Crew Resource Management in Crisis Response
The Perception of Risk
July 14, 2020
Webinar – Question & Answer Recap

How can we be sure that the Failure to Notify statistic isn't partly due to instances of "hindsight is 20/20"?

- We cannot be certain that the Failure to Notify statistic isn't partly due to instances of "hindsight is 20/20", and as an incident analyst, I am pretty certain that there are many biases in play, particularly after a major incident. These color the way we think, and certainly the way we "believe" we perceived risk prior to the event. In addition, there is a phenomenona called "sense making," in which people say random comments (like, "I'm not sure that's safe,") then later will say they specifically "warned" someone about a risk. You and I have both done this, by the way, and had it done to us...we just are not paying attention all the time or misinterpret the comment. It's a tough area - but even if the stats are 80% off - it's still a large issue.

How do you promote a change to a "just culture"?

- Most organizations start to incorporate a "just culture" because they value a more open and fair work environment. Changing to a "just culture" requires organizational and personal effort - and it's a JOURNEY, not a destination, so always it is a work in progress. If you're open to it, e-mail me at Paul@SGCPartners.com and ask me for the white paper, and I will send you a white paper that outlines ideas related to this. We have had people circulate this paper to get the discussion started.

Do you have any recommendations for online or in-person human factors/crm classes?

- Many larger hospitals have "TeamSTEPPS" training, which is ok and a decent start (but as I mentioned, has weaknesses in practice). You might check with your local hospital - also, look for Embry-Riddle University Human Factors Training online; they have one of the more robust, recognized, formal training programs in the world.

How do you balance admittance of failure and legal liability?

- You're going to get sued anyway if you harm someone or something. Look into the recent programs related to the concept of DA&O, which stands for "Disclose, Apologize, and Offer." Most major hospitals now who strive for high reliability have some sort of DA&O program. Imagine finding out you were harmed, and the provider told you nothing and will not share any information so they don't get sued. What will you do? You could sue and get the info during the discovery process. In the meantime, the attorneys make their boat payments and you're really upset that they are hiding something from you, or not willing to admit an error. Or you could go through the DA&O process of the provider telling you, "We made this error, we are profoundly sorry it happened, here is what we are doing to prevent this from occurring again, and here is some money because we harmed you." All the major EMS and healthcare clients we work with have similar programs. If you're interested in the DA&O concept, e-mail me at Paul@SGCPartners.com, and ask for DA&O information.

Additional Resources:

The NASA Ames Research Center has been conducting analysis of individual and team communication dynamics for decades. Research papers on Human Factors relating to communication can be found at: https://www.nasa.gov/content/published-papers/

The 24-7 EMS Online: Crew Resource Management Course can be found at:
https://24-7.hsi.com/course-catalog/24-7-ems-online-crew-resource-management
This course explains the guiding principles and benefits of crew resource management (CRM), a tool designed to reduce errors while safely providing the best patient care possible when responding to incidents. CRM emphasizes effective teamwork, strong team leadership and the importance of workload management and post-incident critiques for response teams.

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