

Patient Safety Committee

***“Good Catch”* Program**

Managers’ Implementation Toolkit



**Timmins & District Hospital
July 2009**

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"Good Catch" Program

Introduction

A person is more likely to be injured or die as a result of a medical error than as a consequence of driving or flying.¹ In 2004, the Canadian Adverse Events Study² determined the incidence of adverse events (AE) in Canadian acute care hospitals to be 7.5%. This rate translates to approximately 185,000 AE's for the almost 2.5 million annual hospital admission in Canada. The study noted "close to 70,000 of these AEs were potentially preventable"³

As part of the ongoing efforts at TDH to develop a patient safety culture and to enhance the current patient safety program, TDH is implementing a "Good Catch" program to encourage the reporting of "near misses".

What is a "Good Catch"?

At T&DH the following definition of a "good catch" will be used:

- * Recognition of an event or circumstance which had the potential to cause an incident or critical incident but which did not occur, due to corrective action and/or other timely intervention following recognition
- * Also known as "a near miss"

The "Good Catch" Program at T&DH is a quality improvement initiative that encourages the identification of potential system errors or problems before they reach the patient and/or cause harm. The program recognizes staff and physicians for identifying "good catches" and is designed to share key finding across the organization.

It is hopeful that the "Good Catch" Program will:

- * further strengthen the culture of quality and safety;
- * allow staff to be recognized for their contributions thereby creating a culture of safety
- * continue to build staff confidence in the quality improvement processes through a non-punitive environment, and taking action to address the issues and concerns identified.

¹ Leape, LL 1991. "The Nature of Adverse Events in Hospitalized Patients. Results of the Harvard Medical Practice Study II". *New England Journal of Medicine*. 324(6), pp. 370-376

² Baker, G.R. et al 2004. "The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada" *Canadian Medical Association Journal* 170(1): 1678-86

³ Ibid

Definitions:

It is important to differentiate between incidents, adverse events, sentinel events and near misses.

Incident:

- * An unexpected and undesirable event/situation that is not consistent with the routine care of a patient.

Adverse event:

- * A negative or unfavourable reaction or result that was unintended, unexpected or unplanned.

Sentinel Event:

- * An unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of health care services.
- * loss of function – sensory, motor, physiological or psychological impairment not present at time of service and not related to an underlying condition
- * impairment lasts for a minimum of 2 weeks.

Near Miss

Accreditation Canada defines a near miss as:

- * an event or circumstance that has the potential to cause serious physical or psychological injury, unexpected death, or significant property damage, but did not actualize due to chance, corrective action, and/or timely intervention.

A near miss is a free lesson in proactive risk management and error prevention. ⁴

“Good Catch”

- * Recognition of an event or circumstance which had the potential to cause an incident or critical incident but which did not occur ie near miss, due to corrective action and/or other timely intervention following recognition.

⁴ Berntsen, KJ 2004. “Valuable Lessons in Patient Safety; Reporting Near Misses in Healthcare” *Journal of Nursing Care Quality*, 19(3), pp. 177 - 179

Program Overview

1. Goals

To reduce the overall number of incidents and adverse events.

2. Objectives

To build a culture of trust by creating and maintaining an environment of non-punitive reporting

To recognize staff and physicians for their contribution to quality and patient safety.

To strengthen the quality culture across the organization and ultimately enhance the quality and safety of services provided.

To provide the system with the opportunity to proactively identify and implement risk reduction strategies

To increase the rate of recognition of unintentional system errors or problems before they occur, to identify and implement corrective action, and to share learning across the organization.

3. "Good Catch" Reporting

Near misses are daily occurrences in the healthcare sector simply because health care professionals are human.

Healthcare professionals hesitate to report "near misses" for a variety of reasons;

- * Lack of understanding
- * Fear
- * Blame
- * Belief that reporting may not result in improvement
- * Complaints about tedious or lack of reporting processes

"Good Catch" Reporting is described in the attached Procedure - "Good Catch" Program.

