chfg
clinical human factors group
working with clinical professionals and managers to make healthcare safer

WHAT GOOD LOOKS LIKE

Observed behaviours of organisations that apply human factors in their daily work

Board management and practice

Clinical management and practice

Team management and practice

Support staff management and practice

Design and procurement management and practice

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ABOUT US

The Clinical Human Factors Group (CHFG) is an independent group (registered as a charitable trust) which aims to demonstrate how embedding human factors can have a significant impact on safety, quality and productivity in healthcare.

The CHFG is a broad coalition of healthcare professionals, managers and users of services who have partnered with experts in human factors from healthcare and other high-risk industries to campaign for change in the NHS.

Our vision is of a healthcare system that places an understanding of human factors at the heart of improving clinical, managerial and organisational practice leading to significant improvements in safety and efficiency. Our Manifesto for change outlines how we plan to achieve this vision.

Our goal is to accelerate the impact of human factors adoption in healthcare. The NHS and healthcare community must "do" the embedding; we will influence, stimulate, motivate, help, guide, coach, coordinate and keep the dialogue going across organisations so that we all get to a world where doing the right thing is easy and doing the wrong thing is hard.

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www.chfg.org.uk

Board management and practice

Board members and management set the organisational culture and enable front line staff to make patient safety their priority. They understand the direct impact of their investments in training, staff levels and procurement decisions. Awareness of human factors at the Board level filters down through the whole organisation.

WHAT GOOD LOOKS LIKE (observed behaviours)

Board members & senior management commit to & understand human factors	Board members and senior leaders engage with managers, consultants, nurses and AHPs to foster teamwork. Together, they proactively identify what could go wrong. They understand the advantage of 'managing by walking around' and use this to gather safety intelligence. They empower and hold staff accountable for identifying improvements, understand what needs to change within the system, and work systematically to implement sustainable improvements.
Policies & procedures are developed, implemented & monitored using lessons from other high risk industries	The Board understand that non-compliance with policies and procedures can reveal important safety lessons. Focus groups are held with staff to identify which policies and procedures are difficult to comply with because of their accessibility, usability or length. Lessons learnt from the groups are used to foresee what could go wrong and to revise and update policies.
Approaches to investigation used by high reliability organisations, including the use of human factors specialists , are common place	After any unexpected patient death the organisation secures the views and insights of a human factors expert to support the investigation team in their task. The organisation adopts approaches to investigation above and beyond the minimum requirement as was described by the former National Patient Safety Agency (NPSA). Completed anonymous reports are part of a monthly "safety" round-up document shared with every clinician and senior manager. It is also circulated to neighbouring organisations.
Healthcare professionals operating outside Standard Operating Procedures (SOP) are managed appropriately	Where concerns are raised about individual behaviours or non compliance a review is initiated. Efforts are made to understand reasons and motivations for non compliance. The organisation reviews the efficacy of programmes aimed at addressing policy mismatch. Senior management work with staff to generate ideas and test solutions.

Clinical management and practice

Clinical staff work at the 'sharp end', and are well placed to identify risks to patient safety. They engage with patients across multiple teams and with junior and senior staff. This can bring challenges that can be addressed by following good practice.

WHAT GOOD LOOKS LIKE (observed behaviours)

Constructive challenge is viewed positively and rewarded	A nurse speaks up to a consultant to question whether the correct procedure is being followed. The consultant thanks the nurse for putting patient safety first.
Staff feel empowered to prioritise safety	A nurse in charge tells the manager that staffing levels are below the minimum ratio and that an agency nurse has been hired. The manager tells the nurse that this is 'the right call'. Together they develop a rolling recruitment programme, identify ways to improve nursing retention and implement a long term solution.
Patients are seen as part of the 'safety team'	A patient on high risk medication is asked to share any concerns about test results or side effects (e.g. for blood sugar or anticoagulation). Staff take time to understand the patient's anxieties, check the prescription is correct, explain to them any changes and ensure these are communicated to their GP on discharge.
Procedures are reviewed on the basis of 'what is right' not 'who is right'	A junior team member observes variations in practice between staff and shares this. Together, the team agree best practice and this is adopted by everyone as a standard way of doing things e.g. establishing, recording and communicating resuscitation status and decisions.
Task priority is maintained in challenging work settings	Staff take steps to reduce distractions and resist pressure to attend to competing demands. They re-organise their workspace to create a quiet zone for undertaking complex tasks e.g. calculating medicine doses for infusions.

Most healthcare professionals work within a team where appropriate and timely communication is key to patient safety. The role of patients and carers within the team is recognised.

