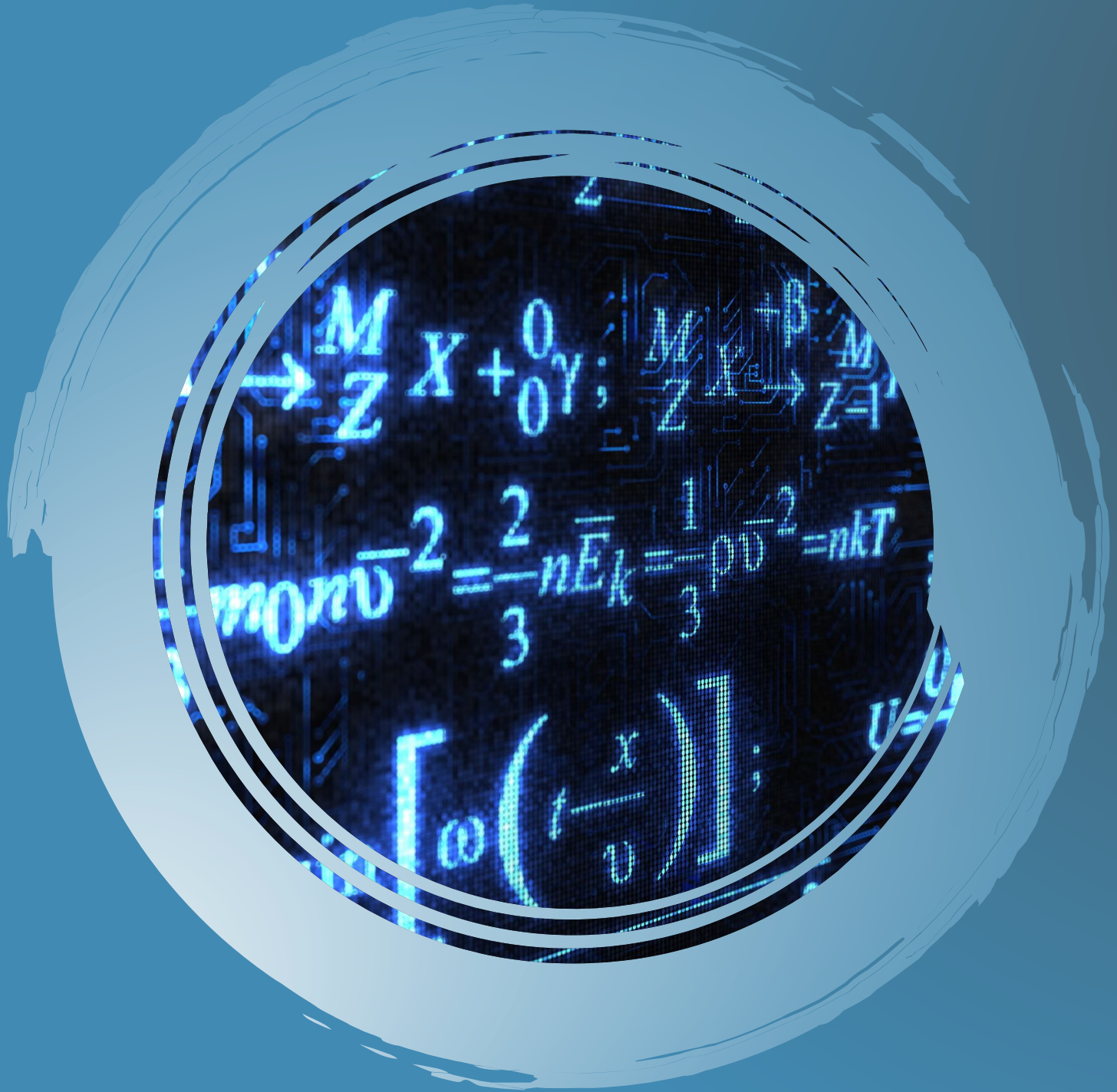

# Formula for Safety: More than a sum of its parts?

Dr Dawn Benson
Dr Lauren Morgan

# Why parents pursue litigation on behalf of their children who had been avoidably injured at birth?

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Systems Safety Ltd.

