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2017 Good Catch Program: Blueprint Companion Guide

EXECUTIVE SUMMARY

The following document provides guidance to accompany the recommended strategies listed within the *Blueprint for Success,* a comprehensive Good Catch/Near Miss program checklist. ADNPSO encourages facilities to compare checklist items to existing internal practices and consider adopting new or additional strategies to complement current approach for increasing Good Catch reports.

REVIEW BASELINE PERFORMANCE

Gather organizational patient safety event data.

Using the organization's existing event reporting mechanism (paper or electronic), run reports on 12 months of data to evaluate overall trends and patterns. It may be prudent to consider other internal systems where patient safety event data is captured separately (i.e., Pharmacy or Laboratory).

Isolate Near Miss data by month.

Review monthly volumes and trends in reporting over time. This will serve as a baseline for comparison on a monthly or year-to-date basis.

Analyze baseline Near Misses to gain qualitative (content) and quantitative (trending) insights.

Assess monthly volumes, originating departments, and types of Near Misses that are reported. Evaluate Near Miss reporting trends over time. Consider the following tips for analysis:

- What is the most common type(s) of Near Miss reported (i.e., Medication, Environmental, etc.)?
- Are the same Near Misses reported repeatedly by single staff member(s)?
- Are majority of Near Miss reports coming from a few departments or individuals?
- Are there departments/areas with NO reported Near Misses?
- Are highs or lows noted in the frequency of Near Miss reports? If so, why?

Establish organizational annual goal/target for increased Near Miss reporting.

Set a stretch goal for increasing Near Miss reporting over established baseline. Refer to facility-specific Patient Safety Strategic Plan to assure alignment. When establishing goal, consider the following industry guidelines:

- % increase over Near Miss Reporting Baseline
- 3 Near Miss reports per clinical staff member per year
- 3 Near Miss reports per adverse event reported per year

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Recognize. Report. Reward.

ASSESS OPPORTUNITIES FOR IMPROVEMENT

Review existing collection method for ease of Near Miss reporting.
Review the Near Miss reporting form in the facility's existing event reporting system (paper or electronic). Ensure that Near Miss reporting is quick, easy and accessible for staff and physicians.

Review organizational definitions, accountability and feedback processes for Near Misses.
Ensure the facility has a clear definition for Near Miss. Confirm that staff and physicians recognize their role in reporting Near Misses, and evaluate organizational feedback processes to emphasize the value of reporting.

Review your facility's most recent AHRQ Culture of Safety Survey results to identify factors/perceptions influencing Near Miss reporting.
AHRQ Culture of Safety Survey results are beneficial in evaluating staff perceptions of an organization's safety culture, specifically on how staff/physicians view their work environment related to patient safety. Some survey items to consider include:

- We are actively doing things to improve patient safety.
- Staff feel like their mistakes are held against them.
- Mistakes have led to positive changes here.
- It is just by chance that some serious mistakes don't happen around here.
- When an event is reported, it feels like the person is being written up, not the problem.
- After we make changes to improve patient safety, we evaluate their effectiveness.
- Patient safety is never sacrificed to get more work done.
- Staff worry that mistakes they make are kept in their personnel file.
- We have patient safety problem in this unit.
- Our procedures and systems are good at preventing errors from happening.
- My supervisor/manager seriously considers staff suggestions for improving patient safety.
- My supervisor/manager overlooks patient safety problems that happen over and over.
- We are given feedback about changes put into place based on event reports.
- Staff will freely speak up if they see something that may negatively affect patients.
- In this unit, we discuss ways to prevent errors from happening again.
- Staff are afraid to ask questions when something does not seem right.
- When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?
- When a mistake is made, but has no potential to harm the patient, how often is this reported?
- When a mistake is made that could harm the patient, but does not, how often is the reported?

