We are committed to building a culture of safety.
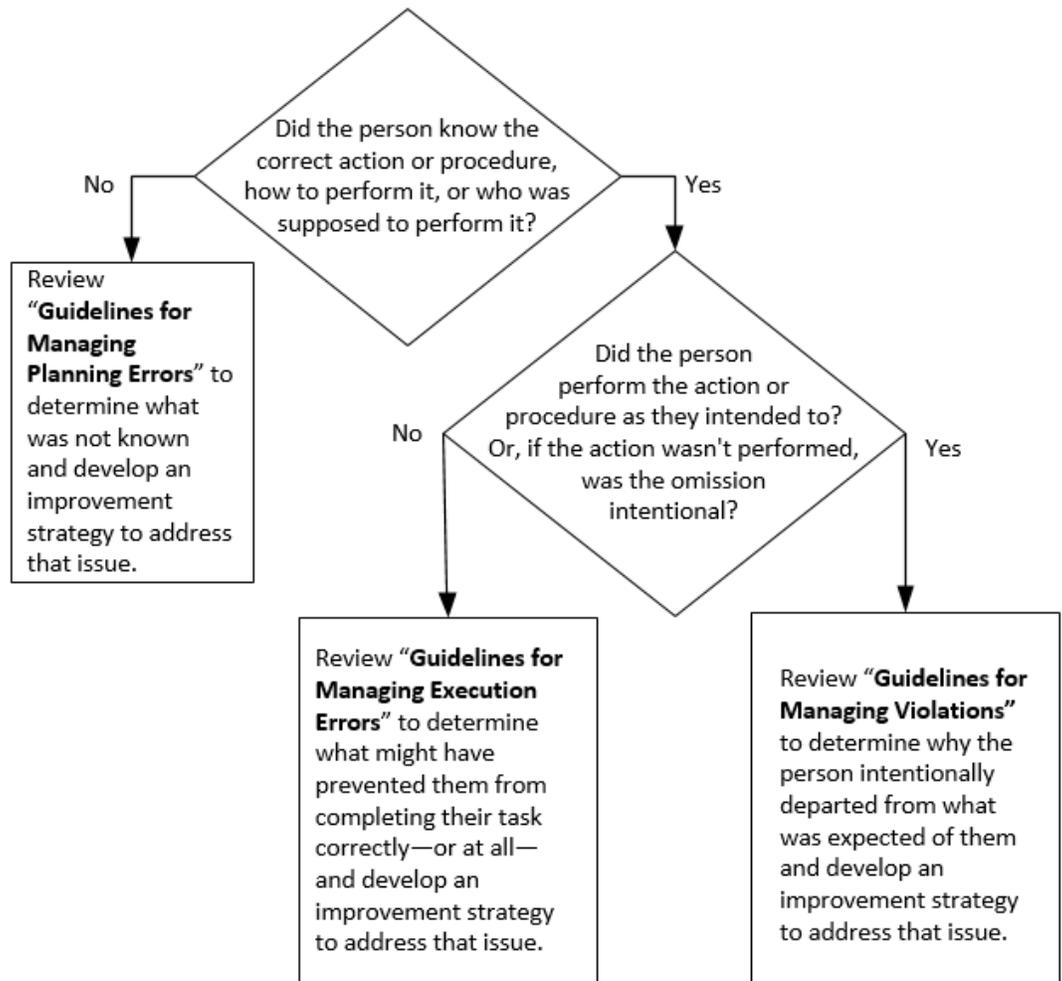# This commitment includes supporting a just culture.

A just culture is one that promotes a questioning attitude, is resistant to complacency and creates an atmosphere of trust in which people are encouraged (even rewarded) for providing essential information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior.

Decision Tree

The order of the questions in the Decision Tree is intentional; we cannot assume that the cause of an error is an intentional violation. First we must explore how the people interact with the system. These questions help the users of this guide avoid assumptions or conclusions about the nature and causes of failures in human performance (e.g., carelessness, recklessness, incompetence, etc.), so that they can correctly identify a category of performance (e.g., errors or violation) and, using the guidelines that follow, understand the underlying causes of this performance. In cases involving more than one individual, multiple categories of performance may contribute to a gap.

