Human Factors – Error or Safety?

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In the work of patient safety there is often a tendency to refer to human factors (HF) when addressing errors that happened. Human factors is therefore often seen as a label or topic of human error. In safety research there is a growing amount of research that explores the boundaries of traditional view on safety and from which the safety II (Hollnagel E.) concept has been established.

In safety II the focus is on getting as many things as possible go right through a proactive and continuous anticipation of developments and events. The explanation of accidents is that things basically happen in the same way, regardless of the outcome. The purpose of an investigation is to understand how things usually go right as a basis for explaining how things occasionally go wrong. Humans are seen as a resource necessary for the system flexibility and resilience instead of a liability or hazard.

This lecture will highlight interesting details from the safety research and how this affects our safety work depending on what standpoint we take on safety and errors. E.g. Safety I: Things go right when people follow the procedures. Work as done is very close to work as imagined. E.g. Safety II: People successfully adjust their actions in work as done to make sure the correct outcome is produced. The task is to find out, what adjustments are made and what we can learn from those adjustments.