26,000 Close Call Reports: Lessons from the University of Texas Close Call Reporting System

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Abstract

The 26,000 close call reports collected through The University of Texas Close Call Reporting System (UTCCRS)—funded by the Agency for Healthcare Research and Quality and a research project of The University of Texas Center of Excellence for Patient Safety Research and Practice—are described in this article, as well as a unique approach to increase reporting. The UTCCRS system was designed as a voluntary and anonymous reporting tool to collect valuable information about close calls. Information from close call reports informed the development of targeted interventions and ultimately led to the identification and implementation of quality improvement projects. To date, the system has received over 26,000 reports. Initiatives implemented to increase the number of reports included an innovative Good Catch Program[©] based on a baseball theme. This initiative was recently awarded the 2007 National Patient Safety Foundation's "Stand Up for Patient Safety" Management Award.

Introduction

Although error reporting has been widely substantiated in the literature as an integral part of safety programs, barriers to implementation continue despite substantial efforts to increase reporting. Although close call or near miss reporting is recognized as a proactive means of error prediction, an increase in reporting has not been achieved consistently or sustained in many of the piloted or implemented safety programs in health care.[1]

Acquiring, aggregating, and acting on near-miss or close-call reports requires a program of awareness and rewards as demonstrated in the "Good Catch Program." In the experience of this program, a concerted effort to raise awareness is necessary. The Good Catch Program was established in the organizational culture by relating the reporting process to an easily understood, common, and non-threatening sporting event.

In a 2004 patient safety article, Edmondson wrote, "Organizations that systematically and effectively learn from the failures that occur in the care delivery process, especially from small mistakes and problems, rather than from consequential adverse events, are rare."[1] The timely review and rating of close calls can provide valuable diagnostic information for insight into a system's vulnerabilities, facilitate the identification of areas for system improvement, and enable rapid systematic correction.[2, 3, 4]

The University of Texas Close Call Reporting System (UTCCRS)[5] was established within the Institute for Healthcare Excellence at the University of Texas M.D. Anderson Cancer Center to

facilitate a proactive approach to preventing errors. The initial low volume of reports submitted by employees was recognized as a barrier to learning from the system. A creative, effective strategy was needed to engage employees in reporting close calls.

Methods

A literature search was conducted to identify strategies to significantly increase reporting. Topics identified from the literature search incorporated into the program design included understanding the role of microsystems within organizations and the importance of engaging frontline employees in safety reporting, understanding why employees do and do not report, identification of essential educational components to facilitate employee participation, the role of executive leadership participation in the program, the feedback process, and employee recognition.

The Importance of Microsystems

Poniatowski and colleagues[6] described organizations as macrosystems that are built upon many interrelated microsystems. Most actual or potential errors in a hospital setting, which directly affect patient care outcomes and negatively affect patient safety, likely occur at the microsystem level.[7, 8] Therefore, to capture safety concerns at the time they are identified, it would be necessary for the program to engage frontline employees of inpatient nursing units as reliable sources of information.[9, 10, 11] However, acquiring reports from the microsystem level has been hindered by several factors. A study of nurses' medication error reporting revealed four factors that explain why employees may not report errors: (1) fear, (2) disagreement over whether an error occurred, (3) administrative responses to errors, and (4) the effort required to report an error.[12]

Fear

In order to overcome employee fears and concerns associated with reporting, a culture of trust must be promoted within an organization.[7, 8, 9] This can best be accomplished by eliminating the possibility of assigning blame or initiating disciplinary action related to reporting.[7, 13, 14, 15] Employees must be made to feel safe to report so that safety concerns can be identified and the systems can be strengthened.[10, 16, 17]

In close call reporting, employees are asked to report situations for which they have already effectively intervened to prevent error. The definition of a close call, as found on the reporting tool, is "a situation that does not cause harm nor reach the patient."[5] The UTCCRS was designed as an anonymous reporting system to protect employees' identity.[13] Reports are screened outside the hospital's risk and quality department by an impartial third party group of experts. Names, room numbers, medical record numbers, and any other identifying information are scrubbed from reports (if they have been entered by an employee). The system does not allow individual reporters to be identified or contacted. However, when a report is entered, a unique tracking number is automatically generated. The employee can use this unique tracking number to re-access the system and review followup notes if they desire feedback (Appendix 1).

