6 factors that lead to human error

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by Frederick Southwick

In medicine, mistakes can cost lives. If prevention is truly part of the cure, it would benefit hospitals to identify the factors which lead to human error and implement measures to reduce serious mistakes.

Individual factors - The responsibility of the caregiver

1. **Fatigue:** Fatigue is a prime factor that causes caregivers to become error-prone. Sleep deprivation can impair a driver's performance to the same extent as someone who is under the influence of alcohol. Imagine an intoxicated person working in a hospital setting, and you'll have a better understanding of the dangers of being fatigued. Each caregiver should feel obligated by his patient responsibilities to always come to work adequately rested.

2. **Emotional stress:** Emotional stress is another factor that can precipitate human error. For example, it's imperative that our minds focus on patient care, rather than on a dispute with a colleague. Safety experts recommend that all providers learn how to control their emotions and interact with fellow caregivers in a calm and constructive manner. Because disruptive behavior poses such a threat to patients, the Joint Commission recognizes this form of behavior as a "sentinel event," an event that increases the risk of patient death or serious physical or psychological injury.

3. **Multitasking:** Another activity that increases the likelihood of errors is multitasking. In an effort to maximize task completion during a shift, caregivers may try to do several things at once. To save time, a nurse may carry medications for two patients, rather than deliver the medicines individually. Experience has shown that this time-saving strategy greatly increases the risk of accidentally switching medications, and these mix-ups can be life-threatening.

Environmental factors - The responsibility of the hospital
4. **Noise:** A noisy environment not only hinders patient recovery, but also can lead to errors. When extraneous noise is present, the brain has greater difficulty focusing on tasks. Ideally, our hospitals should emulate the quietness of a library to create an environment conducive to healing.

5. **Skeleton crews:** Skeleton crews are another risk factor. Many hospitals rely on reduced staff during weekends and holidays, or are short-staffed when someone calls in sick. This is a dangerous condition; when the ratio of nurse-to-patient care is greater than 1:6, the ability to properly fulfill patient needs decreases, increasing the likelihood of multitasking and fatigue.

6. **Culture:** One of the most dangerous hospital cultures is one that encourages the hiding or ignoring of errors. It’s understandable how such an environment develops; physicians, in particular, are conditioned to strive toward perfection. This is an admirable trait; however, those who consider themselves perfect often are in denial. A perfectionist may feel ashamed when he makes a mistake and try to cover it up. When it comes to perfectionists, transparency must be encouraged.

Errors also are less likely to be reported when caregivers are personally blamed. The ideal environment creates a strong safety culture; those in a strong safety culture understand that errors are most often the result of poor systems, not bad caregivers. When a caregiver understands that punishment won’t be a primary response, he is more willing to acknowledge his mistake. Experts should then be brought in to perform a root-cause analysis that will allow everyone to learn from the mistake in order to prevent a recurrence.

In this era of ever-increasing medical complexity, the most important realization is that no one can do it all. Teamwork is vital for efficient care; each professional caregiver possesses unique and equally important expertise that should be shared. And patients themselves should not be overlooked when it comes to error prevention. Patients often know details about their illnesses that can help prevent mistakes; patient suggestions should often be incorporated into decision-making.

By understanding the nature of human errors and working together as teams in open and cooperative environments, we can all reduce the likelihood of human errors.

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