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Human Factors in Health Care

Q. What does the term “human factors” mean?

A. Human factors apply wherever humans work. Human factors acknowledges the universal nature of human fallibility. The traditional approach to human error might be called the “perfectibility” model that assumes that if workers care enough, work hard enough, and are sufficiently well trained, errors will be avoided. Our experience, and that of international experts, tells us that this attitude is counter-productive and does not work.

Q. What does the study of human factors involve?

Human factors is a discipline that seeks to optimise the relationship between technology and humans, applying information about human behaviour, abilities, limitations and other characteristics to the design of tools, machines, systems, tasks, jobs, and environments for effective, productive, safe and comfortable human use.

Q. Why is the issue of human factors in health care important?

A. Human factors issues are major contributors to adverse events in health care. In health care and other high-risk industries, such as the aviation industry, human factors can have serious and sometimes fatal consequences.

However, the health care system can be made safer by recognising the potential for error, and by developing systems and strategies to learn from mistakes so as to minimise their occurrence and effects.

Q. Is it possible to manage human factors?

A. Yes, management of human factors involves the application of proactive techniques aimed at minimising and learning from errors or near-misses. A work culture that encourages the reporting of adverse events and near-misses in health care allows the health care system and patient safety to improve.

Aviation is a good example of an industry that has embraced the study of human factors as an approach to improving safety. Since the mid-1980's, aviation has accepted human fallibility as inevitable and, rather than demand constant perfection that is not sustainable, and publicly punishing error, this industry has designed systems to minimise the impact of human error. The aviation safety record is now a testament to this approach - despite an average of 10 million take-offs and landings annually, there have been less than ten fatal crashes a year worldwide in commercial aviation since 1965, and many of these have occurred in developing nations.

Q. Is a human factors approach used in the Australian health care setting?

A. Over recent years health care professionals have begun to recognise how human factors can significantly compromise the quality of health care that is delivered to Australians. While some effort has been made to develop a systems approach to minimise human error, much more work needs to be done.

Q What is the Council doing in relation to human factors?

- A.** Since its establishment in 2000, the Council has been looking at research on applied human factors in health care to identify lessons for health care professionals and managers. It has also held workshops on this topic to assist in the development of systems to try and reduce errors in the health care setting. Reports on these workshops and forums are available from the Council by visiting their website at www.safetyandquality.org

The Council has also drawn on the work of international experts in human factors to assist in further understanding and developing this area within Australian health care settings.

Information on related Council initiatives can be found in other fact sheets in this series such as *National Open Disclosure Standard* and *Adverse Events Rates*.

Q. How can I find out more information?

- A.** More information on the work of the Council in this area can be obtained by visiting the Council's website at www.safetyandquality.org, or by contacting the:

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