Know Why and Comply

Error types prevented in the Generic Error Modeling System (GEMS)

<table>
<thead>
<tr>
<th>Skill-based</th>
<th>Rule-based</th>
<th>Knowledge-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slip</td>
<td>Wrong rule</td>
<td>Decision-making</td>
</tr>
<tr>
<td>Lapse</td>
<td>Misapplication</td>
<td>Problem solving</td>
</tr>
<tr>
<td>Fumble</td>
<td>Non-compliance</td>
<td></td>
</tr>
</tbody>
</table>

The least you should know

- **Know Why and Comply** is a habit of the mind that ensures that our choices are compliant with best practice. Compliance has always been a cornerstone of safety culture. Blind compliance is not safe - intelligent compliance is safe. Following a policy or protocol without thinking (called cook-booking) is – forgive the pun – a recipe for patient harm.

- Rule-based errors occur when we do not follow policy and protocol. Since patient safety is our first priority, we will be thinking about policy and protocol and applying the rule as to meet the letter and the intent of rule. Stop if rules do not make sense.

How should we use this tool?

- Use **Know Why and Comply** when making choices based on policy, protocol, and professional practice. Think about the rule and the reasons the rule exists. Apply a questioning attitude. If the rule makes sense – then apply the rule in a way that meets both the letter of and the intent of the rule.

- Having a protocol in hand makes the user four times more reliable in applying that protocol. This is called **continuous use**. The protocol is with the user, the user reads and understands a step, the user performs the step, and the user often initials or signs for task tracking. Reference use is performing familiar tasks per policy and protocol from memory. Infrequent or complex tasks should be continuous use.

Did you know?

1. Rule-based errors are sometimes called errors of the head (not errors of the hand) because the execution of the act is correct – it’s the choice of the act that is incorrect.

2. 22.2% of acts leading to serious patient harm are noncompliance, where a choice was made to violate policy. Since people do not violate policy with the intent to cause harm, every noncompliance is also a critical thinking error.

A Case in Point

A nurse knew her patient very well from several stays in her unit. This nurse chose to short-cut the patient identification check – thinking she was perfectly confident she was with the correct patient. She was. What she did not realize was the patient identification check is a three-way matching of patient identity, medication administration record, and the medication. She had the right patient and the wrong med. Her patient survived the med error, but required an 11 day stay in the ICU.