Coaching Approach Outline

1. Explain the goal of the meeting—to establish a shared understanding of the core issue

2. Each person shares their view of the situation (task/role/responsibility) without interruption

3. Understanding is confirmed by restating what was heard

4. Use the decision tree to clarify direction for further action

5. Ask for cooperation in working together to find an effective solution

6. Use the guidelines in the Intervention Selection Tool to identify appropriate solutions

7. If agreement to work together is not achieved, describe choices for further action (may include disciplinary action)

Decision Tree flowchart:

Did the person know the correct action or procedure, how to perform it, or who was supposed to perform it?
- **No** → Review **"Guidelines for Managing Planning Errors"** to determine what was not known and develop an improvement strategy to address that issue.
- **Yes** → **Did the person perform the action or procedure as they intended to? Or, if the action wasn't performed, was the omission intentional?**
  - **No** → Review **"Guidelines for Managing Execution Errors"** to determine what might have prevented them from completing their task correctly—or at all—and develop an improvement strategy to address that issue.
  - **Yes** → Review **"Guidelines for Managing Violations"** to determine why the person intentionally departed from what was expected of them and develop an improvement strategy to address that issue.

A coaching approach will be used during interactions with the employee to investigate the situation.

Guidelines for Managing Planning Errors
(The Plan Is Not Correct)

Considerations for Employee Interactions

1. Begin with the mind-set that what the employee did made sense at the time (the employee had good intentions)
2. Explain your goal—to have a clear picture of what occurred by sharing your perspective and getting the employee's perspective on the task/role/responsibility
3. Share your understanding of the situation and ask the employee to share their understanding of the situation
4. Allow the employee to describe his/her understanding of the task/role/responsibility without interruption
5. Restate what you heard the employee say to ensure a shared understanding of the core issue
6. Console employee
7. Explain that you would like to work with the employee to prevent another situation like this and ask for his/her cooperation in finding a solution
8. If the employee agrees, define next steps (Redesign/Intervention Considerations)
9. If the employee does not agree, describe choices (i.e., progressive disciplinary actions – written warning, probation, termination, etc.

Reasons for the Gap	System Redesign/Intervention Considerations
Don't know WHAT to do. Maybe this is a new topic, new news on an old topic, or they are simply unaware of the need to do something.	o Reallocate tasks to others with appropriate knowledge or experience o Review the orientation and training process for this employee. Did it follow the standard set by the organization? o Provide appropriate training and education
Don't know HOW to do it.	
❖ No process exists.	o Consider developing a process with the input of the users and good process design techniques
❖ Process is unknown.	o Find out why by talking to the users and address the issue
❖ Process is unclear.	o Find out what is unclear to users o Examine work tools and overall flow of process and redesign if necessary
❖ Infrequency of the task requires relearning.	o Memory aids o Assign task to specialists (who will do it more frequently)
Don't know WHO is supposed to do it. Responsibilities might be unclear.	o Clearly define responsibilities o Assign people to back up a particular task
Don't know WHY it should be done in a particular way. Perhaps the provider doesn't understand the benefits of the correct action and so chooses another action.	o Appropriate training/education o Identify the barriers to knowledge and work on those barriers
USED TO DO IT DIFFERENTLY and don't know there is a new way.	o Provide appropriate training/education o Coupling training/education with memory aids may be beneficial
COULDN'T DO IT. Sometimes the correct work forms, equipment, or supplies are not available. Sometimes equipment is not working properly. This would be a planning error on the part of management.	o Ensure that a process is in place for obtaining and maintaining work forms, supplies, and equipment so they are available when needed o Explore the reasons why they are not
DON'T BELIEVE THE SCIENCE. A person may not give up preferred practices and patterns because he/she doesn't buy in to the new science or the old science seems to work just fine.	o Find out why the provider doesn't buy in to the new science, and then address that problem. Is it a knowledge deficit? Frustration with an overwhelming flow of "new science"?

