# 2019 Annual SHOT Report – Supplementary information

# Chapter 10: Handling and Storage Errors (HSE)

## Information technology (IT)-related HSE cases n=76

**Case 10.3: Incorrect use of electronic prescribing system fails to verify traceability**

*A new electronic prescribing system for blood was introduced which allowed staff to fate the transfusion at the point of administration and also to record the transfusion observations. The fate of a red cell unit could not be established because the there was no electronic record. The ward confirmed the unit had been transfused, but further investigation revealed that staff had been recording the transfusion and observations on a piece of paper and transcribing at a later date. On this occasion, they had forgotten. This was not the correct procedure for which they had been trained but was 'normal' practice on the ward.*

### Learning point

- This case demonstrates the use of a manual 'workaround' to mitigate ergonomic issues with an information technology (IT) system. The report suggests that contemporaneously inputting the required data electronically was more challenging than recording it on paper for subsequent transcription. Manual workarounds arise because the ergonomics of a process are not aligned with the realities of completing a task in real world scenarios and lead to poor quality data capture. Recognition of the primacy of the ergonomics of a system should inform the design of IT systems