of steps/process that could potentially cause harm to a patient. The event/incident that is stopped is referred to as a ‘near miss’.

‘Stop the Line’ initiative piloted in HUTH in certain clinical areas and was intended to be used any point in an operating theatre, interventional procedure room or any clinical or other environment when increased patient focus and concentration is required.

Patient safety experts argue that the root causes of near misses and adverse events are similar. Therefore, detecting root causes of near misses can help us to correct these causes and prevent future adverse events. The goal of a reporting system is to identify and remove the root causes of incidents (not merely counting the events) and this can be achieved by near misses.

Methods This initiative rolled out to the Neonatal unit in Hull teaching hospital Mid November 2021. Posters were developed to educate staff on what near misses were and promoting ‘Stop the Line’ reporting through either the DATIX system or paper reporting forms (see figure 1).

Near misses reported were shared as lessons with staff without guilt and blame culture that may be associated with other types of incidents.

-Initiative introduced to senior nursing staff in Band 6 meeting and to nursing educator lead and information distributed to remaining nursing staff.
-Initiative presented to NICU consultant business meeting and on grand round where all medical team made aware about it and how to report near misses and what a near miss event is.

Results This is currently work in Progress:
- Five near misses reported since start of pilot period for this project.
- Four of them related to medications and prescriptions.
- All learning lesson shared with team and reporters praised for been patient safety advocate.
- Pharmacy team involved in the initiative for future reporting and lessons sharing after theme of medication identified as common near miss area.
- Ongoing Staff education and encouragement to report near misses and lessons sharing.

Abstract 1233 Figure 1 Example of paper reporting form made available to staff.

Conclusion Reporting near misses is one of the practical solutions to the perplexing problem of patient safety.

Evidence suggests that the culture of patient safety and the characteristics of errors may have a significant impact on reporting.

REFERENCES
90% of respondents reported knowledge of near miss definition, and similar proportion acknowledges that near misses should be reported (87%) (figure 1).

-Approximately two thirds of staff respondents were knowledgeable how to report near misses (63%) compared to 37% who did not (figure 1).

-Among variable scenarios 73-88% of respondents could identify the near miss events.

-Main suggested barriers to reporting near miss events were time constraints, lack of awareness of importance of near misses reporting and fear of reporting on colleagues involved in the event.

Conclusion There is a gap between staff intent to record a near miss occurrence and actual event reporting which could be either due to low incidence of near misses in the health organization or simply because of under reporting.

REFERENCES