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Implementing a Good Catch Program in Nursing Homes

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Implementing a *Good Catch* Program in Nursing Homes

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Contents

The Working to Improve Safety for Every Resident (WISER) Project

WISER Phase I

The Division of Licensing and Regulatory Services, Maine Department of Health and Human Services (DHHS) contracted with the Muskie School of Public Service at the University of Southern Maine in 2015 to launch the WISER (Working to Improve Safety for Every Resident) project through use of Civil Monetary Penalties funds. The goal of the WISER initiative is to provide nursing facilities in Maine with an opportunity to assess the culture of resident safety in their facility and to identify areas of strength and opportunities for improvement. Nursing facilities received all materials, training, and support needed to assess resident safety culture and identify areas for improvement. Resident safety culture was assessed using the Nursing Home Survey on Patient Safety Culture survey, developed by the Agency for Healthcare Research and Quality (AHRQ). Two-thirds of nursing facilities in Maine (63 of the 103 nursing facilities in Maine) participated in 2015 WISER activities with over 3,000 staff completing the survey instrument.

WISER Phase II

WISER participants are about to enter the second phase of this quality improvement initiative. Maine has been funded for WISER Phase II. The participants will engage in a concentrated learning collaborative to focus on the 3 patient safety domains that represent the lowest scoring areas across all facilities: communication openness, non-punitive response to mistakes, and staffing. In particular, initial activities in Phase II will center on the development and piloting of a near-miss reporting system.

This capstone provides the background research and project design for WISER Phase II participants in their initial near-miss reporting pilot.

Capstone Description

Rationale and processes for reporting near misses and evidence-based tools were collected by a literature search, seminal works by Sidney Dekker and James Reason, and websites for the Agency for Healthcare Research and Quality (AHRQ), the Institute for Healthcare Improvement (IHI), and the Centers for Medicare and Medicaid Services (CMS). Tools, information, and strategies found in this research were evaluated for implementation in Maine nursing homes. The tools provide a communication vehicle for nursing home staff to safely report to management near misses, or mistakes that do not harm residents. To emphasize a positive approach, the project replaces the term "near miss" with "good catch."

The final contract for the WISER Phase II project was delayed and therefore the guided discussion as planned for the project could not be held. Instead, two tools were developed to present to WISER participants once Phase II is underway.

Good Catch tools were created for use in skilled nursing facilities. Along with WISER project participants, additional audiences for this work include long term care patient safety officers interested in internal reporting of near misses to improve their systems and culture change.

Implementing a *Good Catch* Program in Nursing Homes

Literature Review

Near misses are an event or situation in which a mistake or error in care did not harm the resident because the error did not reach the resident or the error reached the resident but only because of chance, which may include a timely intervention, did not cause injury (Kessels-Habraken et al., 2010; Maine Revised Statutes, 2015). The near miss reporting system identifies underlying patterns within the nursing home system of care that may lead to adverse events in order to guide development of error prevention strategies (Karsh et al., 2006; Wagner et al., 2006; Reason, 2000). Effective risk management relies on a reporting culture (Reason, 2000).

Near miss reporting is closely related to the nursing home culture change movement. Beginning in the early 1990s culture change originated with nursing home providers including organizations such as Eden Alternative to deinstitutionalize the nursing home environment and create more homelike facilities. Dispelling traditional top-down decision making, direct care staff are allowed more freedom to provide individualized care for residents resulting in better quality of care (Miller et al., 2014; Castle & Ferguson, 2010).

Human Factors Theory, also called the Swiss Cheese Model

In order to create protective barriers against adverse events, human factors theory also known as the "Swiss Cheese Model" identifies process vulnerabilities within an organization's system that can line up to cause an error. Within a facility, everyday procedures and practices called error traps potentially contribute to an adverse event. The identification of error traps in workplace procedures and environment that consistently cause mistakes can lead to the improvement and creation of safe guards and defenses against recognized dangers. To assess one's organization, defining the boundaries of the system is a challenge because of

interconnected processes and interfaces with technology, other medical facilities, and regulators. The very regulations intended to increase quality and safety often lead to complexity that increases the risk of error (Reason, 2013).

Failures are often identified with those who work directly with residents, or those at the sharp edge of care, and can also be found in latent processes devised at higher levels of the organization, at the blunt end of care. An error can occur without a hands-on mistake being made at all, the error occurs through a combination of vulnerabilities inherent in the system (Reason, 2000; Dekker, 2012; Traynor, 2015). Such an adverse event in healthcare may cost the resident extended time in acute care, permanently or temporarily reduced well-being, and can even cost the resident their life (Dekker, 2012; Dixon & Shofer, 2006).

Using human factors theory as a framework, near miss reporting allows management to comprehend practices they are unaware of in regular work that may allow an adverse event to evade the safety defenses within their system. While detecting these practices, instead of placing blame on people at the sharp end of care, support is furnished by understanding the pressures and reasons for deviation from prescribed care. This alternate focus on system processes recognizes that people and processes are not perfect and that errors are a consequence of this imperfection and not the reason for a mistake. Near miss observations provide management the information to know how to create defenses that protect workers on the sharp edge as well as the residents in their care (Dixon & Shofer, 2006; Reason, 2013; Reason, 2000; Dekker, 2014; Ruchlin, 2004).

Production pressure and prevention naturally work against each other. An organization's resources are a result of production. Prevention uses up scarce resources that could instead be invested into more production. Because the resources for prevention and safety come from production, production exerts a natural precedence over safety (Reason, 1997). It is no surprise,

then, that when safety incentives are reimbursed by Medicaid, the adoption of culture change is

positively influenced. Higher Medicaid reimbursement rates are also associated with higher

quality processes and outcomes because there are more resources (Miller et al., 2014).

Organizational values that favor production values over safety allow unsafe practices, such as

excessive time demands, inadequate equipment, poor human-machine interface, not enough

training, under staffing, low pay, low status, ambiguous or unworkable procedures, and

inadequate communication (Grunier & Mor, 2008; Reason, 1997). Combined with these are

human tendencies to produce errors and commit violations (Reason, 1997). Studies using a

simulated NASA project found that a culture of safety encourages reporting when safety is

valued over budgetary and time constraints (Dillon et al., 2016).

An ideal of perfection is enforced in medical training placing providers into a system error

prone especially because of the wide range of activity and equipment, volume of one on one

interaction, and the frailty of residents (Reason, 2013). Therefore, adverse events in healthcare

have a second victim, the provider who is involved in ae mistake. Often one person at the sharp

edge of care is singled out and isolated in blame. They may be brought up on legal charges and if

charged, lose their employment and license to practice. Even without this level of public

punishment, an adverse event can erode the practitioner's emotional status and disrupt their

ability to continue to perform their professional work (Dekker, 2012; Dixon & Shofar, 2006).

Dekker (2012) describes just culture as combining accountability and trust. In a functioning

society, management and staff take problems within the facility seriously and do something

about them and hold people responsible when accountable. A call for only accountability after an

error providing no opportunity for explanation about what happened and why, creates an

injustice for those involved which will only fortify barriers to building a culture of safety (Dekker, 2012).

After an adverse event, a strong bias leading to blame called hindsight bias is naturally created by knowing the outcome before examining the actions leading up to the event. Study of near misses can help examine and discuss processes without the fear and silence that accompany serious mistakes. When a mistake is made, the investigation needs to focus not on who but what made this happen and address what the person was doing when the error occurred and in what way that action was normal to them at the time (Dekker, 2012). The near miss process allows those at the blunt end of care, those in management, to explore in depth how people at the sharp end work and why they may create a work-around or not follow certain protocols. Production pressure, need for additional training, lack of equipment and support often lead people to choose workarounds and other ways of working in order to meet conflicted goals. On the sharp edge of care, what is termed as "drift" from safety practices occurs as margins of safety are gradually eroded as a result of conflicting demands (Dekker, 2012; Reason, 1997). An attitude of constant vigilance for the potential of large errors to occur must be adopted, especially when day-to-day events are typically accident free (Dekker, 2012; Reason, 1997). On their own, individuals will not retain a sense of danger. A systems approach anticipates worst possible outcomes and readies staff for it on all levels (Reason, 2000; Dillon et al., 2016).

Leadership

Strong leadership is essential to creating and maintaining a culture of safety and to create culture change (Gandhi, 2016; Wagner et al., 2006). The most important activities for management or those in leadership is listening and encouraging staff. A respondent from the WISER survey wrote this telling comment, "I think it could improve on resident's care and

safety if more opinions and suggestions were heard from staff." Implementation knowledge

originates at the sharp edge of care (Dixon & Shofer, 2006; Grunier & Mor, 2008).