4. Review and Selection Criteria – refer to Policy for details

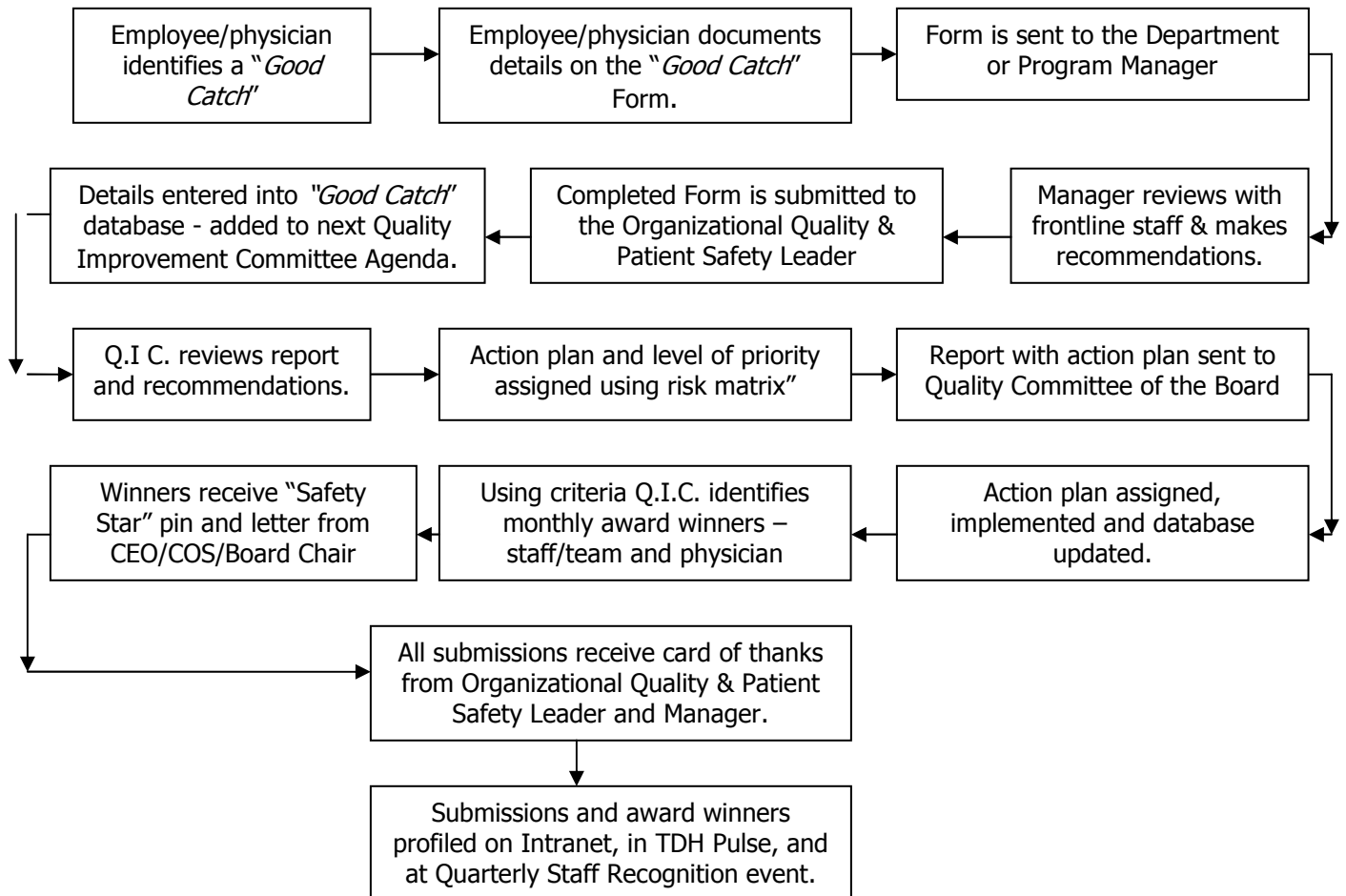
What is a “Good Catch”

- * Recognition of an event or circumstance which had the potential to cause an incident or critical incident but which did not occur ie near miss, due to corrective action and/or other timely intervention following recognition.

All submissions will be reviewed by the Quality Improvement Committee (Q.I.C). On a monthly basis, the 2 submissions that best meet the following criteria will be selected and recognized by the Quality Improvement Committee (Q.I.C):

- * Impact on patient safety
- * impact on quality of patient care
- * impact on service (timeliness, efficiency, effectiveness)
- * Opportunity to spread and increase positive impact across the organization

Process for a “Good Catch” Selection



Protection Strategies for Submissions

The Quality Improvement Committee has been designated as a Quality Assurance Committee within the parameters of the Quality of Care Information Protection Act (QCIPA 2004). The Committee's designation is for purpose of ensuring that any submissions made through the "Good Catch" program are protected from being used as evidence against either the submitter or other healthcare team members.

