TEXAS A&M UNIVERSITY

Whoops!

We thank you for your time spent submitting this report. Your response has been recorded.

Below is a summary of your responses. If you would like to keep a copy, you can click "Download PDF" (optional).

Below is a summary of your responses

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TAMHSC CLRC NEAR MISS REPORTING

INFORMATION SHEET

Implementation of this reporting system is part of a study.

All faculty, staff, students, and standardized patients who experience or observe a near miss in the TAMHSC simulations are invited to participate in this study, which is designed to provide reporters with a platform to practice near miss reporting and to measure self-efficacy to report near misses.

It will take about 5 minutes to complete the questions in the reporting system each time you make a report.

Participation in this study is voluntary. There are no known risks associated with participating. There are no direct benefits to participating in this study. There are no penalties or loss of benefits associated with refusing to participate or stopping participation.

No direct personal identifiers will be collected. Only the research team will have access to your individual responses and the anonymity of all data will be maintained. Your individual responses will NOT be reported to the TAMHSC. All responses to the questions that follow will be analyzed and presented in a summarized format.

Information about you will be kept anonymous to the extent permitted or required by law. People who have access to your information include the Principal Investigator and research study personnel. Representatives of regulatory agencies such as the Office of Human Research Protections and entities such as the Texas A&M University Human Research Protection Program may access your records to make sure the study is being run correctly and that information is collected properly.

Questions about this research study can be directed Dr. Stephanie Payne (PI) at (979) 845-2090, scp@tamu.edu

or Dr. Benny Holland (PI) at (979) 436-0166 or bholland@tamhsc.edu. You may also contact the Human Research Protection Program at Texas A&M University by phone at (979) 458-4067, toll free at (855) 795-8636, or by email at irb@tamu.edu with questions about the research or your rights as a participant.

A near miss (or close call) has been formally defined as “an event or situation that could have resulted in an accident or injury, or illness, but did not, either by chance or through timely intervention” (Bagian & Gosbee, 2000, p. 27). In an educational context where people are learning, errors are expected and common. In the context of clinical simulation, any kind of error could be construed as a near miss. Some examples include:

- failing to check/confirm a patient’s identification information on his/her armband
- dispensing too much medication
- not wearing gloves when drawing blood
- administering the wrong dose of a medication
- forgetting to put down the breaks on a gurney

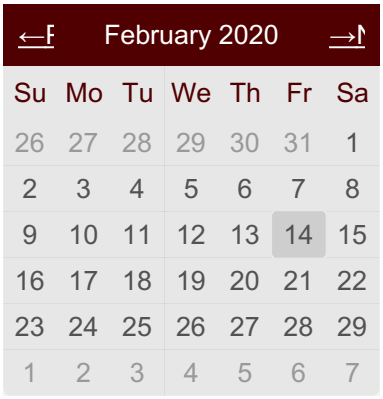
This form is intended to be used by individuals who have personally experienced or observed a near miss during an exercise or simulation. The form is designed to report **one near miss**. If you experienced or observed more than one near miss, please consider submitting more than one form or reporting the most serious near miss. The purpose of this reporting system is to give students the opportunity to report a near miss.

Please do not enter any identifying information on this form. This report is intended to be anonymous.

Click here, if you would like to see a blank copy of the full reporting form in pdf format. Note that due to embedded skip logic, less questions are likely to appear when completing the form online.

Near Miss Information: Please answer as many questions below as possible.

Select the date that the near miss occurred:



2/14/2020

In which location did the near miss occur?

Bryan

- Bryan
- Dallas
- Houston
- Kingsville
- Round Rock
- Temple
- Other

Which of the following simulations was under way? (check all that apply)

- Skills training
- Simulation with mannequin
- Simulation with standardized patient
- Disaster Day
- Other

How did you become aware of the near miss? (check all that apply)

- I committed the near miss (I was directly involved)
- I was involved
- I witnessed (the error or consequence of it)
- I heard about it from someone else
- I learned about it during a debrief with faculty/staff
- Other

Description of near miss: Please describe the near miss in as much detail as possible. Please DO NOT identify any parties involved by name. Instead, use labels like "student 1", "faculty 2", etc.

Please select all medical terms that are relevant to this particular near miss. If the listing below does not contain the type of near miss you are reporting, please select "Other" and provide a descriptive word or phrase.

- Medication
- Blood/Transfusion
- Falls
- Equipment/Devices
- Surgery
- Diagnostic Test/Procedure
- Therapeutic Procedures
- Other Treatment

- [ ] Other Safety Issue
- [ ] Other

Below is list of factors that contribute to near misses organized into categories. Please read through this list to identify which factors contributed to the near miss you are reporting.