WHAT GOOD LOOKS LIKE (observed behaviours)

Lessons learnt from previous incidents are used to improve practice	Underlying causes for gaps between policy, procedure and practice are recognised and openly explored. The part this plays in incidents is actively considered. Incidents are viewed as a system failure rather than an individual's 'fault'. Teams adapt their behaviour and plans based on identified risks at briefings and following the sharing of information about previous incidents.
Communication is improved using briefing and debriefing techniques	Briefings and shared communication are part of everyday practice at this organisation. Safety briefings, safety huddles and time outs are done on each shift, risks are highlighted, and contingency plans agreed. This creates efficiencies and releases time for more direct care.
Potentially unsafe behaviours are challenged	Safety stories learnt from incidents, complaints and observations (including aspects of behaviour) are communicated to staff. Staff meetings, handovers, MDT meetings and other forums are used for this purpose. When challenging behaviour occurs, feedback is given and the team agree how concerns are raised and received. They then practice this and adopt the new behaviour.
Situations where error is more likely are recognised and conditions created to reduce risks	The organisation uses different perspectives to view risks in their system. This is informed by the patient and carer voice, as well as incident reports to 'look back'. Tools and techniques such hazard analysis and safety cases are also used to 'look forward' and test and plan changes introduced.

Support staff management and practice

Corporate and support staff play an important role in patient safety. They view the system from a different perspective than front line staff, providing another opportunity for risk to be identified and avoided.

WHAT GOOD LOOKS LIKE (observed behaviours)

Teams understand their role in patient safety	Staff can explain how their role affects the well being of patients even if they are not face to face with patients or in a clinical setting. They speak up and are listened to when they recognise a patient safety problem. For example accurate records help identify the right patient; clean corridors prevent infection; accurate coding tracks patient status; audit highlights room for improvement; well managed complaints support learning and improve patient experience.
User requirements and testing is integrated into IT system design and procurement	IT staff seek to understand the functional and environmental context of software to ensure good integration between task and the wider system. New IT systems and upgrades are never purchased without first defining the healthcare team's needs. IT staff recognise the need to apply usability and design principles and engage clinical and nursing teams. Hazard analysis and safety cases are developed to anticipate and mitigate risks.
Data reflects the true status of the organisation	Information from a wide range of sources is integrated to measure and monitor safety. Dashboards are easy to interpret and show trend information over time. The organisation understands the need to seek out information which supports them to both MEASURE and MONITOR safety. Staff are never asked to manipulate data to change its meaning or to meet any target.
Medical equipment is standardised across sites	The procurement team reduce the number of different infusion pumps used in the organisation, reducing the risk of dose and rate input errors and making it easier for staff to do the right thing.
Product safety features are appreciated and valued by the purchasing team	The organisation is willing to purchase medicines from a manufacturer that uses good design principles to improve the safety of its products, even though they may cost slightly more than the same medicine from another manufacturer.

Design and procurement management and practice

Staff who design stationary and buy equipment, understand the needs of the user and the patient. They challenge manufacturers to provide evidence forsafety and usability and know what questions to ask. They capture operational risks and escalate safety concerns.

WHAT GOOD LOOKS LIKE (observed behaviours)

Medical equipment is designed on the basis of human factors principles	System and product designs take into account human cognitive limitations and biases. New designs reduce reliance on human memory, present safety critical information prominently, rather than peripherally, and include forcing functions where the safety warning cannot unintentionally be switched off. Manufacturers seek feedback from customers and record usability issues that affect intuitive use. They respond to shortcomings that affect patient safety.
Medical equipment is piloted to ensure it enhances human performance	Staff responsible for design of medical equipment routinely provide information regarding usability trials and compliance with EU legislation. Customers are offered the opportunity to trial equipment before purchase.
Labelling and design of products is based on human factors principles	Manufacturer's desire for safety overrides its desire for strong brand identification. They design labels to deliberately avoid the possibility of confusion e.g. between drugs that may harm. As a result, packaging is more discriminatory, thus reducing the risk that the wrong item will be selected and used on a patient.
Medical equipment is standardised	Manufacturers actively seek to standardise within their own industry where this is likely to reduce errors and enhance patient safety e.g. keypad layout.

WANT TO KNOW MORE ABOUT HUMAN FACTORS?

Getting to grips with Human Factors - Strategic actions for safer care
A learning resource for Boards

Implementing Human Factors in Healthcare - *Taking further steps. 'How to' guide Vol 2*

Implementing Human Factors in Healthcare
'How to' guide Vol 1
www.patientsafetyfirst.nhs.uk

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