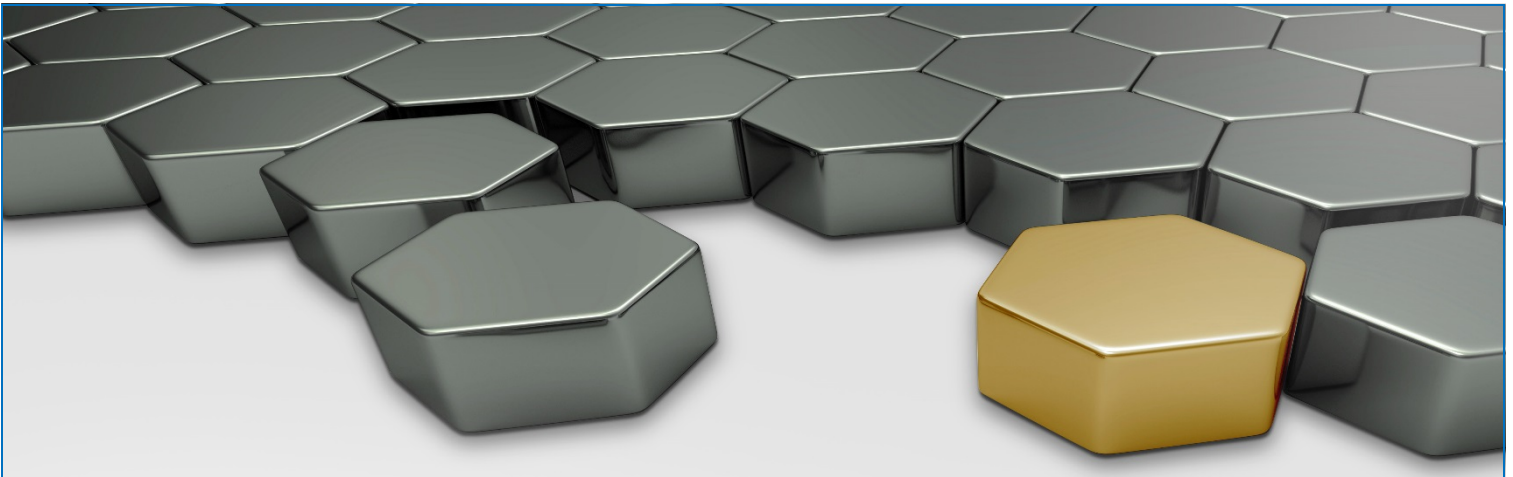




Collaborative Risk Review™ Manual

*A Guide to Planning, Preparing, and
Facilitating Collaborative Risk Reviews*



SG Collaborative Solutions, LLC™
Designed for Impact. Powered by Partnership.

Preface

Introduction and Access

This manual provides instruction on planning, preparing, and facilitating Collaborative Risk Reviews. The manual supports SG Collaborative Solutions organizational clients with access to the SGCS High Reliability™ and Collaborative Just Culture™ suite of integrated products. Users must be employed and authorized by an organization under contract with SGCS.

Online Prerequisites

- *Principles of Reliability*
- *Performance vs Behaviors*
- *Using the Reliability Response Guide*
- *Essential Supervisor Skills*

Other Requirements

- Completion of Training: *Facilitating the Collaborative Risk Review*

Related Documents

- SGCS Reliability Response Guide™ (RRG)
- RRG Instruction Manual
- Reliability Management Team™ Manual

Revision Date of Approval

2021-07-08a

Approved by: K. Scott Griffith

Signature: _____



Feedback

SG Collaborative Solutions values your feedback. Please provide general comments, along with any errors and omissions to: info@sg-collaborative.com

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First Steps, Timing, & Information Gathering

First Steps

The process used for determining first steps may be dictated by the method in which your team receives a request for a risk review, including incidents. For example, the following may all be ways that you and your team could hear of a risk or incident requiring a Collaborative Risk Review. A team member may receive communication from:

- Staff members
- Executives
- Members of the media
- Attorneys or customer representatives
- Regulators
- Other organizations affiliated with yours
- Organizations not affiliated with yours

Your organization will set the threshold which triggers a review, and set guidelines for how the team should respond to requests. The team's response will vary depending on who makes the request and the method of communication used. A request from an external source such as a regulator would likely require a formal response, while a request from a news media might not. A text message from an employee may necessitate a more formal request for a review. Every team should develop a standard response for Collaborative Risk Review requests (See *Attachment #1* for an example of an initial e-mail notification to be sent out when your team receives a request).

Many staff participants who receive an initial e-mail from the team may not know what a CRR is or may be reluctant to participate. You can alleviate their concerns by using the notification to educate participants about the process, goals, and objectives. (See *Attachment #2*, "CRR Overview," for an example of this type of communication).

Timing

It's important to conduct a Collaborative Risk Review as soon as possible after the risk or event is recognized. People's memories tend to fade quickly. The more opportunities they have to informally discuss a process, the more risk there is that misinformation will be generated. The NTSB responds quickly to transportation incidents for a reason: Information from participants and witnesses quickly degrades as people are exposed to bias, media questions, and hypothetical opinions associated with "what went wrong" or "who did what." And the physical system components have a greater chance of being modified, damaged, or "fixed," either purposefully or inadvertently, as time passes.

