Workshop notes

SCIE conference 2005: Workshop 6 - managing risk and minimising mistakes

Workshop 6, 'managing risk and minimising mistakes', looked at the idea of 'near misses' and how social care organisations can learn from mistakes. In particular the workshop asked whether a systems approach could be applicable to the social care sector.

The key issues from the discussions were:

- The concept of a 'near miss'.
- The 'Bad Apple theory' – also known as the person-centred approach, where the individual is seen as the cause of mistakes. This is the prevalent way of understanding mistakes and the theory is that removing the individual removes the problem.
- The new way of looking at human error is based on the 'Bad Barrel Theory' i.e. the 'Systems Approach' where human error is understood in terms of the context or system in which it happened. The focus is on people's tasks, tools and operating environments. Human error is not the conclusion of investigation but the starting point.
- The 'Swiss Cheese Model,' advocated by psychologist James Reason, looks at high risk organisations and distinguishes between 'latent failures' and 'active failures'. The former rooted at higher levels (such as senior managers) of the organisation and the latter associated with the actions of front line workers.
- The National Patient Safety Agency was established in 2001 after high profile tragedies in health services. High-level policy and political push developed a system's approach advocating root cause analysis within the health sector. SCIE's study involved consulting with social workers, practitioners, children and families to see how this model could be transferred to social care.