Understanding the Skill-based Error Problem

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Types of Errors

Knowledge Based (novel situations)

Perform the wrong step because of a lack of knowledge (e.g., Don't know which medication is appropriate)



Rule Based (familiar situations)

Perform the wrong step because of the misapplication of a rule (e.g., I think it is medication x)



Skill-based (experienced situations)

Perform the wrong step because of a slip or lapse (e.g., intend to give the correct medication, but mistakenly give medication x)

(Rasmussen, 1982)



Skill-based (automaticity) errors

- Occur despite having the correct knowledge of how to perform the task
- Occur even with hundreds (or thousands) of hours of experience
- Occur on simple tasks (making coffee) and complex tasks (surgery, flying an airplane)

Prevalence of Skill-based Errors

Domain	% Accidents/Incidents due to skill-based errors	Dataset & Source
Aviation (Military)	50%	US Navy incidents from the Navy Safety Center (1990-1998) (Shappell & Wiegman, 2004)
Aviation (Commercial)	60.5%	199 accidents in the United States from 1990-1996; data from NTSB and FAA (Wiegman & Shappell, 2001)
Aviation (Maintenance)	48%	Survey of 550 aircraft maintenance personnel in Australia (Hobbs et al., 2007)
Mining	~58.9%	508 cases from Australia (2004-2008) (Patterson & Shappell, 2010)
Medical Intensive Care	~53%	120 adverse events in 79 patients; 54 preventable adverse events. In total examined 391 patients with 420 unit admissions in 1490 patient days (Rothschild, 2005)
Railways	63%	19 rail accidents in Australia (Baysari et al., 2009)

Approaches to Dealing with Errors

 Person Approach: Focus on the errors of individuals and blame them for failures of memory and attention

 Systems Approach: Focus on the conditions under which individuals work and build defenses to avert errors or mitigate their effect

Reason (2000)

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Rule Based (familiar situations)

Perform the wrong step because of the misapplication of a rule (e.g. I think it is medication x)



Skill-based (exterienced situations)

Perform the wrong step localise of a slip or lapse (e.g. intend to give the correst medication, but mistakenly give medication x)

(Rasmussen, 1982)



My Goals for Today

• (1) Convince you that no matter how capable we are, there is variability in our performance

Errors are going to happen

 (2) Demonstrate how human factors and our understanding of cognition can help predict where errors might occur

Build robust systems

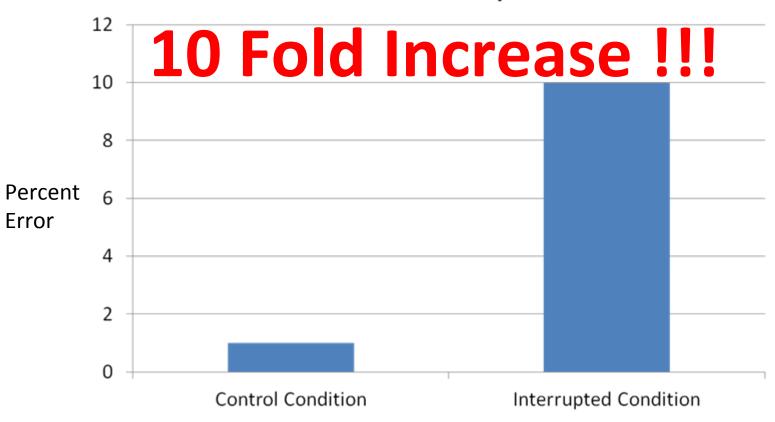
Our Work Conditions

- All of us come to work with intentions to perform at our highest levels, but:
 - Our work environment is full of interruptions
 - Workload is generally high
 - Fatigue and stress are real issues

- How do we perform given these conditions?
 - Research is VERY limited, but we have some info...