Defining Actual and Potential Errors

To ensure that appropriate information would be submitted to UTCCRS, it was important to clearly define close calls ("Good Catches") in the educational component of the program. Hritz, et al.,[18] recommended that reporting systems and improvement interventions continually focus on building an awareness of the occurrence of errors through identification and reporting. To address this recommendation, examples of reports that demonstrated the differences between actual and potential errors were developed, and a list of potential error examples was created as a reference tool. The educational plan incorporated the instruments as exemplars and handouts.

The Importance of Executive Leadership Support

Initiatives led by hospital executives to improve an organization's culture of patient safety can result in a profound and lasting change in the organization's safety culture.[19, 20] Leaders need to visibly guide and support staff through reporting systems that involve recognition and rewards.[21] Therefore, mechanisms for administrative leaders to show support and motivate employees are essential to the Good Catch Program. Continual recognition of progress, shared safety success stories, and celebrations of achievements were incorporated into the program design. Building recognition and reward from executive leaders, including associated financial support, was therefore identified as another important program component.

Recognition of employees' personal ability to effect change was also identified. Plans to recognize patient safety champions with safety award certificates and "Most Valuable Player" (MVP) recognition were included in program design. This was recognized as a needed improvement based on feedback from employees and executives after the original launch of UTCCRS. Barriers and interventions to surpass them are summarized in Table 1.

The Good Catch Program

A baseball theme was used to organize inpatient nursing units into teams and group them in one of four Divisions of an Inpatient Nursing League. A report accepted into the UTCCRS resulted in a point for the team. A unit code generated points for each team, while maintaining the reporter's anonymity. The team and "game" approach engaged frontline staff in a fun, friendly competition on inpatient nursing units as they reported Good Catches identified in daily practice.

As each team joined the league, unit-based in-services were provided using a PowerPoint™ presentation and handouts that included definitions and examples of close calls. Information provided during the educational sessions included definitions of safety and preventable harm; descriptions of a systems view of errors; theories and perspectives about errors in health care; description of UTCCRS with instructions for entering data; and examples of advances in patient safety and human factors in design.

To maintain the program's baseball theme, close calls were renamed "Good Catches." Each unit decided on a team name, and representatives from each team served on a workgroup that met as needed to address "game" strategies. Creative team names included: SCRUBS: Safety Created Regularly & Uniformly by Staff; PEDI: People Effectively Decreasing Incidents; OOPS: Outstanding Outcomes in Patient Safety; The Hazard Hunters; STOPS: Staff Thinking of Patient Safety; and The Awareness All-stars.

Table 1. Summary of barriers and interventions

Identified potential barriers to reporting	Intervention
Microsystems within macrosystems	• Use of the baseball theme to organize units into "teams" to engage frontline employees in the reporting process. • Acknowledgment of "patient safety champions," "most valuable players" on each team. • Promotion of the important role of employees on the frontline of patient safety.
Historical fears of discipline or reprisal for reporting errors	• Changing terminology from near miss or close call to "Good Catch" • Engaging team members in a fun, friendly competition as they report identified safety concerns in daily practice. • Asking unit team members to choose a team name. • Providing positive feedback to assure teams that a higher submission volume of potential error reports demonstrates a greater focus on patient safety. • Providing story-boards for employees to share their experiences with the "Good Catch Program." • Encouraging employees to take credit for all interventions for patient safety. • Promoting a fair and just culture for error reporting.
Differing definitions of actual and potential error	• Providing unit-based in-services. • Providing definitions and examples of actual and potential errors.
Time/effort required for error reporting	• Implementing the End-of-shift Safety Report. • Giving demonstrations of entering reports in CCRS so it can be viewed as a user-friendly database. • Recognizing employees' individual, personal abilities to initiate changes that reduce error by reporting. • Promoting "the power of data." • Awarding one point to a team for every submitted report.
Lack of administrative support	• Enlisting the VP of nursing as the "Inpatient Nursing Good Catch League Commissioner." • Enlisting directors as "coaches" for each division of teams in the "Good Catch League." • Arranging unit visits by executive leadership. • Delivering "Safety Champion Award" certificates signed by executive leaders. • Securing administrative budget approval for "Good Catch" pins and other incentives for team members. • Providing a pizza party for winning teams in each "game" (timeframe).
Lack of feedback about what is being done with submitted reports	• E-mailing weekly "Good Catch Scoreboards." • Publishing updates/progress reports each week in Nursing Newsletter: Reporting themes and action plans to assure time taken to report has been worthwhile. • Providing access codes for employees to locate action plans related to their report submissions.