Please select ALL the factors that may have contributed to this near miss. If the listing below does not contain the factor you want to report, please select "Other" and write in the factors that you think contributed to the near miss. (check all that apply)

- [x] **Clinical Procedure Issues**
- [x] **Forgetting or Misunderstanding**
- [x] **Training Issues**
- [x] **Lack of Experience/Practice**
- [x] **Fatigue, Sickness, or Stress**
- [x] **Environmental Factors**
- [x] **Interruptions/Distractions**
- [x] **Equipment/Technology Issues**
- [x] **Labeling/Packaging of Medication/Product**
- [x] **Communication Breakdown**

- [x] **Workload**
- [x] **Patient/Family Issues**
- [x] **Issues Between People**
- [x] **Order or Transcription Issue**
- [ ] Other

Clinical Procedure Issues:

- [ ] Complex procedure
- [ ] New procedure
- [ ] Procedure was not standard practice
- [ ] Other

Forgetting or Misunderstanding:

- [ ] not following up on an issue
- [ ] not paying attention
- [ ] decision made based on limited information
- [ ] knew about this at the time, but it slipped someone's mind (failure to remember)
- [ ] misheard something
- [ ] misinterpreted a written or verbal instruction
- [ ] misread something
- [ ] misunderstood instructions/information
- [ ] overlooked an important detail
- [ ] thought it was a routine situation, but it was not, and required a different response (misinterpreted the situation)
- [ ] miscalculation
- [ ] Other

Training Issues:

- [ ] Inadequate training on procedure
- [ ] Inadequate training on equipment
- [ ] Incorrect training
- [ ] Incomplete job orientation
- [ ] Additional training needed
- [ ] Other

Lack of Experience/Practice:

- [ ] asked to work beyond credentialing or certification

- [ ] new member on the team
- [ ] have never seen or heard about this before
- [ ] Other

Provider Fatigue, Sickness, or Stress:

- [ ] fatigue or being tired
- [ ] not feeling alert
- [ ] sick or injured
- [ ] stress
- [ ] emotionally distressed
- [ ] Other

Workload/Staffing:

- [ ] emotionally demanding patients and family members
- [ ] working on several tasks at the same time
- [ ] working on other tasks in addition to patient care responsibilities
- [ ] insufficient staffing
- [ ] specialist not available
- [ ] Other

Issues Between People:

- [ ] strained interactions between workers
- [ ] not wanting to challenge a person in authority
- [ ] not having the right to question a superior
- [ ] fear of being reprimanded if asking for clarification or more information
- [ ] unclear team assignment
- [ ] hesitate to take responsibility because of the presence of other team members
- [ ] someone else should have been responsible for this
- [ ] no one took charge of the situation
- [ ] not knowing what others are capable of
- [ ] Other

Environmental Factors:

- [ ] tight space interferes with tasks
- [ ] poorly organized area
- [ ] noisy area

- [ ] area is too hot or too cold
- [ ] slippery floor
- [ ] area is not well lighted
- [ ] unsterile environment
- [ ] Other

Interruptions/Distractions:

- [ ] distracted
- [ ] interrupted
- [ ] several emergencies happening at the same time
- [ ] Other

Equipment/Technology Issues:

- [ ] equipment not available when needed
- [ ] equipment malfunctioned during use
- [ ] incorrect or unclear directions for equipment
- [ ] equipment was programmed incorrectly
- [ ] equipment had expired
- [ ] did not have correct accessories for equipment
- [ ] equipment was a new model which was not familiar
- [ ] Other

Labeling/Packaging of Medication/Product:

- [ ] incomplete label
- [ ] incorrect label
- [ ] damaged label
- [ ] damaged package
- [ ] package looked similar to another product
- [ ] product name on label looked or sounded like another product
- [ ] Other

Communication Breakdown:

- [ ] someone could not clearly hear the person talking
- [ ] could not understand the communication due to a language difference
- [ ] information not received because of a technical breakdown (e.g., phone, fax, or email)
- [ ] inappropriate or unclear directions
- [ ] illegible handwriting

illegible handwriting
not enough information available to make a decision
incorrect information
missing information
information not available when needed
patient record not adequately or correctly documented
Other

Patient/Family Issues:

patient received unclear information about care
patient did not follow instructions
uncooperative patient
uncooperative family/caregiver
family/caregiver did not follow instructions
Other

Order or Transcription Issues:

incomplete order
unclear verbal/written order
order needed correction
order needed additional authorization
order deleted in error
order not transcribed
order transcribed incorrectly
order keyed into computer incorrectly
Other

Please provide any suggestions for how this near miss could be avoided in the future.

Please indicate the extent to which you agree with each of the following items:

	Strongly agree	Somewhat agree	Neither agree nor disagree
1. I am comfortable entering a report about a near miss in which I was involved.	○	○	○

	Strongly agree	Somewhat agree	Neither agree nor disagree
2. I am comfortable entering a report about a near miss I witnessed (but was not directly involved in).	○	○	○
3. Near miss reporting systems are easy to use.	○	○	○
4. Near miss reports can be used to make improvements in patient safety.	○	○	○
5. Near miss reporting is time-consuming.	○	○	○

	Somewhat disagree	Strongly disagree
1. I am comfortable entering a report about a near miss in which I was involved.	○	○
2. I am comfortable entering a report about a near miss I witnessed (but was not directly involved in).	○	○
3. Near miss reporting systems are easy to use.	○	○
4. Near miss reports can be used to make improvements in patient safety.	○	○
5. Near miss reporting is time-consuming.	○	○

How many times have you submitted a report through "Whoops!"? (0 = this is your first time)

Your college:

- ○ Medicine
- ○ Nursing
- ○ Pharmacy
- ○ Public Health
- ○ Vet Med
- ○ Other

Your classification:

- ○ Student
- ○ Faculty
- ○ Staff
- ○ Standardized Patient
- ○ Other

If you have any additional comments about the near miss or the reporting system, please share them below:

If you are just testing the system and not submitting a report of an event that occurred in simulation, please check the box below.

- [ ] Do not use my responses -- I am just submitting a test report