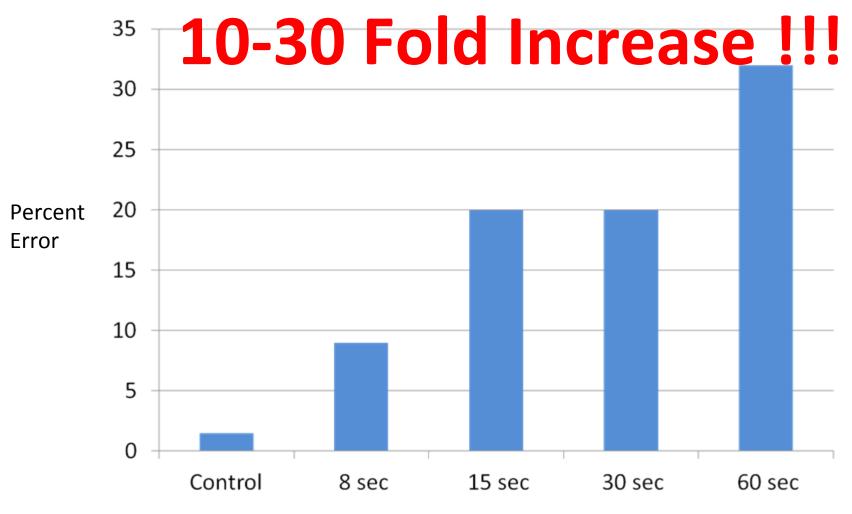
How Disruptive are Interruptions?

Skill-based Error Rates by Condition



(Ratwani & Trafton, 2008)

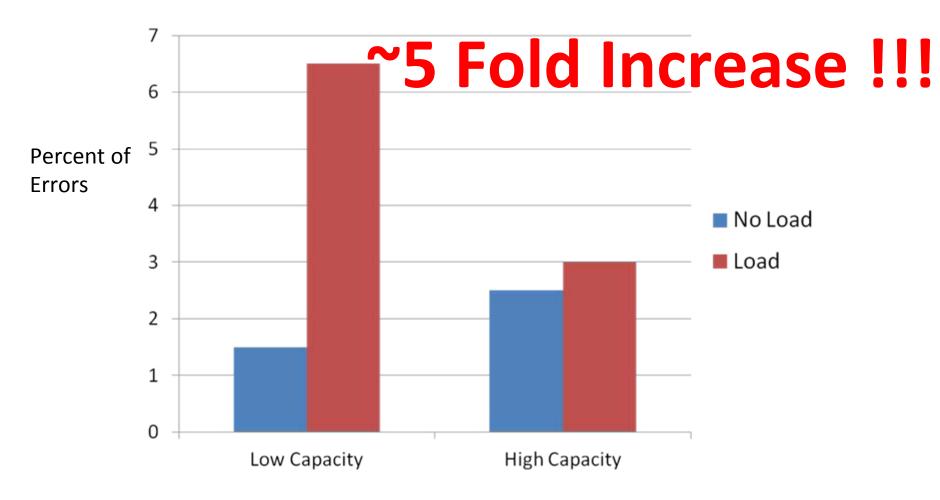
Errors by Interruption Length



(Ratwani & Trafton, 2010)