Several factors generally dictate the timing of a CRR:

- What are the risks of continued, unexamined operations?
- How soon can the team gather the necessary background information, including equipment, records, and front-line interviews?
- What is the psychological status of the involved team members? Are there emotions clouding the team's ability to see and understand the event clearly? Do any conflicts-of-interest exist with team members, such as operational responsibilities or associations with the individuals involved

in an event? The team should be curious and objective, not upset or overly influenced by the type or severity of an adverse outcome.

Note that the “availability of those involved” is not a factor – it is assumed in a High Reliability Organization that leaders will ensure all actors are available on relatively short notice. If CRRs are conducted “when it’s convenient for everyone,” they never happen or happen so long after the risk event that the information gathered is usually incomplete or inaccurate.

Incident/Risk Analysis vs. Investigation

Do not underestimate the difference in methodology and perception between an investigation and a risk analysis. The term investigation suggests a criminal process and punitive measures. Analysis is a better, more accurate term typically used in highly reliable environments to describe how a team reviews a risk event. People are more likely to participate in an incident or risk “analysis” than an “investigation,” and when they do, more likely to contribute useful insight. It’s important that participants understand the purpose of the review is improvement in future operations, rather than punishment or criticism for past actions. We recommend using the term “analysis” because a Collaborative Risk Review is meant to be a retrospective study of risk contributors, in search of proactive measures to identify vulnerabilities and develop strategies.

CRR as a Debrief (Not CISD)

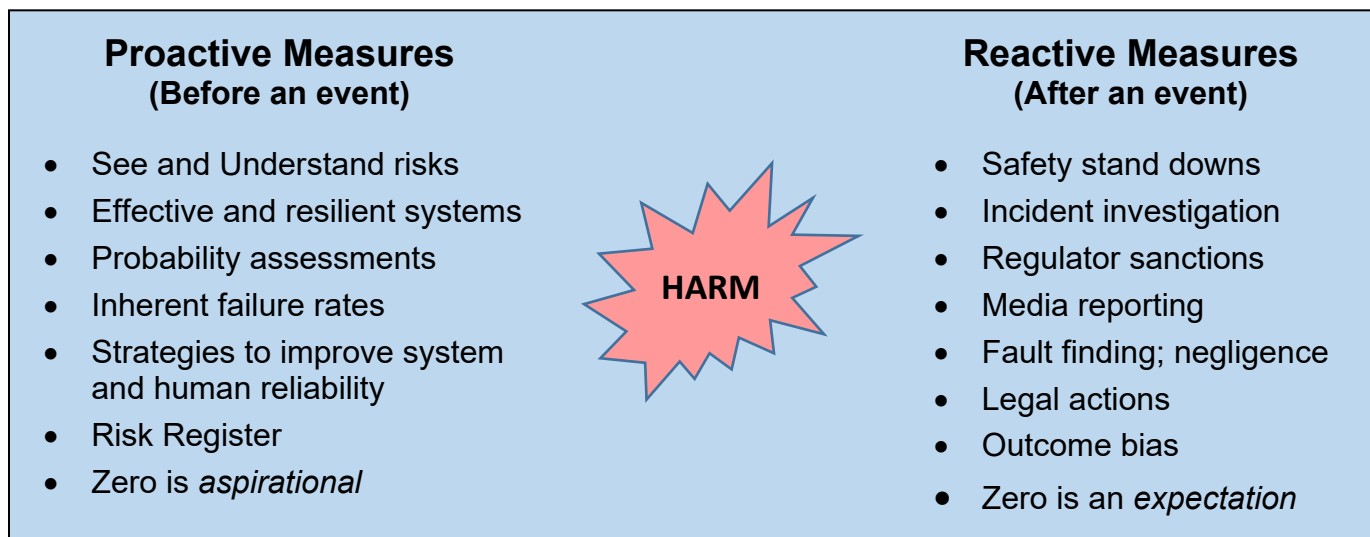
Critical Incident Stress Debriefing (CISD) is a specific approach to supporting employees involved in a critical incident, and who may be experiencing psychological or physical impact from the event. It is its own process, and will not be addressed here. But regardless of whether the team(s) involved in a risk incident have had access to formal CISD, you may still find that the CRR itself often helps people involved openly discuss their feelings and concerns, and support one another. You may also find that some team members are confrontational or angry about the outcome or an individual behavior and want to use the CRR as a place to vent.

As a facilitator, your job is to encourage the support and healthy dialogue, and to intervene when it appears that accusations, blame, or fault conversations have started (See “Managing Conflict”). A well-facilitated CRR often serves as a “debrief” or “hot wash” session where people can learn from each other. It can help if the facilitator keeps participants focused on how team member(s) “Saw and Understood the Risks,” because each operational, clinical, or logistical department will have a different viewpoint.