Things that may not work:
Simple reminders, prompts, incentives, penalties, standardized processes, most performance feedback strategies

Guidelines for Managing Execution Errors
(The Plan Is Correct—But There Is a Failure in Execution)

Considerations for Employee Interactions

1. Begin with the mind-set that what the employee did made sense at the time (the employee had good intentions)

2. Explain your goal—to have a clear picture of what occurred by sharing your perspective and getting the employee's perspective on the task/role/responsibility

3. Share your understanding of the situation and ask the employee if this is also their understanding of the situation

4. Allow the employee to describe his/her understanding of the task/role/responsibility without interruption

5. Restate what you heard the employee say to ensure a shared understanding of the core issue

6. Console employee

7. Explain that you would like to work with the employee to prevent another situation like this and ask for his/her cooperation in finding a solution

8. If the employee agrees, define next steps (Redesign/Intervention Considerations)

9. If the employee does not agree, describe choices (i.e., progressive disciplinary actions – written warning, probation, termination, etc.

Reasons for the Gap	System Redesign/Intervention Considerations
Had the correct plan in mind, but FORGOT. A person can forget because of DISTRACTIONS or INTERRUPTIONS.	o Reminders o Memory aids and prompts o Independent checks o Increasing the user's ability to know where he/she is in the process (e.g., checklists) o Minimize distractions and interruptions o Simplify processes
MESSED UP. While doing a task, two different steps can LOOK ALIKE and a person can forget which step he/she is on. Or, when someone is interrupted during a routine task, he/she may pick up again at a different spot without realizing it. It is also possible that when the task is resumed, it may be remembered as a different task, and that task completed instead of the intended one.	o Independent checks o Improve a person's ability to know he/she is correctly carrying out a task o Mistake-proof the processes o Limit the functions that are possible
Something simply SLIPPED THEIR MIND. Sometimes there is a gap in time between decision and action. If a decision is made to do the task at one point in time, but the task is supposed to be carried out sometime later, then during that gap in time, the task can be forgotten.	o Memory aids and prompts o Decrease the amount of time between the decision and the action
OLD HABITS led them to do a task in a way that is different from how they have been recently trained. Previous experience may lead to incorrect action for the situation at hand.	o Memory aids o Decision support tools

Things that may not work:
Training, education, decision aids that get in the way, incentives, penalties, most performance feedback strategies

Guidelines for Managing Violations (At-Risk or Reckless Behaviors)
(Intended Deviations from Safe Practice—Negative Consequences Are Unintended)

Considerations for Employee Interactions

1. Begin with the mind-set that what the employee did made sense at the time (the employee did not intend the negative consequences or to cause harm)

2. Explain your goal – to have a clear picture of what occurred by sharing your perspective (the employee knowingly violated the policy/procedure) and getting the employee's perspective on the task/role/responsibility to prevent harm

3. Share your understanding of the situation (why you think the employee violated the policy/procedure) and the negative consequences as a result of the employee's actions

   - Describe specific, observable, measurable and/or unacceptable conduct. Have this information before you meet.

4. Ask the employee if this is also their understanding of the situation

5. Allow the employee to describe his/her understanding of the situation without interruption

6. Restate what you heard the employee say to ensure a shared understanding of the core issue

7. Counsel the employee on what is considered acceptable in the situation.

8. Explain that you would like to work with the employee to prevent another situation like this and ask for his/her cooperation in finding a solution

9. If the employee agrees, define next steps (Redesign/Intervention Considerations)

   - If this is a repetitive behavior, consider remedial or disciplinary actions.

10. If the employee does not agree, describe choices (i.e., progressive disciplinary actions – written warning, probation, termination, etc.

