Physical Education, Health and Social Sciences
https://journal-of-social-education.org
E-ISSN: 2958-5996
P-ISSN: 2958-5988

Near Miss in Nursing: Concept Analysis

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DOI: https://doi.org/10.63163/jpehss.v3i2.331

Abstract

Background: Near misses in health care are valuable instances of opportunity to recognize and eliminate anticipated harm prior to its occurrence in the patient. Though extremely common, near misses in nursing practice are underreported, thus cutting their power as safety-improving tools. Objective: This concept analysis investigates the phenomenon of near misses in nursing through theoretical frameworks from Patricia Benner's "From Novice to Expert" and Faye Glenn Abdellah's "21 Nursing Problems." The aim is to define the concept, emphasize its attributes, and affirm its applicability to clinical safety and nursing development. Methods: A literature-based concept analysis was performed, synthesizing findings from scientific journals, international safety guidelines, and nursing theories. The analysis was organized into eight sections: definitions, attributes, antecedents, consequences, and example cases (model, borderline, and contradictory). Results: Five characteristic attributes of near misses were identified: recognition of risk, timely action, lack of harm, reflective practice, and adaptation at the system level. Antecedents of importance are an open safety culture, and consequences are augmented protocols and organizational learning. Theoretical consistency with Benner's and Abdellah's models supports experiential knowledge and systematic assessment of care. Practical instruments like Turnitin, Peergrade, and Moodle Workshop can facilitate documentation and learning from near misses by peers. Conclusion: Near misses play a crucial role in institutionalizing individual clinical experiences into system-wide changes. This discussion reflects the importance of a non-punitive reporting culture, interdisciplinary communication, and technology-enabled safety interventions. Considering near misses as drivers of innovation and learning reinforces their worth in fostering lifelong learning and reflective practice in nurses.

Keywords: Near miss, nursing safety, concept analysis.

Introduction:

Concept analysis is a cornerstone in the development of nursing theory. It transforms abstract ideas into actionable structures that improve clinical practice. This analysis examines near-miss. A central but underappreciated phenomenon in nursing based on Patricia Benner's theory "From Novice to Expert" (1984) and Faye Glenn Abdellah's "21 Nursing Problems" (1960). These theories illustrate how nursing expertise and systematic problem solving reduce potential harm and create safer care environments. Organized into eight sections, this paper summarizes the scientific literature to clarify the role of the concept in improving nursing practice and patient outcomes.

Definition of Near Miss

A near miss is “an event with the potential for patient harm that is intercepted through vigilance, timely action, or system safeguards before reaching the patient” (World Health Organization [WHO], 2009). Unlike errors causing harm, near misses expose latent risks in care processes, serving as sentinel indicators for quality improvement (Woodier et al., 2023). An example of a precarious situation is when a nurse takes an incorrectly labelled sample before processing it. Proactive intervention prevents harm.
A client’s safety incident that did not reach the client and therefore resulted in no harm (Canadian Patient Safety Institute, 2009).
Prevalence and under reporting: Near misses are 7 to 100 times more common than adverse events, but continue to be under reported due to fear of a punitive culture (Lee, 2021; Yang et al., 2021). Experience and clinical judgment: Experienced nurses, following the Benner model, use their experiential knowledge to anticipate risks, while laypeople rely on rigid protocols (Benner, 1984; Grissinger, 2020). Systemic resilience: Organizations with blameless reporting systems eliminate errors by 30% through protocol refinement (Erega and Ferede, 2024; Institute for Safe Medication Practices [ISMP], 2022). Inter professional collaboration: Effective communication between nurses, pharmacists, and doctors prevents 68% of medication errors (Wondmieneh et al., 2020)

Attributes

Five characteristics of near misses in nursing:
1. Risk recognition: Deviations from safe and reliable data (e.g., inconsistent patient identification data).
2. Timely intervention: Interrupting the error cascade (e.g., pausing to review an ambiguous command).
3. No harm done: The patient remains impatient.
4. Reflective practice: Analyse after the event to determine root causes (ISMP, 2022).
5. Systemic adaptation: Institutional changes, such as updated EHR alert checklists (Woodier et al., 2024).

Antecedents and consequences

• Prerequisite: A safety culture that prioritizes transparency, for example through non-punitive reporting systems (Lee, 2021).
• Impact: Improved protocols such as barcode scanning reduce medication errors by 54% (Wondmieneh et al., 2020).

Model case:

• **Scenario:** A junior nurse prepares insulin and breaks to consult with a more experienced colleague. The expert recognizes a tenfold overdose, preventing hypoglycemia. The incident was reported, resulting in a department-wide independent double-checking policy.
• **Attributes:** Risk recognition, intervention, harm prevention, reflection, systemic learning.
• **Theoretical Link**: Benner's advanced novice seeks guidance; Abdellah's Problem 21 ("Preventing violations") is reduced by refining the protocol.

Borderline case:

• **Scenario:** The patient illness remains un diagnosed resulting in delayed healing. A nurse identifies a mistake but believes the physician will verify and correct it. She did not report the error, considers it not her responsibility. The physician unaware of the error, move without warning.
• Missing Attributes: No systemic intervention or learning.
• **Theoretical Link**: Abdellah's problem 3 ("lack of attention") fails due to lack of follow-up.

Contradictory case:

• **Scenario:**

A nurse gives patient penicillin despite the patient having an allergy documented in the record. The patient begins to develop symptoms of anaphylaxis shortly thereafter,
including swelling and breathing difficulty. Having realized the error, the
nurse summons emergency assistance, but the patient's status deteriorates immediately. The failure to verify the allergy leads to a life-threatening reaction..

•**Absent features:** No risk identification, intervention, or systemic learning.

• **Theoretical Link**: Compare Benner's expert intuition with Abdellah's focus on safety.

Theoretical Applications

1. **Benner's Novice to Expert:**
   Novices: Depends on protocol (e.g., "5 Rights" of drugs administration).
   Experts: Anticipate risks through pattern recognition (e.g., questioning untypical doses).
2. **Abdellah's 21 Nursing Problems**:
   Near misses align with **Problem 21** ("prevent injury") and **Problem 18** ("modify environments for safety"). Reporting fosters **Problem 3** ("evaluate care quality").

Conclusion:

These analyses synthesize near misses as an axis of patient's primary safety, refined by Benner's experiential learning model and Abdellah's problem-solving framework. The role of reflective practicing connecting individual experiences to systemic resilience is included among the key findings. As a registered nurse it is known by how important it is for safety culture to be fostered where near misses are viewed as a learning opportunity rather than failures. In practice, the future focus will be placed on interdisciplinary debriefings and alerts based on electronic patient records to transform near miss into catalysts for innovation.

Self-reflection: Through this analysis, an appreciation for nursing theories as dynamic frameworks that adapt to clinical reality has been deepened by us. Near misses are no longer viewed by us as "risk situations", but as valuable data to proactively reshape healthcare.

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