Watch Out for This Turkey—Complacency

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PROBLEM: Blind trust, contentment, and familiarity describe the slow but predictable arrival of complacency on the job. It almost always occurs in the most reliable, safe, and productive parts of an organization, particularly when automation or technology is present. However, complacent reliance on technology can lead to betrayal by the mechanical and electronic equivalent of a "good friend."

We can consider the following example. A pharmacist receives and enters an order into the pharmacy computer. A nurse in the patient-care unit types the patient's name on the automated dispensing cabinet keyboard and selects the drug that matches the patient's name on the screen. A matrix drawer opens. The nurse is directed to a specific coordinate to retrieve the dose.

About 99.99% of the time, everything works out as planned. With such a high degree of accuracy and knowledge that the cabinet is "computerized," it is understandable that the nurse believes nothing will go wrong. Unfortunately, that trust can be easily broken if the pharmacy technician places the drug in the wrong matrix when he or she restocks the machine. In that situation, the nurse could open the right drawer, take a dose from the proper coordinate, quickly glance at the label, but fail to notice that it is the wrong product.

This familiar "grab-and-go" manner of drug administration contributes to the mental bias that the right drug is being delivered. The use of bar-coding for inventory and drug administration can help, but experience with automated dispensing technology suggests that caution is needed. Even though the bar code on a drug container is matched with the proper matrix location of an automated dispensing unit, loading the equipment is a manual operation. As a result, errors are possible.

Thus, technicians might scan the bar code on a zippered bag of unit dose medications for verification and entry to the drawer, then grab the rest of the products in the bag and load them without checking the labels. If the bag contains any erroneous medications or strengths, then stocking errors are possible, even with bar-coding.

To handle complacency in the best manner, one first needs to understand the human factors involved. Complacency is embedded within a mental bias that allows our experiences to guide our expectations. The mental resources needed to process information are reduced by this shortcut, because present circumstances are normally a good match with past occurrences. Thus, mental resources are devoted to the more interesting and complicated parts of a task.

SAFE PRACTICE RECOMMENDATION: Fortunately, there are a few things we can do to reduce complacency in the workplace:

- Staff members can begin by increasing their awareness about the adverse effects of complacency and try to counter their belief that "it can't happen to me."
- Prompts can be used to remind people of errors that might occur when they "blindly" trust automation and technology.
- Staff members should be encouraged to periodically monitor their work with technology and automation to identify personal patterns of thinking and behaving that are likely to fuel complacency.
- A staff meeting could be devoted to sharing these observations so that common issues can be identified.
- Primary discussion points can be used to develop specific plans to work on issues in which complacency may lead to errors, such as stocking the drug-dispensing equipment and the grab-and-go method of drug administration used during busy periods.
- Artificial errors can be placed in the system to test when and where errors attributable to complacency are likely to emerge. However, to prevent an artificial error from reaching a patient, staff members must establish and follow strict institutional guidelines for such tests and carry them out in a controlled setting. An example might include simulations of order entry for erroneous medication orders to determine the effectiveness of computerized messages to alert the staff to the problem.
- Staff members should be involved in helping to interpret the test findings and in suggesting solutions to problems.

REFERENCES

1. Young MS, Stanton NA. Attention and automation: New perspectives on mental underload and performance. *Theor Issues Ergonomics Sci* 2002;3:178–194.