In 2004, the Agency for Healthcare Research and Quality (AHRQ) conducted the

Customer Needs Assessment Interview with healthcare management leaders known for their

commitment to patient safety to find out how nonprofit health systems were creating and

applying patient safety initiatives. The assessment revealed that the literature did not provide

specific context or practical implementation that caused uncertainty among leaders about how to

convert patient safety knowledge into practice (Dixon & Shofer, 2006; Arnetz et al., 2011).

Executives surveyed reported unsettled launches on their pioneering patient safety inventions.

One management team conducted frequent "sit-arounds," rather than do executive "walk

arounds" that led to the discovery of dangerously unusable equipment and its subsequent

replacement. Another practice used a metric that numbered "lives saved" when communicating

lowered numbers of infection rates. Senior management in another healthcare facility each

signed and sent thank you notes to near miss reporters (Dixon & Shofer, 2006).

Tools for Reporting

The University of Texas M.D. Anderson Cancer Center's original "Close Call Reporting

System" allowed anonymous reporting and didn't require patient identification. The online and

paper reporting only yielded 175 reports in two and a half years. Along with low response,

anonymity prevented the chance to understand the human factors and processes in the system

that needed improvement. The Center improved their near miss reporting system with a new

"Good Catch Program," that entailed an end-of-shift safety report with real time data collection

carried out in friendly, team-based competitions among their nursing units. The new program

used positive language for the program name and all communication, management leadership-

sponsored rounds, and workgroup ambassadors from various disciplines. Initially, 2,000 to 3,000

near miss monthly reports were received and then report numbers leveled out to between 1,000

to 2,000 reports per month, or an average of between twelve thousand to twenty-four thousand

reports annually compared with an average of 58 reports per year. With this success, they then

switched to an online reporting system where good catch entries are inserted directly into a

database with identified reporters (Traynor, 2015; Summers & Massey, 2005).

More tools used for reporting in medical settings include Common Formats (Clark, 2012),

2-Challenge Rule, SBAR (Situation, Background, Assessment, Recommendation)

communication tool (Dumitrescu & Ryan, 2014), and the voluntary anonymous Safety Net web-

based reporting tool of the Association of (peri)Operative Registered Nurses (Killen & Beyea,

2003).

Many medical systems adopted safety measures already in practice at other high-reliability

organizations such as aviation and nuclear power because healthcare is a later adopter of near

miss reporting (Wagner et al., 2006). To help further understand complex systems, high-

reliability theory was developed from studies of high-risk organizations such as aircraft carriers,

nuclear power plants, and air traffic control that have low accident rates. This theory recognizes

that individuals who operate and manage complex systems are not able to sense and anticipate

problems generated by the system. High-reliability systems embody a culture of trust and

helpfulness, with friendly and open relationships in a workplace that encourages creativity and

goal achievement (Ruchlin, 2004).

Nursing homes have the advantage of learning from programs in various healthcare settings

to guide them at lower expense in time and personnel. Wagner et al. (2006), offer 5 near miss

reporting systems successfully used in alternate industries with suggested tweaks for a nursing

home near miss reporting system. In a study by Crane et al. (2015), the process of creating a

reporting system for primary care practices can inform nursing home managers how reports can

be received and acted upon. See the Appendix for descriptions of reporting tools and industry

examples mentioned in this text.

Technology

According to the AHRQ assessment, ideal safe systems institutionalize a strong safety

culture and use technology and automation (Dixon & Shofer, 2006). For example, a patient

safety phone hotline to report a patient safety issue is a quick way for busy caregivers to report

(Dixon & Shofer, 2006; Wagner et al., 2006). Recent incentives for implementation of

technology encourage near miss reporting with simple, easy to use forms (Wagner, et al., 2006).

The University of Vermont Medical Center uses a simple one-page online form for reporting

(Traynor, 2015).

Barriers to Reporting

Just asking staff to report their mistakes or the mistakes of colleagues and superiors is not

enough to overcome barriers to reporting (Dillon et al., 2016). Research has shown that

healthcare staff are more likely to report adverse events in non-punitive workplaces with good

work rapport among staff (Arnetz et al., 2011).

Unknown consequences as a result of reporting are a barrier more closely related to health

care workers. The small size of some nursing homes may cause a fear of supervisor retaliation

and disclosure to outside entities that may lead to litigation. Workers need to know what will

happen to their reporting, how it is kept, if it is de-identified, and if they are legally liable as a

result of reporting. Transparency in reporting and guidelines for implementation are necessary

for clear communication with staff (Wagner et al., 2006, Kapp, 2003). Having an independent

organization analyze reports is ideal to encourage reporting, if this option is feasible (Leape, 2002). All potential reporters should know the following:

- What happens to those who report?

- How exactly will the organization, manager, and supervisor respond?

- What are the rights and obligations of the reporter?

- Will reported information stay within the organization or will others such as the media or a state prosecutor have access to these records (Dekker, 2012; Grunier & Mor, 2008).

Employees also need to know their reporting is actually heard and acted upon. Follow up is essential to show reporting led to improved resident care. Some facilities give staff regular updates about the changes made as a result of their near miss observations (Wagner et al., 2006). At Memorial Medical Center in Modesto, California near miss reporters are publically congratulated as those who pay attention, find things, and educate staff about what to look for. Each month at the University of Vermont Medical Center, one near miss participating employee at the Center wins a $100 gift card, a good catch pin, and a write-up in the company newsletter (Traynor, 2015).

Goal clarity was also a predictor of communication about incidents (Arnetz et al., 2011). A definition of what a near miss entails should be clear. Reporting is not a vehicle for revenge on colleagues and supervisors (Wagner et al., 2006). Those reporting need to understand the difference between a near miss observation and what must be reported to Medicare and Medicaid and the state, and near misses that are part of mandatory reporting, such as falls (Wagner et al., 2006).

A common barrier to collecting and learning from near misses is the fear of punishment for having made a mistake. Words such as "report," "investigation," and even "near misses" suggest

the punitive quality of a "write-up." Positive language reinforced by the nursing home culture

can help to overcome mistrust that holds people back from reporting (Coyle, 2005; Dekker,

2014). Positive language made a difference in the near miss program at the University of Texas

Anderson Cancer Center nursing units already mentioned. The Center revised their Close Call

Reporting System to an improved Good Catch Program careful to use positive language for the

program name and all communication, with improved access to management and opportunities

for staff involvement (Traynor, 2015; Summers & Massey, 2005).

Conclusion

As staff at the sharp end are encouraged to report near misses, the organization can learn,

protect, and improve the system that cares for their sick and vulnerable residents. If staff believe

reporting actually improves patient outcomes, trust that they will not be punished, and

understand the importance of their participation, their buy in will help to strengthen a culture of

safety (Dekker, 2012; Reason, 2000). Barriers to reporting need to be addressed, which may

include staffing shortages, a top-down organizational structure, and an adversarial regulatory

environment causing fear of litigation, reprisal, and embarrassment after committing an error. If

humans are vulnerable to mistakes, errors are recognized as a consequence of imperfect people

and imperfect systems rather than one individual being the lone cause of a mistake.

For near miss reporting to be effective, the goals of an organization must be aligned with

safety. Requirements imposed by the organization in terms of cost and time can erode quality of

care and safety considerations if there are not enough resources. This is related to staffing

shortage, an area of improvement identified by the WISER study, with everyday demands of

caregiving pressuring staff at the sharp edge of care (Dekker, 2012; WISER study). Management

will understand better what is going on in their facility as their staff share their observations of

near misses which will create a nursing home culture where people feel safe and are encouraged

to report, a just culture providing protection and promoting trust (Ruchlin et al., 2004).

Keywords: nursing home, near miss, long term care, just culture

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The *Good Catch* Program for WISER Phase II

Near misses are an event or situation in which a mistake or error in care did not harm the resident because the error did not reach the resident or the error reached the resident but only because of chance, which may include a timely intervention, did not cause injury (Kessels-Habraken et al., 2010; Maine Revised Statutes, 2015). A near miss reporting system identifies underlying patterns within the nursing home system of care that may lead to adverse events in order to guide development of error prevention strategies (Karsh et al., 2006; Wagner et al., 2006; Reason, 2000). The near miss tools offered here are called *Good Catches* to encourage an inviting communication vehicle to encourage staff participation. The word report has been changed to observation to distance this activity from any inference to write-ups and punishment.

