SOUTHWESTERN NEWS

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DON'T PLAY THE BLAME GAME: LEARN FROM ERRORS INSTEAD

DALLAS — March 3, 1995 — Making an error in the course of one's job can result in embarrassment or frustration. In medicine, it could mean the difference between life and death.

Dr. Harold Kaplan, professor of pathology at UT Southwestern Medical Center at Dallas, is launching a project aimed at helping to eliminate mistakes by establishing a national model through which professionals in blood transfusion medicine can report and study errors to understand the causes better and to prevent them.

Kaplan received a three-year $700,000 grant from the National Institutes of Health to design an error-reporting system that will collect human-error data in transfusion medicine including "near-miss" errors, which often go unnoticed.

"Although the blood supply is safer now than it has ever been, it is a more complex system now than in the past. Human errors, although minimized through standardized procedures and double-checking, may still occur," Kaplan said. "The hypothesis is that there are many more near-misses than actual accidents. By recording and studying near-misses, we can analyze our procedures and correct any built-in faults that may contribute to errors people make."

An example of an effective error-reporting system already in existence is the Aviation Safety Reporting System. "This voluntary, no-fault reporting system run by NASA (National Aeronautics and Space Administration) has made a major contribution to aviation safety," Kaplan said. "Our plan is to develop an optimal safety-reporting system in transfusion medicine by building on knowledge developed in aviation safety and other error-critical fields like the nuclear-power industry, as well as the fields of human factors analysis and cognitive psychology."

He and his co-investigators in the Office of Medical Education, Drs. Jim Battles and

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Mary Whiteside, associate professors of biomedical communications, are starting to design the process by determining what an ideal error-reporting system might be. To do this, they must answer such questions as:

— What is the best way to capture errors?

— What is the best way to get them reported?

— What is the best method by which errors are completely described?

— And what is the best way to analyze and classify these errors?

"By answering these questions, we can design the database necessary to support development of effective strategies to prevent errors or correct any flaws in our procedures," Kaplan said.

Helping the UT Southwestern team in answering these questions are individuals from NASA, TU Electric's Comanche Peak nuclear-power facility, community blood collection centers, hospital transfusion services and other experts in the fields of artificial intelligence and cognitive psychology from the University of Wisconsin, Georgia Institute of Technology, the University of Kansas and Ohio State University.

Three blood-collection centers are involved in the project: New York Blood Center, BloodCare in Dallas and the Oklahoma Blood Institute. Transfusion medicine personnel from three hospitals also are participating in the study; among them are professionals from Parkland Memorial Hospital in Dallas and hospitals affiliated with New York University School of Medicine and the University of Southern California School of Medicine.

The team's ultimate goal is to provide an error-reporting system to enhance human performance in transfusion medicine. "If designed properly, hopefully, our system should be a transportable model to other medical disciplines," Kaplan said. "The emphasis for an error-reporting system is not to blame people but to optimize human performance in complex systems."

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