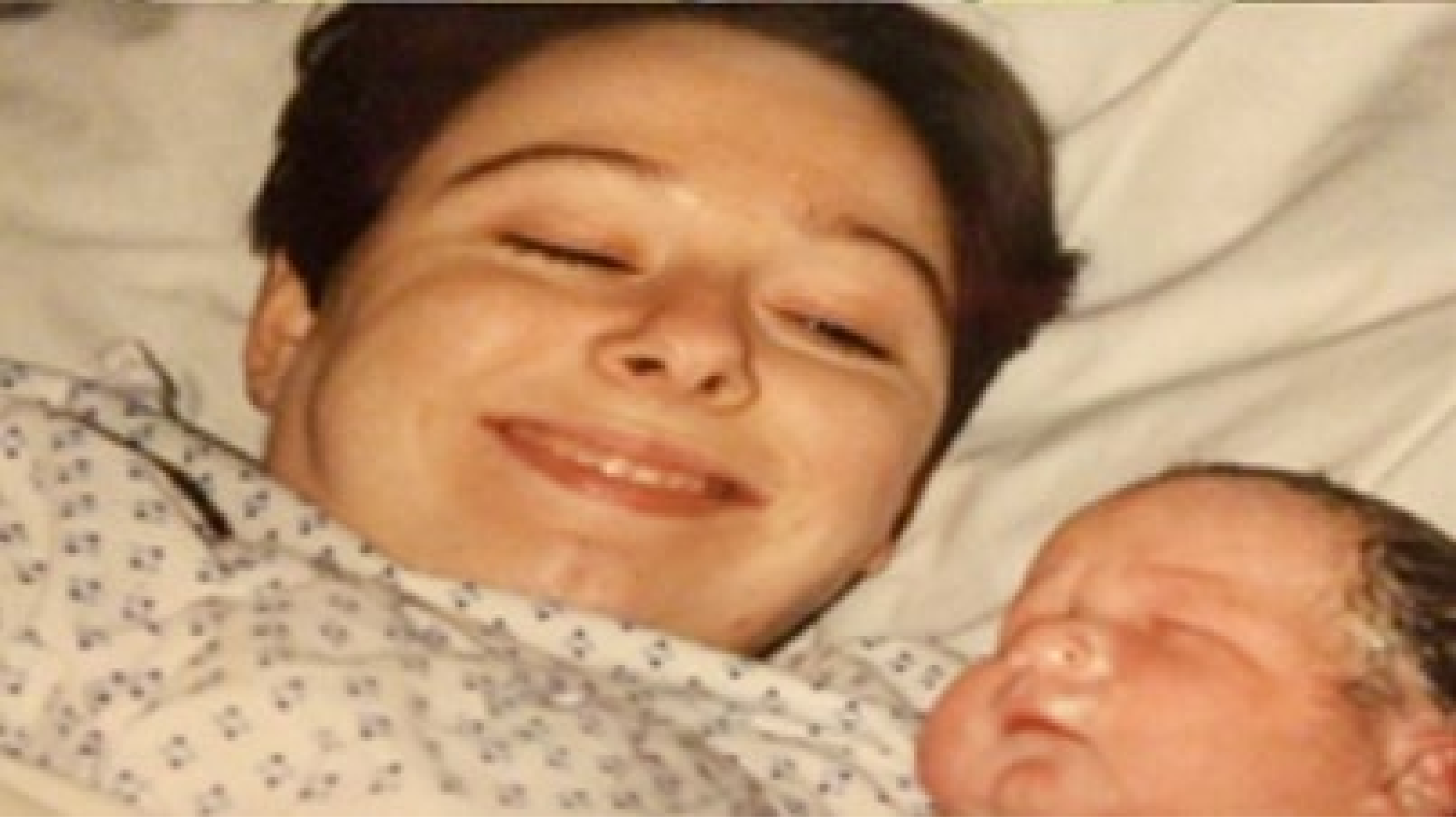
# What parents wanted from litigation

- Answers about what had happened; findin
  through inconsistencies and often s
- Lessons to be learned – l
- Resolution - of
  that th
  ation that litigation would help
  e of the state for support services

Litigation often fails to satisfy claimants

Vincent, C. & Taylor – Adams, S. (2001) 'the investigation and analysis of clinical incidents' in Vincent, C (ed) *Clinical Risk Management: Enhancing Patient Safety.* London: BMJ Books pp:439-460

"... While a particular practice or omission may be the immediate cause of an incident, closer analysis usually reveals a series of events and departures from safe practice, each influenced by the working environment and the wider organisational context".