Near miss reporting is closely related to the nursing home culture change movement that originated with nursing home providers with organizations such as Eden to deinstitutionalize the environment and create a home-like facility for residents. Culture change offers more choice for residents with collaborative decentralized decision making that empower staff to provide individualized care (Miller et al., 2014; Castle & Ferguson, 2010).

The *Good Catch* supports culture change by allowing staff at all levels to safely speak up to improve the systems in which they work. For some in management, the hardest part of leading will be letting go of power so that those lower in the hierarchy can speak. Effective risk management relies on a reporting culture. Staff will need to trust management and their peers as they report on their mistakes and the mistakes of others, including mistakes made by their supervisors (Lenoci-Edwards, 2016; Reason, 2000).

The culture in a facility is formed early by factors including the kind of work done, policies, and how it sees itself in the outside world. Culture holds together daily functioning and

drives the safety process. Strong leadership by those in management is key to creating and

maintaining a culture of safety (Gandhi, 2016; Wagner et al., 2006). To create a psychologically

safe environment, leaders in management must first model the behavior they want from staff and

speak up to their superiors about concerns (Lenoci-Edwards, 2016). Nursing home culture

characteristics to consider include:

- Common understanding, such as the attitude toward residents and whether or not

   constructive disagreement is encouraged

- Environment which encourages participation level of staff and provides access to

   people in management

- Everyday language, positive or negative, empowering or disabling (Ruchlin et al.,

   2004)

- Employee attitude toward the facility, such as pride in working at the nursing home

   (Bridges, 2014).

Building a culture of safety through trust will take time and consideration. A *Good Catch*

program is fueled by success and never driven by fear of punishment. Systematic planning of

short-term wins will help to anchor *Good Catches* within the facility's culture, to shift safety

from being a priority to being a value (Dekker, 2014; Ruchlin et al., 2004).

Handling Mistakes

When a mistake is discovered, the human tendency is to immediately place blame on the

individual in closest proximity to the error even before a thorough investigation is made. Those

investigating need to be aware of this tendency and resist hindsight bias to allow the true story of

what happened to emerge and why practices that led to the error made sense to the individual at

the time. Most people arrive at work and begin their shift intending to do good work. In a well-

functioning culture, management and staff take problems within the facility seriously and do

something about them and hold people responsible when accountable. *Good Catch* reporting

does not exclude accountability for obvious intentional error such as stealing or abusive

behavior. The difference is understanding the reason for error, especially at the sharp end of care

where staff work directly with residents, as the processes and working environment is managed

while meeting production and policy requirements set farther from the residents where policies

are set at the blunt edge of care. This shared responsibility allows for a just culture where all true

processes that lead up to harm in care can be identified and acted upon. Instead of asking, "who

did this," the question becomes "what happened;" and instead of thinking "if only they did it

differently," the question is "why did it make sense to them when they did it this way" (Dekker,

2012; Dekker, 2014). By only considering who is accountable with no opportunity to understand

what happened and why, there is no justice for those involved and this injustice will build

barriers to safety (Dekker, 2012).

Addressing Barriers to *Good Catches*

Acquiring voluntary reports from staff about their mistakes or the mistakes of colleagues

and superiors will require strategy in order to overcome barriers to reporting (Dillon et al. 2016).

The staff will need to clearly understand the goal of sharing *Good Catch* observations (Arnetz et

al., 2011).

Definition. All staff need to understand and use the same definition of a *Good Catch*: an

event or situation in which a negative outcome could have occurred but did not. They need to

understand that *Good Catches* happen more frequently than adverse events and their detection

will prevent an adverse event (Crane, et al., 2015).

What a *Good Catch* entails should be clear. (Wagner et al, 2006). *Good Catch*es can be defined as harm that does not reach the resident or may also include a broader definition that includes incidents that reach the resident but do not cause harm. If staff feel ashamed or in the past were punished for mistakes, a narrow and positively stated definition that only includes incidents that do not reach the resident may be the definition to use initially. The best definition may depend upon the context of each nursing home (Kelssels-Habraken et al., 2010). Reporters need to understand the difference between what must be reported to Medicare and Medicaid and the state, compared to what is shared as a *Good Catch* (Wagner et al., 2006).

Value of *Good Catch* reporting. In an environment where an adverse event has not happened in recent memory, latent attributes within the system can combine unexpectedly to create harm. For example, the latent attribute may be a short cut that has always worked in the past or an obstacle to following prescribed procedures. Over time those necessary work arounds used to meet production demands within financial constraints at the sharp end of care creep farther from official protocol. *Good Catches* help to understand the drift between official work procedures and how work is actually done (Reason, 2000; Dekker, 2014).

Facility management need to continually communicate a sense of urgency about patient safety including the use of *Good Catches*. An attitude of constant vigilance for the potential of large errors to occur must be adopted, especially when day-to-day events are typically accident free. On their own, individuals will not retain a sense of potential danger to patient safety. Management endorsement of *Good Catches* can remind and prepare them. A systems approach anticipates worst possible outcomes and readies staff for it on all levels (Reason, 2000; Decker, 2014; Dillon, et al., 2013).

How *Good Catches* are shared. Clear guidelines about the procedure for sharing *Good Catches* is necessary (Wagner et al., 2006).

Teach Back technique in a group or with an individual can help gauge how well staff understand the procedure. For information about Teach Back, visit http://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx (Unity Point Health, 2014).

Reward and punishment. Fear of consequences as a result of reporting is a barrier in health care facilities. The small size of some nursing homes may cause a fear of supervisor retaliation. It needs to be clear that reporting is not a vehicle for revenge or punishment and will not be used for staff performance evaluation. Research has shown that healthcare staff are more likely to report adverse events in non-punitive workplaces with good work rapport among staff (Arnetz et al., 2011).

How *Good Catches* are stored. Staff members need to know what will happen to their reporting: how the information is kept, if it is de-identified, if the reported information will stay within the facility, and who can access the information. Management in each facility will need to decide how to keep their *Good Catch* data. Staff need to be told their legal liability, for example, will other parties such as the media or a state prosecutor have access to these records (Dekker 2012, Grunier & Mor 2008).

Demonstrate the use and value of *Good Catches*. Management then can close the loop by demonstrating to staff who have shared *Good Catches* how their feedback is positively received. The cycle of reporting, feedback, and action will then be linked to the prevention of an error, improved wellbeing for residents, and greater pride for the staff (Lenoci-Edwards, 2016).

To encourage more reporting, follow up is essential to show that reporting led to improved patient care. Some facilities give staff regular updates about *Good Catch* reports at meetings or in newsletters, post *Good Catch* observations and response, and award incentives such as gift cards (Wagner et al., 2006).

Good Catch Implementation

All staff including those in office administration, laundry, housekeeping, and nutrition, not only nursing staff, need to be included. Some facilities may want to include volunteers, family members, and of course, residents. A decision to identify or not identify the patient and healthcare provider needs to be made. When *Good Catches* are anonymous, one event may be reported several times, skewing results. Anonymous reporting prevents finding out more about the processes that led up to the error. It may be necessary to build trust before asking for the identity of those who report their *Good Catch* (Crane et. al., 2015).

Orientation with Staff

All staff need an orientation before implementation. Errors are often discovered at the sharp end of care, where caregivers work closely with residents. Errors are also found in settings such as office administration, housekeeping, food preparation, and maintenance.

The orientation can be a simple 10-minute discussion. Provide the *Good Catch* observation form and a copy of the excel *Good Catch* Diary to show staff. The "Addressing Barriers to *Good Catches*" section above provides approaches to discussing *Good Catches* with your staff.