The facilitator who recognizes that the “debrief” function can be as important (or more so) than the “fact-finding” discussions or proposed proactive solutions generally has a more cooperative and engaged group during and after the CRR. In most cases, if a formal CISD process is deemed necessary, the CISD should take place prior to the Collaborative Risk Review.

Explaining Left and Right of Harm Concepts

The terms Left of Harm and Right of Harm can help in a discussion of the activities that take place after an incident. If the harm event, or the undesired risk, is in the center of the discussions, then anything to the right is considered a reactive response to the event, and anything to the left, which would happen before the event, is considered a proactive measure (See diagram below).



It's important to note that there is not a good or bad side to any event – if you pay attention and resources to both proactive and reactive measures. No one engaged in high-consequence work, such as aviation, healthcare, and firefighting, wants to see an undesired outcome, particularly when a customer or employee is harmed. But in high-consequence, high-risk work, we inevitably will see failures in our systems and in the humans who operate in them.

We are aware of the potential harm to an employee or customer, but we also must be aware of the potential harm to an employee involved in an incident or the potential harm to the organization. Regulatory agencies, the news media, prosecutors, and even fellow employees often engage in finding fault. Fault-finding can be important for the necessary legal, personal and financial accountability exercises after an undesired outcome, but it rarely provides us with insight into proactive measures that might help us manage and/or minimize future risks.

This is an important concept, because as the facilitator of a CRR, you may uncover data, facts, discussions, behaviors, or performances that indicate the organization, or some people involved, are legally exposed. A CRR, which is designed to establish proactive measures you can take to avoid future risk, will often uncover sensitive information that may be used against the people involved in the analysis. It is crucial to have your Risk professionals, as well as your Quality and Safety professionals, collaborate in gathering information before a CRR. In sensitive cases, they should co-facilitate the session to ensure information is managed appropriately and according to policy. In addition, all communication, slides, and other materials used for a CRR should be appropriately marked with the organization's confidentiality statements.

Balancing Proactive Analysis with Reactive Risk Management

Facilitators (or Risk Management Team members) who understand *Proactive* (Left of Harm) vs. *Reactive* (Right of Harm) strategies, and how managing both are necessary to resilience, can make good recommendations and provide safe and effective feedback.

For example, there may be concerns that the legal system, news media or regulators may use information gathered in the pre-work (case and records analysis and interviews) or during the CRR against the organization. This may cause you to delay proactive strategies recommended during a CRR to improve systems, performance or behavior. Careful review of the recommendations, and vetting them through a collaborative team approach, is the best method for ensuring effective, resilient action that safeguards protected legal information and avoids unnecessary exposure for the organization.

Planning for the Analysis and CRR

Step One: Determining Who Conducts the Analysis

As organizations initially become familiar with the High Reliability process, and begin conducting Collaborative Risk Reviews, the majority of the CRRs are facilitated by members of the organization's Reliability Management Team. However, as the organization matures, and the process of High Reliability alignment and then integration occurs, there is an expectation that front-line supervisors, department managers and directors, and others in positions of responsibility will analyze risks and events at their own level and within their own teams or domains. Generally, by the time the organization is ready to be externally certified in High Reliability, there will be a stratification of case reviews based on the complexity of the risks being evaluated, and whether or not external regulators or agencies are involved. The following method is one pioneered by SG Collaborative to ensure every level of the organization takes responsibility to manage risk, quality, and safety in their own departments and at their own level. However, we emphasize that this method is fluid, the descriptions can and will change based on the level of expertise at the front line and also at the director and RMT level, and organizations typically are adapting as they gain expertise.

GREEN Locally Managed	These are typically issues that have no major consequence, and may happen often as part of daily operations.	• Deviations from standard protocol • System issues that create an opportunity for staff to "short-cut" • Near-miss events discussed at huddle
YELLOW Support from Team	• These are usually incidents involving greater consequence, multiple units, etc.	• Hand-off issues between units • Team problems • System failures with no harm but higher consequence outcomes
RED "Go Team" CCR	• These typically include sentinel events, complex risk scenarios, multiple unit risks, etc.	• Sentinel event with harm and indications it could repeat • Complex poorly understood situations • Multi-unit, large team risk events

- **Green** risk cases are typically managed solely by front-line supervisors or managers who have completed the on-line and Live Learning Session training curriculum for High Reliability. These are low-to-moderate-risk events where front-line supervisors or managers need no external support. Using the Reliability Response Guide™ and methods they have learned, they identify the risks and competing priorities and discuss potentially more resilient systems. They then manage the human performance and/or behavior issues locally through Performance Improvement or Corrective Action strategies. Finally, they report system findings and recommendations to the RMT, which adds these to the Risk Register if necessary.

- **Yellow** risk cases are those where front-line supervisors or managers may request or need at-the-elbow assistance with the fact-gathering process and with facilitating interviews, analysis, or conflicts across departments. These usually are moderate risk events and often involve more than one department. Supervisors or managers contact the RMT or an RMT member, depending on how the team functions. Either in-person or over the phone, the RMT member would help with the high reliability process.
- **Red** risk cases typically involve high-risk near-miss events, or events that involve some form of undesired outcome, including major property or physical harm. In these instances, RMT members often facilitate an in-person Collaborative Risk Review, and may also provide some Go Team support by visiting the area(s) where the event happened and helping front-line managers identify system, human performance, and human choice contributors.