Quality Improvement Department representatives and administrators of the UTCCRS were included as workgroup members. Team representatives were assigned the important position of Patient Safety Champion and were given responsibilities to facilitate communication of program information to their team members. Weekly scoreboards were e-mailed to representatives for posting on the units. A friendly competition between units was promoted by encouraging team members to submit reports and earn points for their team.

The team in each Division that entered the greatest number of Good Catch reports during a "game" was recognized in the institution's Nursing News & Information weekly newsletter and awarded a pizza party. In addition, MVPs were identified on each team, and each received a patient safety champion award certificate signed by executive leadership. An Inpatient League World Series is currently in the planning stages. The World Series event will provide a forum for organizational level recognition of employee participation in the Good Catch safety initiative.

Executive Leadership Support

The Vice President of Nursing served as the Inpatient League Commissioner to ensure that executive leadership was provided. Four department directors served as head coaches for each Division to enhance visible administrative support for the program. Every 6 months, a new Division of four to five nursing units was formed. Education and mentorship were provided for all team members until all four Divisions were participating in the program.

The Vice President of Nursing visited each unit approximately 4 months after they joined the program and distributed Good Catch pins to participating team members. Team members prepared patient safety storyboards and shared information about the different types of Good Catches. Several teams had t-shirts made with a team logo and wore baseball caps during the unit visit. One team decorated the staff lounge as a dugout. In addition, incentives for nurses (e.g., "Safety Awards") were sponsored and promoted by executive leadership to acknowledge individual nurses as patient safety champions during each 6-month game.

Results

The University of Texas Close Call (UTCCRS) reporting system was launched at The University of Texas M.D. Anderson Cancer Center in May of 2003. Dissemination activities included various intranet and e-mailed notices and articles and brief in-services on participating units. In October 2005, the system was opened to all units and became part of the in-service information given to all employees. A single portal icon (named "Safety Reports") was placed on all computer desktops to allow users to access either the online incident reporting system or to report a close call through UTCCRS.

The Good Catch program was piloted on five acute care units beginning December 12, 2005. Between December 2005 and July 2007, 25,921 reports were received, with a dramatic increase in reporting ocurring each time a "season" began or new leagues opened. Each season runs from January to June and from July to December (Figure 1).

Categories Reported in Good Catch

The reporting categories in UTCCRS are not mandatory; the reporter can choose one category or many categories or even not to categorize. The total count of categories (26,622) was higher than the total number of reports received (25,921) because reporters chose several categories in some reports (Figure 2).

Contributing Factors

The contributing factors list in the UTCCRS was developed in an extensive consensus-building exercise as the system was developed[13] (Appendix 2). The total count of factors identified in Figure 3 (29,273) is greater than the total number of reports received (25,921) (Figure 1) because there are no mandatory reporting fields, and reporters might have chosen more than one (Figure 3).
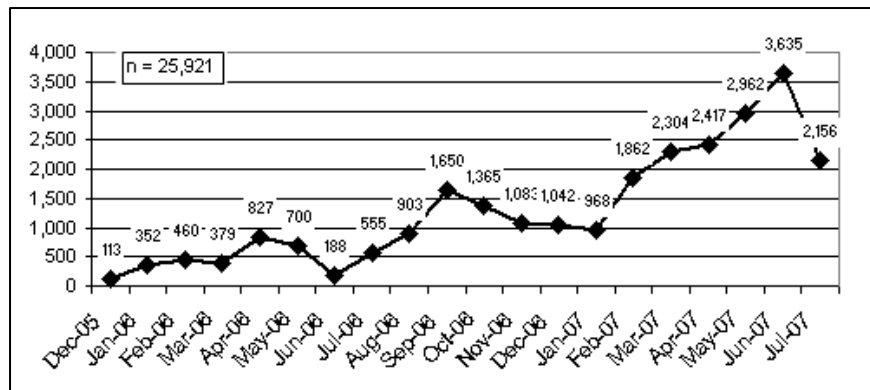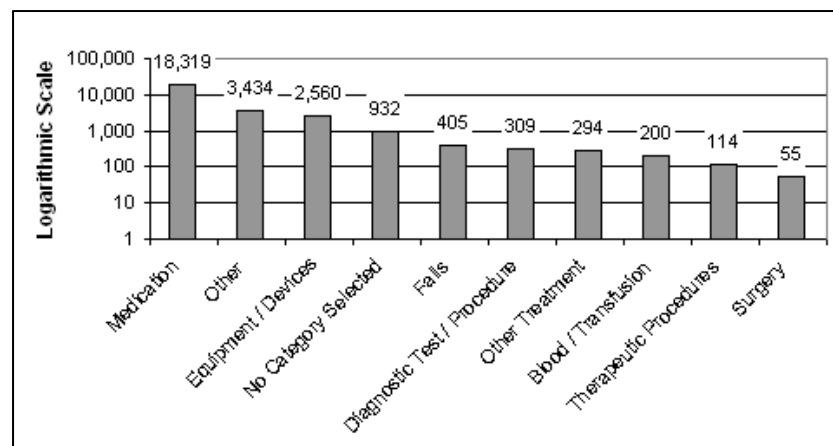