Orientation Part One: Introducing the *Good Catch*. Meet so that no one is missing or coming in late. Distribute the *Good Catch* observation form to all attending. Explain to all staff the following:

- The goal of the *Good Catch* program

- Definition of a *Good Catch*

- Value of *Good Catches*

- Central role of staff to find the *Good Catches*

- Culture shift from blaming individuals to finding vulnerabilities within the system:

  the way work is done, the environment, production constraints, and resources issues

  that lead to errors (Coyle, 2005)

- How *Good Catch* reports are received, used, and archived

  o Demonstrate the reporting procedure

  o Who has access in your facility to the data

- Go over ground rules, e.g.

  o Ask <u>what</u> happened, not <u>who</u> did this

  o *Good Catch* observations will be met with approval and not punishment

  o Huddle information is not shared outside of the huddle, if using huddle tool

  o Share respectfully

  o Keep to 5-minute time limit

- Announce incentives

Orientation Part Two: Implementation Meet at the end of shift or later the same day. As a reminder ask a staff person to recapitulate the reporting procedure

- Go over ground rules

- Reassure staff that *Good Catch* sharing will be rewarded by all involved and those

  who share the *Good Catch* are encouraged to suggest a solution

- Officially announce the beginning of collecting *Good Catches* and incentives

Strengthening *Good Catch* buy-in

Demonstrate management support. Management should be available and visible with walk rounds to show interest in each person's work, not only discussing safety to show a personal interest and instill pride and recognition (Ruchlin et al., 2004). For an explanation about

management leadership walk rounds, visit

http://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx (Frankel,

2014).

Regularly encourage staff by communicating and showing how their contribution counts by

announcing, posting, publishing, and giving out incentives to reward how their *Good Catches*

changed the way work is being done for the better.

Engaging staff members from all departments will help the near miss program gain

strength. A staff person who is trusted by their peers can be a safety champion to whom other

staff can express concerns. For more information about safety champions, visit

http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx (IHI,

2016). Staff can also be surveyed about their reaction to persistent problems to brainstorm

solutions.

Considerations

- Use positive language, always

- Avoid adding complexity by creating many new rules which increase chances of an
  adverse event

- Look for events likely to recur, have potential seriousness, and are within one's
  control to change

- Be sure all staff have equal access to tools for sharing their observations

Collecting and storing data

Some systems collect *Good Catches* over 3 months and then analyze the data for trends and

repeated observations when the Quality Assurance Committee meets. In the beginning more

immediate feedback may fuel the process. The following are basic steps for later refinement in individual facilities.

- *Good Catches* are collected from staff through the *Good Catch* observation tool

- Information is placed into the *Good Catch* Diary excel file

- Over time, the frequency of certain errors can be observed by a sorting function on the excel sheet

- Information is reviewed by the patient safety officer to identify possible quality improvements or good interventions

- The information and recommendation from the Patient Safety Officer is then given to the Director of Nursing for review

- The Director of Nursing then meets with the Medical Director to determine next steps, with other members of the nursing home Quality Assurance Committee

- Staff members whose *Good Catch* observations led to quality improvements are recognized and rewarded

Improving *Good Catch* Data. Once a quality improvement activity is selected as a result of *Good Catches*, use the Plan Do Study Act (PDSA) cycle. Track the process until it is replaced, no longer needed, or has become an ingrained habit and other priorities have taken its place. For information about using PDSA cycles, visit:

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

(Demming & Shewhart, 2000).

Conclusion

These are guidelines based on the literature for implementing a near miss, or *Good Catch* program. Every nursing home will need to tweak these guidelines to fit their facility and then to continuously improve thereafter. The literature suggests beginning a pilot with staff from one area of the facility receptive to this work and to create early success. For staff that are worried of reprisal, perhaps many staff, keeping observations anonymous and focusing on errors that do not touch the patient may be safer for them to start. The value of the presence of leadership with walk rounds and friendly feedback cannot be over emphasized. The literature suggests beginning with a foundation of clear definitions of what a *Good Catch* is and what it entails, clear procedures and clear evidence of why this is so important. Then show how the *Good Catches* become quality improvement with positive communication and recognition.

Feedback questions for WISER nursing home participants

Questions from WISER nursing home participants may come after a simulation of the orientation process. Here are questions to stimulate more conversation.

- What changes to the Diary or forms would make sense?

- What aspect of their facility culture can help promote sharing?

- What are the barriers to use at their facilities?

- Are there staff members who can be safety champions to lead other staff?

- Would various shifts at their facility make it hard to have huddles? Would it be easier or more difficult to talk to staff in a huddle or have them share by themselves online?

Good Catch Implementation Checklist

❑ Determine your definition of a *Good Catch*

❑ Decide to identify or not identify the patient and health care provider

❑ Choose the *Good Catch* collection tool that is a good fit for your facility

❑ Plan Orientation

❑ Plan how you will initially motivate your staff with communication and incentives

❑ Set in place who will input observations into the *Good Catch* diary excel file

❑ Create review team

❑ Plan feedback cycle

Setting Your People Up for Success

Prepare this information for staff

❑ <u>What?</u> All staff will need to understand what a *Good Catch* is

❑ <u>Why?</u> Staff need to know why *Good Catches* are important to residents and

themselves

❑ <u>Establish ground rules</u>

❑ <u>Where does it go?</u> Staff need to know what is done with their information

❑ <u>Non-punitive</u>: Staff need to know they will not be punished for *Good Catches*

❑ <u>Efficacy</u>: Show how specific *Good Catches* made a difference in how work is done

Two *Good Catch* Tools

Using tools for near miss reporting in a nursing home is still a recent development and therefore only 2 tools, Common Formats and the IHI Nursing Facility Trigger Tool, were designed for nursing homes and are already in use at nursing facilities. These tools were not chosen for the WISER project for these reasons. Common Formats is used mainly to report adverse events to an outside Patient Safety Organization. The reporting of adverse events would not as easily encourage a non-punitive reporting culture and communication openness. The trigger tool would not involve all staff, only high-level nurses and higher management and therefore would not naturally contribute to a non-punitive reporting culture or to open communication with staff involvement (Adler, 2015; AHRQ, 2014). Other tools in the literature include a phone hot line that may conflict with policies requiring staff to silence their phones while working. Options that require extra staffing such as an online blog appeared to present an extra burden on nursing home staffing and also required all staff to have access to a computer (Goldfeder, 2002). All tools found in the literature are described in the Appendix with links to resources when possible.

The following two tools have been selected from the literature and modified for nursing home use. The cheerful success of the safety huddle at the University of Texas was chosen for its substantial staff involvement and their program's contribution toward a non-punitive reporting culture with open communication between staff and management (Summers & Massey, 2005). The second tool is a simple online form with a supplemental paper form to accommodate those who do not work on a computer, chosen because it is widely used in different settings (Crane, et al. 2015; Traynor, 2015: Wagner et al., 2006).

The online form is intentionally kept to one page and has less questions than the huddle form for the following reasons. The huddle form is made to resemble issues that may be covered in the huddle discussion. The identity of the person will be known in the huddle, to keep consistent the identity of the reporting person is optional on the huddle form. Without follow up, the fill in lines for contributing circumstances and additional information would not flow into the excel sheet from the survey as data points and were not included. The online form information would not be received as close in time to the error as the huddle information. The qualitative description of the *Good Catch* is essential information and remains on both forms.

The Nursing Home *Good Catch* Safety Huddle

Consider beginning with a pilot group for a limited time period with a willing manager in one area of your nursing home.

With the full facility participating, gather *Good Catches* at the end of each shift from everyone who works in your facility. Nursing home shifts often vary for different personnel, such as 8 hour shifts for CNAs, 12 hour shifts for nurses, day hours for administration, and shifts for laundry, housekeeping, and maintenance. Once several *Good Catches* have been used for quality improvement, consider holding an all staff meeting to share interventions and observations from various shifts and functions from the whole facility.

How the Huddle works

1. Orientation at the beginning of shift on the first day or evening

   - At the beginning of the shift, bring everyone in the area together, be sure no one is missing

   - Hand them a *Good Catch* Safety Huddle form to look over

   - Introduce *Good Catches* and value for reducing adverse events

   - Explain central role of staff to find *Good Catches*

     o Culture shift from blaming who to learning why events happen

     o Information is not used in performance evaluations

     o A non-management staff person will write *Good Catches* on huddle form

   - Show the *Good Catch* Diary excel sheet to show how information will be recorded

   - Tell them huddles will be 5 minutes and keep to it

   - Set ground rules, for example

     o Ask <u>what</u> happened, not <u>who</u> did this

- o *Good Catch* observations will be met with approval and not punishment

- o Huddle information is not shared outside of the huddle

- o Keep to time limit

- Tell them staff will meet at the end of the shift for the huddle

2. At the end of the shift on the first day and subsequent days:

- Bring staff together and give them a safety huddle form as a reminder

    - o Ground rules reminder

    - o Be mindful to be encouraging and non-punitive

    - o Be brief, listen

    - o Invite staff to fill out form if they need to make a briefing alone, have forms

        and pencils available

- Collect data on huddle form filled out by staff champion who is not in a position to

    evaluate or discipline staff. For discussion, huddle leader can use a white board or

    just use verbal communication. Best if management write nothing down during

    these meetings

For information about staff champions, visit

http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx (IHI, 2016)

- To encourage verbal participation, prepare topics (see below) in case there is low

  response

> Sample topics for discussion to prime staff conversation
> - What if two residents with the same or similar name are on the floor
> - Who is at risk for falls
> - Do you talk to residents about food, activities, medications, and care? Encourage questions and feedback from residents.
> - Can each resident hear and/or see you?
> - Why would a resident at risk for falls walk without aid?

