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Avoiding "Drift" Into Harm

Reinforce effective safety practices by addressing workarounds.

The melody of the nursery rhyme "Rock-a-Bye Baby" is recognized around the world. It elicits an image of a cradled baby perched high in a tree, lulled to sleep by gentle breezes. Suddenly, the bough breaks, and the cradle and baby fall. The workaround to let nature do the rocking has worked—until it has failed.

Every day, actions, inactions, choices and practices, while well-intended, load stress onto the boughs of our tree of safety. The boughs routinely bend, and sometimes break, as illustrated by the case of a former Tennessee nurse convicted after a medication error led to the death of a patient in 2017.

Though the case has sparked justifiable outcry and debate over the criminalization of medical errors, it also highlights vital lessons that healthcare leaders—the metaphorical arborists of safety—can take to identify, prevent and address choices, practices and conditions that lead to the bending and breaking of boughs.

Leaders understand safety is a dynamic property of a complex system and that it's their responsibility to strengthen safety through the systems, processes, cultures and behaviors necessary for safe and reliable care. Safety in healthcare depends on the collective vigilance of an entire organization to avoid being lulled into a false sense of security, believing that because no "boughs" have broken recently, everyone is safe. The reality is that every day in healthcare, clinicians make choices and operate in conditions that are not safe.

Given the ubiquitous risk of errors across all healthcare settings, leaders need to take action regardless of their organization's record on, or reputation for, safety.

Sidney Dekker, PhD, professor at Griffith University in Brisbane, Australia, and an expert in human factors and safety systems, asserts that the unintentional (and often unnoticed) "drift" from effective safety practices is the root cause of human error. This drift incubates slowly and is often not recognized until a serious event occurs. Actual practice is decoupled from the standards, practices and professional accountability that were acknowledged as necessary for safety, and this new performance is gradually routinized and tolerated by the system, as long as no immediate adverse events or outcomes occur. Dekker calls this "normalization of deviance."

Normalization of Deviance

Common causes of normalization of deviance in healthcare include rules that don't make sense and impede productivity, particularly when under time pressure and heavy patient loads. Normalized deviance commonly results when imagined or desired work fails to align with the realities of actual work and when technologies intended to support safety disrupt performance instead.

Workarounds—behaviors that deviate from prescribed practices—are shortcuts to accomplish a goal more readily in the face of perceived or real barriers. Normalization of workarounds happens when repeated patterns of deviation do not result in harm, leading to the belief that harm from these deviations is not possible. Normalization also occurs when individuals believe that rules don't apply to them because they are good at their jobs and not inclined to make mistakes, or when they believe that a different approach is justified for the patient.

Normalization calcifies when staff are afraid to speak up when they observe deviations, fearing punitive action for doing so, or they are discouraged by prior reports that have not resulted in change.

Finally, normalization of deviance is perpetuated when leaders fail to recognize and accurately convey the implications of such practice, dilute and downplay the findings of system faults or choose to overlook challenges that may be resource-intensive and costly to address.

Examples of normalized deviation persist across healthcare, and common examples include failure to check patient identifiers prior to administering medications, batch preparation of medications for multiple patients at a time, failure to re-sheath needles prior to disposal, failure to follow personal protective and infection control practices, such as handwashing, and failure to use checklists.

System Design Defects

Latent errors result from underlying, and therefore less visible, defects in the design of systems, environments and technologies. These defects erode the protective defenses of systems and allow errors to reach the patient. Latent errors set the stage for vulnerability and harm and often emerge due to lack of, poorly designed or malfunctioning systems; weak supervision; inadequate policies; unclear roles and responsibilities; and communication breakdowns. The compounding of latent and active failures heightens the risk of adverse events.

The Tennessee nurse case offers insight into a multitude of active and latent failures that may have contributed to the medication error that caused the patient's death. They offer important signs deserving of our attention such as overrides of the automated medication dispensing cabinet being reported as common practice to avoid delays (strongly suggesting normalization of this workaround); EHR upgrades that can contribute to delays in accessing medications from the ADC; dangerous paralytic agents (like the medication that led to the patient's death) not being excluded from the ADC override list, nor sequestered from other medications; a failure to confirm the name of the medication on the front label of the vial dispensed from the ADC; the absence of barcode scanning technology and access to an EHR in the radiology setting where the medication was ultimately administered; and the lack of clear policies and procedures for monitoring patients who receive anxiolytics (the medication the patient should have received).

Course of Action

Given the ubiquitous risk of errors across all healthcare settings, leaders need to take action regardless of their organization's record on, or reputation for, safety. Here are suggested actions:

- Fully commit to safe and reliable care and the elimination of harm as the daily work of leaders and the organization. The *National Action Plan to Advance Patient Safety* and *Leading a Culture of Safety: A Blueprint for Leaders* are two resources from the IHI Lucian Leape Institute and ACHE that provide guidance for leaders.
- Embrace high-reliability principles in the intentional design of systems, and ensure professional accountability for safe and reliable care for everyone in the organization.
- Acknowledge the propensity of humans to "drift." Anticipate, seek out and understand the frequency and causes of deviation, such as overrides and workarounds, and act when such practices are identified before harm occurs. Conduct interprofessional, proactive risk assessments to understand the frequency, rationale and locations of overrides, near misses and harm events. Share trends, examples of positive deviation that accomplish goals while not compromising safety, and priorities for improvement.
- Incorporate questions about drift and workarounds into safety huddles, and engage staff in identifying areas for improvement.
- Implement technologies designed to promote safety (e.g., barcode medication administration solutions, five-letter drug entry for medication search and selection, EHR alerts and alarms) and standardize solutions across settings whenever possible.
- Anticipate what might go wrong with technologies before implementation, and in advance of upgrades and user interface changes.
- Engage safety experts, human factors experts, direct care team

members, patient and family advocates, and technology vendors in human-centered design, implementation, monitoring and evaluation of solutions to eliminate risks. Use action hierarchy, a component of Root Cause Analysis and Action, or RCA^2 "squared," to identify strong and intermediate actions beyond weaker actions, such as training and protocol revisions, to mitigate or prevent adverse events.

- Embrace the five rights of medication use and fair and just culture models to evaluate and design policies, procedures, systems and expected behaviors *before* any harm occurs.

- Encourage and reward reporting of near misses and harm events.

- Ensure full support and transparency for patients, families and the workforce when errors and harm occur.

This is a long list, to be sure. But together, intentional steps are necessary to significantly improve and sustain safety by identifying and preventing the normalization of deviance before harm occurs. ▲

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Editor's note: *The National Action Plan*, blueprint, Action Hierarchy tool and other safety resources are available at ihi.org and **ache.org/Safety**.