



Leanne Faraday-Brash

Why is common sense a non-starter?

Human beings are fallible and we can't rely on any individual to make the right decision in every circumstance.

A nurse in a UK hospital who thought she was performing the routine task of injecting a saline solution into a mother who had just given birth was instead injecting an epidural drug.

She had mistakenly taken it from a cupboard where both products, which had almost identical packaging, were stored together. The mother died an hour later from complications.

So, why didn't someone use their common sense to warn of the need to keep these completely different drugs in different cupboards?

Organisational psychologist Leanne Faraday-Brash of Melbourne-based Brash Consulting says the vast majority of people make sensible, common-sense decisions most of the time but they may struggle in certain circumstances.

Chain of command

She says that nursing, like the armed forces, is widely accepted as a 'command-and-control' environment that is distinctively hierarchical.

It may be that the desire and ability to question a particular decision has been stamped out of many nurses very early in their careers.

They may also feel unsafe in taking the initiative or sticking their necks out to challenge things because they are frightened of the responses they may get from those in authority, who may not be prepared to admit that

any decision that's been taken is erroneous.

According to Faraday-Brash, the incidence of bullying in the nursing profession has been established to be above average. She says people can be scared to speak out for fear of being victimised or demeaned for suggestions they make around safety or any other workplace issue.

They may want to rely on their common sense or their own intuition, but will still accede to orders that have been given, because they've been trained to do so or are fearful of repercussions.

Ways of thinking

Faraday-Brash says case studies have shown that nurses often have preferred ways of thinking that mean that while they are detailed, structured, industrious, sequential and procedural – as well as empathetic and intuitive – their natural way of thinking may be neither holistic nor concerned with the big picture. They simply may not consider the broader implications of what they are doing.

Faraday-Brash says in the case of mistaken identity with regard to drugs, nurses often focus on detail and structure but like the rest of us, they may also fall prey to assumptions based on pattern recognition and habit. Questions about how the drugs

got there, or about why the hospital doesn't have a policy of separating potentially dangerous drugs that look similar, may never have been asked. Nurses are often likely to do 'what feels right'.

Faraday-Brash says humans are not always completely logical, and only react spontaneously to danger when it's perceived there is danger. "Hence, if we don't sense there is a risk in all those medications sitting there side by side on the shelf, we won't necessarily be vigilant."

Sifting through

She says that each of us is cursed with a reticular activating system that allows us to take in relevant information and filter out information that isn't considered relevant.

"If we didn't do that, we would be massively overwhelmed, even debilitated, and not able to make a single decision or take any action," she says.

"So, of necessity, we have to 'thin slice' information," she adds. "And that is why we have to have fail-safes and double cover – because we often rely on a small amount of information to make fairly big judgements about things and about people."

Paralysis and habit

Faraday-Brash says individuals often possess blind optimism that

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says 'nobody is going to get up in the morning wanting to do a bad day's work or make a catastrophic mistake that could have very negative consequences for themselves or anybody else'. Otherwise, the fear of the consequences could paralyse us every day.

