JONA
Volume 37, Number 11, pp 499-503

THE JOURNAL OF NURSING ADMINISTRATION

The Good Catch Pilot Program

Increasing Potential Error Reporting

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With only 175 reports submitted into an available close call reporting system during 2.5 years, the Good Catch Program was implemented to promote 3 strategies: (1) changing terminology from "close call" to "good catch," (2) implementing an "end-of-shift safety report," and (3) executive leadership sponsored incentives. The authors discuss the program and its positive outcomes in increasing potential error reporting.

Healthcare errors are costly from human, economic, and societal perspectives, with all patients and healthcare providers vulnerable to its detrimental effects.[1] In 1999, the Institute of Medicine released the report "To Err is Human," detailing an estimated 44,000 to 98,000 deaths annually related to healthcare errors.[2] The Institute of Medicine has recommended that organizations establish processes for voluntary reporting of errors. In response to growing concern over the problem, in 2004 the Institute for Healthcare Improvement launched a patient safety campaign to save 100,000 lives. In December 2006, the Institute for Healthcare Improvement published a revised goal to save 5 million lives.[3] In addition, the Agency for Healthcare Research and Quality and the Joint Commission on Accreditation of Healthcare Organizations have promoted the use of patient safety indicators to guide organizational efforts to improve patient safety.[4,5]

Although healthcare organizations are macrosystems built on many interrelated microsystems, most errors effecting patient care outcomes and that negatively affect patient safety occur at the microsystem level.[6] Thus, the prevention of errors needs to start at the microsystem level. Nurses are often the final checkpoint to assure that hospitalized patients receive safe care. Nurses' participation in potential error reporting is critical to an organization's patient safety process.

One of the best methods of preventing error is to learn from actual and potential errors. Therefore, to prevent error, employees in an inpatient hospital setting need to speak freely about errors that occur or could potentially occur on their units. Such open communication about actual or potential errors recognizes likely mistakes and identifies how a system may be contributing to mistakes. On a national scale, voluntary reporting by frontline practitioners has created a positive approach to detecting errors and safety problems.[7] Effective error reporting systems provide useful data for root cause analyses so that proactive interventions can be designed to prevent error and promote patient safety. For an error reporting system to be effective, however, employees must be willing to submit potential error reports. At our major cancer center, we found that only 175 reports were submitted during 2.5 years by 13,000+ employees from all departments in the organization that could access the close call reporting system (CCRS) to report identified potential errors.

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Close Call Reporting System

The objective of a potential error reporting system, such as the CCRS, is to detect major and minor problems inherent in systems before they lead to complications or harm patients. According to the literature, the following elements are essential to the design and implementation of an error reporting system: acknowledges the concerns of frontline personnel, is a learning tool, and focuses on disseminating positive actions that reduce or eliminate identified problems.[8]

The CCRS, an anonymous reporting system, is available in electronic and paper formats. Only potential errors (ie, those that do not reach a patient) are entered in the CCRS. The CCRS analyzes provider reporting and detailed information about potential errors to determine patient safety concerns. The CCRS provides anonymity, ensures confidentiality of data, and incorporates a mechanism to provide feedback to participants by assigning each report a number that can be used by reporters to view the actions taken on the information they submitted.

Close call reporting systems have been used in aviation, petrochemical, and nuclear industries. The benefits of close call reporting include a greater frequency of reporting, fewer barriers to data collection, limited liability resulting from proactive responses to identified potential errors, and a better way to capture usable data for improvement. Reports submitted to this type of database can identify processes that require system improvement and enable rapid systematic corrections.[9]

The CCRS supports efforts to increase the number of reported errors, close calls, and near misses; allows for timely review and rating of potential errors; and can provide valuable insight into a system's vulnerabilities. Data collected in our CCRS at the cancer center include the total number of close call entries reported, the total number of contributing factors, and a number of factor descriptors, such as forgetting, communication, transcription, labeling, staffing, interruption, experience, and fatigue.

In 2003, our CCRS was implemented to promote patient safety and potential error reporting as an organizational priority. Educational sessions introduced the program that informed employees of the option for anonymous error reporting and taught them how to use the system. Inservice presenters stated the organization's belief that it is human nature to make mistakes and to correct and learn from errors. Employees were encouraged to report close calls, near misses, and potential errors; identify possible causes of the error; and develop creative solutions for the concerns.