RMT members would *rarely take over an investigation or analysis*. The exception may be **Red** incidents, as noted above, which typically involve high-risk near-miss events, or events that involve some form of undesired outcome, including harm. In these events the organization may request the RMT facilitate the investigation or analysis, gather facts, develop system recommendations, and use the Triad process to recommend solutions.

Regardless of the level of risk being analyzed, RMTs should always leave the job of managing performance issues and behavioral issues to front-line supervisors who have that responsibility. **RMTs should not create Performance Improvement Plans or recommend any specific type of Corrective Action.** Through the Triad process, the RMT may recommend that a person get remediation through a performance improvement plan, or receive coaching or corrective action. But it is the responsibility of front-line supervisors and Human Resources to develop and administer these response.

RMTs may manage the organizational Risk Register and identify areas of vulnerability. These vulnerabilities could be in many areas of risk, such as legal exposure, clinical, operational, customer service, equity, quality, etc. These vulnerabilities will often generate the need for further analysis. The organization may need to develop Objectives and Key Results (OKRs) to determine where the organization will apply reliability improvements.

For example, after several case analyses and customer service reports, a hospital RMT identified that the organization had been providing inequitable care. Some of the Risk Register metrics demonstrated that a person's color, disabilities, nationality, and/or financial status were affecting the quality of care delivered. The RMT was asked to determine how the organization might integrate more effective and resilient strategies to address these risks.

Step Two: Use a Planning Checklist

When you take the first steps in a CRR, using a checklist is essential in making sure you don't leave out important steps. If you think you will be conducting a Risk/Incident Analysis and a CRR, it is important to ensure staff are appropriately notified and that associated equipment and data are secured. Also, the leaders of a specific department often ask to be informed when their team members will be engaged in a CRR. Using a checklist will make this more reliable. (See the "Analyze, Prep and Plan" checklist in *Attachment #3*).

Step Three: Communicate and Secure Equipment & Data

Using the checklist, first ensure that customers, staff, family, and other involved parties have the immediate support they need – physical, emotional, and psychological. Next, contact the appropriate people to confirm that any equipment and data that may have been involved is secured or sequestered, including any written, audio, video or digital data. This might mean storing sensitive electronic documents on a protected server separate from the organization's network, for instance.

Next consult with the Safety Director or designee to see whether the incident warrants a larger, more coordinated and comprehensive response (See *Attachment #11*, "Complex Event Coordination"). Then prepare for your review of the data and your interviews. Again, following the checklist helps ensure reliability.

Step Four: Initial Review of the Reports and Charts

The initial review of most risk cases should start with reviewing reports and/or charts. Don't review written policies and procedures at this early stage. This is a known source of bias toward how people "should have" acted.

Be careful not to call what's in a chart or written report "facts." These should be considered known elements of the case (written documentation), but in many cases written documentation has been proved inaccurate before, during, or after the CRR. Most people document the information as they perceive it. And even machine-generated documentation, such as a monitor feeding information into a flight database or patient chart, can be found inaccurate. Go in with the understanding that what you are reading may be an incomplete picture.

This is especially true if a timeline is part of the chart or report. Timelines can be very helpful in understanding a sequence of events. Unfortunately, most timelines carry a heavy bias – they represent only things relevant to the incident or risk being studied. Few timelines are what we call "three-dimensional," which would introduce unrelated factors happening simultaneously that may affect system or human performance. Ask a few pertinent questions to give you better overall situational awareness:

- What else was going on at the *same time* that may have been distracting?
- Were there any other demands on the system or the people that, in your opinion, may have affected the outcome or the process?
- How often do these simultaneous issues happen?

Considerations during every report or chart review:

- Typically, starting at the latest element in the chart and working backward is the most efficient use of your time. There are exceptions, particularly related to risks the organization has seen frequently. But in most cases, working backward from the event or primary identified risk will work best.
- Check for any chart updates, merges and modifications. If there is an electronic record of who accessed the report or chart, take note of this and correlate it to any new or edited entries.
- Is the information in the report or chart relatively consistent with the story you heard – the risk report? Look for inconsistencies and any additional data you might need to provide further clarification. This may include maintenance records, lab reports, radiology, etc.

- Are the notes in the report or chart consistent with the metrics that have been entered? In other words, if there is a narrative, does it support what's in the data fields, such as gauge readings, vital signs, etc.?
- Are there issues in the documentation that require further clarification? If so, determine whether this is best done through interviews, further research or other methods.
- Look carefully and start noting **Contributors** when you see them. Whether a Contributor is categorized correctly at this point is not important. Just capturing it is crucial. For example, in a report, you might find that the writer documented that she was fatigued. This likely would initially be written down as a Human Performance Factor, but you might find during further interviews that the fatigue was because of a system issue (e.g., mandatory overtime) or a personal choice (partied late before work). Start with a report sheet/note sheet that has these categories so you reliably document Contributors:
 - Who was involved? Write down the “Actors” as you discover them in your analysis.
 - What are the System issues that seem evident in the report?
 - Do any Human Performance issues (knowledge, skills and abilities, distractions, etc.) appear?
 - What Choices may be related to the case (rules, policies, best practices)?