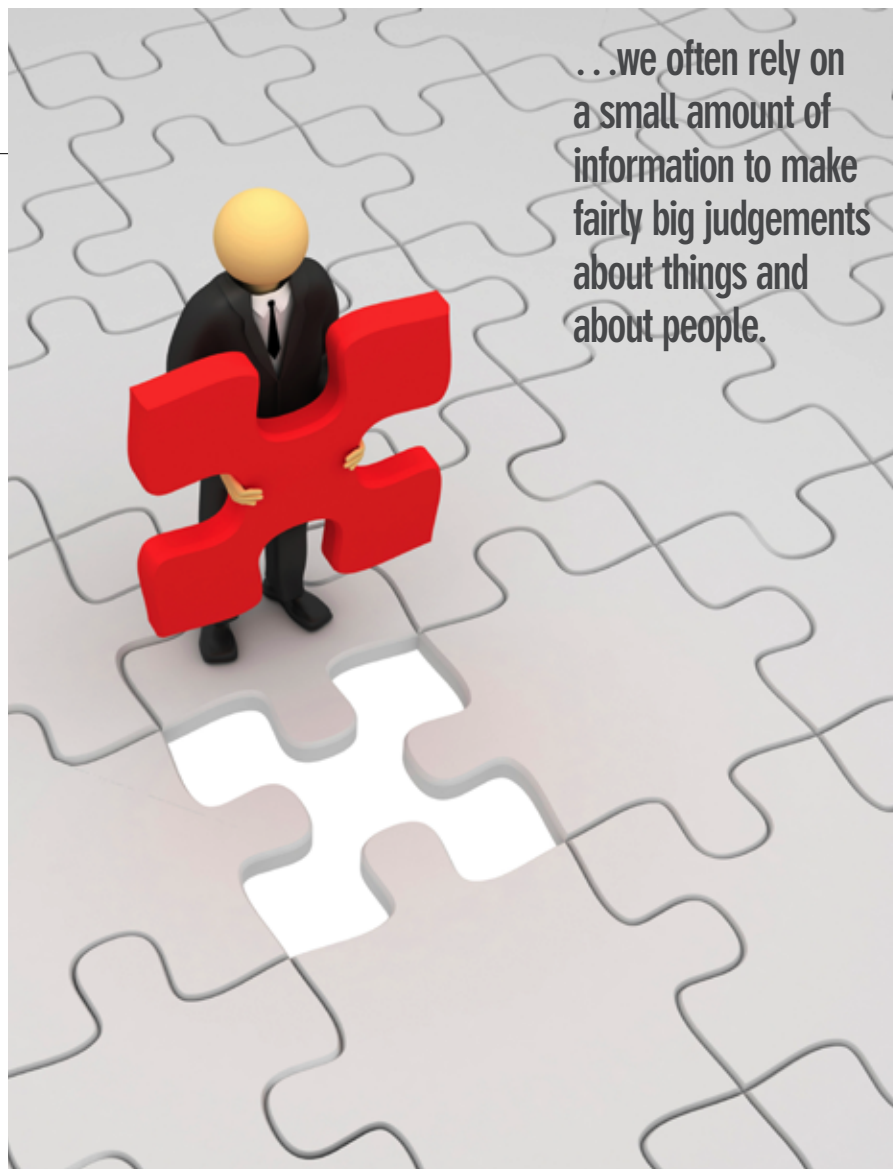
"We can't afford to dwell on all the terrible things that could happen or we would all be too scared to act or take jobs that have a high degree of risk associated with them," she notes.

She says it is very natural for people to become habituated to risk and to assume that if anything bad happens, it won't happen to them or be perpetrated by them, and to assume that other people are going to do the right thing to keep everyone safe.

Response measures

Because common sense isn't necessarily common, organisations need to consider the following measures.

- Identify the risks to which people have become habituated. Attempt to raise consciousness about the potential consequences, no matter how unlikely, and find ways of helping them make an emotional connection.
- Step up training regimens; be prepared to mark down (or fail) those who don't demonstrate efficient competence, then coach them;
- Create a culture in which people routinely ask about the broader implications of any decisions that are made;
- Create a safe, secure and supportive climate so people feel free to challenge the status quo and aren't fearful of showing initiative or asking, "Why are we doing this?"; "Why are we doing that?" A healthy safety culture must be anti-hierarchical so the most junior person who comes into the organisation with a fresh perspective will feel confident about



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coming forward.

- Create fail-safe and multiple touch-points for high-risk tasks such as drug dispensing.

Contextually, none of this can occur in a vacuum. "Double cover or overseeing by another person on drug dispensing may not be possible in a severely short staffed hospital," notes Faraday-Brash. "The best systems will not work in a context that doesn't support them."

When people are under huge work pressure so that they are "permanently in flight" mode, they might make instinctive decisions, take short cuts and not do what they have been trained to do.

Faraday-Brash says the classic example is the "extraordinary high number" of Australians who, when asked in a survey what telephone number they should call in an

emergency, responded 911 (instead of 000) because of what they had absorbed from American television programs.

The bigger picture

Faraday-Brash says it may be easy to understand how one nurse made a mistake in failing to read the label on a bottle that looked so similar to another bottle with medication in it. Yet a whole team of people working and regularly using the drug cupboard never thought to question the soundness of the placement of these incompatible drugs, instead relying on an individual's high state of alertness and attention each time someone went to the cupboard.

The nurse made one isolated mistake with huge consequences. There was an unacceptable margin for error that had never been addressed. 