Understanding Barriers to Reporting

Error reporting systems depend on the ability of a practitioner to recognize an error, believe the error is significant enough to warrant reporting, and overcome the embarrassment of committing an error or the fear of reprisal for reporting a mistake.[10] A study by Low and Belcher[11] estimated that nurses only report 5% of significant errors, often reporting only those considered to be life threatening. Factor analyses in a study of medication error reporting by Wakefield et al[10] revealed 4 factors that explain why staff nurses may not report errors: fear, disagreement over whether an error occurred, administrative responses to errors, and the effort required to report an error. Understanding why nurses do not report errors is important to improving interventions designed to prevent error.

A further hindrance is that incident reporting can be time-consuming, depending on the complexity or user-friendliness of a reporting system, as can repeat fixes or work-a-rounds. A goal was therefore set by Division of Nursing leadership to develop a program that would increase potential error reporting and seek employees' input about alternatives or solutions to safety challenges. Organizational, workgroup, and professional culture were considered throughout the development and planning stages so that they would be incorporated in the Good Catch patient safety program design.

The Good Catch Program

Nurses on inpatient units identified and corrected potential patient safety errors as part of daily practice, but these potential errors and fixes were not often reported to the CCRS. In response to the low number of potential errors reported, we designed the Good Catch Program. The program implemented 3 strategies: (1) changing terminology of a potential error from "near miss" or "close call" (which acknowledges potential error) to "good catch" (which acknowledges proactive practice); (2) implementing an "end-of-shift safety report" that allows nurses to identify and discuss concerns related to patient safety that occurred during the shift; (3) promoting incentives (such as safety awards) sponsored by executive leadership to acknowledge individual nurses.

The Good Catch Program pilot was implemented in December 2005 in 5 inpatient nursing

units. Using a baseball theme, each inpatient unit formed a team to participate in friendly competition. Each team set a goal to increase the number of Good Catch reports. Each Good Catch report resulted in one point for the unit's team. The team that had the greatest number of reports over a designated period was recognized by executive leadership. The CCRS accepts both paper and online reports, but only online reporting was used by the program so that a point could be assigned for each report. Although the Good Catch Program maintains anonymity of the reporters, identifying the unit where the Good Catch was caught was necessary to allow the team to earn points. Each unit was assigned a CCRS entry code for scoring. Since its inception, Good Catch reporting has remained voluntary.

Recognition and Rewards

In the design of a program, employees must be given the time to do voluntary reporting, be properly motivated, and have consideration of the work group culture. In addition, employees need to be praised for raising safety concerns, acknowledging potential errors, and identifying recurrent medical mishaps.[8] It is also important to provide feedback to participants and show improvements resulting from their reports; this demonstrates that the data submitted in error reports are being used appropriately, thereby maintaining a high level of reporting and enthusiasm.[12]

As part of the Good Catch program, each month, patient safety champions, called most valuable players in accordance with the baseball theme of the initiative, on each unit were selected and awarded a certificate, signed by the vice president and chief nursing officer to recognize staff contributions to patient safety. Furthermore, units that initiated systems changes through Good Catch identification were recognized in the institution-wide, weekly online nursing newsletter. Providing reward and recognition for Good Catch reporting addresses a critical element of patient safety program design.

End-of-shift safety reports allowed real-time discussion of potential errors and possible solutions at the unit level. As part of the reports, team members were asked to recall interventions during the shift that promoted patient safety and were reminded to report any Good Catches. Each unit kept a log to ensure that end-of-shift safety reports were regularly conducted. This strategy shows a continued focus on patient safety.

Executive Leadership's Role

Executive leadership must create an environment of psychological safety that fosters open reporting, active questioning, and frequent sharing of insights and concerns.[13] Leaders also need to guide and support staff to identify and report close calls or near misses through developing and implementing a reporting system that involves recognition and rewards.[14] Executive leaders can empower and support teams to learn to identify and analyze factors that threaten patient safety and to intervene when necessary. The participation of executive leadership in programs to improve an organization's culture of patient safety can result in a substantial, profound, and lasting increase in error reporting and improve employees' perceptions of an organization's safety culture.[15] Executive leaders must emphasize safety as an organizational priority, provide financial support for safety projects, and demonstrate a willingness to provide support and motivate employees. They can do this by recognizing progress, sharing success stories, and regularly celebrating patient safety achievements.

Our chief nursing officer made rounds on Good Catch Program pilot units to distribute the Good Catch pins to participating team members. These visits created an opportunity for open discussions with executive leadership about patient safety, the types of actual and potential errors identified, and acknowledgement of employees' interventions or suggestions to prevent error and promote patient safety.

