‘Good Catch’ Initiative
Promoting reporting of medication safety near misses

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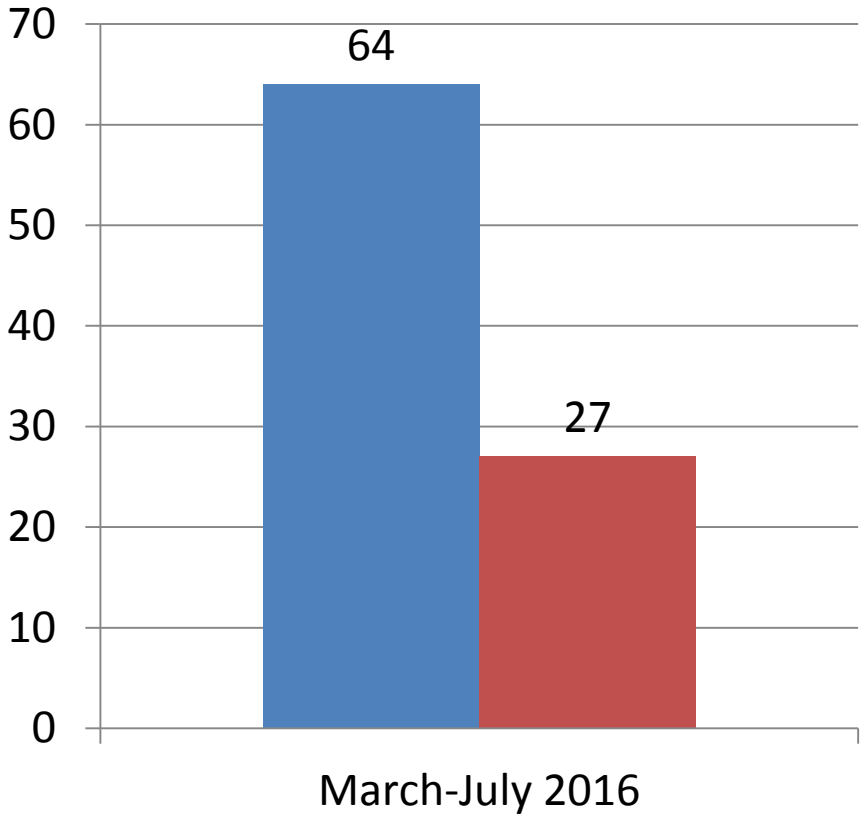
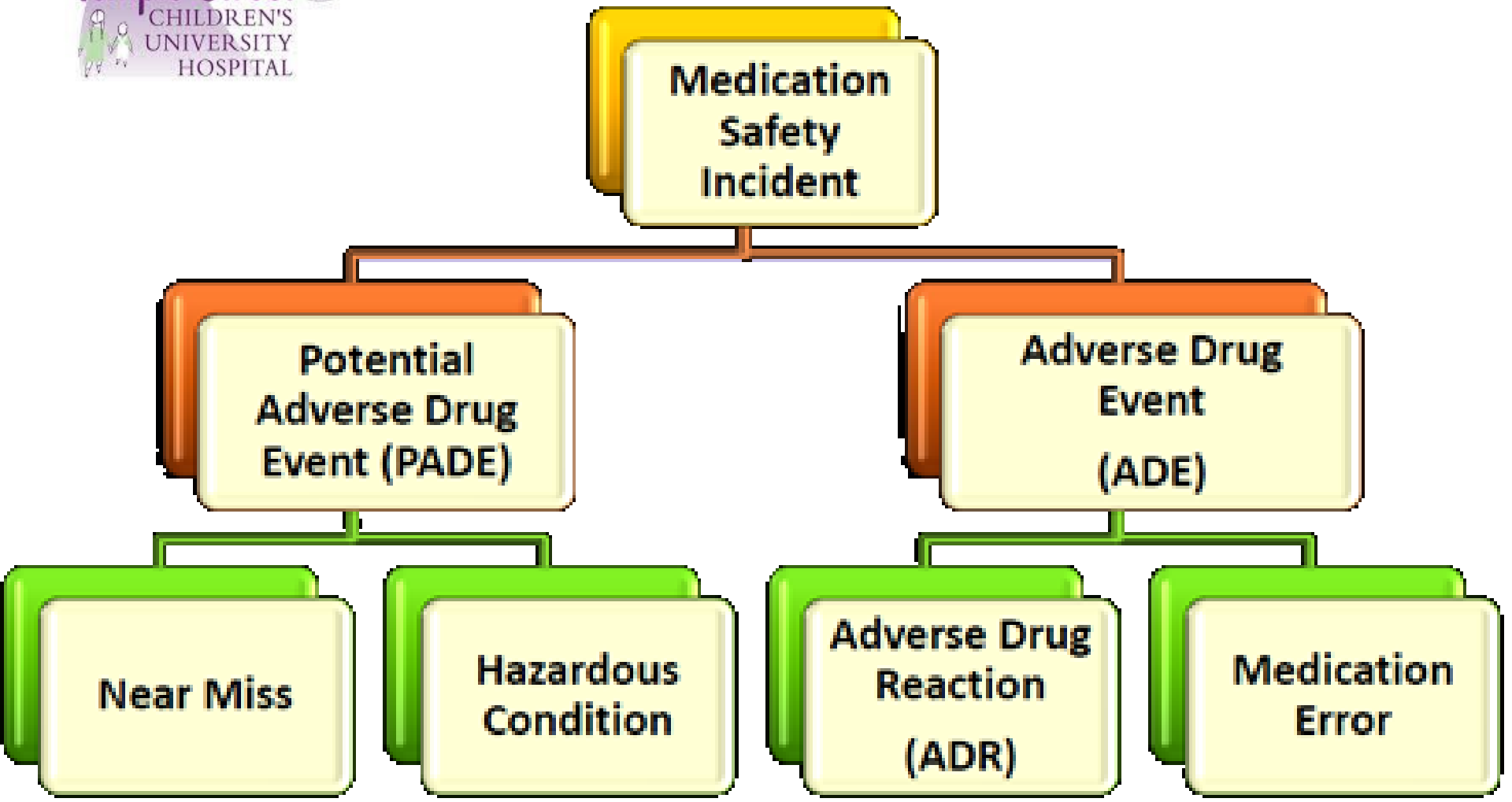