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| HRO value | Organisational level concern |
|---|---|
| 1. Pre-occupation with failure | • Encourage error reporting<br>• Accept human error as inevitable<br>• Obsession with avoiding overconfidence |
| 2. Reluctance to simplify | • Unwillingness to simplify a situation<br>• Create more complete pictures of situations<br>• Encourage spanning of boundaries, negotiating, scepticism and differences in opinions |
| 3. Sensitivity to operations | • Ongoing concern with the unexpected<br>• Attentiveness to those on the front line<br>• Acknowledgement that the cause of an accident is often not the result of a single active error but rather multiple slips and lapses that can be latent (present but inactive) in the system |
| 4. Commitment to resilience | • Ability to identify, control, and recover from errors<br>• Errors and failures kept small<br>• Practice worse case scenarios<br>• Develop strategies to expect and react to the unexpected |
| 5. Deference to expertise | • Encourages communication of expertise from all levels<br>• Decisions made on the front line<br>• Migrate decision-making to its lowest possible level<br>• Cultivate diversity |

Weick and Sutcliffe

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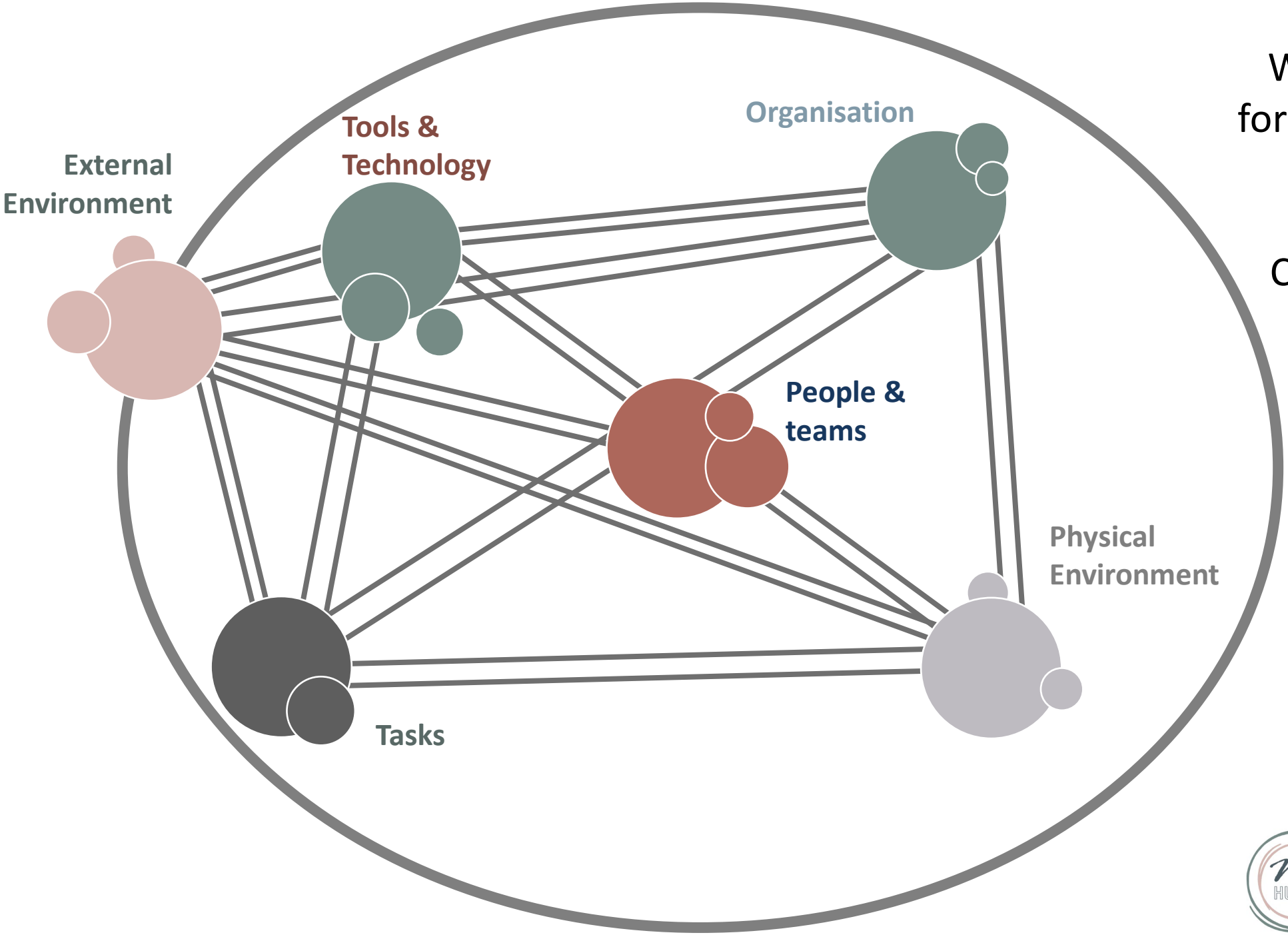
# Work system design for patient safety: the SEIPS model

