Results from Multi-Institutional Implementation of a Near Miss Resident Conference
Justin Ahn1, Bruce Dalkin2, Hunter Wessells3, Eric Bailion-Landa4, Tom Chi5, Mathew Sorensen2
1University of California San Francisco, 2University of Washington, 3University of California San Diego
Corresponding author: Justin Ahn justin.ahn@ucsf.edu

Introduction
LIMITATIONS OF PRESENT-DAY M&M
• Department-wide setting with superiors
• Fear of accusation, judgment, shaming
• Extensive preparation required
• Focuses only on high acuity cases
• Excludes near-miss events

SIGNIFICANCE OF NEAR-MISS EVENTS
• More common than serious events
• Early warning signs
• Valuable for learning
• Underreported
• Not openly discussed

METHODS
For more information on collaboration & implementation at your department, contact: justin.ahn@ucsf.edu

Examples of Near-Miss Events

RESULTS
• 45 cases recorded
• 6 separate 1-hour sessions
• 5 residency programs
  University of Washington
  Virginia Mason Medical Center
  Madigan Army Medical Center
  University of California San Francisco
  University of California San Diego

Figure 1: Number of Cases By Category

Examples of Cases Presented
• Near wrong side stent placement in ureteral injury consult
• Stapler misfire on hilum during nephrectomy
• Urinary retention misdiagnosed as bilateral hydroureteronephrosis
• Delayed ureteral stent 4-5 days for septic ICU patient
• Lost needle in abdomen when removing from robotic port
• Lost bladder tumor specimen at end of TURBT
• Kayexalate given to ileus patient (risk for bowel necrosis)
• Inability to contact attending on call for surgical consult
• Pushback from IR team resulting in delayed drainage
• Painful scrotal change without topical anesthetic
• Equivocal bladder lesion initially not biopsied, actually UC
• Peritoneal dialysis catheter removal w/o hemodialysis plan
• Missed malignant path dx on path report addendum
• Missed contralateral ureteral stone on CT
• Failure to arrange patient follow-up after discharge

Survey Responses
• Total n = 23 responses
• 95% felt that the conference was worth continuing

Figure 2: “I think the conference should be held…”

Figure 3: “To summarize in one word, I found the conference to be…”

Conclusions
• A novel near-miss QI conference was well-received at 5 separate programs & can be easily implemented
• We are expanding to other programs/specialties & have created a central online database to share cases and lessons learned

For more information contact: justin.ahn@ucsf.edu