Encourage Reporting Through A “Great Catch” Program

Background

Near misses are errors caught prior to reaching the patient. Studies suggest that near misses occur as much as 100 times more frequently than serious events.\(^1\) Therefore, these events provide the most fertile opportunity for gathering information that will inform process modification, improve compliance to standard processes, and identify new error pathways. While “near miss” is the term utilized in RO-ILS to align with the federal Agency for Healthcare Research and Quality (AHRQ), practices may want to consider utilizing a more positive term such as a “great catch” when promoting error reporting and learning with staff.

Practices may want to consider developing a formal program centered around this concept to promote reporting and response to near misses. “Great Catch” programs aim to improve safety culture by taking a proactive, non-punitive, just approach to identifying and addressing potentially harmful errors before they reach patient(s) and increase overall safety awareness. This can be accomplished by recognizing and rewarding staff who participate, including staff in the development and implementation of mitigation strategies, and sharing lessons learned.

Three Key Aspects of a Great Catch Program

1. Recognize and Reward Staff for Submitting Near Misses.

Ideas include:

- Thank the person who submits the event (e.g., verbally, via email, card)
- Give a “Safety Champion of the Month/Quarter” award at regular staff meetings.
- Reward staff with prizes (e.g., gift cards, credit to cafeterias/gift shops). This could be for the staff member who identified a great catch or provided exceptional patient care. Alternatively, all staff that reported an event could be entered into a random drawing.
- Be creative in identifying incentives. For example, staff could receive a lapel pin or be given an opportunity to sign institution-specific memorabilia (e.g., basketball) or have their name added to a plaque. These serve as long-standing visual reminders of staff successes and importance of safety work.
- On a regular basis and especially during Patient Safety Awareness Week each March, thank and recognize all staff for their contributions and commitment to making safety a priority.

\(^1\) Wallace, S, Mamrol, & Finley, E. (2017). Promote a Culture of Safety with Good Catch Reports. The Pennsylvania Patient Safety Authority. Sep;14(3)
2. **Ask the Submitter and Frontline Staff for Improvement Suggestions.**

Since frontline staff are often most intimately involved in the processes, they are frequently in the best position to suggest process improvements. This is also a key aspect of getting buy-in for implementing effective change.

3. **Share Great Catches and Safety Success Stories.**

Methods of disseminating information may include:
- Discussion at daily safety huddles and regular staff meetings.
- An internal newsletter.
- A “Great Catch Board”. This is a public display in a secure, staff-only location that is updated on a regular basis. The example below is a practice’s Great Catch Board in their staff lounge but virtual “boards” may be helpful for multifacility practices.

Great Catch Boards might include:
- **Great Catches identified at the practice** (e.g., a brief description of the event, how an error was prevented/caught, and lessons learned). A thoughtful analysis of root causes helps to solidify the non-blaming, just culture. If the practice is comprised of multiple facilities, there could be multiple great catches for each facility.
- **Safety behaviors/principles** (e.g., utilizing the SBAR technique\(^2\) to improve communication).
- **Education from the national RO-ILS program** (e.g., case studies or cases from aggregate reports).
- **Suggestion Area** (e.g., staff suggest solutions to a process issue related to a theme or great catch).

---
\(^2\) Institution for Healthcare Improvement. SBAR Tool: Situation-Background-Assessment-Recommendation. [http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx](http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx)
❖ **Staff Successes.** This area could be utilized to detail improvements to processes in response to events, or data that show the impact of these process changes. Another possibility is to post a photo of the “Safety Champion of the Month/Quarter” with the staff’s permission.

❖ **Important expectations, mottos, or standards for the practice.** It may be helpful to highlight the practice’s commitments to patient safety, culture, and incident learning. For example:

- **To err is human.** We expect staff to be human and for us to develop smart processes to minimize and catch errors.
- There will be **no reprisal** for reporting. We are committed to a just culture.
- When we need a quality intervention, we focus on the **process.** When things are going well, we focus on the **people.** Staff will be celebrated for identifying and helping address error pathways.

Practices may want to select a rotating theme for the Great Catch Board in which the safety principle is related to local great catches and/or national case studies.

With all three aspects of a Great Catch program, there are few important overarching elements – such as timely execution. For example, one practice has made it a habit and expectation that a Reviewer (i.e., designated individual(s) responsible with reviewing internal RO-ILS events) will reach out to the staff member within 24-hours of submitting an event and listing their name as the reporter. Additionally, each practice must be cognizant of their resources, practice size, and current culture. Therefore, the specific tactics will vary between practices. Lastly and most importantly, leadership support and the continuous use of positive language promoting safety behaviors and tools are critical for the program’s success. Effective programs need to create an environment of non-punitive reporting, encourage feedback, and demonstrate results and improvements.

**Benefits**

Great Catch programs promote a culture of reporting and learning and acknowledge staff for their vital role in identifying system or process vulnerabilities before there is an incident. This can help the practice:

- build confidence, especially in staff who are hesitant to report,
- increase morale, respect, and transparency,
- encourage engagement through inclusion,
- demonstrate the value of incident learning,
- identify improvement strategies by tracking and trending opportunities,
- proactively implement risk reduction strategies,
- promote actions that enhance quality and safety practices, thereby motivating safety behaviors.

**Author**

RO-ILS would like to thank Sarah Lombardi, BS, R.T(T), Regional Quality and Safety Coordinator, Smilow Cancer Hospital at Yale New Haven Health for helping author this program education.

**Need Additional Assistance?**

If you have any general questions about the RO-ILS program, please contact roils@astro.org. For specific assistance related to an event, please contact radoncsupport@claritygrp.com or at 708-667-7730.

---