

QUALITY CONFERENCE: OUR COLLECTIVE MINDSET FOR HIGH VALUE CARE

SAFETY CULTURE: WHY HUMAN FACTORS MATTERS MORE THAN EVER TO BETTER PATIENT SAFETY

Speaker chair: Professor Jane Reid, Clinical Director Wessex Patient Safety Collaborative, Wessex Academic Health Science Network

Speakers: Dr Ian Randle, managing Director, Hu-Tech Human Factors and Beatrice Fraenkel, Chair, Mersey Care NHS Foundation Trust

This session gave an overview of what “human factors” is, some of the theory behind the principle of human factors, and also some practical examples of its application.

Prof Jane Reid outlined what human factors is and some of its historical context. Human factors has been applied as an organising principle in many different industries that require a focus on improving safety - including the aviation and nuclear and manufacturing. When applied to healthcare, it can be defined as “enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities, and application of that knowledge in clinical settings”. The end goal of this approach is to remove unacceptable variation in service quality, patient experience and clinical outcome

Dr Ian Randle provided some of the theory behind human factors. He made the point that human factors is not yet a routine part of risk management in healthcare, but it is growing. He noted that while the key areas of focus for human factors in other high hazard industries have huge overlap with health – staffing, fatigue, communications, competence and procedures etc – the lessons from those industries are not yet being applied in a systemic way across healthcare. He gave a key example of this being the case: in other industries, they have designed processes that mean it is impossible for one person to make a single mistake that has catastrophic consequences - however in healthcare this still consistently occurs. He emphasised that reducing human error needs to become a system or organisational responsibility, rather than simple the responsibility of groups of individuals (no matter how highly trained they are)

Beatrice Fraenkel outlined how her trust had introduced human factors into its approach to risk management. The board has a relentless focus on quality reports while striving to also maintain a strong grip on finances. She noted developing the measures of quality outcomes was through a process of genuine co-production between staff and services users. This has meant doing things that initially seemed counterintuitive, such as trying to reduce some patient observations and having a strict policy of not putting hands on patients unless absolutely required. However, this has resulted in a reduction in staff disciplinary cases, fewer required restraints and serious incidents, as well as more satisfied patients.