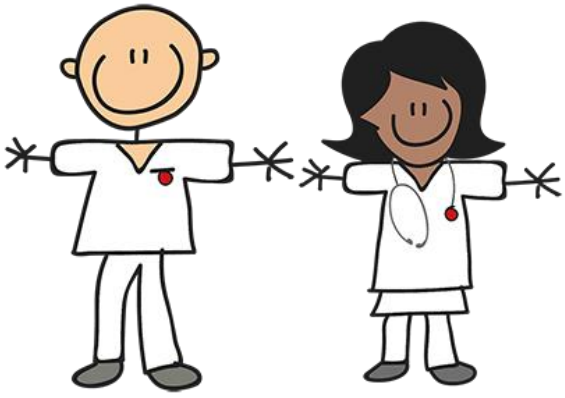
TO ERR IS HUMAN

Human Error. Time for a rethink?



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PSIRF AND HUMAN ERROR

Have you ever added milk to someone's tea, despite them asking for black tea just two minutes beforehand?

Have you ever grabbed the wrong bunch of keys as you hurried out of the house, despite knowing that on this day you needed the other bunch?

We've all done things like this...

In practice, have you ever lifted the wrong bag of fluid, intending to choose saline but take glucose?

To ERR IS HUMAN! But somehow we have forgotten that, which is in fact a deadly mistake.

Let's take a big step back. How do we actually want our staff to behave in healthcare? Do we want 100% error free performance? No errors at all? Sounds appealing! Let's go for that. But, we know, when we stop to think about it, that this is impossible because our staff are human. And humans ERR. We would need to have 100% automation (robot staff?) to remove all the "human error". Maybe that sounds appealing to you right now, but think about what you would be losing. You would lose your staff's ability to rise to the occasion, flex how and when they do things, deal with the unexpected (think back to the pandemic, or even the most recent staffing crisis in your area).

So, if we can't have 100% error free performance, is it fair to set up a system that expects that as its standard, coiled ready to spring to deal with the next human to err?

Some of you may say yes, it is fair, it is a standard and we must all strive to be as error free as possible. That we need a system set up

to maintain these standards, that staff must be accountable for when they make an error.

Sounds reasonable on the surface, but what such a system says to staff is that they are expected to be superhuman and never make an error, and if they do, a whole world of pain will come crashing down on their heads. So what happens? Staff will never tell you about all the near-misses that they had, how they detected the error and made things right. You think your system is working brilliantly until the day comes when the error is not detected and harm is done.

There is another way.

It is possible to both accept that humans will err and maintain high standards. This approach asks us to change fundamentally how we think about error.

First of all, it asks us to stop using the word error. That implies a mistake on behalf of the human (and many have made careers out of classifying all the ways humans can make mistakes). Rather, we are asked to accept that the human is part of a system, a system with many elements including things like the environment, the tools and technology, other humans, Tasks, organisations, and even external influences like the weather or government.

If we accept that, the next step is to understand that the system produces all the outcomes, not just any one element. It is the system that generates both wanted and unwanted outcomes.

When there is a wanted outcome, we can say "more like that please" and look to see how that wanted outcome happened, what great interactions happened there? Did the environment, for example the layout of a ward, mean that it was possible for the human to observe the most unwell patients and therefore respond immediately when one deteriorated? Can we strengthen this? Get more outcomes like that? Can we keep that bay for the most unwell patients? Can other wards learn from this interaction with layout and staffing?

But also, when there is an unwanted outcome, we must say, "how can we reduce the chance of that outcome?" We must look and see how the unwanted outcome happened, what interactions unfortunately came together? Did the environment, for example the layout of a ward, mean that it was impossible for the human to observe the most unwell patients and therefore it was not possible to respond immediately when one deteriorated? Can we dampen this down? Can we make changes to our system, can we better match staffing levels to layout for example?

Perhaps there were other factors at play in the system described above, perhaps shift length and rota patterns, perhaps the complexity of the tasks that the human had to perform, perhaps the workload- capacity balance was off, maybe it was intolerable hot, perhaps equipment was missing.

We want our systems to support the human, to take account of the ways that humans may act (or not act), and ideally reduce the impact of those times when humans don't manage to do as they intend to do. (And we know our staff intend to keep patients safe).

We want our systems to generate more wanted outcomes and fewer unwanted ones.

We must therefore take a systems approach and learn how to make improvements that will drive the system to generate more wanted outcomes.

This is the fundamental shift in thinking demanded by the new PSIRF, prompted by the fact that our current methods have had minimal impact on patient safety.

It is, therefore, a deadly mistake to ignore the system and punish, retrain or further constrain the human. Let's stop talking about "human error" and focus on strengthening our systems.

To learn more, please consider using Being Human in Healthcare Ltd for your organisation's PSIRF training needs.

We also explore these concepts further in our updated Human Factors for healthcare Leaders Course, now available virtually, and in our two-day virtual Human Factors Train-the Trainer Course.

To learn more, visit our website

www.being-human.org.uk