Suggestions to assist in assuring and reassuring staff and to remain compliant with QCIPA:

- * Inform staff that submissions will be treated as QCIPA documents
- * Emphasize the importance of making the submissions as factual as possible and leave analysis to Q.I.C.
- * Emphasize the importance to all staff and Q.I.C. members the importance of maintaining confidentiality of information generated.
- * "Good Catch" submissions do not include any patient identifying information.
- * No patient information, health care providers identification or unit names are involved in public communications
- * Ensure that all acknowledgement of submissions to the "Good Catch" Program and subsequent improvement opportunities are done in a general non-specific form e.g.
 - Say "caught wrongly labelled medication prior to it reaching the patient"... rather than saying "the Hydromorphone was wrongly labelled as SR Morphine in Pharmacy for the patient in room ___ and fortunately was caught by the RN assigned that day."
 - Say "an automatic labeller is being introduced in the Pharmacy" rather than saying " the practice of manually labelling medications is being replaced by an auto labeller due to the recent near miss on unit ____ with Hydromorphone"

How Will Staff be Recognized?

The monthly recognition program will include the following:

- "Safety Star" pin awarded to the staff/team and physician "Good Catch" of the month
- All recipients will receive a letter signed by the CEO, Chief of Staff and the Board Chair.
- A thank you card signed by the Organizational Quality and Patient Safety Leader and the employee's Manager/Director (or Chief of Staff if a physician) will be sent to all individual(s) who report a near miss.
- All near misses and follow-up will be logged in the "Good Catch" area on the Intranet.
- All recipients will be acknowledged at the quarterly Employee Recognition Awards.

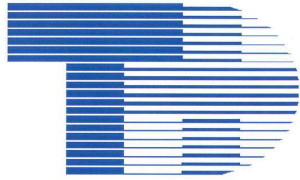
Suggestions for Department Implementation

Suggestions for implementing the "Good Catch" program at the unit level include:

- Ensure forms and posters are prominently placed on the unit
- Discuss the program at staff meetings.
- Discuss the programs at daily safety huddles.
- Add the program to the communication box
- Encourage staff individually at every opportunity to participate
- Engage physicians in the program

Possible Staff Questions

1. Who is going to see the forms?
 - Your manager, the members of the Quality Improvement Committee and the Organizational Quality and Patient Safety Leader.
2. How will confidentiality be maintained?
 - You are not required to sign the initial submission if you choose not to
 - Your name will only be used with your permission
3. Will my Manager be notified of the "Good Catch"?
 - The initial form will be submitted to your manager so that it can be discussed at the department level
 - Frontline staff are often in the best position to make recommendations regarding process improvements
 - Remember that this is a non punitive process and we encourage reporting in order that we can ensure a safe environment and establish a culture of reporting and continuous improvement.
4. Can I fill out the form and not sign my name?
 - Yes you can but without your name we will not be able to recognize your contribution.



Timmins and District Hospital

Procedure Name: <i>“Good Catch”</i> Program			
Procedure No.		Approved Date:	July 2009
Lead /Approving Director:		Reviewed Date:	
	Chief Nursing Officer	Revised Date:	
Documents Replaced (if any)			

Preamble: Procedures describe in detail how to perform certain functions, often in a step-by-step fashion. A Procedure is often associated with a particular policy or policies.

Name of Procedure: *“Good Catch”* Program

Purpose

The procedure will describe how staff, physicians and volunteers can report “near misses” and how that *“Good Catch”* will contribute to an overall environment of quality, patient safety through reduced error.

Distribution/Practice Setting

All Departments

Equipment/Supplies

N/A

Definitions:

“Good Catch”: Recognition of an event or circumstance which had the potential to cause an incident or critical incident but which did not occur ie near miss, due to corrective action and/or other timely intervention following recognition.

The event **did not reach** the patient/staff/visitor/physician

Near Miss: an event or circumstance that has the potential to cause serious physical or psychological injury, unexpected death, or significant property damage, but did not actualize due to chance, corrective action, and/or timely intervention.

Procedure

The following process is to be followed in the event of a "Good Catch".

1. Complete the "Good Catch" Report Form - Appendix A
2. Complete as much detail as possible to assist with analysis
3. Submit to Program Manager/delegate
4. Manager reviews the report with frontline staff within 5 days (where possible) using the Good Catch Case Review Tool - Appendix B
5. The completed form is submitted to the Organizational Quality and Patient Safety Leader for entry into the data base
6. The completed form is included in the agenda package for the next Quality Improvement Committee
7. The Quality Improvement Committee will review the analysis and action plan for opportunity to spread learning's across the organization eg policy or procedure changes, education of staff etc
8. The Quality Improvement Committee will apply the Risk Matrix to determine hierarchy for corrective action – Appendix C
9. Final report with recommendations and timelines for evaluation and reporting back are provided to the Quality Committee of the Board and Board
10. Implementation of recommendations are based on urgency
11. Recognition – a letter is sent to the individual(s) responsible for identifying the near miss by the Organizational Quality and Patient Safety Leader.
12. The near miss(es) with the greatest impact will be recognized quarterly using criteria below.

