



4-step method to identifying and navigating roadblocks

This tool uses a **4-step method to identify and navigate roadblocks**. It helps you explore situations more deeply so your team can understand what happened, why it happened, and what can be improved. This tool helps you to avoid a situation becoming a complaint.

How to use it:

1. **Summarise the situation** – describe what happened clearly and briefly.
2. **Answer the 4 questions** – step through what happened, why it happened, what influenced it, and what can be improved.
3. **Reflect as a team** – discuss the responses with colleagues, share insights, and explore ways to strengthen practice.
4. **Act** – identify immediate steps and longer-term improvements to support safe, respectful care.

This resource is a **reflection tool**. It works alongside your organisation's existing policies and processes, helping teams learn from everyday situations and adjusting practice where needed. If relevant, record this occurrence in your Incident Management System.

This tool is not a complaints handling or incident management tool. Please refer to formal complaints handling and incident response processes for situations requiring formal action.

Share this template with your team lead to support them in applying it with their teams.

On the following pages, there is an **example scenario** and a **template** you can use in your own organisation.

The 4-step method to identifying and navigating roadblocks

The method is used to look past the immediate outcome and understand the deeper factors that contributed to the situation.

By exploring these factors, organisations can identify opportunities to strengthen:

- processes
- communication
- learning and guidance
- systems and supports for workers.

Event occurs	
1. What happened?	Describe the situation clearly and briefly. Include who was involved, what was done, and what you observed. Where possible, include the perspectives shared by those involved to build a fuller picture of the experience.
2. Why did it happen?	Explain the immediate factors or circumstances that led to the situation. Consider what influenced the actions or outcomes in the moment, including what information was available, how it was understood, and any communication that informed decision making at the time.
3. What influenced this?	Look deeper into internal or external factors. Reflect on whether broader system, policies, processes, learning material or communication elements shaped what happened. This may include how information is shared, consistency of messages, handovers, or how guidance is interpreted across the team.
4. What can we improve?	Identify what support or improvements may help prevent similar situations in the future. This may include strengthening communication approaches, creating more opportunities for shared understanding, and ensuring the older person remains informed, involved, and central to decisions moving forward. If relevant, record this occurrence in your Incident Management System.

When an issue, concern or challenge arises, it's natural to focus on the immediate outcome or to think the cause is linked to a single action. In care environments, situations are often shaped by a mix of factors such as communication, processes, systems, training or how guidance is interpreted.

The 4-step method to identifying and navigating roadblocks is a reflection tool that supports teams to explore a situation more deeply and identify the underlying factors that may have contributed to it. Open and respectful communication between providers, workers, the older person, and those supporting them helps build a shared understanding of what occurred and what matters most moving forward.

When using the 4-step method, it is important to involve all parties in the process, including workers and the older person, and to create an environment where they feel comfortable sharing their experience.

- The older person who was affected should be actively involved in the resolution of the issue, the way forward and improvement areas that are found. Keeping the older person informed and involved throughout the process supports transparency and ensures their preferences, experiences and outcomes remain at the centre.
- The workers are an integral part of the reflection process. Hearing what happened from the workers point of view provides more context around the situation and can inform areas for improvement for the greater workforce. Ongoing communication throughout the process

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supports workers to reflect on their actions, share insights, and contribute to practical and meaningful improvements.

- For providers, consumer advisory bodies can help to promote and lift the voice of the older person in this process, strengthening communication and connection between people receiving services and those delivering them.

The purpose of this method is to understand:

- **what** happened
- **why** it happened
- **what support or improvements may help** better manage similar situations in the future.





This approach supports a culture of identifying opportunities to improve as a process of best practice, where shared communication and reflection contribute to stronger, more responsive care.

On the following page, you can see how this method can be implemented in an aged care environment to better understand the root cause of an issue or problem, giving you the opportunity to adjust practice. You can then apply this method in your organisation.

4-step method to identifying and navigating roadblocks - *example scenario*

In a residential aged care home, a worker is checking in on Mr Petrov. During the visit, Mr Petrov complains that his neighbour, Mrs Chen, is playing her music loudly. He can hear it from his room, and it disturbs his rest.





He has visitors arriving imminently and would like to have a nap before they arrive, but the music he can hear from Mrs Chen's room is preventing this from happening. Mrs Chen has a right to listen to music in her room, and Mr Petrov has a right to a private and quiet space.

Question	Response
 <p>What happened?</p>	<p>The worker understood that both Mrs Chen and Mr Petrov had rights that had to be considered and upheld but realised that they were at odds. Attempting to find a middle ground, the worker spoke to Mrs Chen and let her know that someone had complained and she had to turn the volume down. To make sure that Mr. Petrov wouldn't hear the music, on the way out of his room, the worker closed the door behind them.</p> <p>While Mrs Chen was still able to listen to music, and Mr Petrov had a quiet space, neither were happy with the resolution and felt like they were not consulted about the options and had no input.</p>
 <p>Why did it happen?</p>	<p>The worker understood their responsibility to provide rights-based care and knew that both older people had rights that must be upheld. But when the 2 residents' rights clashed, the worker made decisions based on their learning to date and the perceived rights-based solution they chose did not satisfy either person.</p>
 <p>What influenced this?</p>	<p>The learning and guidance available to the worker equipped them to deliver care to older people, but further learning could be given to prepare them for more complex scenarios, such as when these rights compete.</p> <p>Without the necessary learning, confidence and communication skills, it was difficult for the worker to know how to act as a mediator and find a solution that both parties agree with.</p>
 <p>What can we improve?</p>	<p>Giving workers more support and guidance around complex situations that have arisen since implementation of the Act may alleviate concerns they have.</p> <p>Immediate action: Speak with the worker to understand how the incident occurred, and step through how it could have been managed differently. Examples include:</p> <ul style="list-style-type: none"> • speaking with Mrs Chen to find a more suitable time that she could listen to music that wouldn't interrupt Mr. Petrov's rest • offering Mrs Chen or Mr Petrov noise-cancelling headphones • giving Mr Petrov a quieter area that he could rest in until his visitors arrive. <p>Use this scenario to share in reflective practices such as team meetings to encourage a shared understanding for other workers.</p> <p><i>Note: The names of this scenario have been changed to de-identify the people involved. Always de-identify when discussing scenarios.</i></p> <p>Long-term action: Include this scenario as a reflection discussion in learning sessions.</p>

Use the following template to apply the 4-step method to identifying and navigating roadblocks to situations or events that have occurred to inform the approach you will take.

4-step method to identifying and navigating roadblocks template

[Outline the situation/incident]

Question	Response
 What happened?	[Describe the situation clearly and briefly. Include who was involved, what was done, and what you observed.]
 Why did it happen?	[Explain the immediate, in-the-moment factors or circumstances that led to the situation. Consider what influenced the actions or outcomes.]
 What influenced this?	[Look deeper into internal or external factors. Reflect on whether broader system, policies, processes, learning material or communication elements shaped what happened.]
 What can we improve?	[Identify areas of improvement and actions to be taken to prevent similar situations in the future. If relevant, record this occurrence in your Incident Management System.]

This tool helps you to avoid a situation becoming a complaint. *This tool is not a complaints handling or incident management tool.*

For information regarding complaints handling visit: [Good complaints practice for providers | Aged Care Quality and Safety Commission](#)

For information regarding incident management visit: [Incident management | Aged Care Quality and Safety Commission](#)