Once you have your notes, and have a list of the people and departments involved, use your notes and list of actors to set up any necessary interviews before the CRR. An overview of these “Contributing Categories” and the information you should be obtaining and analyzing is included as *Attachment #4*.

Step Five: Initial Interviews

Setting up interviews can run the full spectrum from a quick phone call and open dialogue to extremely difficult with a person being combative or defensive. Even during initial interviews, some staff who belong to a labor organization may ask to have a representative present.

Make sure they know you are not trying to find fault; you are just trying to get some more information before the CRR. It can be helpful to call in some assistance when an interviewee appears to be on guard. Work your internal channels to find someone who can join the interview and help defuse some of the anxiety. Conduct these more like a conversation over coffee than a deposition.

Important point: One decision you will need to make early in the fact-gathering process is whether to interview individuals involved in the risk or event as a group, or independently. This can be an important decision based, in part, on the potential severity of the organizational response to individuals. There are, of course, a few times when separating people for interviews is important. In cases where: suspected behaviors meet the conditions of higher culpable behavior; truthfulness of the individuals is in question; or power gradients exist that may limit participation and candor, organizations may require independent statements and interviews. (For example, during law enforcement interviews and most legal depositions, team members are separated to see if their stories differ.)

The downside to this approach, however, is it can bias the investigation toward perceptions of punishment and may limit the free flow of information needed to fully see and understand the risk(s). For an open, collaborative process designed to find proactive solutions to risk, segregating the people being interviewed creates big problems. Most people's perceptions are not completely accurate, so it is extremely rare to have everyone tell the exact same story when segregated (this be suspicious to a veteran investigator, for example). And it leaves you the chore of trying to find out which story is most

accurate. In these situations, separate interviews and statements may limit the effects of bias, the potential for false narratives, and potential power gradients.

Our recommended default standard is to interview participants together, as a group. In most instances, a group interview such as described in the Collaborative Risk Review Manual™ and Triad Review Process will yield improved collaboration, insights, and optimized solutions. Whenever possible, interview teams as a group, not individually. Having teams interview together allows members to support each other and confirm times and sequences. It generally gives a much richer and more comprehensive view of what happened.

Other important points:

- **Be curious during interviews.** If you have experience in the interviewee's domain, recognize going in that you will carry bias into the process.
- **Stay tuned in to potential areas of conflict.** How tense are people? Are they placing blame somewhere else? Do they need more support?
- **Recognize your context.** If you are a professional Risk Manager and/or attorney, you often are looking for signs of negligence. That's fine, but you may overlook contributing factors or determine that "the organization is not at fault" and therefore there is "nothing to see here." You carry the same context and bias if you are affiliated with Safety, Risk, Operations, Logistics, etc. Be self-aware of this.
- **Take notes.** Keep them secure, and prepare to build your slides based on your review of the chart or report and your interview notes.

Interviews before a CRR are not always possible. In most cases, interviewing everyone before the CRR is impossible because work schedules, timelines, and the like. Try not to let a delayed interview delay the CRR.

CRR Notifications and Personal Preparation

Notifying the Participants and Setting Initial Expectations (e-mail)

A reliable and consistent process for notifying everyone is important. There are various ways to do this, but most high-consequence organizations create a policy and/or expectation that anyone engaged in front-line operations will attend CRRs. Managers, Supervisors, and Leaders must be prepared to be flexible with schedules and work assignments because CRRs are a key method for finding proactive methods of managing system and human risk.

It is generally safer to be more inclusive and “over-invite” than to be restrictive. After all, a CRR is a learning process, and the more people who are exposed to the methods and good facilitation, the better they get at seeing, reporting, and managing risk.

The initial e-mail or communication with invitees should set some initial expectations. Without being too wordy, include a brief but concise statement of expectations. For example: “This is an opportunity to collaborate on how we might minimize future risks; it is not a fault-finding exercise.” (See again *Attachment #3* for an example of this type of messaging).

Prepare Yourself for the CRR Facilitation

Establishing some credibility and setting people at ease are important. It'll be difficult for people in attendance to share crucial information, which might be personally or professionally embarrassing, if they don't feel at least a little bit comfortable. Here are the Top Five Facilitation Skills (Summary included as *Attachment #5*):

1. **Be heard, facilitate hearing:** Stand and face the group when you talk. If you know you have a quiet voice, speak up. Don't yell, obviously, but use a microphone if it's a large room or a large group of people. It's frustrating to people in attendance if they cannot hear you, or if you face the screen or board when you talk.
 - a. If there is a phone bridge in use, put the receiver as close to you as possible. Speak toward the phone bridge when possible.
 - b. Be prepared to repeat questions that are asked. This can be difficult at first, but you are facilitating collaboration and understanding; if the people in the back can't hear the person asking a question, repeat it. It can be helpful, when someone asks a question, to say something like, “Did everyone hear that question, or should I repeat it?” Or just paraphrase and repeat the question: “Dr. Able asked if the lab reports were available at the time of the decision – from our review, it looks like they were not. Does anyone have different information?”
2. **Acknowledge different viewpoints:** You set the tone appropriately when you let people know there will be different perceptions of risk in the room. This should be represented on a slide or handout, but it is also important to say something like: “During this session, we will undoubtedly see and understand the risks differently. Please remain curious and consider other viewpoints carefully. Seeing these different perceptions is a crucial piece of how we manage risk in the future.”

