Results from Multi-Institutional Implementation of a Near-Miss Resident Conference

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Introduction

- Limitations of present day M&M
  - Department-wide forum
  - Potential of judgment, shaming
  - Extensive preparation
  - Focus on high acuity cases

- Importance of near-miss events
  - Not openly discussed
  - Underreported
  - More common than serious events
  - Valuable learning
  - Early warning for worsening or recurring risk

Methods

- Trialed new separate 1hr conference w/residents from multiple urology residency programs to review near-miss events and personal clinical errors

- Residents only except 1 chosen faculty moderator

- No slides or formal presentations

- Separate from M&M conference

- 2 min. presentation / case

- 3 min. open discussion / case

- Cases recorded in de-identified database for later review/analysis

- Residents surveyed about conference
Results

45 total cases discussed
6 separate 1hr sessions
5 residency programs

Number of Cases By Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Procedural Error</td>
<td>7</td>
</tr>
<tr>
<td>Interprovider Communication Problem</td>
<td>6</td>
</tr>
<tr>
<td>Near Wrong Surgery, Side, or Patient</td>
<td>4</td>
</tr>
<tr>
<td>Provider-Patient Communication Problem</td>
<td>3</td>
</tr>
<tr>
<td>Misinterpretation of Clinical Information</td>
<td>2</td>
</tr>
<tr>
<td>Missed or Delayed Diagnosis or Care</td>
<td>1</td>
</tr>
<tr>
<td>Medical Decision Error</td>
<td>0</td>
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</tbody>
</table>

EXAMPLES OF CASES PRESENTED

- Near wrong side stent placement
- Stapler mistire on hilum during nephrectomy
- Urinary retention misdiagnosed as hydronephrosis
- Delayed ureteral stent for septic inpatient
- Lost needle in abdomen when removing from port
- Lost bladder tumor specimen at end of TURBT
- Kayexalate given to ileus patient
- Inability to contact attending on call
- Pushback from IR team resulting in delayed drainage
- Painful scrotal dressing change w/o anesthetic
- Benign appearing bladder lesion, actually UCC
- Peritoneal dialysis catheter removal w/o HD plan
- Missed malignant path dx on path report addendum
- Missed contralateral ureteral stone on CT
- Failure to arrange patient follow-up after discharge

SURVEY RESULTS

- 23 survey responses
- 95% felt conference worth continuing
- Q3 month interval preferred
- Impressions:
  - educational
  - therapeutic
  - enjoyable
  - inspirational

CONCLUSION

- Near-miss conference was well received and easily implemented
- Expanding to other programs/specialties
- Centralized online case database

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