PSNet
PATIENT SAFETY NETWORK

The relationship between patient safety culture and the intentions of the nursing staff to report a near-miss event during the COVID-19 crisis.

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Idilbi N, Dokhi M, Malka-Zeevi H, et al. The relationship between patient safety culture and the intentions of the nursing staff to report a near-miss event during the COVID-19 crisis. J Nurs Care Qual. 2023;38(3):264-271. doi:10.1097/ncq.0000000000000695.
https://psnet.ahrq.gov/issue/relationship-between-patient-safety-culture-and-intentions-nursing-staff-report-near-miss

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If reported, near misses – also called “good catches” – present opportunities for healthcare organizations to learn about potential errors, identify system improvements, and improve safety culture. This mixed-methods study including 199 nurses, who worked in COVID-19 units, found that intent to report near misses was high (78%) but follow-through on reporting was low (20%). Qualitative analyses highlight the role that personnel/physical/mental overload, poor departmental organization, and fear of punitive measures play in underreporting near-miss events.