3. **Be clear:** Make the text on your slides readable. Be succinct and use bulleted information for rapid assimilation. Too much on a slide can make it difficult for attendees to follow you, and they probably will read ahead. Use a clear, simple font in a size that can read from the back of a relatively large room. Better to have two slides that are readable than one with everything crammed on it.
4. **Make it safe:** It sounds counterintuitive, but position yourself to move *toward* conflict. If someone in the room starts becoming angry or confrontational (see “Managing Conflict”), slowly moving in their direction while redirecting the conversation has proven effective.
5. **Stay focused:** Stop and summarize often. Time can go by quickly in a CRR – at the end of every main point, transition points, or at least every 10 minutes, stop briefly and summarize. There are tips below on some effective methods to conduct these summaries.

Opening and Facilitating the CRR

Opening the CRR and Setting the Tone

Be prepared to feel uncomfortable. It's rare that a CRR doesn't bring some residual tension into the room. Something happened, or nearly did so, and a CRR usually involves a discussion of failures in our systems and our humans – many of whom are attending. Opening with a general frame in mind – something for people to remain focused on – can be helpful.

- Frame: "How do we become safer in the future? Can we? How might this type of risk or event affect the organization, and other employees in your position doing the same work?"
- Frame: "Not everything we discuss needs a solution. Some risks are inherent in our business and cannot be easily reduced. Stay curious, keep an open mind."

A template slide for opening a CRR is included as *Attachment #6*. We recommend you use this type of template, one that outlines expectations and ground rules, at the beginning of every CRR. Adding the "content" slides of the case (or risk) being reviewed after the lead-in slides is the most common method.

Addressing Potential Bias

Let people know up front that encountering biases in any analysis is common. Bias is a difficult topic – but if we can collectively or individually see areas where it might affect how we manage customers, employees, or others, we can figure out methods to minimize its impact.

In some cases, particularly those related to potential inequity risks, expert opinions, or longstanding practices, overcoming biases can require more resources. If you think having someone trained in managing these biases present for the CRR would help, plan for that.

During the normal course of analyzing the risks during the CRR, you, the facilitator, may uncover what you think is a bias that creates risk, or vulnerabilities. It might be an operational manager who refuse to examine a system or process for which they have responsibility. Or a supervisor who is related to or had a previous, personal disagreement with someone else involved in an event. If that happens, collaborate with your team after the CRR and determine the best way forward. You might have to meet individually with the operational manager in this example, to examine the perceived bias further, and determine whether or not this poses additional risk in the operating environment. Similarly, in the example of an individual who has had a previous personal disagreement, you might have to determine whether or not this poses additional risk.

Remember, bias risks are found in the same Contributing Categories as all other risks:

- Does our System create the opportunity for the bias to affect customers, service, or employees?
- Is there a Human Performance issue? Do our employees have the knowledge, skill, and proficiency to see and understand biases, and manage them? Are we cognitively aware of the biases?

- Is there a Human Behavioral risk? Is the System effective, and the human has the necessary training and cognitive awareness but *chooses* to take a biased approach?

Knowing which of these categories (individually or collectively) is a contributor to the bias risk will help when it comes time to prepare and propose a risk mitigation plan.

Attachment #7 contains additional resources for seeing, understanding, and managing bias.

Presenting and Discussing the Events and/or Risks

Presenting the case is straightforward. Narratives are powerful – follow your bullet points on the key aspects of the case, but try not to just read slides. Some tips for presenting the case:

- **Start with a substantive reason you are all there.** You have done the opening and set the tone and expectations – now present the risks as they were presented to you.
 - “We are here to discuss a case involving a 23 y/o male trauma patient who was admitted to our hospital on January 6th, 2019, at 1300. As you will see from the notes and information we present, the case is complex and involved several departments.”
- **Present the information you found in the reports, charts, and interviews.** Stop often and ask:
 - “Does anyone have more information about this point?”
 - “Can someone clarify for the group what happened after this?”
 - “Are there any suggestions on how we might manage this in the future?”
 - Direct **questions to people you know were involved:** “Julia is the PACU nurse who was on duty that day – Julia, could you lead us through what happened, and your perceptions that day?”
- **Have someone take notes.** Try to capture what was said and who said it.
- **Acknowledge and document suggestions for proactive measures.**
- **Keep the conversation moving forward.** When there is a gap – someone involved is not present, or needed information is not available – re-affirm with the group that you will try to get the information and continue with the dialogue:
 - “We may need more information from radiology, so I will follow up with them and make that information available to you. In the meantime, can we continue with the discussion around the events that afternoon?”
 - **Watch time closely.** Stay focused, and when people wander, bring them back:
 - “Your information is important, but because of our time constraints, I’d like to follow up with you about that issue after this meeting if I could.”
 - “I am so sorry for interrupting you, but I need to refocus the group on ...”
 - “I would like to circle back with you later to make sure I fully understand your concerns.”
- **Stop and summarize.**

