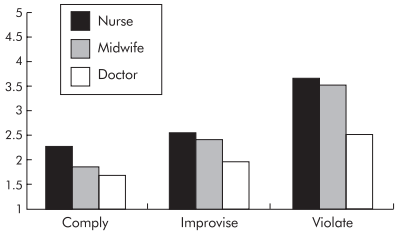
ACTION POINTS

Compiled by Tim Albert

Q: How can we use mistakes to improve health care?

Two British psychologists gave 315 health professionals a number of short scenarios describing various errors and asked them how likely they were to report each incident.

- All were reluctant to report adverse events to a superior.
- Doctors were more reluctant to report them than nurses or midwives.
- All were more likely to report them when a protocol had been violated and the outcome had been bad.



The authors conclude that the NHS should look to other organisations, such as Shell Petroleum and British Airways, where more proactive systems of error management are used.

See page 15

"The importance of using **all** *types of error to bring about safer care needs emphasising to staff, but this can only be done in an atmosphere of trust"*

(commentary, page 7)

▸ ACTION POINT

The current system of reporting mistakes in the NHS is ineffective, mistakes go unreported: change is needed.

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Q: How can we stop people leaving out important steps in complicated tasks?

The most common source of human error is leaving out a necessary step in a procedure. Certain steps have characteristics that make them more likely to be omitted, and these can be identified in advance. Professor James Reason of the University of Manchester carried out three experiments:

- 95 people rated 15 potential omission errors during the task of photocopying. The most common, which he had predicted using the risk factors, was leaving the last original in the photocopier.
- 147 undergraduates listed their strategies for remembering necessary tasks. The most common techniques were post-it notes, diary entries and lists.
- 10 academic psychologists were asked how these strategies met the five criteria for a good reminder.

"The provision of timely and suitably located reminders will make a substantial dent in the number of future omissions", he wrote.

See page 40

▸ ACTION POINT

Reduce errors by identifying those steps most likely to be omitted, and provide suitable reminders.

Q: How can we improve our understanding of non-compliance?

Non-compliance is a major problem: 30–50% of patients do not take their medicine as directed, and one study in the US has estimated the annual cost at $100 billion. The traditional psychological model has not proved to be effective at predicting individual behaviour. A more promising approach would be to look at non-compliance in terms of human error theory. This widens our approach from studying the person who made the error to looking at organisational and local factors that caused them to make that error. "This promises to be a significant advance in our understanding and solution of non-compliance", says the author.

See page 81

▸ ACTION POINT

Improving patients' use of medicines requires us to understand non-compliance as part of a social process.

Q: How easy is it to get doctors and nurses to adapt to a new drug recording system?

Hospital doctors in Denmark traditionally dictated drug prescriptions or wrote them in rough. They were written out or sorted by their secretaries, who then gave them to nurses to put into the patients' notes. This was a major source of error. A new system was introduced in which doctors entered the prescriptions directly onto drug charts. Some months after the changes the researchers asked seven doctors and eight nurses for their opinions. They found that the changes conflicted with existing structure, culture and routine and caused resistance and a range of alternative 'solutions'. The authors comment: "We have changed our implementation strategy for the new system which now includes specific training, enhanced leadership, use of local opinion leaders, formation of local networks and iterative audit and feedback".

See page 19

▸ ACTION POINT

Successful introduction of new procedures requires much groundwork with the staff affected, otherwise cultural norms will limit progress.