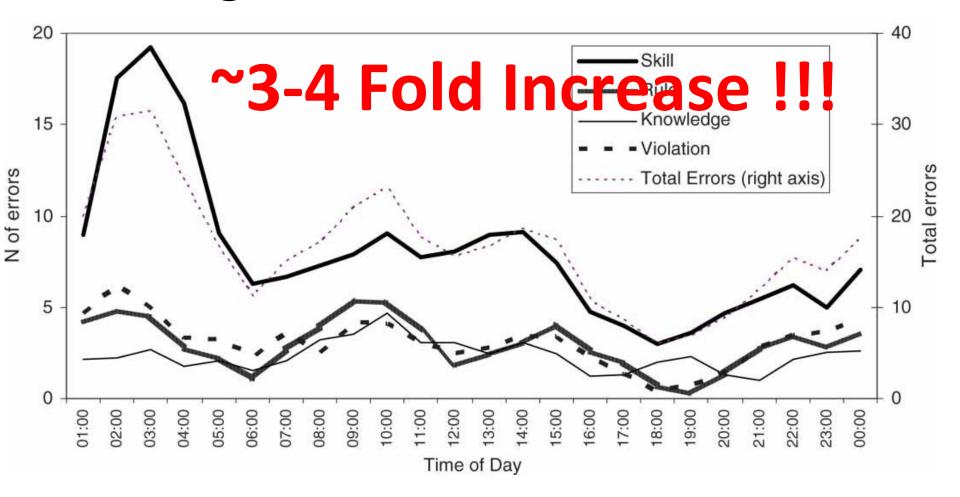
Workload and Error Rates



(Byrne and Bovair, 1997)



Fatigue and Skill-based Errors



Errors in airline maintenance crews by circadian rhythms (Hobbs et al, 2010)



Accept these Conditions as Normal

 None of us are resistant to the influence of interruptions, workload, or fatigue!

 Begin to accept that there is natural variability in our performance— plan accordingly

How do we Leverage a Systems Approach?

 Focus on our interaction with the environment and design for error

"Make it easy to do the right thing"

How do we Design for Error?

 Study the work environment, work conditions, and dissect the tasks to be performed

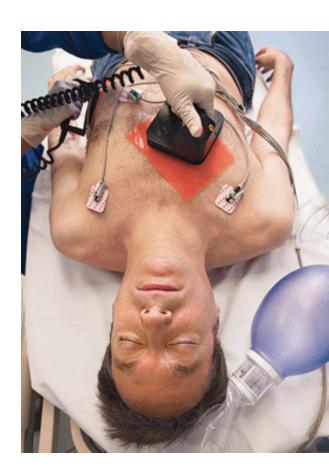
Focus on understanding human capabilities in context

Identify high risk areas and mitigate risk

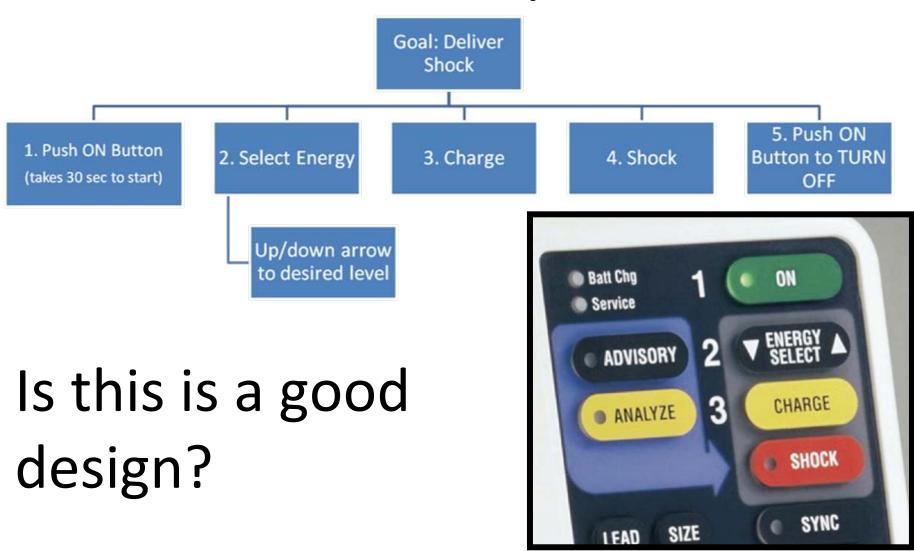
Defibrillator Example

- Cardiac Arrest Work Conditions
 - Interruptions?
 - High workload?
 - Fatigue, stress?