Figure 1. UTCCRS "Good Catch Report," count by month: December 2005 – July 2007.

Conclusion

Sensemaking of Good Catches

Battles, et al., described safety data as requiring "sensemaking" conversations based on data acquired from detection tools, such as reporting mechanisms.[22] Sensemaking also assists in categorizing and prioritizing the risk knowledge that comes from reported events. This essential component of an organization's safety plan is necessary to create a proactive culture and proactive intervention for safety.[10] Close calls—or

Figure 2. UTCCRS "Good Catch Report," count by category: December 2005 – July 2007.

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good catches—are included in the safety data that contribute to an institution's safety plan and interventions.

Aggregating themes from the Good Catch Program has informed several quality initiatives. The Good Catch program has generated a number of safety interventions based upon collected data and the "sense" made of these reports. Many of the reports provided data that confirmed

Figure 3. UTCCRS "Good Catch Report," count by contributing factor: December 2005 – July 2007.

systems mechanisms were in place to prevent actual errors from occurring. Examples of system error prevention mechanisms include: medication administration record (MAR) reconciliation; 8-, 12-, or 24-hour chart checks; and increasing double-checks on reported high-alert medications. Multidisciplinary teams have utilized good catch data to generate short- and long-term quality improvement projects.

In a health care organization, a large collection of good catches provides challenges. The first challenge is to familiarize the organization with the volume, purposes, and nature of safety reporting. The number of reports is daunting when each one is considered individually, and certainly few organizations maintain the resources to respond equally to each report. Battles, et al., describe the analytical tools necessary to assist staff working with such data to "overcome the limitations of the individual mind" so sense can be made of larger data sets.[22] After "sense" has been made, the challenge is to provide interventions based on such reports, so that changes can be made to reduce system-level vulnerabilities found in the data.[10]

Challenges

Initially, many of the teams expressed concerns by questioning whether a high number of good catches might "look bad" for a unit. Positive feedback was provided to assure teams that higher numbers of submitted reports supported a greater focus on patient safety. Also, because historically reports were submitted only when an actual error had occurred, a "change in thinking" was required. Some teams raised questions about why units with more submitted reports were being recognized, while units that just "fixed" concerns but did not report them were not being rewarded. This question provided the opportunity to educate employees that although they continually intervened to ensure safe care, the "fixes" needed to be reported so that systems issues could be identified and addressed.

Program coordinators and administrative leadership affirmed that positive recognition was being provided to units that were submitting a high volume of reports. Reports were communicated as "nursing interventions for patient safety" and close call reporting was promoted as an opportunity for employees to document their important role in the front line of patient safety.
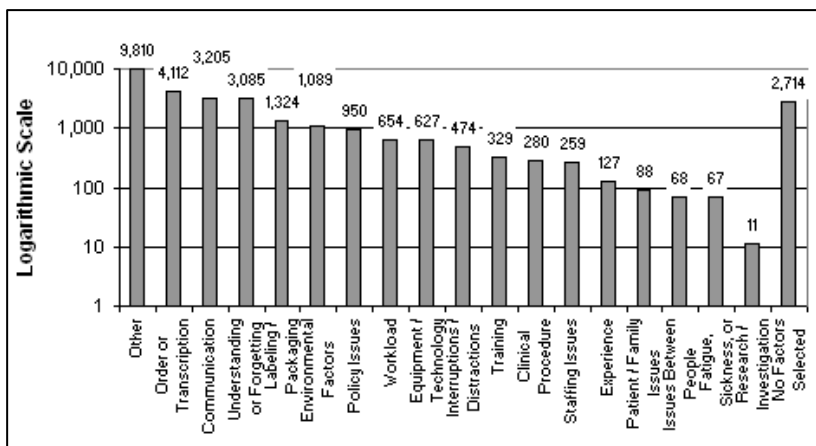
By successfully increasing the numbers of reports submitted to the University of Texas Close Call Reporting System, the Good Catch program has provided a supporting mechanism for the organization to systematically and effectively learn from safety interventions implemented on the front line. Gaining insight about areas of potential vulnerability has allowed the organization to be proactive with interventions to eliminate risk for potential errors and to decrease the possibility of an actual error occurring. Each Good Catch has contributed to safer patient care.

