

Concept Definitions for Triggering and Triage Questions

Human Factors/Communication: Questions help assess issues related to communication, flow of information, and availability of information as needed. These questions also reveal the importance of communication in use of equipment and application of policy and procedure, unintended barriers to communication, and the organization's culture with regard to sharing information.

Example: *A new resident has requested as part of her plan of care to be able to lie down after lunch to take a rest. She requires assistance to transfer from her wheelchair to the bed. When not assisted, her family indicated that she attempts to transfer herself and she has fallen in the past. The day shift nursing assistant caring for the resident on the day of her admission shared this information with the evening nursing assistant as the care plan and the written information for nursing assistants about this resident's preferences had not yet been written. This information did not get communicated to the night shift and the next day a new nursing assistant was assigned to this resident.*

Human Factors/Training: Questions help assess issues related to routine job training, special training, and continuing education; including the timing of that training. Training issues may concern application of approved procedures, correct use of equipment, or appropriate use of protective equipment or barriers. These questions also focus attention on the interfaces between people, workspace, and equipment.

Example: *A new graduate nurse started working on the transitional care unit this week. A medication error occurs related to transcription of a new medication received via a telephone order.*

Human Factors Fatigue/Scheduling: Questions weigh the influence of stress and fatigue that may result from change, scheduling and staffing issues, sleep deprivation, or environmental distractions such as noise. These questions also evaluate relationships to training issues, equipment use, management concern and involvement.

Example: *An LPN was nearing the end of a double shift. It had been a difficult shift but it was the end of the month and she was asked to double check the last few MARs for the next month so they could be put into the medication record.*

Environment/Equipment: Questions help evaluate factors related to use and location of equipment; fire protection and disaster drills; codes, specifications and regulations; the general suitability of the environment; and the possibility of recovery after an error has occurred. These questions show that what appears to be equipment failure may relate to human factors issues, policy and procedure questions and training needs.

Example: *While the resident is away from his room in physical therapy, the housekeeper unlocks the bed to move it so she can mop the floor underneath and reach up to the floor boards. The housekeeper forgets to reset the wheel locks before moving to the next room.*

Rules/Policies/Procedures: Questions help assess the existence and ready accessibility of directives including technical information for assessing risk, mechanisms for feedback on key processes, effective interventions developed after previous events, compliance with policies, the usefulness of and incentives for compliance with standards, and regulations. The qualifications of the facility and employees for the level of care provided; orientation and training for compliance with safety and security measures including handling of hazardous material and emergency preparedness; and the availability of information to all part time, temporary, or voluntary workers and students are also considered.

Example: *A nurse hired for the day through the local temporary agency is not familiar with your facility and unlocks the back door in order to smoke during break. This door should remain locked as it is an important safety barrier for residents that like to walk on that floor but would not be safe to leave the building independently.*

Barriers: Barriers protect people and property from adverse events. Questions assess protective barrier strength, fault tolerance, function and interaction/relationship to Rules/Policies/Procedures and Environment/Equipment.

Example: *Equipment supply switched to a new vendor for disposable gloves. The gloves on the universal precautions cart easily tear during care for the resident with shingles in the contagious stage.*

Human Factors/Communication

In this section, address all questions.

1. Was the resident correctly identified?
2. Was information from various *resident* assessments shared and used by members of the team on a timely basis?

If no, this could be a Root Cause/Contributing Factor.

3. Did existing documentation provide a clear picture of the resident needs, plan of care, and the resident's response to treatment? Including:
 - Assessments
 - Plan of care
 - Nursing assistant assignment sheets
 - Orders
 - Progress notes
 - Multidisciplinary team notes
 - Medication administration record
 - Lab reports
 - etc.

If no, this could be a Root Cause/Contributing Factor.

4. Was communication between management/supervisors and front line staff adequate?
Was it:
 - Accurate
 - Complete
 - Using standard vocabulary and no jargon
 - Unambiguous

If no, describe how management/supervisors and front line communications are not adequate.

5. Was communication between front line team members adequate?
 - Nursing assistant to nursing assistant while covering for breaks
 - Nurse assigned to the resident and nursing assistant
 - Nursing assistant to nurse
 - Therapy staff to nursing
 - Nursing to therapy staff
 - Nursing to dietary

If no, describe how communications between team members were not adequate.

6. Were policies and procedures communicated adequately?

If no, describe how policies and procedures were not communicated adequately. If this is an issue, see the [Rules/Policies/Procedures](#) questions.