Risk Assessment Process

The Quality Improvement Committee, acting within the QCIPA legislation, will review each report.

A Risk Priority Matrix will be utilized to determine events that require immediate follow-up and/or a more in-depth analysis. See Appendix C.

Recognition Process

On a monthly basis, each submission will be evaluated against the following criteria:

- * Impact on patient safety
- * impact on quality of patient care
- * impact on service (timeliness, efficiency, effectiveness)
- * Opportunity to spread and increase positive impact across the organization

The individuals (one physician and one staff/team) who submitted the 2 near miss reports which demonstrated the greatest impact to patient safety will be awarded a "Safety Star" Pin and will receive a letter signed by the CEO, Chief of Staff and the Board Chair.

A thank you card signed by the Organizational Quality and Patient Safety Leader and the employee's Manager/Director will be sent to all individual(s) who report a near miss.

All near misses and follow-up will be logged in the "*Good Catch*" area on the Intranet.

All recipients will be acknowledged at the quarterly Employee Recognition Awards.

Quality of Care Information Protection Act (QCIPA 2004)

The Quality Improvement Committee has been designated as a Quality Assurance Committee within the parameters of the Quality of Care Information Protection Act (QCIPA 2004). The Committee's designation is for purpose of ensuring that any submissions made through the "*Good Catch*" program are protected from being used as evidence against either the submitter or other healthcare team members.

Documentation

N/A

References

1. Capital Health Regional Quality – Good Catch Implementation Program
2. Implementing a Good Catch Program in an Integrated Health System; Healthcare Quarterly Vol. 9, Special Issue October 2006

Appendices/Links

Appendix A – "*GOOD CATCH*" Reporting Form

Appendix B – "*GOOD CATCH*" Case Review

Appendix C - "*GOOD CATCH*" Risk Assessment Matrix

Appendix A

***"GOOD CATCH" ...
REPORTING FORM***

Appendix B

***"GOOD CATCH"
REVIEW TOOL***

PRIVILEGED & CONFIDENTIAL

(PREPARED FOR Quality Improvement Committee – Q.I.C)

"GOOD CATCH" REVIEW TOOL

INITIAL REVIEW DATE: _____

REFERENCE #: _____

What happened? (Briefly describe the "Good Catch")

Contributing Factors?

IDENTIFY POTENTIAL CONTRIBUTING FACTORS ...

*e.g. - physician
who forgot to order
a test has been
working for 24 hrs
or*

*- RN working
double shift forgets
to administer a
medication*

Information Management

- Patient correctly identified?
- Documentation provides a clear picture?
- Training issues?
- Communication issues?
- Level of automation appropriate?
- Others? _____

Environment

- Noise levels interfere with voices/alarms?
- Lighting adequate for tasks?
- Adequate air, water, surface temperature?
- Area adequate for people & equipment?
- Clutter or inadequate storage?
- People flow adequate, optimal?
- Work areas, tools etc. located correctly?
- Security?
- Others? _____

Safety Mechanisms

- Did anything stop or decrease harm?
- Equipment safety mechanisms functional?
- System designed to be fault tolerant?
- Others? _____

Equipment

- Display & controls understandable?
- Equipment detects & displays problems?
- Standardized or several different models?
- Maintenance/upgrades up to date
- Warnings/labels understandable
- Training issues?
- Others? _____

Policies and processes

- Audit/quality control for process?
- Do people work around official policy?
- Standardized process or order set?
- Use of checklists or other tools?
- Policies available
- Policies accessible
- Others? _____

Human Resources Issues

- Staffing levels?
- Orientation/training?
- Fatigue?
- Supervision of staff?
- Others? _____

Why did it happen? (Root cause/contributing factor statements)

How to prevent it?