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Appendix 1

Close Call Reporting System Features List

Close Call Gathering:
- Allows hospital employees a place to anonymously report close calls that they witnessed, took part in, or simply heard about.
- Employee can enter suggestions on how to prevent this close call from happening in the future.
- Employee can track the progress of his or her report through a system-generated tracking number and password that only the employee can access.
- A qualifying question will be asked before reports are entered to detect any occurrence that actually reached the patient; in that case, the employee will be redirected to a form or process defined by each participating hospital.

Reports:
- Reports entered from any hospital will be available to the administration of that hospital only.
- Each participating hospital will be assigned a secure Web site for administrators to receive statistics on reports entered from their hospital and do a comparison to all reports entered.

Quality Assurance:
- Each report entered is reviewed by a member of the Close Call Reporting System project team within 24 hours.
- Any staff names or ID numbers, patient names, or medical record numbers are removed from records.
- If a report is found to have data that actually indicate that the occurrence did reach the patient, a designated contact for that hospital will be contacted immediately.

Compliance:
- System complies with all Americans with Disabilities Act (ADA) requirements.
- System complies with all HIPAA mandates as followed by the University of Texas system.
- Some customizations can be made for each participating location to assure localized compliance.

Security:
- System is set up on dual servers (separate database and Web servers) with the database placed behind a secure firewall.
- System is monitored 24/7 for unauthorized access or "hacking" attempts.
- System is protected by the most up to date virus protection available.
- System has internal monitors set to page support personnel should there be a system failure.
- Regular backups of the data are performed

No.

The University of Texas Close Call Reporting System

Please do not write any identifying information on this form. This report is intended to be anonymous.

I understand the purpose of this study and I have decided to participate in this research project. I understand that I may refuse to answer any (or all) of the questions in the below reporting system. By answering any of the following questions, **I am giving my implied consent to participate in this study.** Please enter your institution code in the space below.
Institution Code: _____

If you would like to track the progress of this report, please write down or remember the report number in the upper right-hand corner of the this page and enter it in the "Track a Report" section of www.utccrs.org.

Was the action caught before it was carried out and could reach the patient? ☐ Yes ☐ No
If your answer is NO, please do not use this form to report this situation.

Part A. Close Call Information Please answer as many questions below as possible.
Date of Close Call _____ (mm/dd/yy) Time of Day Close Call Occurred _____ am / pm
Location of Close Call _____
How did you become aware of the Close Call   ☐ Involved   ☐ Witnessed   ☐ Heard About It
☐ Other_____

Part B. Reporter Information
What is your current profession?   ☐ Dietician   ☐ Licensed/Registered Nurse   ☐ Pharmacist
☐ Physical Therapist   ☐ Physician   ☐ Physician Assistant   ☐ Radiology Technician
☐ Respiratory Therapist   ☐ Other_____
How many years have you worked in this profession? _____ years
How many years have you worked at this institution? _____ years

Part C. Description of a Close Call
Please describe the close call in as much detail as possible. Please DO NOT identify any patients or employees by name, medical record number, or employee ID.
_____
_____
_____
_____
_____
_____
_____

Please provide any suggestions for how we may avoid this close call in the future.
_____
_____
_____
_____
_____
_____

Part D. Type of Close Call
Please place a checkmark next to each term that applies to this particular close call. If the listing below does not contain the type of close call you are reporting, please check "Other" and provide a descriptive word or phrase that best describes this close call.
☐ Medication   ☐ Blood /Transfusion   ☐ Falls   ☐ Equipment/Devices   ☐ Surgery
☐ Diagnostic Test/ Procedure   ☐ Therapeutic Procedures   ☐ Other Treatment
☐ Other_____

Continued on other side

Part E. Close Call Contributing Factors Please place a checkmark next to the factors that may have contributed to this close call. If the listing below does not contain the factor you want to report, please check "Other" and provide a descriptive word or phrase that best describes this close call. Please checkmark ALL sentences that were associated with the close call.