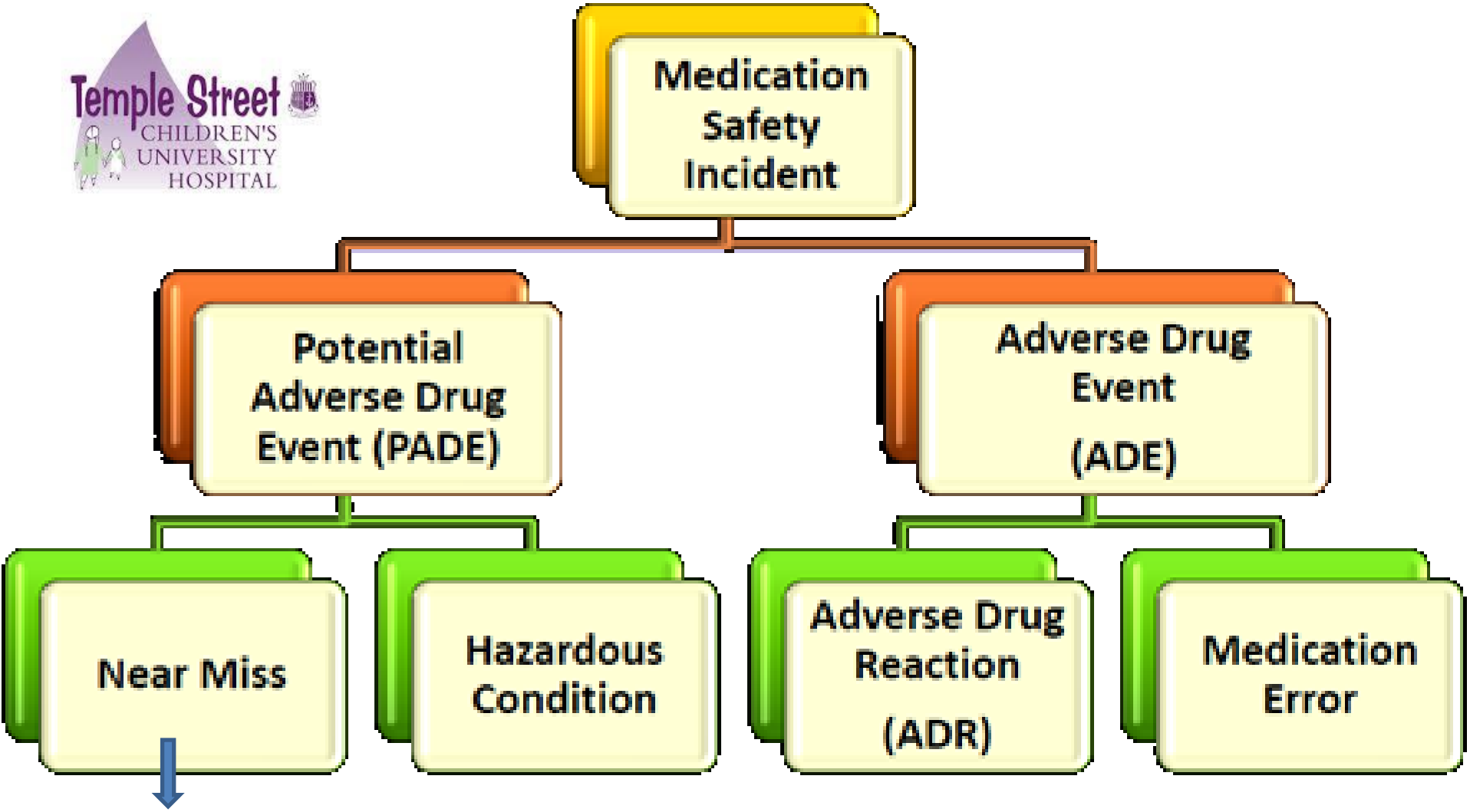
"We have very few near misses"

