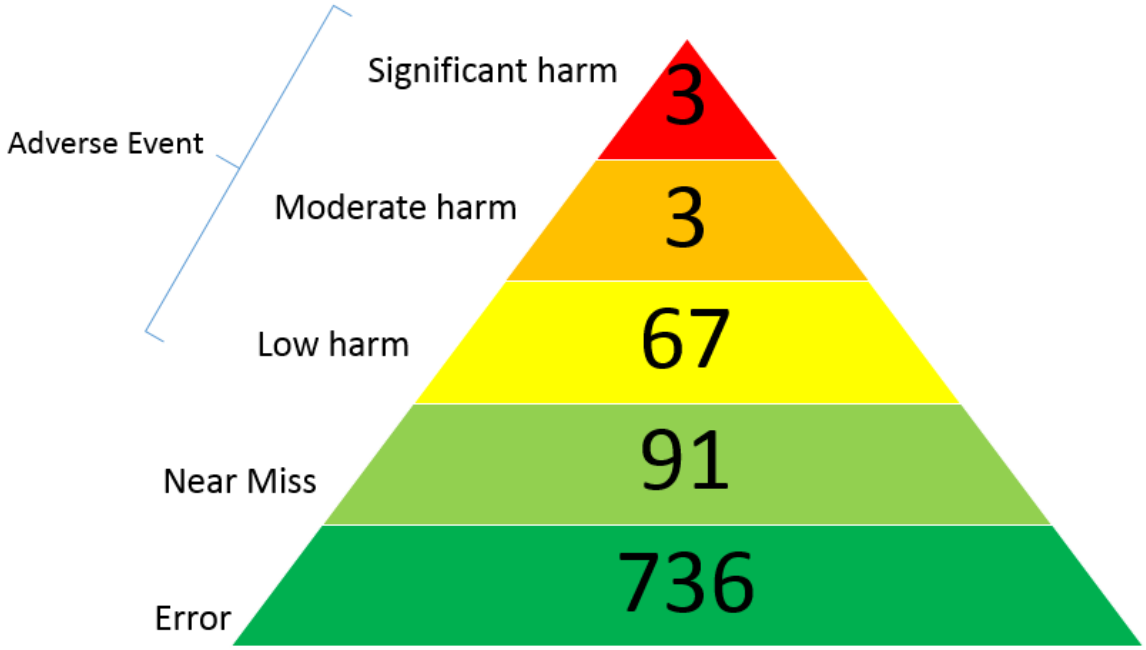

Fig 3. Breakdown of mistakes made by FY1s over first 20 weeks of FY1, calculated from responses to question 5.

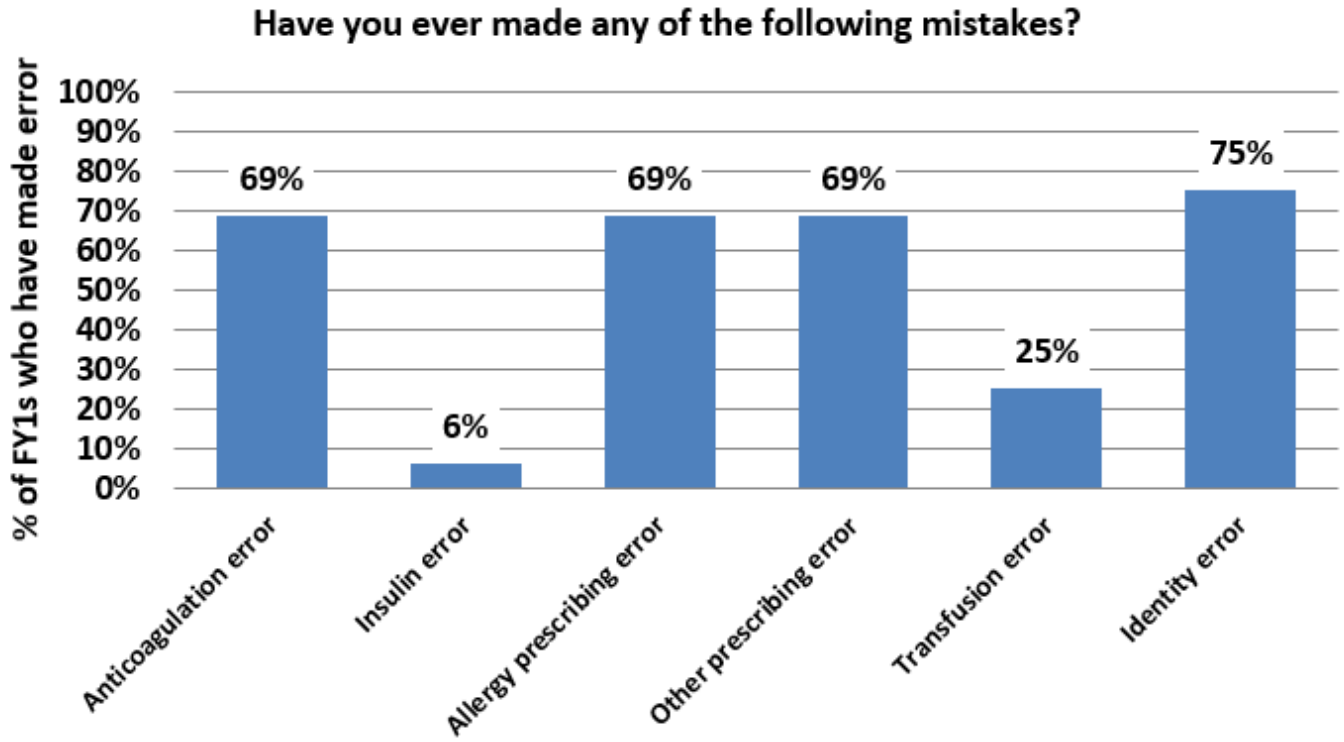

Fig 4. Percentage of FY1s who have made common categories of mistakes, calculated from responses to question 3.