Clinical Procedure Issues
☐ complex procedure
☐ new procedure
☐ procedure was not standard practice
☐ other_____

Environmental Factors
☐ tight space interferes with tasks
☐ poorly organized area
☐ noisy area
☐ area is too hot or too cold
☐ slippery floor
☐ area is not well lighted

Equipment/ Technology Issues
☐ equipment not available when needed
☐ equipment malfunctioned during use
☐ incorrect or unclear directions for equipment
☐ poorly designed equipment
☐ equipment was programmed incorrectly
☐ date for use on the equipment had expired
☐ did not have correct accessories for equipment
☐ equipment was a new model which was not familiar
☐ other_____

Communication
☐ someone could not clearly hear the person talking
☐ could not understand communication due to a language difference
☐ information not received because of a technical breakdown (e.g., phone, fax, or email)
☐ inappropriate or unclear directions
☐ illegible handwriting
☐ not enough information available to make a decision
☐ incorrect information
☐ missing information
☐ information not available when needed
☐ patient record not adequately or correctly documented

Order or Transcription Issues
☐ incomplete order
☐ unclear order
☐ order needed correction
☐ order needed additional authorization
☐ order deleted in error
☐ order not transcribed
☐ order transcribed incorrectly
☐ order keyed into computer incorrectly
☐ other_____

Research /Investigation Issues
☐ patient did not have complete informed consent
☐ patient not registered on the research study
☐ prescriber not authorized under the research protocol
☐ procedure not authorized under the research protocol
☐ other_____

Training Issues
☐ inadequate training on procedure
☐ inadequate training on equipment
☐ incorrect training
☐ incomplete job orientation
☐ additional training needed
☐ other_____

Patient/ Family Issues
☐ patient received unclear information about care
☐ patient did not follow instructions
☐ uncooperative patient
☐ uncooperative family /caregiver
☐ family/caregiver did not follow instructions
☐ other_____

Fatigue, Sickness or Stress
☐ fatigue or being tired
☐ not feeling alert
☐ sick or injured
☐ stress
☐ emotionally distress
☐ other_____

Workload
☐ several patients with a high acuity level
☐ too many admissions/discharges
☐ several complicated patients
☐ emotionally demanding patients and family members
☐ working on several tasks at the same time
☐ working on other tasks in addition to patient care responsibilities
☐ other_____

Issues Between People
☐ strained interactions between workers
☐ not wanting to challenge a person in authority
☐ not having the right to question a superior
☐ fear of being reprimanded if asking for clarification or more information
☐ unclear team assignment
☐ hesitate to take responsibility because of the presence of other team members
☐ someone else should have been responsible for this
☐ no one took charge of the situation
☐ other_____

Experience
☐ asked to work beyond credentialing or certification
☐ new member on the team
☐ recently started working at this institution
☐ have never seen or heard about this before
☐ other_____

Interruptions/Distractions
☐ distracted
☐ interrupted
☐ several emergencies happening at the same time
☐ other_____

Policy Issues
☐ patient did not have complete informed consent
☐ missing policy
☐ policy conflicted with another policy
☐ policy not followed
☐ unclear policy
☐ other_____

Labeling/Packaging
☐ incomplete label
☐ incorrect label
☐ damaged label
☐ damaged package
☐ package looked similar to another product
☐ product name on label looked or sounded like another product
☐ other_____

Staffing Issues
☐ no one took charge of the situation
☐ team lacked adequate supervision
☐ workload not well-distributed across available staff
☐ wrong types of team members available
☐ not enough staff on duty
☐ problems scheduling appropriate staff
☐ too many new staff on duty
☐ other_____

Understanding or Forgetting
☐ not following up on an issue
☐ not paying attention because this event always occurs
☐ this had been reported before, but nothing had been done about it
☐ decision made based on limited information
☐ knew about this at the time, but it slipped someone's mind
☐ misheard something
☐ misinterpreted a written or verbal instruction
☐ misread something
☐ overlooked an important detail
☐ thought it was a routine situation, but it was not, and required a different response
☐ happened many times before, but have become accustomed to it occurring
☐ other_____

Thank you for submitting a report using the UTCCRSI

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