High Reliability Organizations

Good Catches & Near Misses

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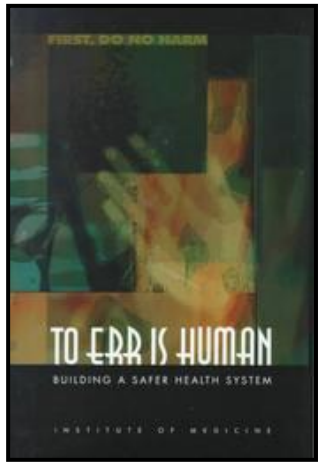
Harm in Healthcare:

"A 747 a Day"

- 1999 Institute of Medicine report:

  To Err is Human

  - 44,000 to 98,000 Americans die annually from medical errors
    - 98,000 = 268 people/day (Boeing 747)
    - 44,000 = 120 people/day (Boeing 737)
- 2001-03: ~300,000 deaths (HealthGrades, 2005)
- 2007-09: ~240,000 deaths (Dept. HHS, 2011)



Hospitals hurt 18 percent of patients, study says

November 25, 2010

The NEW ENGLAND JOURNAL of MEDICINE

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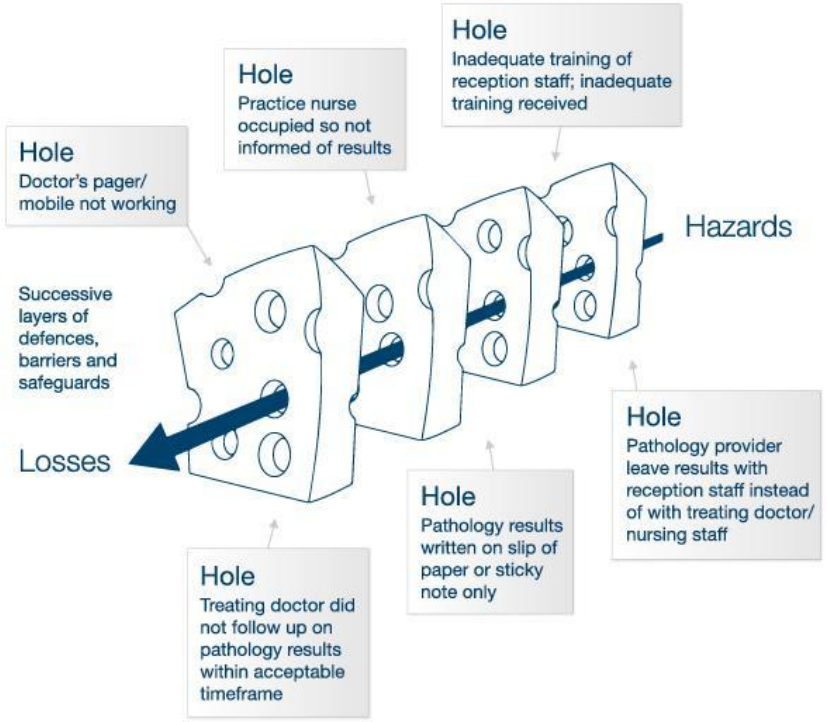
A deviation from Generally Accepted Performance Standards (GAPS) that…

Serious Safety Event
- Reaches the patient
- Results in moderate to severe harm or death

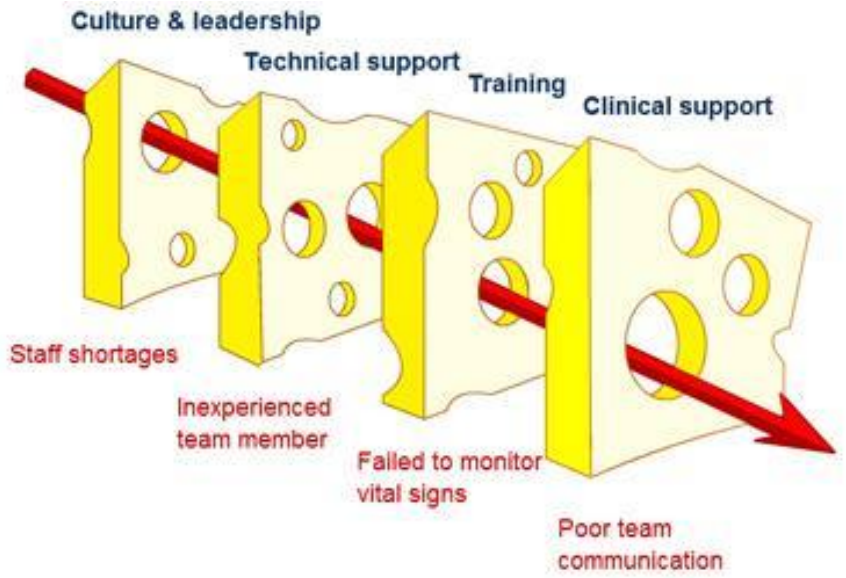
Precursor Safety Event
- Reaches the patient
- Results in minimal harm or no detectable harm

Near Miss Safety Event
Does not reach the patient – error is caught by a last strong detection barrier designed to prevent event

The Swiss Cheese Effect



Some holes due to active failure. Other holes due to latent conditions (resident "pathogens").