- Remind staff they will meet again the following day

3. Analyze data and forming quality improvements

- At the end of the period, e.g. month or several months, the frequency of certain errors,

  locations, time of day, etc. can be observed. The data is reviewed and analyzed by the

  Patient Safety Officer, Director of Nursing, and Medical Director and other Quality

  Assurance Committee members

- All staff can be surveyed about possible solutions to persistent problems

- Share with staff how their specific *Good Catches* were made into a specific quality

  improvement to make residents safer

4. Ending the pilot

- Ask staff for suggestions on how to improve the huddle

- Modify plans without altering the goal

- Regularly encourage staff by showing how their *Good Catch* observation contributed

  to a quality improvement.

- Toward the end of the pilot, ask staff if this was helpful

- After pilot, review data and share with staff

- Determine whether or not to continue huddles and with what modifications

- How your facility collects, uses, and benefits from *Good Catch* information should be customized and improved over time using a respected tool such as the Plan Do Study Act (PDSA) cycle. For information about using PDSA cycles, visit: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx (Demming & Shewhart, 2000).

Rewards

This model has been used with promising results. One facility went so far as to create teams of nursing units with a baseball theme that competed and were rewarded for sharing the most observations. In some facilities, management leaders give out gift cards, send thank you notes, and publicly recognize participants. With your staff's feedback, you can get creative and have some fun with incentives.

Be mindful to stay positive and non-punitive, remember to ask <u>what</u> happened not <u>who</u>

Limitations

- Buy in may take time

- It will take extra discipline to keep the time limit to 5 minutes

Positive contribution

- Staff have an immediate and quick way to report

- Non-punitive approach may lead to better overall communication and safety culture

- Information is fresh

Resources

Visit the following Institute for Healthcare Improvement web sites for more information about huddles also known as safety briefings.

Institute for Health Care Improvement (2004) Safety Briefings Tool. Cambridge, Massachusetts,

USA Retrieved from http://www.ihi.org/resources/Pages/Tools/SafetyBriefings.aspx

Institute for Health Care Improvement (2004) How to conduct safety briefings. Cambridge,

Massachusetts, USA Retrieved from

http://www.ihi.org/resources/Pages/Changes/ConductSafetyBriefings.aspx

Other resources include

Leadership Walk Rounds. For an explanation about management leadership walk rounds,

visit http://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx

Safety Champions. For more information about safety champions, visit

http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx

Plan Do Study Act (PDSA) cycle. For information about using PDSA cycles, visit:

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

The *Good Catch* Diary excel sheet

Date & time	Good Catch description	Event Code	Location Code	Seriousness 1-10	Resolution	Contributing Factors	Suggested Solution	Comment	Quality Improvement? Y/N

Sort the reporting excel file by codes to detect frequency patterns over the course of months. The

Good Catch **Safety Huddle Observation Form**

Location codes include places in the facility (Atrium, main room, toilet, shower, etc.)

Areas where nonclinical staff work may be coded to include additional aspects such as

documentation error, environmental hazards, and correct handling of food, laundry, and infection

control, e.g. washing hands. Kind of event such as falls, bed sores, medication, infection,

identification of correct resident is listed by The Joint Commission. 2015 Long Term Care

Medicare/Medicaid Certification-based Option National Patient Safety Goals published by the

Joint Commission identifies correct resident identification, medication, infection prevention,

falls, pressure ulcers for accreditation. These measures can serve in part as coding options for the

Safety Huddle Form collection vehicle. The form can be found at

http://www.jointcommission.org/assets/1/6/2015_LTC2_NPSG_ER.pdf

A copy of a prototype form is on the next page:

Safety Huddle *Good Catch* Observation form

All *Good Catch* forms are completely Anonymous and Confidential

Use this form for Good Catches only if NO significant harm came to the resident or staff person as a result of the event. Actual injury needs to be reported via other channels.

Date: __ __ / __ __ / __ __   Time _____:_____ ❑AM ❑PM (approximate)

Name and Department (voluntary) _____

1. Good Catch description (DO NOT USE NAMES IN YOUR ANSWER)._____

   _____

   _____

   _____

   _____

2. How would you classify this event? (Please check all that apply)
   - ❑ A. Medication related
   - ❑ B. Bed sores
   - ❑ C. Falls
   - ❑ D. Infection Prevention
   - ❑ E. Identification of correct resident
   - ❑ G. Laundry
   - ❑ H. Nutrition, food
   - ❑ I. Missed, delayed, or incorrect care
   - ❑ J. Communication problem
   - ❑ K. Administrative glitch
   - ❑ L. Other: _____

3. Where did this event occur?
   - ❑ A.   Atrium
   - ❑ MR. Main Room
   - ❑ T.   Toilet
   - ❑ SB. Shower or Bath
   - ❑ H.   Hallway
   - ❑ DR. Dining Room
   - ❑ G.   Garden
   - ❑ O.   Other: _____

4. Please rate the seriousness of this event on the following scale, by circling the best response.

   [NOT AT ALL serious]   0 1 2 3 4 5 6 7 8 9 10   [EXTREMELY serious]

5. How was the problem resolved?

   _____

   _____

   _____

6. What circumstances may have contributed to the problem?

_____

_____

_____

_____

7. What is your suggestion for a solution to prevent this problem in the future? _____

_____

_____

_____

_____

8. Is there anything else you would like to add? _____

_____

_____

_____

_____

Good Catch! T**hank you for making a difference!**

The Nursing Home *Good Catch* Online Form

A very simple one-page form to report *Good Catches*. Participants will require access to a computer. A companion hard-copy form may also be made available for those without access to a computer. A drop box or self-addressed, stamped envelope can be provided to submit paper forms. *Note:* If used for this tool, Survey Monkey can collect data as a CSV file, which can be transferred into an excel sheet without showing identity. For more information, visit surveymonkey.com

Orientation

- Call an all staff meeting, be sure no one is missing

- Hand them a hard copy form to look over

- Introduce *Good Catches* and value for reducing adverse events

- Explain central role of staff to find *Good Catches*

- Demonstrate online submission

- Show the *Good Catch* Diary excel sheet to demonstrate how information will be recorded and kept, explain analysis procedure, #3 below.

How to use the online and paper form

1. When a staff person observes a *Good Catch*, they can go to a dedicated web site to fill out a simple one-page form, a prototype sample follows this section

2. The form will automatically collect the following

    a. Date and time of *Good Catch*

    b. Description of event and its resolution

    c. Category check-boxes: event, location

    d. Suggestions for prevention

3. At the end of the period, e.g. month or several months, sort the excel file to observe the frequency of certain errors, locations, time of day, etc. The data is reviewed and analyzed by the Patient Safety Officer, Director of Nursing, and Medical Director and other Quality Assurance Committee members

4. All staff members also can be surveyed about possible solutions to persistent problems

5. Make quality improvement

6. Share with staff how their specific *Good Catches* initiated each quality improvement

Limitations
- Not all staff may have access to a computer

Positive contribution

- Staff have an immediate and quick way to report

- Entry can be anonymous or identification can be optional

Continuity

- Ask staff for suggestions on how to improve *Good Catch* reporting and modify plans without altering the goal

- Regularly show appreciation to staff with announcements, postings, and other displays showing *Good Catch* improvements

- How your facility collects, uses, and benefits from *Good Catch* information should be customized and improved over time using a respected tool such as the Plan Do Study Act (PDSA) cycle. For information about using PDSA cycles, visit: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx (Demming & Shewhart, 2000).

The collection forms are based on the Patient Safety Reporting System (PSRS), in development by the **National Aeronautics and Space Administration**. Visit

http://psrs.arc.nasa.gov/programoverview/index.html

PSRS is based on the NASA Aviation Reporting System http://asrs.arc.nasa.gov/index.html

Additional resources

Leadership Rounds

http://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx

Safety Champions.

http://www.ihi.org/resources/Pages/Changes/AppointaSafetyChampionforEveryUnit.aspx

Plan Do Study Act (PDSA) cycle

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

The *Good Catch* Diary excel sheet

Date & time	*Good Catch* description	Event Code	Location Code	Seriousness 1-10	Resolution	Contributing Factors	Suggested Solution	Comment	Quality Improvement? Y/N

Sort the reporting excel file by codes to detect frequency patterns over the course of time.