19,751 Admissions (day cases and inpatients)

Temple Street CHILDREN'S UNIVERSITY HOSPITAL



Temple Street CHILDREN'S UNIVERSITY HOSPITAL



never reached the patient

or

reached the patient but did not cause harm

Background

Problems

- Passive surveillance
- Under-reporting common

Aim

- Assess barriers to and promote increased reporting of near misses

Barriers

- Difficulty navigating through RESPOND reporting system, requiring information not readily to hand
- Length of time to complete report: minimum of 8 minutes per case
- Assumption that another staff member would complete the report
- Lack of feedback on submitted reports

Actions taken

1. Medication Safety Working Group
2. Paper-based alternative developed & launched April 2017
3. Simple ‘tick the box’ design, 1-2 minutes to complete
4. Low cost with booklet placed on all wards & in the res
5. Near misses rebranded as good catches
6. Form anonymised
7. NCHD and Nurse champion

Form

Temple Street Children's University Hospital
MEDICATION SAFETY REPORT FORM

Affix a Patient Identification Label

Patient Name:

Hospital Number:

Date of Birth

Consultant: Speciality:

Date of Report (DD/MM/YYYY):_____

Date of Incident (if different): _____

Time of Incident (24 hr clock):_____

Ward/Dept: _____

Grade of person reporting incident_____

CATEGORY OF EVENT

Actual ❑ Good catch (Near miss) ❑

STAGE OF PROCESS WHERE EVENT OCCURRED

Prescription ❑ Ordering/Supply ❑ Dispensing ❑ Administration ❑ Storage ❑ Monitoring ❑

