Curriculum Development Centers Program

Awardee of The Office of the National Coordinator for Health Information Technology

Unit 6a: HIT Facilitated Error – Cause and Effect

Component 7: “Working with HIT Systems”

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Unit 6 Objectives

- Explain the concept of facilitated error in HIT
- Cite examples of situations where HIT systems could increase the potential for user error
- Analyze sources of HIT facilitated errors and suggest realistic solutions

Error in Healthcare

- High Stress – Distraction - Busy
- Cognitive Limitations
- Stuck in Thinking
- Unclear Directions
- Unclear Labeling/Poor Layout
  - Juxtaposition

“I was ordering Cortisporin, and Cortisporin solution and suspension comes up. The patient was talking to me, I accidentally put down solution, realized that’s not what I wanted . . . . I would not have made that mistake, or potential mistake, if I had been writing it out because I would have put down what I wanted”

Error in Healthcare

The Quaid Twins – Movie

This slide contains a link to a video from YouTube that illustrates an avoidable medical error involving the Quaid twins. The link below was accurate as of August, 2010. A GOOGLE search on the Quaid twins and medication error will result in numerous links to this particular news item.

http://www.youtube.com/watch?v=XEbf9bliOus

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Error in Healthcare

- Role Change/Communication Change/Workflow Change
- Undue Trust?
- Currency & Appropriateness
- Alert Fatigue
- System Rigidity