***Good Catch* Online Form codes**

2015 Long Term Care Medicare/Medicaid Certification-based Option National Patient Safety Goals published by the Joint Commission identifies correct resident identification, medication, infection prevention, falls, pressure ulcers for accreditation. See the form at

http://www.jointcommission.org/assets/1/6/2015_LTC2_NPSG_ER.pdf . These measures can serve in part as event coding options for the *Good Catch* collection form. Nonclinical work may be coded to include documentation error, environmental hazards, and correct handling of food, and laundry. Location codes include places in the facility (atrium, main room, shower, etc.).

A copy of a prototype form is on the next page:

Good Catch Online Form

All *Good Catch* forms are completely <u>Anonymous</u> and <u>Confidential</u>

Use this form for Good Catches only if NO significant harm came to the resident or staff person as a result of the event. Actual injury needs to be reported via other channels.

Date of *Good Catch*: __ __ / __ __ / __ __   Time _____ : _____ ❑am ❑pm (approximate)

1. *Good Catch* description (PLEASE DO NOT USE NAMES IN YOUR ANSWER). _____
   _____
   _____
   _____
   _____
   _____

2. How was the problem resolved? _____
   _____
   _____
   _____

3. How would you classify this event? (Please check all that apply)

   ❑ A. Medication related   ❑ G. Nutrition, food
   ❑ B. Bed sores   ❑ H. Missed, delayed, or incorrect care
   ❑ C. Falls   ❑ I. Communication problem
   ❑ D. Infection Prevention   ❑ J. Administrative glitch
   ❑ E. Identification of correct resident   ❑ K. Other: _____
   ❑ F. Laundry

4. Where did this event occur?

   ❑ CR. Common Room   ❑ H. Hallway
   ❑ T.   Toilet   ❑ A. Atrium
   ❑ SB. Shower or Bath   ❑ G. Garden
   ❑ DR. Dining Room   ❑ O. Other:_____

6. What is your suggestion for a solution to prevent this problem in the future? _____
   _____
   _____
   _____

Good Catch! Thank you for making a difference!

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Appendix. Overview of Reporting Tools and Industry Examples

The following tools were identified in the literature as either easily transferable to use in a

nursing home or actually developed for use in nursing homes as in the case of Common Formatts

and the IHI Nursing Facility Trigger Tool. The tools are ordered in terms of their relevance for

initiating a near miss program that will encourage non-punitive reporting and open

communication beginning with the most likely to succeed.

1. Briefings or huddles

A quick 5-minute huddle to collect near miss reports at the end of each shift. Some

facilities give prizes, thank you notes, and company recognition. For resources about how to use

the huddle, visit

http://www.ihi.org/resources/Pages/Changes/UseRegularHuddlesandStaffMeetingstoPlanProduct

ionandtoOptimizeTeamCommunication.aspx and for an example of a facility that used this tool,

visit https://innovations.ahrq.gov/profiles/multifaceted-program-increases-reporting-potential-

errors-leads-action-plans-enhance-safety (Traynor, 2015; IHI, 2004; Summers & Massey, 2005).

How briefings work
You may want to begin with a pilot group for a limited time period with a willing manager:

- At the beginning of the shift, bring everyone together and be sure no one is missing

- Hand them the safety briefing form to look over

- Introduce near misses and their purpose to reduce adverse events

- Reinforce that staff identity will not be recorded and show data collection tool

- Be clear that staff will not be punished for near miss reporting

- Go over huddle procedure, e.g. each person share in turn around a circle

- Tell them briefings will be 5 minutes and keep to it

- Tell them staff will meet at the end of the shift for a huddle

Huddle at the end of the shift

- Bring staff together and give them a safety briefing collection form

  - Be positive and non-punitive

  - Be brief

  - Provide forms so that staff can make a briefing alone

- Data is collected on a briefing form filled out by staff peer not management

- Encourage participation and prepare topics (See list below) in case there is low response

  - Sample topics for discussion to prime staff conversation

    - Be careful if two residents with the same or similar name are on the floor

    - Who is at risk for falls

    - Talk to residents about food, activities, medications, and care. Encourage questions and feedback.

- Remind huddle participants they will meet again the following day

Continuity

- Ask staff for suggestions on how to improve the briefing

- Modify plans without altering the goal

- Toward the end of the pilot, ask staff if this was helpful

- After pilot, review data and share with staff

- Determine whether or not to continue briefings and with what modifications

Limitations

- Buy in may take time

- It will take extra discipline to keep the time limit to 5 minutes and use positive language all the time

Positive contribution

- Staff have an immediate and quick way to report

- Non-punitive approach will lead to better overall communication

- Information is fresh

2. Reporting Forms

The following online and paper forms can be used together to include those who do not have regular access to a computer to report (Traynor, K., 2015; Wagner et al., 2006).

These tools are based on Patient Safety Reporting System (PSRS), in development by the National Aeronautics and Space Administration-NASA (2010), found at

http://psrs.arc.nasa.gov/programoverview/index.html . PSRS is based on the NASA Aviation

Reporting System found at http://asrs.arc.nasa.gov/index.html

2A. Online Reporting Form

A simple one-page form to report near misses can be anonymous, have optional identification of reporter, or have mandatory identification of reporter. Some facilities do not make identification mandatory until after the staff experiences encouragement and reward for near miss reporting. For the online form, participants will need access to a computer.

How the online form works

1. Staff person observes a near miss and fills out a one-page form online

2. The form data goes into a spread sheet

3. Information is reviewed by the Quality Assurance Committee, initial review by the Patient Safety Officer, Director of Nursing, and Medical Director

4. At the end of the period, e.g. 3 months, the frequency of certain errors can be observed

5. Share findings with staff and brainstorm solutions to persistent problems

6. Try solutions using Plan Do Study Act (PDSA) cycle

7. Share with staff specifically how their near miss report created a quality improvement

Limitations

Some staff such as those who work in laundry, maintenance, and food service may not have access to a computer

Positive contribution

- Staff have an immediate and quick way to report

- Entry can be anonymous

2B. Paper form

How the paper form works

1. Place one-page reporting forms in plastic holders at locations easily accessible to all employees

    a. They will need to be replenished by administration staff

2. When a staff person observes a *Good Catch*, they fill out a form and place it in box next to the plastic holders. Another collection mode could be by U.S. mail.

3. The patient safety officer or administrative staff enters data on an excel spread sheet

4. Data is reviewed by the patient safety officer at the facility

5. Information is reviewed by the Quality Assurance Committee, initial review can be by the Patient Safety Officer, Director of Nursing, and Medical Director

6. At the end of the period, e.g. 3 months, the frequency of certain errors can be observed

7. Share findings with staff

8. Brain storm with staff possible solutions to persistent problems

9. Test solutions using Plan Do Study Act (PDSA) cycle

10. Share with staff specifically how their near miss report created a quality improvement

Limitations

Filling out the form and submitting it may not private

Positive contribution

- All staff are included

- Staff have an immediate and quick way to report

- Residents, family, and visitors can be included

3. Patient Safety Phone Hotline

The phone will provide prompts with the same information collected by forms. Although this reporting system was not described in detail, it would not be difficult to construct a phone messaging system to record staff reports (Wagner et. al, 2006).

How a phone hotline works

1. When a near miss is observed, they call it in on their cell phone or facility phone

2. An automation may capture data points, e.g. press 1 for [x].

3. The call goes into an answering machine or service

4. Designated office staff collect the calls and enter the information onto an excel sheet

5. At the end of the period, e.g. 3 months, the frequency of certain errors can be observed by a sorting function on the excel sheet

6. Information is reviewed by the Quality Assurance Committee, initial review can be by the Patient Safety Officer, Director of Nursing, and Medical Director

7. Share findings with staff and brain storm possible solutions to persistent problems

8. Improve solutions using Plan Do Study Act (PDSA) cycle

9. Share with staff specifically how their near miss report created a quality improvement

Limitations

- It must be made clear that this is not the number to call in an emergency

- Phone messages may not be anonymous

- This may conflict with a policy forbidding personal cell phone use while working at the nursing home

Positive contribution

Staff have an immediate and quick way to report

4. Near Miss Website Blog

This professional information exchange is modeled from a near miss web site for fire fighters. To see the web site, visit www.firefightersclosecalls.com (Goldfeder, 2002).