TYPE OF EVENT

Adverse Drug Reaction (ADR)	❑	Incorrect storage	❑
Allergic reaction to known allergen	❑	Incorrect time	❑
Contraindication to use of medication	❑	Incorrect patient weight / BSA / BMI recorded	❑
Drug omission (no. of episodes.....)	❑	Infusion pump incident	❑
Drug Security issue	❑	Interaction: (Drug – drug, drug-food)	❑
Expired drug	❑	IV infusion problem (diluent type / volume, rate of administration)	❑
Incorrect anatomical site	❑	Medication on admission / transfer / discharge incorrect	❑
Incorrect diluent / method of reconstitution	❑	Monitoring issue	❑
Incorrect dose (over/under/extra)	❑	Non-compliance with hospital policy	❑
Incorrect drug / drug formulation	❑	Therapeutic duplication	❑
Incorrect duration of treatment	❑	Unauthorised self-administration / administration by parent	❑
Incorrect frequency	❑	Unclear / incomplete documentation	❑
Incorrect patient	❑	Unclear / incomplete / incorrect dispensary labeling	❑
Incorrect route	❑	Unclear / incomplete prescription	❑
Other (please specify)			

Description of Event / Good catch (near miss)

OUTCOME

Did event result in harm (e.g. pain, injury, development or worsening of symptoms? Yes ❑ No ❑ Uncertain ❑

Details:

ACTION

Was action required to treat the patient? Yes ❑ No ❑

Antidote administered	❑	Oxygen	❑
Drug therapy	❑	CPR administered	❑
Laboratory tests performed	❑	Intensive care	❑
Observation of vital signs increased	❑	Reported to HPRA	❑
Other (please specify below)			❑

PERSONS INFORMED

Consultant / Team	Yes ❑	No ❑	Not Applicable ❑	Doctor notified _____ Bleep no____
Patient/Parent aware	Yes ❑	No ❑	Not Applicable ❑	Informed by _____
Nursing admin	Yes ❑	No ❑		Person informed _____
Documented in the health care record	Yes ❑	No ❑		

CONTRIBUTING FACTORS

Identify any apparent contributing factor(s) to event			
Calculation error	❑	Medication not cancelled	❑
Communication factors	❑	Medication unavailable	❑
Documentation error	❑	Multiple kardexes for patient	❑
Drug look-alike/sound-alike confusion	❑	Order misinterpreted/misread	❑
Equipment malfunction	❑	Procedure/policy not available	❑
Illegible/unclear prescription	❑	Procedure/policy not followed	❑
Information missing on prescription	❑	Transcription error	❑
Knowledge/skills deficit	❑	Work environment factors	❑
Other (please specify):			

MEDICATION(S) INVOLVED

Generic name(s): *(e.g. prednisolone)*

Brand name(s) if applicable: *(e.g. Deltacortril)*

Strength(s) /concentration (s); dosage form (s); route(s): *(e.g. 5mg tablets po)*

Batch Number: **Expiry Date:**

(Batch no. and Expiry Date are required if reporting an adverse drug reaction or a flaw with a particular medication)

INFUSION PUMP DETAILS

Brand/Make of pump: **Other:**

Pump Asset No: **Other:**

Has Clinical Engineer been notified? Yes ❑ No ❑

Name of Reporter _____ Contact phone number/bleep/e-mail _____

Note: Name of reporter and contact details are optional; however it can facilitate follow-up and feedback if they are provided.

ENTERED ON RESPOND Yes ❑ No ❑ RESPOND REF NUMBER_____

If applicable, please describe any follow-up or actions identified or taken to reduce the chance of this incident recurring. Do not delay submission of report to complete this section - action taken can be notified at a later date.

Please fill out the form as completely as possible, and send in confidence (by hand, internal mail) to: The Risk Management Department. The Risk Manager may be contacted on extension 1800 or at paula.day@cuh.ie