7. Was the correct technical information adequately communicated 24 hours a day to the people who needed it? For example, if the resident required specialized equipment or a device used infrequently at the nursing home was the information needed to provide care related to the equipment or device shared?

If no, describe how communication about technical information is not adequate.

8. Were there methods for monitoring adequacy of staff communication? Were there methods for:
- “Read back” on telephone orders
 - Confirmation messages - confirmation of lab results called to the physician or nurse practitioner,
 - Debriefs following a critical episode such as a fall with injury
 - etc.

If no, this could be a Root Cause/Contributing Factor.

9. Was the communication of potential risk factors readily available and communicated in such a way that all staff and or residents (if applicable) could use the information? For example was a translator provided or critical written information available in other languages that match resident or staff populations.

If no, this could be a Root Cause/Contributing Factor.

10. Was there a recall, alert or bulletin from the manufacturer on file for the equipment or medication that was part of this event or close call? Were relevant staff members aware of the recall, alert or bulletin? (language revised slightly)

If this is an issue, consider [Environment and Equipment](#) questions.

11. If relevant, was the resident(s) and their family/significant others actively included in the assessment and treatment planning?

12. Did management establish adequate methods to provide information to employees who needed it in a manner that was easy to access/use, and timely?

If no, this could be a Root Cause/Contributing Factor.

13. Did the overall culture of the nursing home encourage or welcome observations, suggestions, or "early warnings" from staff about risky situations and risk reduction? (Also, has this happened before and was anything done to prevent it from happening again? Consider pulling previous incident reports or near miss reports)

14. Did adequate communication across departments or levels of staff occur?

Human Factors/Training

In this section, address all questions.

1. Was there a program to identify what is actually needed for training of staff?

If no, this could be a Root Cause/Contributing Factor.

2. Was training provided prior to the start of the work process? Such as incorporated in orientation? Is there an annual training update related to the process?

If no, this could be a Root Cause/Contributing Factor.

3. Were the results of training monitored over time? Beyond classroom training, is there a process to observe for the appropriate implementation of the process after the training? Is there an annual competency validation on the process?

If no, this could be a Root Cause/Contributing Factor.

4. Was the training adequate? If not, consider the following factors:

- Supervisory responsibility
- Procedure omission (Was there an adequate and well understood procedure to accompany the training? Was the written procedure easily accessible?)
- Flawed training
- Flawed rules, policy, or procedure

If yes to any of the points, go to the [Rules/Policy/Procedure](#) questions.

5. Were training programs for staff designed upfront with the intent of helping staff perform their tasks without errors? For example, did the training include scenarios to allow staff to problem solve likely or potential barriers to performing the task?

If no, this could be a Root Cause/Contributing Factor.

6. Had procedures and equipment been reviewed to ensure that there was a good match between people and the tasks they did; or people and the equipment they used (i.e., human factors engineering)?

If procedures were not followed as intended, see the [Rules/Policy/Procedure](#) questions.

7. Were all staff trained in the use of relevant barriers and controls?

If yes, see the [Barriers](#) questions.

8. If equipment was involved, did it work smoothly in the context of:
 - Staff needs and experience
 - Existing procedures, requirements, and workload
 - Physical space and location

Could the equipment be used safely in the space available, for example, did the configuration of the resident room allow the staff to safely use the Hoyer in the resident room?

If equipment was involved, see the [Environment and Equipment](#) questions.

Human Factors Fatigue/Scheduling

In this section, address all questions.

1. Were the levels of noise or other environmental conditions appropriate? For example, were there alarms, call lights, or overhead paging that were factors?
2. If applicable, were environmental stressors properly anticipated?
 - *If stressors were anticipated, see the [Human Factors/Training](#) questions.*
 - *If stressors were not anticipated, why weren't they anticipated?*
3. Did personnel have adequate sleep?
4. Did scheduling allow personnel adequate sleep?
5. Was fatigue properly anticipated?
6. Was the environment free of distractions?
7. Was there sufficient staff on-hand for the workload at the time? (i.e., Workload is too high, too low, or wrong mix of staff. If staff rotates, or called in to cover on a new group of residents, are there safeguards in place to ensure competence and safe care for the residents who are new to the staff person? Examples –are charts, med carts, supplies set up similarly to other areas of the nursing home? Is information about individualized resident needs readily available to the new staff?)

If yes, see the [Human Factors/Training](#) questions.

8. Was the level of automation appropriate? Were there processes that should have been automated that were not that led to the concern? (i.e., too much or not enough.)

If yes, see the [Environment and Equipment](#) questions.

Environment and Equipment

In this section, address all questions.