Reasons for the Gap	System Redesign/Intervention Considerations
DON'T HAVE TO DO IT. Sometimes the following lead to someone knowingly not doing a task. ❖ Routine violations are permitted ❖ People perceive that they are above the rules because of position or experience ❖ Correct behaviors are not reinforced	o Review the orientation and training process for this employee (for all employees). Did it follow the standard set by the organization? o Ensure that policies (when they are necessary) and procedures are consistently enforced o Provide positive, consistent, and timely feedback for desired behaviors
FRUSTRATION leads to workarounds. ❖ Sometimes a person won't do a task because it is frustrating ❖ Sometimes the correct work forms, supplies or equipment are not readily accessible or easy to use	o Redesign aspects of the work (tasks, tools) to eliminate or change the source of the frustration o Look at the design of the workspace to ensure that forms, supplies, equipment are accessible and convenient
POLICIES DON'T ACCOUNT FOR EVERYTHING. If following an existing policy would result in a bad outcome for a patient, a provider might violate the policy to do what he/she thinks is best for the patient.	o Review the policy/procedure to see if it is too restrictive, inappropriate, or outdated o Update or modify policy/procedure as appropriate o Alter to allow for contingencies or special cases
GOAL CONFLICTS. Sometimes a person has to make a choice between two or more important tasks that both should be done.	o Redistribute tasks o Simplify processes
Know they should do it differently, but choose to do it THE WAY THEY'VE ALWAYS DONE IT.	o Find out why the old way is preferred and address that issue o Remove the positive consequences of violating and reward correct behavior
There are POSITIVE CONSEQUENCES FOR VIOLATING. People violate rules because they see positive consequences for doing so. (Often the positive consequence is *time saved*.)	o Conduct an at-risk behavior investigation o Remove the positive consequences of violating and reward the correct behavior

Things that <u>may not work</u>: Training, education, reminders, prompts, memory aids, punishment

Intervention Glossary

Memory aids are a way of putting the correct plan in the world (in a book, on a piece of paper, in a computer program) instead of putting that correct plan only in someone's head. When we have too many things to remember, we need help. Memory aids are something that we use when our short-term memory won't be large enough or when our long-term memory won't be precise enough.
Examples:

- A Physicians' Desk Reference
- A "Pain Management Form" created by a nursing home to help practitioners through the process of pain management
- Pocket guides
- Written instructions on using a mechanical lift

Prompts provide a cue as to what action should be taken next. Prompts are appropriate to use when people tend to lose their place in a process, when they are unlikely to remember what comes next, or when there are a number of potential options.
Examples: Seat belt indicator light on the dash of your car

- New defibrillators that tell you if you have placed the defibrillator pads incorrectly
- Electronic medical record asks you about immunization status as you enter new resident information

Reminders grab our attention. They bring to our remembrance the fact that something needs to be accomplished. Unlike a prompt, a reminder is always there. Because reminders are always there, we can "stop seeing them."
Reminders should be used when we are likely to forget something, when our attention is likely to be diverted, or when vigilance is required.
Examples:

- The "sticky note" on the door, on the phone, on the fridge… it grabs our attention and reminds us to do something
- Signs hanging in maternity rooms reminding everyone to wash their hands before holding the new baby
- Personal protective equipment stations at the entrance to a resident's room when there are infection control concerns

Independent checks are when two people perform the same task at the same time and compare the outcome for validity.

Example:

- I ask John and Jane to work independently of each other to add the following numbers on a piece of paper: 53 + 818 + 125 (= 996). After they finish, they compare answers. **Independent checks are stronger than double checks** because our eyes tend to see what they expect to see, which is a correct answer.
- Medication count with two staff

Double checks are when one person performs the task and then asks another person to check the work completed for correctness.

Example:

- Charge nurse confirms proper resident positioning in chair after CNA positions resident
- Resident Care Manager confirms proper wound care dressing after nurse places dressing

A **Process** is a systematic set of steps taken to reach an identified outcome. Creating a process (or altering a current process) is one solution to planning errors. Creating or altering a process is appropriate when there is no process currently, when the current process doesn't address the needs of the users, or when the current process has unrealistic expectations (for instance, that people will perform perfectly every time).

Example:

- Physician offices need to routinely test their patients who have diabetes. What is their current process for identifying patients who are overdue? Is there a process? Do they use a registry?

Education is putting knowledge in people's heads. It is the intervention most often used in health care. Unfortunately, it is often employed in the wrong circumstances. Education is appropriate when people make errors because they don't know what to do, when they make errors because they don't know why they should do a task, or when they make errors because the science has changed and they used to do the task differently.

Example:

- The science of treating patients with chronic pain or diabetes has changed in the last 15 years. If practitioners do not know the new science, and therefore treat their patients the same way they did 15 years ago, then education can help them know what the new science is. Coupling education with memory aids can be very effective.