Carayon et al., 2006

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# The reality of work…

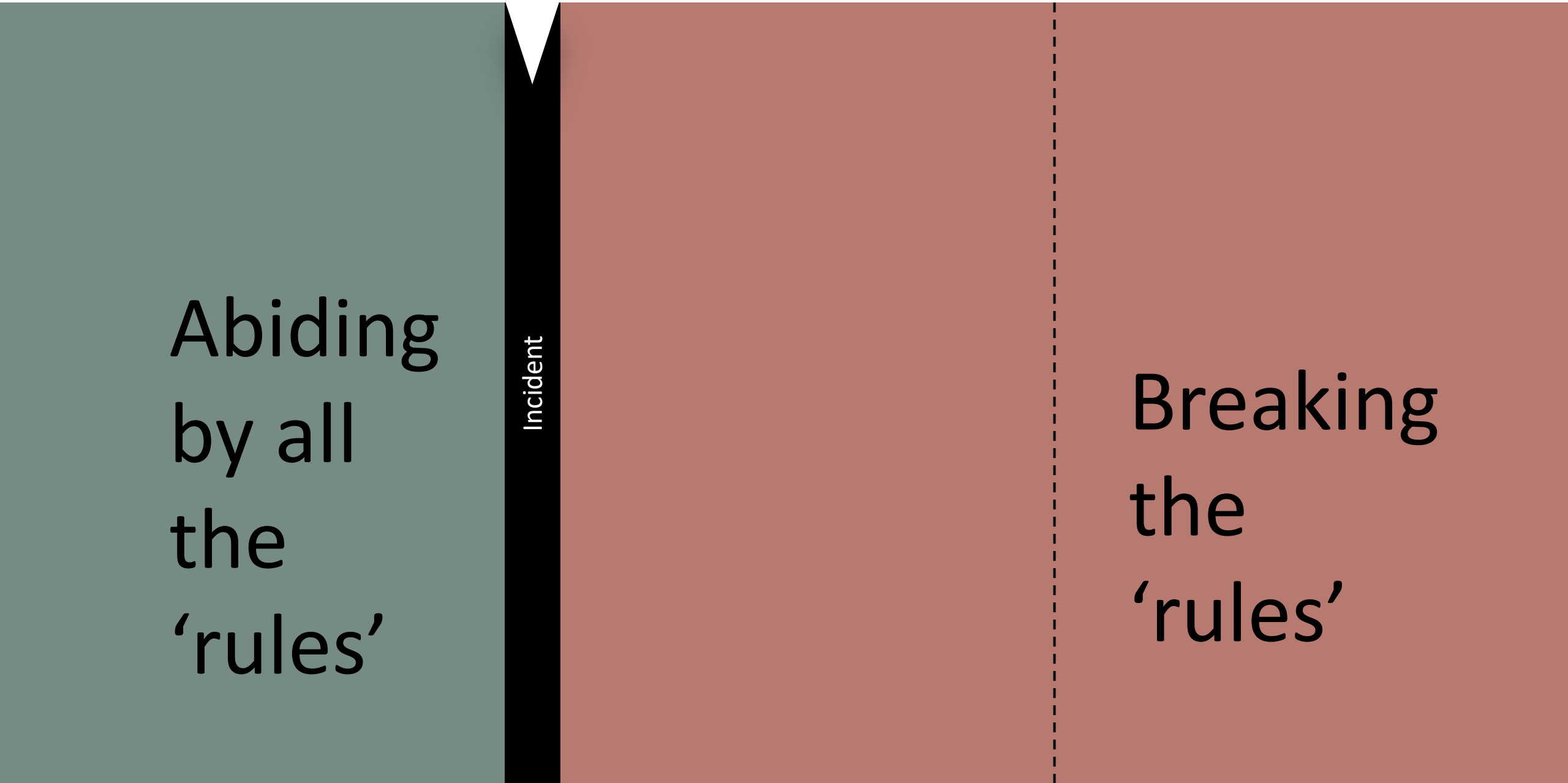
Abiding by all the ‘rules’

