Supporting a Culture of Safety: Improving Near Miss Reporting in a Health-System Specialty Pharmacy

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Highlights

Quality Management Committee guidance may *promote a just culture* while helping to *meet accreditation requirements.*

Interdisciplinary collaboration and all-staff engagement led to *increased voluntary near miss reporting* and *improved staff perception of documenting mistakes.*

Background

- Specialty Pharmacy accreditation standards require analysis of errors and near misses to monitor dispensing accuracy.
- Identifying a specific, measurable, achievable, time-bound (SMART) near miss goal challenged the Quality Management Committee (QMC) due to low reporting.

Objectives

To improve voluntary near miss reporting and identify a SMART goal for near misses that would contribute to the psychological safety and just culture in our specialty pharmacy program.

Description

Setting	Design	Outcomes	Analysis
Single center HSSP, URochester Medicine Specialty Pharmacy	•Quality initiative project •11/2022 – 10/2025	•Voluntary reported near miss quantity •Percent positive & negative staff responses to Section D: Documenting Mistakes in AHRQ SOPS® Community Pharmacy Survey	Descriptive

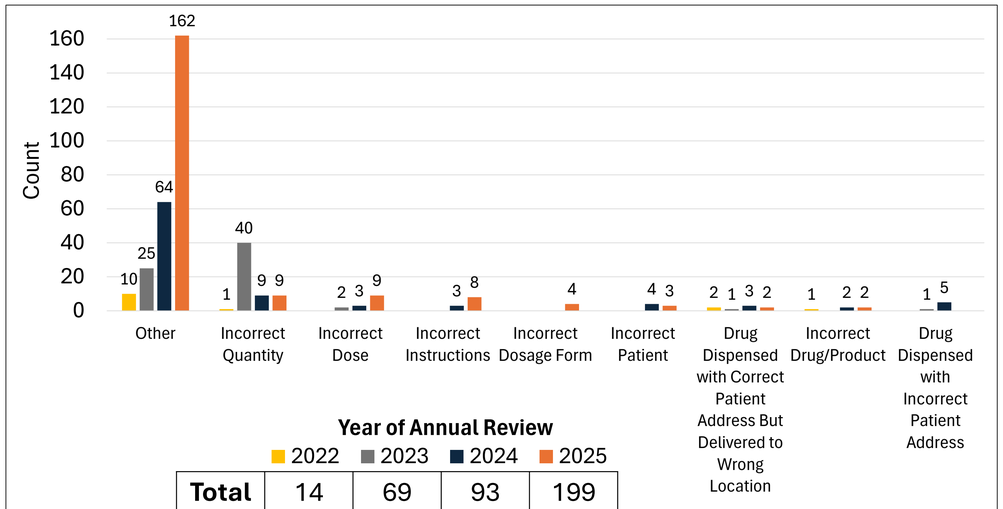
This project was undertaken as a QI initiative, and as per the URochester Medicine Guideline for Determining Human Subject Research it did not meet the definition of research according to 45CFR46.

Results

Table 1. URochester Medicine Specialty Pharmacy

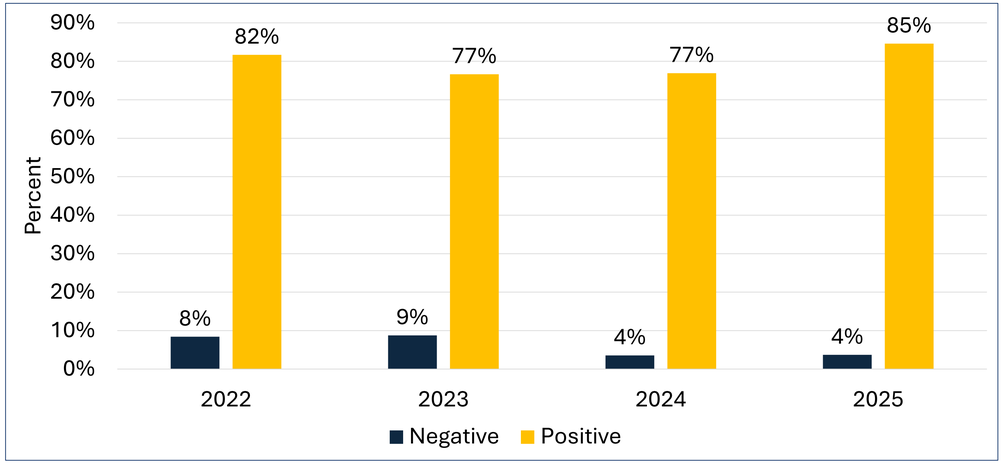
	2022	2023	2024	2025
Staff, n	55	59	73	80
Prescription Fills, n	55,047	67,071	84,940	104,147

Figure 1. Annual Voluntary Near Misses Reported



Total	14	69	93	199

Figure 2. Responses to SOPS® Community Pharmacy Survey: Section D. Documenting Mistakes



Key: AHRQ SOPS®, Agency for Healthcare Research and Quality Surveys on Patient Safety Culture®; **HSSP,** health-system specialty pharmacy; **MMI,** morbidity, mortality, and improvement; **PDSA,** plan do study act; **QI,** quality improvement; **QMC,** quality management committee; **SMART,** specific, measurable, relevant, time-bound

Figure 3. PDSA Cycles and Interventions

PDSA Cycle 1 (2023):

- AHRQ SOPS® Survey-related SMART aim
- Annual Morbidity, Mortality, and Improvement (MMI) Conference

PDSA Cycle 2 (2024):

- "Good Catch of the Week" sharing
- Monthly staff prize and recognition
- Near miss education incorporated with the annual MMI Conference

PDSA Cycle 3 (2025):

- Event category optimization in reporting software
- Near miss:Preventable error SMART aim
- Oncology Clinic Process Improvement Project with near miss focus

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