Case Study B

The following is from an interview with a unit nurse:
"Some years ago they made Temazepam a controlled drug. This meant that every time I had to give it, I had to lock up the drug, wait for a colleague to come with me, both of us take the prescription cart to the drug cabinet, count the tablets in the bottle, take out the dose, fill in the book, go and check the identity of the patient and prescription again together and then give it."

"On my unit, we often had up to 12 patients needing Temazepam so suddenly the evening drug rounds were taking forever. The drug cabinet was at the other end of unit. In the end, we started taking the bottle out of the drug cabinet at the start of the round and putting it in our pocket."

"We'd then just fill out the book as we went along; we had to check all the controlled drugs later in the night anyway. We all knew we were doing it wrong but it just seemed crazy trying to do it the right way when we were so busy and the reason for changing the policy seemed to be more about it needing to be counted to prevent abuse rather than it presenting a risk to the patients."

Some of the common human factors that can increase risk include:
- mental workload
- fatigue
- distractions
- the physical environment
- physical demands
- device/product design
- teamwork
- process design
- medical device design

<u>Applying what you've learned:</u>

1. What are some human factors principles involved here?

2. How could Human Factors Engineering been applied to this scenario to reduce risk?

Modified from: http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Human%20Factors%20How-to%20Guide%20v1.2.pdf