Official Use Only

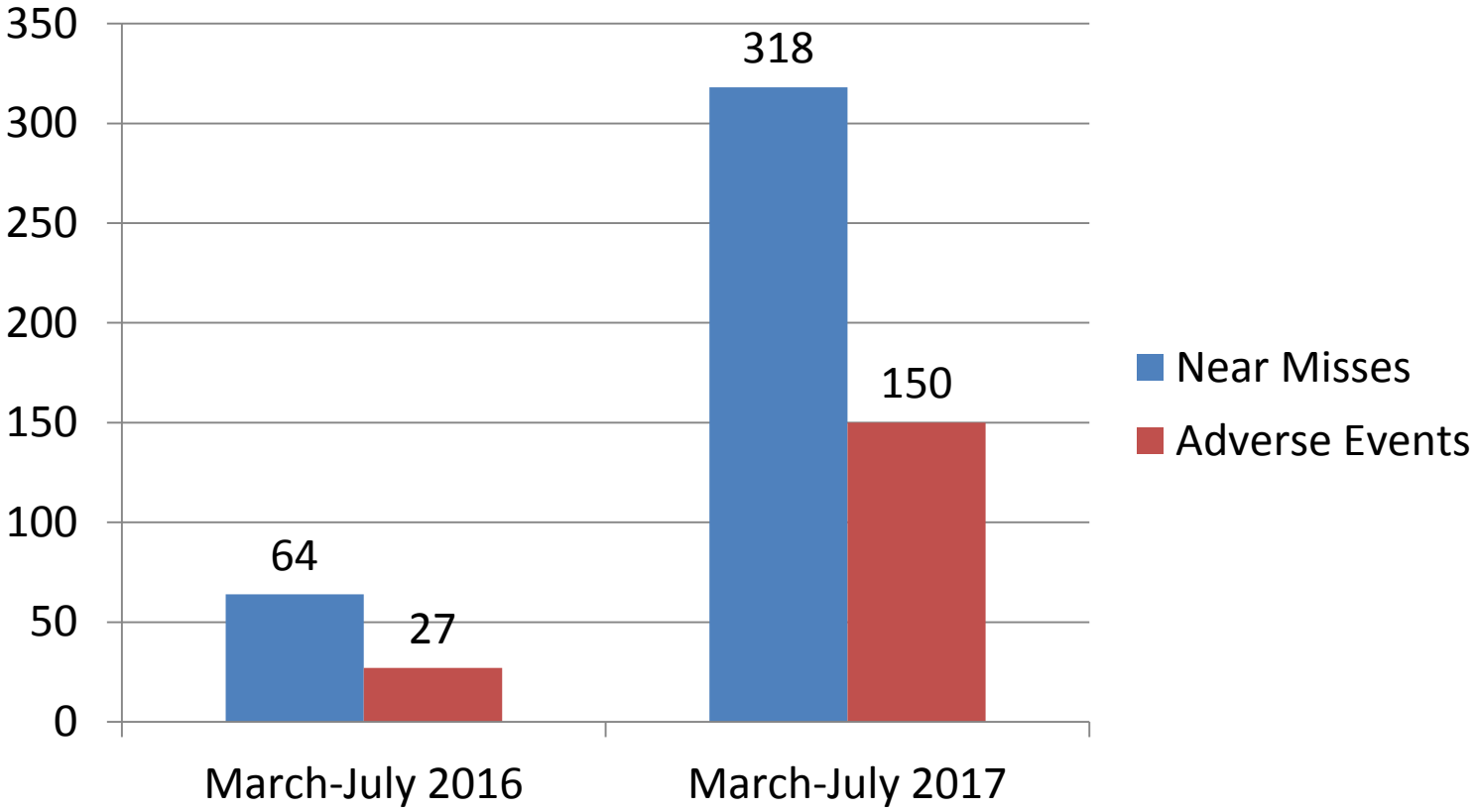
Date received:_____

NCCMERP Category:_____ Nursing Administration Notified:_____

Severity_____ CIS Notified_____

Likelihood of recurrence_____

Results


350
300
250
200
150
100
50
0
64
27
318
150
March-July 2016
March-July 2017
Near Misses
Adverse Events

Sustainability

- Feedback
- NCHD champion
- Redesign of online reporting module
- Still under-reporting?
- Consider high risk medications card
- New Clinical transfer task module within Clinical portal linked to BNFc and Crumlin formulary
– Warning box for high risk medications

Thank you…

To the incredibly amazing team at Temple Street

- Caroline O’Connor
- Reena Patel
- Paula Day
- Karen Cunningham

Tips

- You are not alone
- Think small to go big
- Front line ownership is key
  - Engage the engaged
  - Try and win over the middle group
  - Recognise some people will never come along….
- It’s good to fail, but pick yourself up…
- Don’t be hard on yourself
- Remember you are here to advocate for NCHDs
- Don’t forget interns and non-scheme trainees