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Identify other strengths and barriers of the Near Miss reporting process.
Assess organizational factors that impact Near Miss reporting. Consider what the facility does well and where there is room for improvement. Gauge perceived strengths and weaknesses through leadership rounds, huddles and/or interviews. Some areas to reflect on may include:

- Awareness & Importance of Near Misses
- Staff Knowledge and Use of Event Reporting Mechanism
- Adoption of Non-Punitive, Just Culture
- Feedback Processes for Reporters (or lack thereof)

OBTAIN SENIOR LEADERSHIP SUPPORT

Seek endorsement, support and resources for improvement efforts.
When approaching leadership, be prepared to discuss:

- Scope of Good Catch Campaign
- Benefits of Participation
- Alignment with National Initiatives
- Overview of Event Reporting Data (Incident, Near Misses and Unsafe Conditions)
- Baseline Near Miss Data
- Campaign Stretch Goal
- Reward and Recognition Plans (Internal and/or External Programs)
- Oversight and Operational Needs
- Proposed Resources

DESIGNATE OVERSIGHT TEAM/COMMITTEE

Modify ADNPSO template to establish a team charter.
Examine the facility's committee structure to designate an existing team or form a new oversight team. Adapt ADNPSO's charter template to address purpose, scope, members, and responsibilities for facilitating the Good Catch Program.

Appoint a team facilitator.
Designate a staff person with team facilitator knowledge and skills to guide and direct the internal activities of the oversight team.

Identify multidisciplinary change agents.
Recruit strong, well-respected staff leaders who are versed in change management to drive increased Near Miss reporting. Assure the members are diverse in clinical backgrounds and disciplines (e.g., nurses, physicians, pharmacists or ancillary staff who lead by example, possess persistence, positive attitude, etc.).

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Orient team members and change agents to program objectives.
The following should be covered during the oversight team orientation:

- Team Charter
- Near Miss Definition
- Importance & Benefits of Near Miss Reporting
- Facility Baseline Data
- Assessment Results
- Good Catch Program Goals/Objectives
- How Safety Culture Affects Near Miss Reporting
- Strengths, Barriers & Possible Solutions

DEVELOP ACTION PLAN

Tailor actions to address barriers and leverage strengths of Near Miss reporting.
Utilize findings from the baseline data reviews, AHRQ Culture Survey, and/or other assessments to develop strategies aimed at addressing weaknesses and enhancing strengths.

Educate frontline staff/physicians.
Develop education materials (huddle talking points, PowerPoints, CBL materials) in advance of campaign launch. Be sure to include the definition of a near miss and examples, campaign objectives, how to report near misses, goals, and internal reward and recognition program.

Define internal communication channels for generating awareness and enthusiasm.
Identify numerous methods and avenues for promoting the program and highlighting successes to ensure ongoing staff engagement. Consider staff meetings, town halls, safety huddles, shift change, newsletters, email alerts, screensavers, leadership rounds, etc.

Develop schedule and responsibility for reviewing Near Misses and goal progression.
Assign accountability within the oversight team to monitor near miss reporting, monthly review of Near Miss details and evaluation of goal progression. Continuous review of qualitative and quantitative data will help identify opportunities to redesign system and process vulnerabilities.

Consider developing or revitalizing an internal reward and recognition program.
Developing or revitalizing an internal Good Catch Reward & Recognition Program is a proven way for leadership to demonstrate support and motivate staff participation. Shared success stories, celebration of achievements and continual recognition are key components of the design. Examples may include certificates awarded at meetings/huddles, spotlights in the monthly newsletter, Thank You notes or even small incentive awards.

Establish schedule and accountability for recommending Good Catch Award winner.
Consider empowering the oversight team to review the Near Misses and nominate staff/physicians/teams for both internal reward and recognition.

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PREPARE FOR LAUNCH

Utilize ADNPSO educational and promotional materials to bolster staff engagement.
ADNPSO's toolkit includes resources that can be downloaded and adapted for internal use, including:

- Screensavers, Posters, Infographics, Intranet Banners and Email Signatures for use in introducing and promoting the Good Catch Program
- Charter Template for defining the oversight team's roles and responsibilities
- Presentation Template for educating frontline staff and physicians

Educate frontline staff and physicians.
Expose all frontline staff and physicians to Near Miss education. Use a variety of communication channels, including learning management system, intranet, staff meetings, town halls, huddles, etc. Repetition is encouraged and can lead to stronger engagement. Organizational leaders, managers and supervisors should be groomed to serve as educators for their respective areas.

Implement action plan.
Execute action plan to ensure effective launch and employ ongoing evaluation to monitor success and sustainability.

SUSTAIN MOMENTUM

Provide timely, relevant feedback at all organizational levels.
Assign the oversight team with responsibility for keeping the organization apprised of Good Catch Program status and progress. Ensure communication is extended to all levels of the organization, including Near Miss reporters, committees, departments, and leadership.

Recognize frontline staff/physicians/teams via internal reward program.
Adopt a continuous process for recognizing patient safety champions and celebrating employees' commitment to effect change and improve care delivery.