Human factors in patient safety

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Risk of Harm

- 1 in 1,000,000
- 1 in 250,000
- 1 in 124,000
- 1 in 10

Safety in Hospital - UK

- Healthcare is a high hazard industry
- Approx. 10% (900,000) of patients admitted to hospital experience an incident
- 72,000 of these incidents/adverse events contribute to the death of patients

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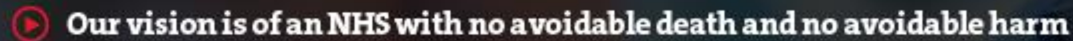
Making the safety of patients everyone's highest priority



Human Factors

What situations increase the likelihood of us making mistakes

Understanding this helps us put in place checks that help us and our colleagues do the right thing every time.

Help our colleagues to do the right thing

Human factors

Break down communication barriers

In many medical mishaps

- there were people in the room at the time that knew a mistake was being made or
- knew what needed to be done to save the situation.

However they felt too junior or ‘insignificant’ to speak up.

Have you ever….?

- Put the wrong fuel in the car?
- Sent an email to the wrong person by mistake?
- Sent an email without the desired attachment?
- Deleted the wrong document?
- Locked yourself out (house or car)?
- Left the house and forgotten to lock the door?

And if so, when??

Factors affecting human attention

- Fatigue
- Stress, anxiety, fear
- Competing demands
- Environmental conditions
  - *Clutter, motion, poor lighting, noise*
- Too many handoffs
- Shift work

Day Surgery

- Busy environment
- Large numbers of patients
- Several handovers as patient moves through
- Competing demands on staff
- Sometimes low staff numbers
- Locum/Agency Staff

All key issues in Human Factors

5 steps to Theatre safety

Briefing

Sign in

Time out

Sign out

WHO CHECKLIST

Debriefing

5 steps to safety

Briefing

Sign in

Time out

Sign out

Debriefing

Briefing

What is it?

The plan for the day is discussed by all team members

When?

Initiate the briefing before the first case of the day, once all team members are available in the department

Why?

Ensure a shared understanding of the plan for the day
Anticipate and prepare for problems

Briefing

Who is leading the briefing?
It can be any member of staff
Consider rotating the lead

People
Team members introduce themselves
Clarify roles, responsibilities, actions and interactions
Is anyone missing?
Does everyone feel comfortable about today?
Qualify any supervision/assessment considerations
Remember - we're part of a team
Everybody has a valid role, perspective and opinion

Briefing

List
Overview of the list
Any changes?
Anticipated events e.g. Fire Alarm test, Industry observer
Details of each case
Be clear about the plan, expectations, special considerations e.g. latex allergy/positioning
Any equipment problems?
Any special equipment required?

Human factors

- Humans make mistakes

- We know what leads to mistakes

- I suggest it is in our hands to make our units safer