How the web blog works

1. When observed, firefighters log into the dedicated link and enter their near miss

2. Reassurance on the form states that the information is kept confidential with no consequences as a result of reporting

3. After review by the site administrator, the entry is posted

4. Participants can see what others post and learn from the experiences and mistakes of others

5. The posts can be used to involve the whole staff in a "what would you do" training exercise, see drills section on the fire fighters link named close calls

Limitations

- It is only accessible to those with computer access and ability

- There is no face time between management and staff

- Someone has to maintain the site and make judgements about the postings

Positive contribution

- Anonymous postings for all to consider

- Postings can be segregated for different areas

- Real experience can be used for discussion to find solutions

5. Safety Net

Safety Net is a near miss reporting system of the Association of (peri) Operative Registered Nurses (AORN) used to collect stories from perioperative nurses and clinicians about occurrences that could have resulted in error but did not. AORN planned to analyze these stories, learn from common themes, and offer practice guidance to prevent similar events from occurring. Near-miss stories also can provide helpful information about the clinical environments in which care is provided and provide human factor details about noise level, distractions, interruptions, ineffective communication, fatigue, and procedure complexity. The system is no longer found on the web (Beyea, et al., 2006; Wagner, et al., (2006).

6. Situation, Behavior, Assessment, Recommendation (SBAR) Communication Tool

This communication tool gives a framework to convey all information pertinent to a resident's condition or environmental situation. SBAR communication technique can be combined with other tools to make communication more effective (Martin, 2008; Dumitrescu & Ryan, 2013).

How SBAR works

Use this formula when discussing resident conditions or any situation:

S=Situation (introduction, a concise statement of the problem)

B=Background (pertinent and brief information related to the situation)

A=Assessment (analysis and considerations of options — what you found/think)

R=Recommendation (action requested/recommended — what you want)

For the Institute for Healthcare Improvement (IHI) SBAR Communication Technique visit:

http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx (Ascano-Martin, 2008)

Positive contribution

- Especially useful between interdisciplinary workers who may not use the same communication patterns or terms

- Staff would learn a professional communication protocol used in other medical settings that may also improve their work beyond near miss reporting

7. Two-Challenge Rule

Taken directly from aviation industry, this rule cuts across hierarchal boundaries to challenge unsafe behaviors as they are happening. This tool can be combined with another as an aid to communication.

How it works

This scenario is adapted for a nursing home situation. When a healthcare worker observes the wrong treatment to a resident or a situation that compromises safety, in the spirit of shared responsibility, they learn to speak in a pattern that is direct (advocacy) and uses inquiry (question). This makes communication clear by describing clearly the perceived problem in a way that is called crisp advocacy-inquiry and that requires an answer about correction or next steps. With no satisfactory response, or an oblique response, the observer repeats the message.

With no response to correct the situation, this process allows/mandates the observer to solicit

help from others to correct the situation (Pian-Smith, et al., 2009; Dumitrescu & Ryan ,2013).

Here is an example: The floor nurse doesn't respond to a suggestion to call maintenance

after the water pitcher spilled in the hallway. She is the only one designated to call maintenance

when needed.

Type	Example
Lowest: Say nothing	--
Say something oblique	"Really?"
Advocate or inquire repeatedly, with	"I'm concerned about the water on the floor" OR "I'm uncomfortable with the way this floor is so wet." OR "What do you think?"
Best: Use of crisp advocacy-inquiry	"I'm wondering about the risks to falls when there's water on the floor. How do you decide how to proceed?"

Limitations

- The practice would need to be adopted by those in charge as well as staff

- This procedure has not been tested in a real clinical setting, only as a simulation

Positive contribution

It would empower staff to halt a potentially harmful action or circumstance.

8. Common Formats

A major goal of Common Formats is to collect aggregate data of adverse events from many

facilities to form a large sample to identify underlying systematic processes affecting patient

quality and safety in many healthcare facilities. The development of Common Formats for

electronic patient safety event reporting and analysis is authorized by the Patient Safety and

Quality Improvement Act of 2005 (Patient Safety Act) and the Patient Safety and Quality

Improvement Final Rule (Patient Safety Rule). This legislation called for the establishment of

Patient Safety Organizations (PSOs) to collect and analyze the data and a Network of Patient

Safety Databases (NPSD). The Agency for Healthcare Research and Quality (AHRQ) is the lead

federal agency on quality to care research responsible for coordinating all federal quality-

improvement efforts and health services research (Couig 2005).

Created and administered by the Agency for Healthcare Research and Quality (AHRQ),

Common Formats is a standardized reporting tool for Patient Safety Organizations (PSO) which

are authorized by AHRQ to collect and analyze data from health care facilities to identify

information and trends beyond only one facility. It establishes common definitions and reporting

formats in order to uniformly report patient safety events. Voluntary information shared with the

Patient Safety Organization are protected from discovery, litigation, or punitive action (Couig,

2005; Clark, 2012; AHRQ, 2014). For more information, visit

https://www.psoppc.org/psoppc_web/publicpages/nursinghome

Common Formats collects near miss reports with adverse events and are not used solely for

near miss reporting from Patient Safety Organization members. While using Common Formats

for adverse event reporting, participating facilities can also use this tool to find near misses.

How Common Formats Works

1. Register with a Patient Safety Organization, see www.psoppc.org

2. Enlist a computer format available to all staff to report

3. Train staff

4. Begin reporting each incident using:

    a. Healthcare reporting form for incidents, near misses, and unsafe conditions

    b. Patient in Formation form for incident reporting

    c. Summary of Initial report incidents, near misses, and unsafe conditions

5. Receive feedback from other providers contributing to the PSO

Limitations

Common Formats goes beyond reporting near misses and collects data about unsafe conditions and adverse events when the patient is harmed. Reporting to a Patient Safety Organization requires multiple forms and may be labor intensive. The formality of Common Formats and the weight of adverse event reporting may intimidate new near miss reporters and may not be fast or simplistic. Identification of the reporter sent outside the facility with the report may also be a barrier to staff members even though by law reporters are protected and de-identified. If a nursing home is already using Common Formats, it is a helpful and thorough tool to not only track facility events but to contribute to a larger project to understand the processes and patterns that lead to resident and patient harm. This does not take the place of other mandatory reporting.

Positive contribution

The use of Common Formats definitions is recommended because it instills universal definitions and will increase understanding with other facilities. The standard definitions can be used with other close catch reporting tools.

9. IHI Skilled Nursing Facility Trigger Tool

This tool measures adverse events and may not be as effective for near miss events because retrospective resident records are used. For online training to use the trigger tool, go to http://www.ihi.org/education/WebTraining/Expeditions/August-2016-SNF-Trigger-Tool-Measuring-Patient-Harm-Skilled-Nursing-Facilities/Pages/default.aspx beginning August 10, 2016.

How the Trigger works

Once a month, 20 patient records are selected by randomization to detect triggers or clues that may lead to an adverse event or near miss including preventable and unpreventable events. (Adler, et al., 2015).

1. Establish a review team: two trained nurses and physician to check and authenticate findings

2. Define and draw a sample. Collect full medical records for each sample.

    a. Clearly define population, residents with specific medical challenges e.g. patients with urinary catheters, or those with dementia, or the general population

    b. Only those stays with admission date during observation period

    c. Use random sampling method at consistent intervals to draw sample, See IHI.org for random sampling methods

3. Structure review process

    a. Suggested order of record review: (Adler et al., 2015, p13)

        1 Hospital discharge summary

        2 Diagnoses/operative/coding information from preceding hospitalization

        3 SNF admission diagnoses and intake assessment

        4 Skin assessment (to determine new or worsening pressure ulcers)

        5 Medication administration record (MAR)

        6 Intake assessment

        7 Prescriber orders

        8 Pharmacy medication regimen reviews (particularly if acute change in mental status or other possible drug effects)

        9 Nurse progress notes

        10 Physician progress notes

        11 Minimum Data Set (MDS) Care Area Assessments (CAAs)

12 Mental health records, including psychiatry, psychology, psychiatric social

worker (particularly when on psychotropic medications)

13 Laboratory test results

14 Diabetic treatment/glucose monitoring form

15 Social service notes (family complaints may be documented here)

16 If time permits, other areas of the record, such as physical therapy notes and

nutrition notes

b. Limit review to first 30 days of admission

4. Find triggers or clues to conditions that may lead to adverse events in resident records

using the list above.