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Anatomy of a Near Miss

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Good Catch!

A near miss or a close call is an event that did not reach a patient but only because of chance or timely intervention. It's a good catch and a WIN for patients, staff and hospitals because it presents the opportunity to take corrective action and prevent future risk or harm.

A good catch can be made in any department by any clinician, manager or staff member.

A patient, who regularly takes Coumadin for a clotting disorder, is scheduled for surgery. During a pre-op discussion with the anesthesiologist, the patient reveals he was not aware of instructions to cease taking the medication in the days prior. His surgery is postponed.

A nurse enters a patient's room with a medication to be administered. Upon checking the patient's armband, she realizes she has the wrong medication.

A social worker discovers physician notes showing up in the wrong patients' EHR charts and brings the issue to the attention of the nurse manager who calls in IT to investigate. IT detects a glitch in the EHR's mapping mechanism.

Following surgery, OR staff note a smoldering odor and discover a warming unit that is turned "OFF" but is plugged in and secured to an IV pole and touching the patient bed. Further inspection reveals hot, singed coils and bed linens as well as exposed wires on the back of the warming unit. The device is pulled out of service immediately.

A patient was moved to the OR without Hand-Off of Care being appropriately communicated or documented.

A technician discovers that a patient, deemed high risk for falls, has been returned to a chair without a chair alarm.

Near Miss Reporting is all about LEARNING!

A near miss caught today could prevent an occurrence from happening tomorrow! See one. Report one.

GOOD CATCH

Recognize. Report. Reward.

What if we could stop harm before it happened?

Actually, we can.

Most preventable harm is preceded by a string of related near misses. These close calls are free lessons. They offer valuable revelations of our weaknesses AND strengths -- our opportunities for improvement. That's why making your Good Catches known is so important!

Here's what happens when you identify and report Good Catches.

Staff are supported and empowered to report near misses when they occur.

TRUST BUILDS AMONG STAFF

Data is collected through frontline staff near miss reporting.

LEARNING & SHARING OCCURS

Data is analyzed to identify trends and opportunities for improvement.

Resources are redirected into proactive efforts to fix flawed systems and processes.

ADVERSE EVENTS DECREASE

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GOOD CATCH

Near Miss Reporting: It's all about LEARNING!

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Promoting Good Catches

Figure 2. Good Catch poster

Seattle Cancer Care Alliance

Patient Safety

"Good Catch" Award

- Staff are recognized for these Good Catches through near miss reporting in Patient Safety Net (PSN)
- When reported in PSN, near misses also help the SCCA to learn where gaps in our healthcare delivery system may exist

YOUR ACTIONS HELPED TO PREVENT EVENTS FROM REACHING PATIENTS.
FOR THAT, THE PATIENT AND MANY OTHERS THANK YOU!
SCCA Quality/Patient Safety

Anne Devine, Cancer Navigator:
Assisted a patient who fell on the clinic grounds

Joseph Kim, Alliance Lab Phlebotomist:
Caught and corrected a patient ID discrepancy before it reached the patient

Kerry McMillen, Clinical Supervisor, Nutrition Therapy:
Caught and corrected an ORCA documentation issue

SPOT RECOGNITION

"ON THE SPOT" recipients are selected for their continued vigilance and commitment to patient safety and infection prevention. Winners receive a beautiful certificate (suitable for framing) and a Red Brick Bistro gift card.

MAY SPOT AWARDS

Infection Prevention had the pleasure of awarding two Spot Awards during May. Our Spot Award winners were both staff members who were noted making an exceptional effort towards preventing infection in the SCCA clinic. These small efforts make a big difference! Infection Prevention is all about preventing moments for infection transmission, and every moment truly counts.

Everyone is invited to submit Spot Awards nominations by emailing ip@seattlecca.org.

THE MAY WINNERS WERE:

Leo Riojas *(SLU Imaging Dept)*—Exceptional attention to infection prevention practices in the Imaging Department

Sharon Raschko *(SLU General Oncology)*—Key communication for a patient needing airborne precautions

ALLIANCE ALERT | THE STAFF NEWSLETTER OF THE SEATTLE CANCER CARE ALLIANCE | MAY 2016

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QUESTIONS?

CALL US!

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