Environment

1. Was the work area/environment designed to support the function it was being used for?

2. Had there been an environmental risk assessment (i.e., safety audit) of the area?

If no, consider reviewing the [Rules/Policy/Procedures](#) and [Barriers](#) questions.

3. Were the work environment stress levels (either physical or psychological) appropriate (e.g. Temperature, space, noise, intra-facility transfers, new admissions, construction projects.)?

If yes, go to the [Human Factors/Scheduling/Fatigue](#) questions.

4. Had appropriate safety evaluations and disaster drills been conducted?

5. Did the work area/environment meet current codes, specifications, and regulations?

Equipment

6. Was equipment designed to properly accomplish its intended purpose?

7. Did the equipment involved meet current codes, specifications, and regulations?

8. Was a documented safety/maintenance review performed on the equipment involved? If relevant, were recommendations for service/recall/maintenance, etc., completed in a timely manner?

9. Was there a maintenance program in place to maintain the equipment involved?

If no, go to [Rules/Policy/Procedures](#).

10. If there was a maintenance program, did the most recent previous inspections indicate that the equipment was working properly?

11. If previous inspections pointed to equipment problems, what corrective actions were implemented and were they effective?

12. Were adequate time and resources allowed for physical plant and equipment upgrades, if problems were identified?

13. Was there adequate equipment to perform the work processes?

14. Were emergency provisions and backup systems available in case of equipment failure?
15. Had this type of equipment worked correctly and been used appropriately in the past?
16. Was the equipment designed such that usage mistakes would be unlikely to happen?
17. Was the design specification adhered to?

If yes, go to the [Human Factors/Training](#) questions.

18. Was the equipment produced to specifications and operated in a manner that the design was intended to satisfy?
19. Were personnel trained appropriately, to operate the equipment involved in the adverse event/close call?

If no, see the [Human Factors/Training](#) questions.

20. Did the design of the equipment enable detection of problems and make them obvious to the operator in a timely manner?
21. Was the equipment designed so that corrective actions could be accomplished in a manner that minimized/eliminated any undesirable outcome?
22. Were equipment displays and controls working properly and interpreted correctly?
23. Was the medical equipment or device intended to be reused (e.g. not a Single Use Device)?

Rules, Policies, and Procedures

In this section, address all questions.

1. Was there an overall management plan for addressing risk and assigning responsibility for risk?
2. Did management have an audit or quality control system to inform them how key processes (related to the adverse event) are functioning?
3. Had a previous audit been done for a similar event, were the causes identified, and were effective interventions developed and implemented on a timely basis? Was the process change maintained?
4. Would this problem have gone unidentified or uncorrected after an audit/review?

5. Was required care for the resident within the scope of the facility's mission, staff-expertise and availability, technical and support service resources?
6. Was the staff, involved in the adverse event or close call, properly qualified and trained to perform their functions?
7. Were all involved staff oriented to the job, facility, and unit policies regarding: safety, security, hazardous material management, emergency preparedness, life-safety-management, medical equipment, and utilities management?
8. Were there written up-to-date policies and procedures that addressed the work processes related to the adverse event or close call?
9. Were these policies/procedures consistent with relevant federal and state policies, standards, and regulations?
10. Were relevant policies/procedures clear, understandable, and readily available to all staff?

If no, go to the [Human Factors/Communication](#) questions.

11. Were the relevant policies and procedures actually used on a day-to-day basis?
12. If the policies and procedures were not used, what got in the way of their usefulness to the staff?
13. If policies and procedures were not used, what positive and negative incentives were absent?

Barriers

In this section, address all questions.

1. What protective barriers and controls were involved in this adverse event or close call?
2. Were these barriers designed to protect residents, staff, equipment, or environment?
3. Was resident risk considered when designing these protective barriers and controls?
4. Were these protective barriers and controls in place before the event happened?
5. Had these protective barriers and controls been evaluated for reliability?
6. Were there other protective barriers and controls for work processes?

7. Was the concept of “fault tolerance” applied in system design?
8. Were the relevant barriers and controls maintained and checked on a routine basis by designated staff?

If no, go to the [Rules/Policy/Procedures](#) questions.

9. Would the adverse event have been prevented if the existing barriers and controls had functioned correctly?
10. Were the system(s) or processes tested before they were implemented?
11. Did the audits/reviews related to protective barriers include evaluation of plans, designs, installation, maintenance, and process changes?

If yes, go to the [Rules/Policy/Procedures](#) questions.

12. Did management have a method for identifying what the results of the system changes would be before implementation?

If yes, go to the [Rules/Policy/Procedures](#) questions.