Standardize/simplify

- Standardize/simplify equipment
- Standardize/simplify protocol
- Remove unneeded step(s)
- Education/communication
- Other _____

Improve or New Devices

- Better controls/displays
- Better integration
- More fault tolerant
- Additional equipment
- Other _____

Automation/computerization

- Automatic calculations
- Provide reminders
- Assist decision making
- Improve Technology
- Other _____

Improve Environment

- Improve flow of personnel
- Better lighting, noise, clutter
- Better stowage, signage, etc.
- Other _____

Create an action plan

Risk reduction strategies	Timelines	Person responsible

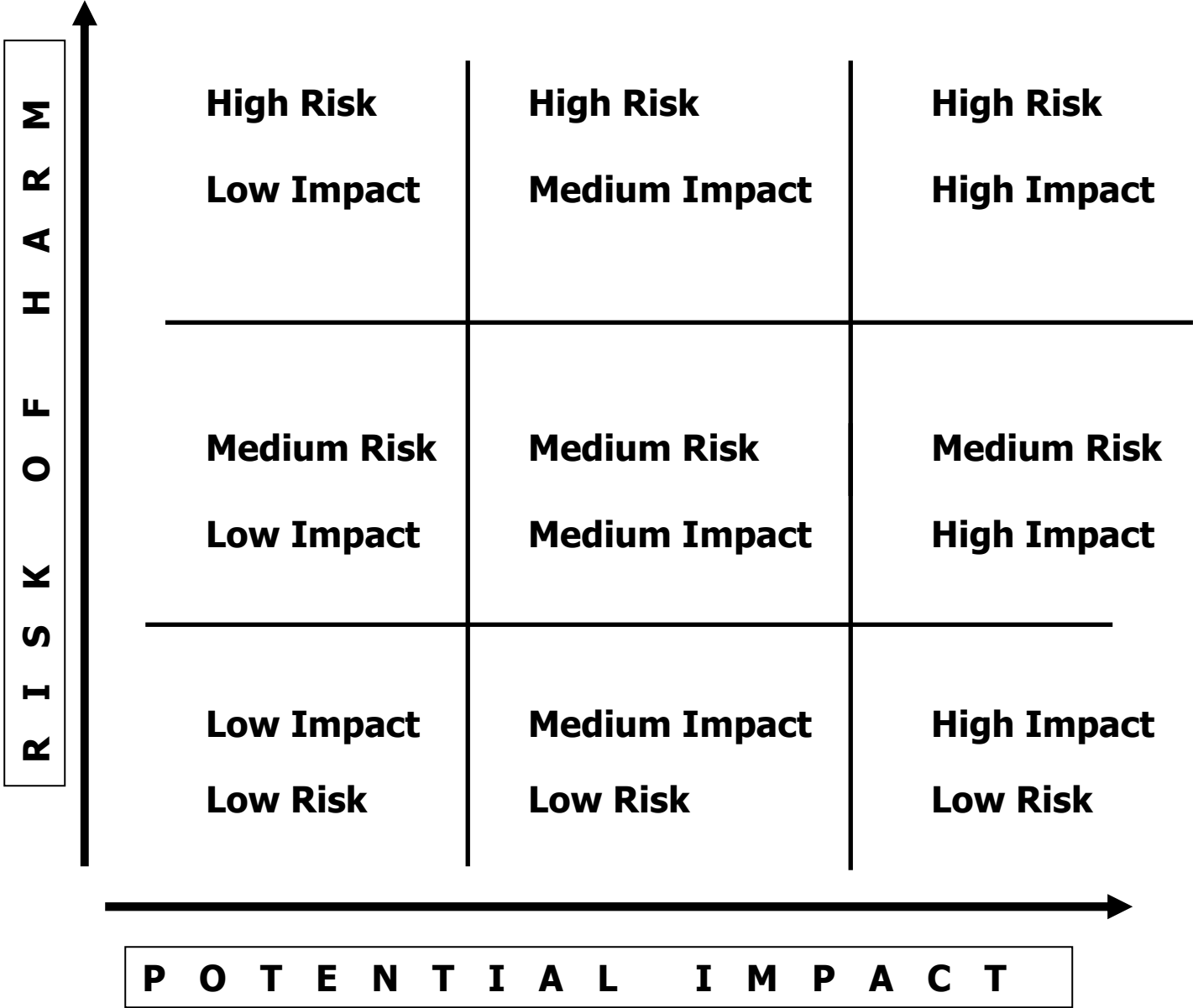
Evaluate Effectiveness

Indicators	Review Date

Appendix C

"GOOD CATCH"
RISK ASSESSMENT MATRIX

Risk Assessment Matrix



Evaluative Criteria

- * Negative impact on patient safety
- * Negative impact on quality of patient care
- * Negative impact on service (timeliness, efficiency, effectiveness)
- * Potential reoccurrence