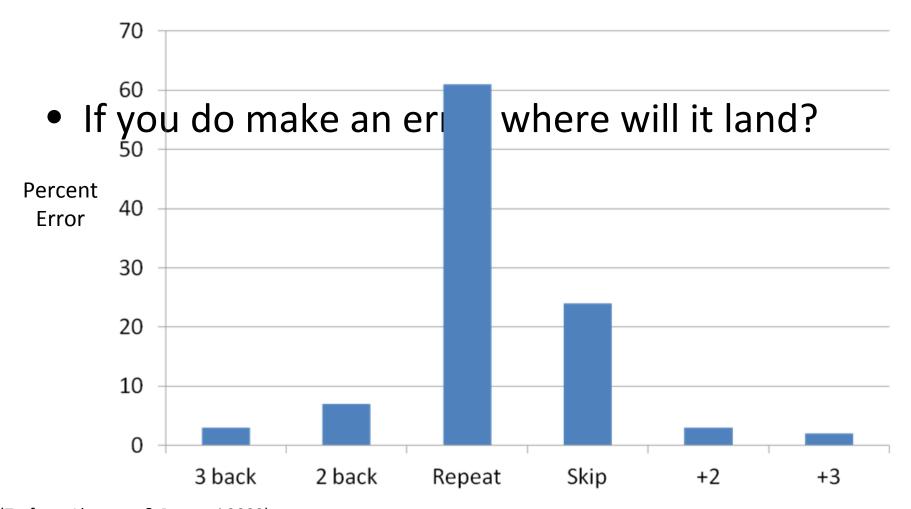


Task Analysis





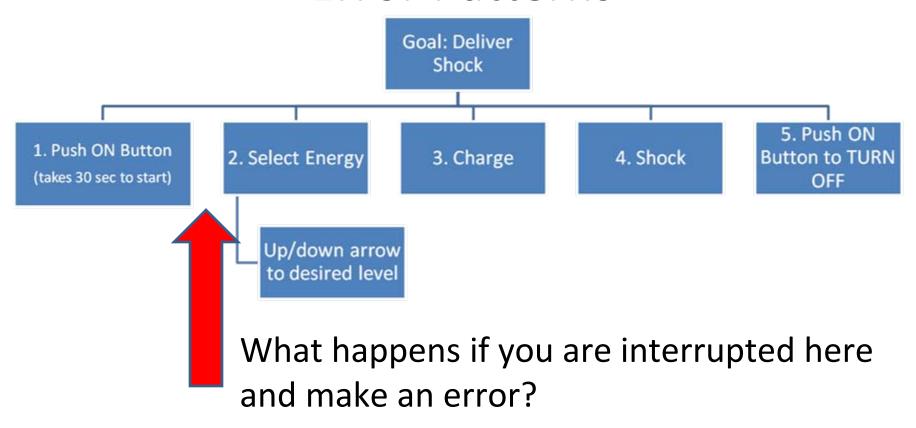
Understanding Skill-based Error Patterns



(Trafton, Altmann, & Ratwani 2009)



Understanding the Task in Relation to Error Patterns

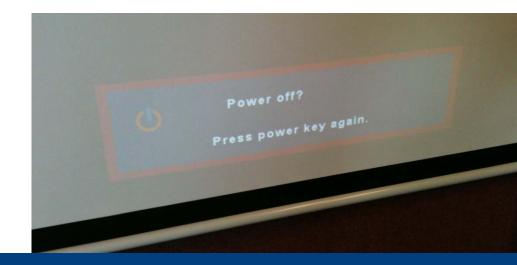


There is a high likelihood you will repeat the previous action



Consequences

- Defibrillator will power down and it can take
 2-3 minutes to restart
- Solution?
 - Anticipate that a "repeat" action is likely
 - Design for the error



(Hoyer, Christensen, et al., 2008) (Fairbanks & Wears, 2008)

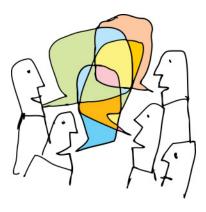


Where do we go from here?

- Skill-based errors are prevalent and have fundamental cognitive underpinnings
- We cannot reduce these errors by policy or training
- We can develop robust systems by applying cognitive theory to the design of systems

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Discussion



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