*“legal illegal”*

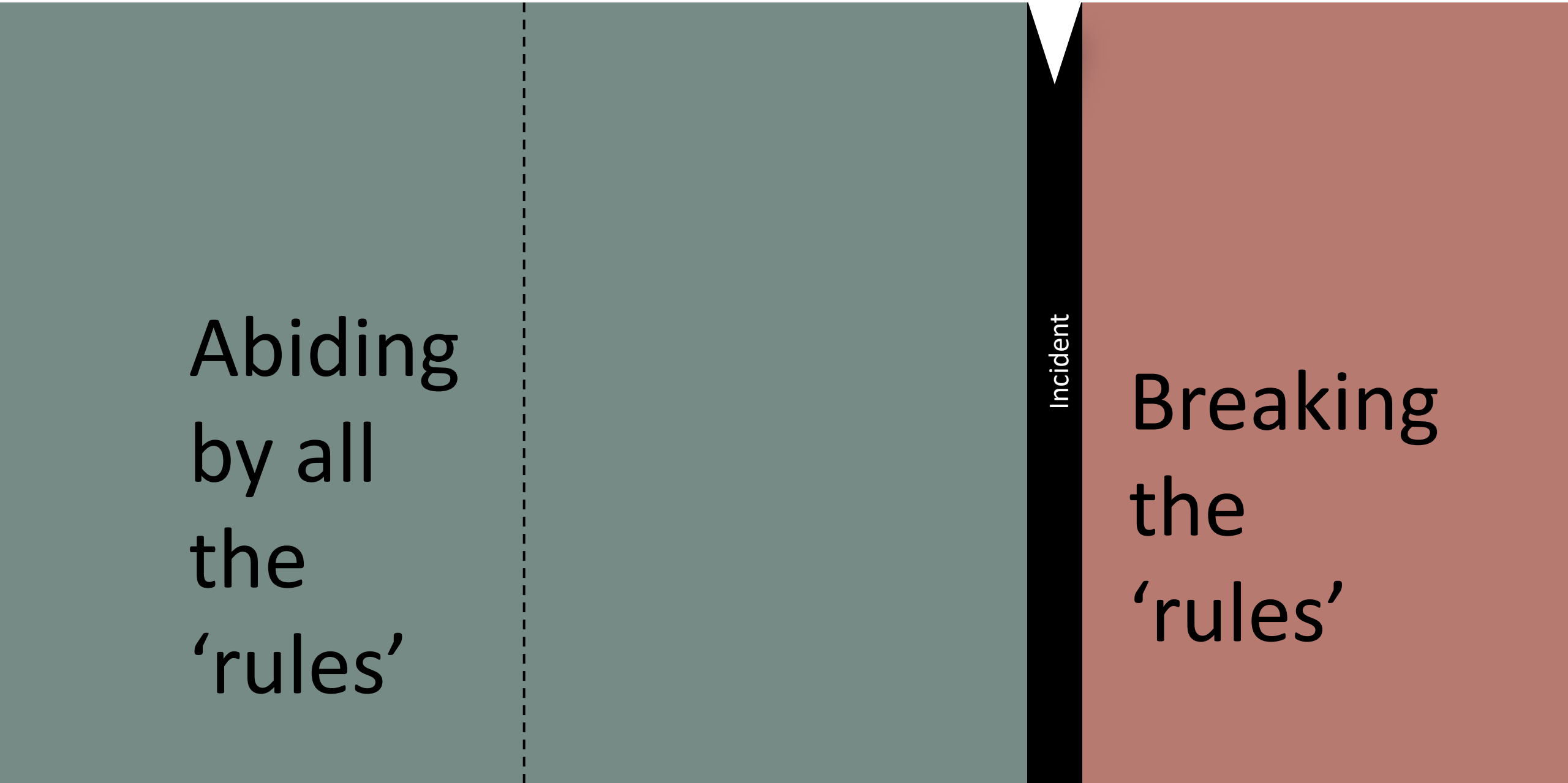
Grey area

Breaking the ‘rules’

