



“This article describes the modification of the Human Factors Analysis Classification System based on James Reason’s theory of error causation for use in health care.” Diller et al (2014).

Reference:

Diller, T., Helmrich, G., Dunning, S., Cox, S., Buchanan, A. and Shappell, S. (2014) The Human Factors Analysis Classification System (HFACS) Applied to Health Care. American Journal of Medical Quality. 29(3), p.181-190.

The Human Factors Analysis Classification System (HFACS) applied to health care
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Abstract:

In spite of efforts to improve patient safety since the 1999 report, To Error Is Human, recent studies have shown limited progress toward preventing serious error. Most hospitals use root cause analysis as a method of serious event investigation. The authors postulate that this method suffers from 4 problems: (a) the use of root cause analysis is neither standardized nor reliable between organizations, (b) hospitals focus on “who” did “what” rather than on “why” the error occurred, (c) the identified causes are often too nonspecific to develop actionable correction plans, and (d) a standardized nomenclature does not exist to allow analysis of recurring errors across the organization. This article describes the modification of

the Human Factors Analysis Classification System based on James Reason's theory of error causation for use in health care. This method resolves the 4 deficiencies noted above. The authors' experience investigating 105 serious events over 2 years is described.

Other intravenous and vascular access resources that may be of interest (External links - IVTEAM has no responsibility for content).

Guide for intravenous chemotherapy and associated vascular access devices from Macmillan. CancerUK IV chemotherapy information.