Feedback to Employees

Providing feedback places importance on the time employees spend reporting errors and values their role in promoting patient safety. Strong quality management processes and positive responses to error reports increase employee willingness to report and enhance patient safety.[16] Employees need to receive feedback about the types of errors reported, themes or trends across units, how the potential error will be investigated, and any changes in processes or systems that result from data analysis. Staff in the Quality Improvement Department helped review the Good Catch reports and analyze the themes of safety concerns and systems issues across units. They also facilitated root cause analyses, when appropriate.

Two team members from each participating unit served on a Good Catch Workgroup as program champions. Representatives from the Quality Improvement Department, managers of the CCRS program, and unit associate directors also participated as members of the workgroup. The numbers of submitted reports by unit (scores) were sent weekly by e-mail to all workgroup members, department directors, and associate directors. A weekly program progress report and monthly

summary of report themes were also e-mailed for distribution. The role of each workgroup member is to facilitate communication of information to their team and promote friendly competition to increase/maintain the numbers of reports that are submitted by team members. The workgroup met as needed to discuss program information. A future goal is to include representatives from any departments associated with identified report themes.

Good Catches that led to systems changes were reported in the weekly nursing newsletter as a source of feedback to employees. For example, one of the nursing units identified a connection problem with side ports in tubing manufactured by a provider company. The company was contacted and performed a quality assessment of the manufacturing process that verified the nurses' concerns. As a result, the company's manufacturing process was revised and the nursing team received a letter of appreciation from the manufacturer. Sharing success stories such as this affirms that the time taken to report a concern can lead to actual system changes and reduce error; this helps employees understand their role in making significant contributions to patient safety.

Results

During the first 9 weeks of the 6-month pilot, 300 employees participating in the Good Catch Program submitted more than 800 potential error reports. At 6 months, 2,744 potential error reports had been submitted by the 5 inpatient nursing units. Implementation of the Good Catch Program resulted in a 1,468% [(2,744 − 175)/175 × 100%] increase in potential error reporting. Key areas identified for intervention in Good Catch reports included medication dispensing and labeling, transcription, communication, equipment, policy issues, clinical procedure issues, and fall prevention. Action plans were developed to address these safety concerns.

The Good Catch Program has successfully addressed the importance of employees identifying safety issues so that solutions to potential errors can be developed and implemented. The Good Catch Program has had the ongoing support of administrative leadership and has significantly increased potential error reporting within the organization. Employees have noticed a change in culture since the implementation of the program. Good Catch teams acknowledged an initial reluctance to report errors because of fear of reprisal or concern that more reports on the unit would reflect negatively on the unit. However, ongoing support was provided to assure the teams that reporting Good Catches allows employees to take credit for their interventions and acknowledges their important role on the front line of patient safety.

Discussion

Implementation of the Good Catch Program increased Good Catch reporting by the 5 pilot units. In addition, key areas were identified for intervention, and action plans were developed to address the safety concerns. Initially, nurses were hesitant to report potential errors; however, as they saw the positive response from the administrative leadership team and actions taken to address systems issues, participation increased. Based on the positive response and increased reporting, the pilot program will be implemented on all inpatient nursing units with a goal of expanding the program throughout the institution. A formal evaluation of the Good Catch Program has been initiated by the authors. The Institutional Review Board approved the study, and data collection is in progress.

Plans are also in progress to include all nursing units in the Good Catch Program by forming an inpatient league comprising divisions and teams that will participate in friendly competitions to improve the patient safety culture. Divisional playoffs will conclude with a World Series and recognition of all inpatient nursing units that contributed to an increase in Good Catch reporting. While expanding the program, data will be collected pre–program and post–program implementation, and results of the *Hospital Patient Safety Culture Survey* will be used to identify important information related to changing organizational patient safety culture.[17] By expanding the program and increasing Good Catch reporting to identify and proactively address patient safety concerns, the number of actual error reports should decrease over time.

To translate the Institute of Medicine's recommendation for voluntary error reporting into practice, it is critical that leaders understand human and systems factors in error and develop approaches that provide rewards, recognition, and feedback to support nurses who often serve as the final checkpoint to reduce errors that can harm or kill patients. The Good Catch Program may provide a useful model to assist other organizations with the development of a positive error reporting culture to ensure that patient safety standards are met and patient care and outcomes are continuously improving.

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