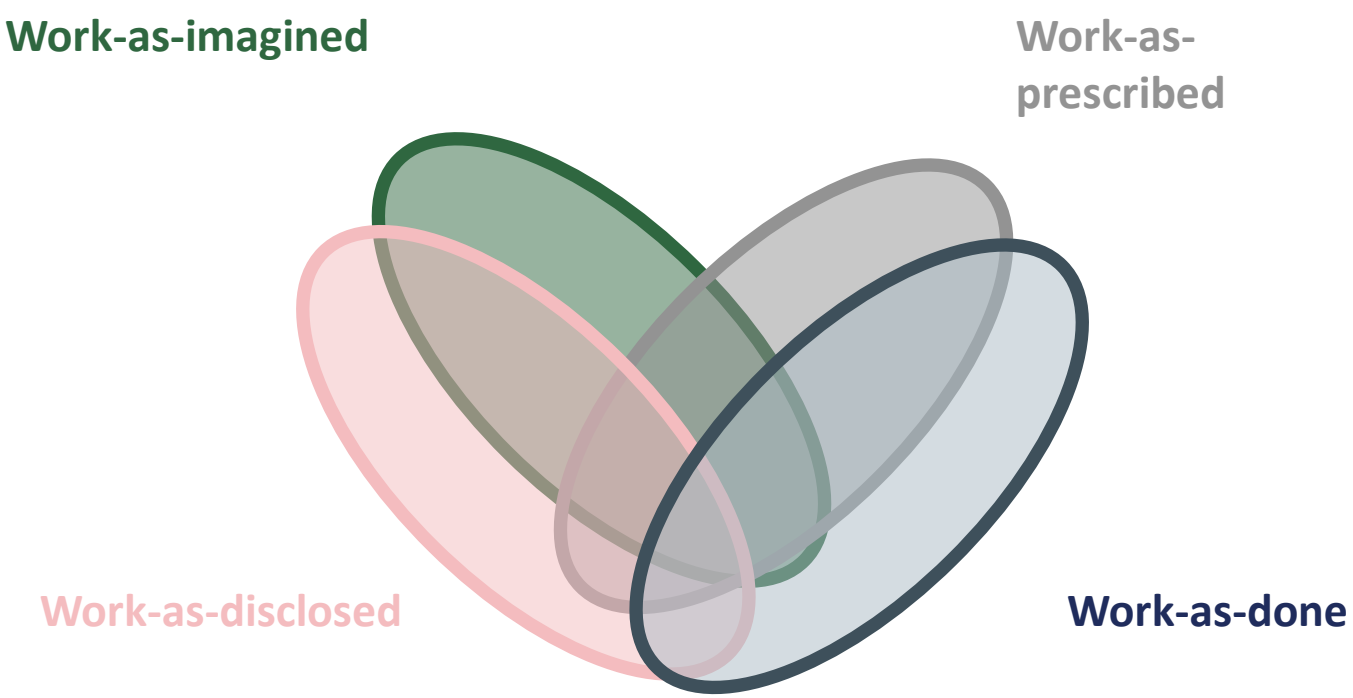
# Incident with a poor outcome



# Incident with a good outcome



# Varieties of human work – Shorrock, 2016



Dawn: What would you like to ask them, if you could meet the midwifes and the doctors that were part of your care at the time?

Michael: I guess, just kind of… it's a tricky one because … they wouldn't have done it on purpose. But they might have thought like, once they realised their mistake they probably thought, she (Michaels mum) was right.

Dawn: How do you feel towards them?

Michael: No different to any other doctor or hospital staff because they do make mistakes. They're only human. Only a mistake from a hospital staff is going to be greater than someone who isn't because their mistake impacts other people.

# "Only Human"

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