5. Measure incident using the National Coordinating Council for Medication Errors

Reporting and Prevention (NCC MERP) Index for categorizing Errors, see below

Near Miss Harm does not reach resident	A Level	Circumstances or events occurred that had the capacity to cause error.
	B Level	Error occurred but did not reach the patient or resident.
	C Level	Error occurred that reached the patient or resident but did not cause harm.
	D Level	Error occurred that reached the patient or resident and required monitoring to preclude harm or confirm that it caused no harm.
Adverse Event Harm reaches resident	E Level	Error occurred that may have contributed to or resulted in temporary harm and required intervention.
	F Level	Error occurred that may have contributed to or resulted in harm and required an initial or prolonged facility stay.
	G Level	Error occurred that contributed to or resulted in permanent patient or resident harm.
	H Level	Error occurred that required intervention to sustain the patient's or resident's life.

	I Level	Error occurred that may have contributed to or resulted in patient or resident death.

Source: *NCC MERP Index for Categorizing Medication Errors (February 2001) from Adler et al., 2015 p 13,*

6. Document Review of Findings on the SNF Trigger Tool Worksheet available with IHI course.

7. Analyze Trigger Tool Review Data as events

   a. Per 100 SNF admissions or per 1,000 resident days

   b. Use each resident record as a data point per month

   c. Show trends over time using a run, trend, or control chart, see IHI.org for guidance

Limitations

- Only includes events related to acts of commission and will not show acts of omission

- Does not include information from staff at the sharp end of care

- Missed opportunity to engage staff

- Requires dedicated staff time of two nurses and one physician monthly, estimated time spent for 20 cases at 25 minutes per case

- The tool is engineered for adverse event reporting, not near miss reporting

- Only examines what is in the records that are reviewed and may exclude near misses

- Retrospective design using deductive reasoning from closed patient records. (Closed records are the records of residents who have left the facility.)

- Training cost is $750 per phone line

Positive contribution

- No identified reporting

- Tools and support on IHI.org

Near Miss Projects in Progress

The following are site-specific examples from the literature to consider:

Primary Care Study Example (Crane et al. 2015)

In a research study of 7 primary care practices, near misses were reviewed every 2 months by a core implementation team. All staff members could anonymously report near misses on an online form. This form had been previously field tested. The form takes about 2 minutes to fill out. See Near-Miss Reporting Form on page 69.

Staff attended a one-hour orientation and every two weeks received emails encouraging participation. Near miss reports were received by the medical director and screened for adverse events causing patient harm, checked to ensure patient information is de-identified, and reviewed for possible initiation of a quality improvement. The practice leaders were given a brief overview about how to initiate a Plan Do Study Act (PDSA) cycle. After 3 months of successful reporting, each practice was expected to begin one improvement process based on near misses.

The information was further processed by the researchers who worked with the primary care offices. Near misses were coded according to care errors using a primary care taxonomy published in Quality Safety Health Care 2002;11:233– 8. by Dovey, et al. and rated subjectively by the team members from 0 (not serious) to 100 (extremely serious). Each event was rated for potential harm and cost to the patient and the cost to the facility if harm had occurred, from 0 (none/minimal), 1 (some), 2 (a lot).

Veterans Medical Center Example (Coyle, 2005)

In a Martinsburg Veterans Affairs Medical Center in West Virginia, a Close Call Reporting system was designed to encourage staff reporting in a blame-free environment. After the research of James Reason, the system was named the "Swiss Cheese Program." Communication to staff

included a graphic of the Swiss cheese model that described fallible decisions by management on

slices of Swiss cheese, e.g. lack of training or knowledge, inadequate supplies and equipment,

communication gaps. In this way management not only modeled the behavior they sought in

staff to find vulnerabilities in their system but also shared in accountability for system flaws. The

Medical Director recognized all Swiss Cheese submissions received from staff with a framed

certificate, and a commemorative slice of foam Swiss cheese at employee meetings. Employees

presented their near miss or Swiss Cheese submissions at the meetings and their idea written up

in the employee newsletter.

Combined Construction and Veterans Medical Center Example (Coyle, 2005; Cambraia et

al, 2010)

Combination of examples from a construction company in Brazil, with processes used at

the Veterans Medical Center, above. When the form or phone message communicating the near

miss is submitted, the information goes to one designated patient safety manager or risk

manager. This person collects the information and takes initial action to mitigate the situation if

needed.

The designated person may place the near miss information into an excel spread sheet diary

to track frequency and reporting (Cambraia, et. al., 2010). See sample excel below adapted for

nursing home.

Date and time	Location	Describe the event	Causes	Suggested Solution
February 3, 2016, 3 pm	Atrium	Resident fell on the carpet	The light was hitting her eyes and she wanted to close the curtains. When she got up too fast she fell	Check the atrium in late afternoon to ask residents if the low sun light coming into the room is okay or bothering them

The near miss may be graded by the Patient Safety Manager as to whether a safety intervention occurred or if a system redesign is required. Other ways to grade observations is whether or not the near miss is traceable to be able to gain more information if more is needed for a root cause analysis, how much risk or potential for an adverse event was involved, the nature of the event such as physical characteristics, and details that may reveal a pattern such as location, time of day, and context (Cambraia et. al., 2010).

After the Patient Safety Manager has reviewed the near miss, the report with recommendations is sent to the Director of Nursing for review. The near misses then may be discussed between the Director of Nursing and Medical Director to determine a quality improvement. If the near miss is used for quality improvement, the employee or employees are shown how change is made by their referral, and they are rewarded by recognition and/or incentive (Coyle, 2005).

Near-Miss Reporting Form [Adapted for single-page display]

Near-Miss Reporting Form for Physicians and Staff   Date: __ __ / __ __ / __ __

All Near-miss Reporting forms are completely Anonymous and Confidential   mo   day   year

Use this form for NEAR-MISS reporting only if no significant harm came to the patient as a result of the event. Actual injury needs to be reported via other channels.

1.   Is the event related to a specific patient?   ☐ Yes   If yes   please answer Questions 2-5
                                                              ☐ No   If no   please skip to Question 6

2.   What are your past experiences with this patient (select one response)?
        ☐ NEVER seen pt + NOT familiar w health problems
        ☐ HAVE seen pt but NOT familiar w health problems
        ☐ SOMEWHAT familiar with the pt and health problems
        ☐ QUITE familiar with the pt and health problems
        ☐ VERY familiar with the pt and health problems

3.   What is the patient's age (estimate if unsure; if <2 years, state age in months). ____ ____ ☐___ years   months

4.   Does this patient have a CHRONIC health problem (select one response)?   Yes☐ No ☐ Don't know Comment on this question:

5.   Does this patient have a COMPLEX health problem (select one response)?   Yes   No   Don't know

    Comment on this question: ☐   ☐   ☐

6.   What happened? (Please think about what, where, and who was involved. DO NOT USE NAMES OR DATES IN YOUR ANSWERS).
        Response: _____

7.   Please rate the seriousness of this event on the following scale, by circling the best response.

    [NOT AT ALL serious]   0 1 2 3 4 5 6 7 8 9 10   [EXTREMELY serious]

8.   What was the result? (Please think about actual and potential consequences.)
Response: _____

        9. What may have contributed to this (Please think about any special circumstances in play when this event happened?)
Response: _____

10.   What could have prevented it? (Please think about what could be changed to prevent this threat to patient safety)
Response: _____

11.   How often do you encounter events like this in your practice (select one response)?

    ☐ This is the first time ☐ Seldom (1-2 times per year)   ☐ Sometimes (3-11 times per year)   ☐ Frequently (once per month or more)

12.   Where did this event occur?
Response: _____

13. How would you classify this event? (Please check all that apply)
        ☐ Missed or delayed diagnosis
        ☐ Medication related problem
        ☐ Missed, delayed, or inappropriate preventive service
        ☐ Procedural or judgment error
        ☐ Communication problem
        ☐ Administrative glitch
Comment on this question:

14. Is there anything else you would like to tell us?
Response: _____

Thank you for taking the time to report this situation

From R. Crane, S., Sloane, P.D., Elder, N., Cohen, L., Laughtenschlaeger, N., Walsh, K, Zimmerman, S. (2015)

Reporting and Using Near-miss Events to Improve Patient Safety in Diverse Primary Care Practices: A

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