- “OK, it’s been 30 minutes, and it’s time to stop and summarize briefly.”
- **Clarify what is being discussed.** It can be for everyone or just for yourself:
 - “Can we back up for a minute and talk more about that?”
 - “I’m not sure I understand the process as you described it – can you please help me?”
- **Test proactive suggestions for equity conformance by ensuring you propose counterfactual scenarios:**
 - “OK, the patient was a 32 y/o English-speaking white man, insured, with his own transportation and family support. Are we sure our Systems, Human Performance Factors, and Behavioral Expectations would work the same way if the patient were a 32 y/o Hispanic or Black female, houseless, uninsured, with only public transportation available to them?”
 - Be willing to examine and test assumptions.

Recognizing and Managing Conflict and Stress Points

Stress is expected during CRRs, and conflict is inevitable in some of them, particularly when there’s been an undesired outcome. Good facilitators will be prepared, based on the initial interviews and reports. If there was finger-pointing, anger, or frustration expressed in the initial interviews, the facilitator should consider opening the session with one of the statements related to how we see risk differently (No. 2 on the list of *Top Five Facilitation Skills*, above).

The most effective method for managing conflict during a CRR is to redirect the energy. Someone wants to rehash an issue or wants to know why something was or wasn’t done. Covering “why it wasn’t done” is not helpful. Recasting the conversation to “how do you think we could do this better in the future?” is often effective at redirecting the conversation to proactive measures, not fault-finding. An example from an actual CRR:

“Why didn’t you answer the phone at 4:45 PM? I know your department is open until 5:00 PM.” This created a situation where someone who was supposed to answer the phone would have to explain (and in this case, offer good reasons related to staffing) why they didn’t answer the phone that day. When the question was asked, the facilitator immediately interrupted the person who answered the phone before they could offer their explanations: “Let’s stay focused on what we’d like to see in the future – if you believe having someone available to always answer the phones would mitigate future risks, what options do we have, and what problems might that create in the department?”

You also will have situations where two people want to debate who’s clinical or operational approach should have, or would have, made a difference. There are so many different, appropriate, and successful ways to treat patients, and to fly aircraft and fight fires, that it’s easy for participants to debate the most appropriate clinical approach, strategy, or tactic. This is one of the surest ways to get sidetracked during a CRR. The best way to handle this kind of conflict is to acknowledge that there are different views of specific “Best Practices” and let the group know that you will facilitate a later meeting of “experts” where these strategies can be properly discussed.

This isn't to say that we shouldn't take a look at human performance. We know there are people who don't follow protocol or use known best practices. If you, as the facilitator, think someone has a valid point about how a patient or situation was handled, rather than engage in front of the group – where people are bound to get defensive – redirect (again) to a separate discussion:

- If the people involved are being civil, and the conversation is relevant to finding a collaborative solution, demonstrate how they might find common ground:
 - “It appears you see two different risks, or the same risk in different ways. Can we explore that a little more? This isn't personal – with our varied backgrounds and experiences, it's normal for all of us to perceive vulnerabilities and risks differently.”
- If there is a significant disagreement about tactics, strategy, or treatment that needs a more in-depth analysis (not an open CRR), propose a separate meeting to discuss it:
 - “There are definitely some differing opinions on how this scenario/patient could be managed in the future. We'll help set up a meeting with the professional group (Pilots, Fire Officers, Physicians, etc.) that has domain expertise here so we can collaborate on a potential solution. In the meantime, let's continue with our analysis – any other steps we might take?”

If anyone in the CRR loses their self-control and starts yelling, or makes objectionable personal comments to someone, or becomes physically imposing (such as getting in someone's personal space; a rare occurrence, but it does happen), the facilitator should immediately:

- Take control of the conversation and remind everyone why we are gathered;
- Let the person know they are making other people feel unsafe;
- Ask the person to leave the CRR if they cannot manage their behavior.

If the person continues, or refuses to manage his or her behavior, it is appropriate to close the CRR, thank everyone for coming, and let them know there will be a follow-up communication about what happens next. The facilitator should immediately report the behavior to the appropriate leader in the organization. The facilitator may need to have someone who attended the CRR contribute to this report to validate the behavior so it's not a “he said, she said” situation.

Closing the CRR, Documentation, Feedback

Closing the Session

Staying on time is important – most CCR's are limited to one hour. If the facilitator thinks the case is too complex to be closed in an hour, a follow-up session can be scheduled. In closing the session:

- Summarize the Contributors that have been identified;
- Summarize the Suggested Remedies that have been discussed;
- Thank everyone for taking their valuable time to collaborate;
- Provide contact information for people who want to follow up with the facilitator or other Safety, Quality, or Risk team members;
- Encourage different teams to meet afterward and engage in collaborative problem-solving;
- Let everyone know your intentions about Feedback.

