Near Misses Meetings

Aims:

1. To promote a culture of “no blame”
2. To share learning
3. To feedback information and make recommendations to clinical governance

Set up:

1-2 hour FY1 meeting once a month during Tuesday FY1 teaching time.

- 1 junior doctor to lead the session
- 1 scribe to complete certificates
- 1 consultant to facilitate and offer advice or guidance (start session by describing a mistake that they have made)

Not present at the meeting:

- Consultant Patient Safety Lead to feedback any relevant issues to
- Contact in clinical governance to feedback issues and immediate concerns to

Recommendations should also be fed back to the Patient Safety Steering Group and the Safer Medicines group which both meet monthly.

The session:

Introduction

Matters arising

Feedback from previous concerns raised

Near Misses:

Invite juniors to discuss a mistake they made

For each mistake discussed-

- What happened?
- When did it happen?
- Why did it happen? Contributing factors.
- What have you learned? What do you want others to learn from your mistake?
- Key actions- Any recommendations for system change to prevent further mistakes?

Close

Problem Based Learning Record

Chair		Date
Scribe		
Brief Summary of Problem		
Contributory Factors		
Personal Learning and Reflection		
Key Actions	Individual: •	
	Organisational: •	
Consultant Signature:		

Near Misses and Recommendations

Mistakes Discussed	Recommendations/Key Actions
e.g. Tazocin to penicillin allergic patient	Red allergy band