Northwell Health®

PATIENT SAFETY NEWSLETTER

Vol. 12: Issue 1 – March 2021

A Publication of the Institute for Clinical Excellence & Quality / Patient Safety

TRUST, REPORT, IMPROVE

Speaking-up & Reporting Near Miss/Good Catch Events Helps Reduce Harm and Promote Safety

Organizations that achieve high reliability, that is, to effectively reduce serious hazards, have emphasized "*safety culture*" as a key factor in promoting excellence in performance. A strong safety culture promotes the identification and reduction of risk as well as the prevention of harm. According to the National Academy of Sciences, errors are treated not as personal failures, but as opportunities to "*improve the system and prevent harm*." A culture of safety that fully supports high reliability has three central attributes: trust, report, and improve.

Quality and safety in healthcare is not just about outcomes. While, we are concerned with the safety events that reach the patient, we also need to focus on Near Miss/Good Catch events. A Near Miss/Good Catch is a patient safety event that did not reach the patient. These events provide valuable data that can assist in setting patient safety priorities and measuring actionable quality improvement outcomes. According to Marella, Director of Patient Safety Reporting for ECRI (2017), quality care and patient safety is dependent on processes and behaviors. It is essential to correct those likely to lead to poor outcomes and reinforce those that are likely to lead to positive outcomes. Studying Near Miss/Good Catch events can prevent errors before they occur. Healthcare professionals shouldn't just worry about keeping their patients free from temporary or permanent harm. Rather, they should be preoccupied with keeping them free from unnecessary risk and adverse events. *(Patient Safety Movement Foundation, Dec 2017)*

Near Miss/Good Catch reporting can be transformed into meaningful data that drives improvement projects with the goal of eliminating harm. Sharing data with front line staff as well as staff across the organization fosters open communication, promotes educational opportunities, and encourages positive change in both policy and practice that can ultimately enhance and shape Northwell Health's commitment to quality and safety.

What can we learn beneath the surface?

A deep dive into Near Miss/Good Catch reporting will reduce risk and improve safety for both patient and employee.

"A culture of safety that fully supports high reliability has three central attributes: trust, report, and improve."
(Patient Safety Movement Foundation, Dec 2017)

Patient Safety Awareness Week – Together we are Better, Stronger, Safer highlights the collective effort of working together to promote Near Miss/Good Catch reporting.

NEVER DISMISS A NEAR MISS

"By building trust and encouraging reporting, leaders empower an organization's most valuable resource – its people – to be always vigilant for hazards in the face of varying conditions." *(Safety I-to Safety II: A White Paper." September 2013)*

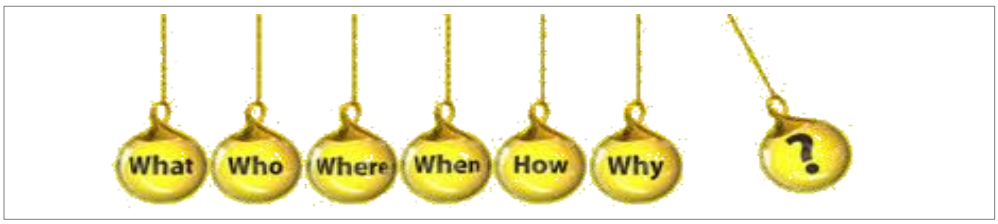
Part of a Culture of Safety is the establishment of psychological safety. The Patient Safety Movement Foundation (2017), states that psychological safety encompasses the creation and maintenance of an environment where staff feel safe reporting issues and near misses, thus preventing harm from ever reaching a patient. In a recent article, The Joint Commission discusses psychological safety as an important determinant of reporting. Organizations that fosters psychological safety may see increased reporting and improve care delivery and patient safety. *(The Joint Commission Journal on Quality & Patient Safety, Volume 47, Issue 1, Jan.2021)*

Guiding Principles provided by the Institute of Clinical Excellence & Quality/Patient Safety's in 2021 will help all team members work towards eliminating all preventable harm and mortality through enhanced reporting. Near Miss/Good Catch reporting is a vital part of the strategic plan.

GUIDING PRINCIPLES

- Patients first, safety always
- The *Six Aims* of the National Academy of Sciences *(formerly the Institute of Medicine)*. Healthcare must be:
  1) Safe
  2) Effective
  3) Patient Centered
  4) Timely
  5) Efficient
  6) Equitable
- Teamwork and open, two-way communication promote a culture of patient safety.
- High reliability is essential for optimal patient outcomes.
- Individuals are going to make mistakes. Expect them and prepare for them.

Near Miss/Good Catch events that are identified and corrected before doing harm are encouraged to be reported which in turn provide a learning experience for the organization and prevent future failures. *(Chassin&Loeb, TJC2013)*



Northwell Health's **improveNorth** Safety Event Reporting System enables all team members to report Near Miss/Good Catch Events using the *Type of Event Decision Tree*.

Reporting Near Miss/Good Catch events is important for these reasons:

- They provide information on active and potential vulnerabilities in healthcare safety systems.
- They are more frequent than events causing harm and provide information about errors from the perspective of health care workers in different positions.
- Analysis of high frequency or high-potential-severity near miss reports makes it possible to identify system opportunities and learn from them in the context of daily workflow or systems use.

Patient Safety Word Search

D O I L Y N Z O N V O G V G X Q N O X X
C N P P A T X F X Y A H G A L B I P B F
V C R E J Z J M A K E L M C C K R R Z F
J A E Q J A P R E V E N T I O N Z G W R
T F V J F I C O M M U N I C A T I O N E
E W E R E S P O N S I B I L I T Y O J P
A Q N A W A R E N E S S G C M H I W B O
M W T O N V M A O R U F A J P G S N C R
W S I Z I C Y E Z P N U U B V O X E O T
O Z O S E N L W L P O S I T I V E R N H
R W N U R I M P R O V E M E N T U S S E
K B C O S Z T V M D A R B Y K X X H C N
L W C F P R O G R E S S Q T Y M V I I G
I N T E R D I S C I P L I N A R Y P O A
T E I K S K N O W L E D G E L G K A U G
R X P E X M A X N A H V L U B Q G B S E
U W R T E O G L U O Z T X G G K P V N M
S P V P C U L T U R E P P M P F R V E E
T E M P O W E R M E N T S A F E T Y S N
P V P S P U R P O S E F U L A D N G S T

Awareness	Engagement	Positive	Responsibility
Communication	Improvement	Prevention	Safety
Consciousness	Interdisciplinary	Progress	Teamwork
Culture	Knowledge	Purposeful	Trust
Empowerment	Ownership	Report	

Look for information on celebrating Patient Safety Awareness Week
(March 14 - 20, 2021)