Are There Necessary Immediate Risk or Vulnerability Mitigation Steps?

There are rare instances where *immediate* action is necessary to mitigate future risk. At times, System, Human Performance, or Human Behavior vulnerabilities are uncovered during the CCR (or during the pre-work) that require immediate attention. If anyone on the team, or any one of the participants, says they see a vulnerability or risk they think requires urgent and timely intervention, the facilitator is responsible for identifying the appropriate channels for this notification.

The facilitator should document the concerns as they were expressed or seen. The facilitator also should document any steps he or she took or notifications made recommending immediate interventions. These may include Safety Stand-Downs, Temporary Suspension of Privileges, Immediate Engagement of Human Resources, Lock-Out, Tag-Out procedures on equipment or calling in outside expertise.

Documenting the Contributing Factors and Suggested Remedies

Always document Contributing Factors by category so appropriate follow-up measures can be designed and the organizational Risk Register is accurate. At a minimum, any summary should include the following information and Contributing Factors (For an example, see *Attachment #8*)

Summary of Incident:

- Basic information about the incident and risks.
- References to the appropriate charts or other documentation.
- The departments and individuals involved.

Summary of Contributing Factors:

- Notes about how participants **saw and understood the risks**.
 - List any Competing Priorities that may have affected system or human performance
- List any **System Issues** that were identified: Was the system Effective? Resilient?

- Document any **Human Performance Factors**, such as distractions, knowledge issues, cognitive problems, etc.:
 - Were they System-related Human Performance Factors?
 - Were they Personal Human Performance Factors?
- Document any Behavioral Choices that may have contributed to the risks:
 - Policies, procedures, or best practices not followed, and if known, why.

Proactive Measures – Suggested Solutions and Assignments:

- What are the suggested System remedies?
 - Who is responsible for following up?
 - Are these remedies Strong, Moderate, or Weak?
(Assess the strategy for its level of Proactive Resilience (See *Attachment #9*))
 - What are the audit measures, and how will you know these are effective?
- What Human Performance Issues must be addressed?
 - Who is responsible and what are the suggested remedies?
- What Behaviors must be addressed?
 - Who is involved? HR, Manager/Supervisor, etc.

Assessing Proactive Strength:

- A helpful exercise is to engage those attending the CRR in evaluating the relative proactive strength of the suggested remedies (System, Performance, or Behavioral). Using the following table as an example, how might you assess whether the mitigation strategy will manage future risk? (This table is also incorporated into the CRR Report Template, Attachment #8)

STRONG System Focused	• Effective Automation • Failsafe Mechanisms • Forcing Functions • <i>Resilient</i> Lean Design	• Improved Devices, Usability Tested • Optimal Process Redesign • Architectural Improvements • High Fidelity Capture Opportunities
MODERATE Human Performance Focus	• High Fidelity Simulation • Checklist/Cognitive Aids • Reduce Distraction • Increase Detectability	• Eliminate “Look & Sound Alike” • <i>Optimized</i> Redundancy • Standardize Equipment/Processes • Team & Communication Training
WEAK Behavior Focus	• Classroom Training/Ed. • Additional Double Checks • Additional Documentation • Warnings & Signs	• Safety Bulletins, E-Mails • New Written Procedures • Highly Detailed Processes • Memos, Policies, Best Practices

Internal and External Reporting Pathways

Once the documentation is complete, file the necessary reports based on the level of risk, the need for intervention, and the organization's policies related to the findings (See *Attachment #10a & #10b* for examples of Internal and External reporting methods):

- What are the **Internal** reporting channels?
 - Who does the report?
 - What information do they need?
 - Why is the report being made?
 - What are the expectations for the recipients of the report?
 - Is there feedback expected?
 - How do you document that the report was made?
- What are the **External** reporting channels?
 - Who does the report?
 - What information do they need?
 - Why is the report being made?
 - What are the expectations for the recipients of the report?
 - Is there feedback expected?
 - How do you document that the report was made?

Additional Technical Information

Safe Practices for Electronic / Videoconference Risk Reviews

In 2020, the COVID-19 pandemic changed the way many organizations collaboratively analyzed risk. Previously, case materials, conversations, and suggested remedies could be viewed and discussed in confidential surroundings. With the increased use of email, fax, and videoconference technology to conduct sensitive case and risk analyses, organizations have recognized the need to establish some “best practices” associated with the confidentiality and security of materials, conversations, digital access, and other factors that are generally taken for granted when everyone can gather in one room. SGCS has collaborated with clients to develop a “Safe Practices for Electronic / Videoconference Risk Reviews” document, included as *Attachment #12*.

Sample First Steps Checklists and Complex Incident Coordination Guide

These checklists represent what can be used or created to help staff determine the “First Steps” to take when engaged in mitigating several kinds of risks and vulnerabilities. For example:

- Complex incident where there are major logistical and operational needs (*Attachment #13*)
- Standard checklists for managing risk incidents (*Attachment #14*), such as HazMat or Bio exposure, Engineering Risks, Standard Clinical Investigations (with and without harm events) and Injury to Staff Events.