enhanced SEA

NHS Education for Scotland

REPORT FORM

TITLE OF REPORT:

NAME:

ADDRESS/LOCATION:

EMAIL:

DATE EVENT IDENTIFIED:

DATE REPORT COMPLETED:

WHO CONTRIBUTED TO THE ANALYSIS?:

- Evidence suggests that the application of 'Human Factors' knowledge enhances performance and wellbeing in the workplace and improves understanding of the **complex system interactions** which contribute to significant events.
- A simple way to view the discipline of 'Human Factors' is to think about the **interactions** between three work-related factors: **People, Activity** and the **Environment** – and how they can combine to impact on people's health, safety-related behaviour and patient care.
- This report can be completed after analysing the significant event on your own, or it can reflect the comprehensive analysis carried out by your wider care team.
- The key to a more **in-depth analysis** is identifying the system issues and interactions that **contributed** to a significant event.
- A deeper understanding of why the event happened will prompt a more focused, meaningful and detailed **Action Plan** for improvement.

For more information visit the *enhanced*SEA website: www.nes.scot.nhs.uk/shine/

1. About the Significant Event

Please describe what happened
(Please outline in sufficient chronological detail including how it happened, who it happened to and the location of the event).

What was the impact or potential impact of the event?
(Please consider what may have been the emotional effect of the event on yourself and others, where appropriate, and the clinical, professional and organisational implications).

2. Applying a Human Factors Approach

Please outline the different system factors that contributed to WHY the event occurred, taking into account how these different factors interacted with each other and led to the event happening.

(People Factors (e.g. severity or uncertainly associated with patient condition; social and personality factors; clinician and staff training, skills, knowledge & competence; and physical and psychological characteristics such as fatigue, stress, motivation and needs).

Activity Factors (e.g. job task demands such as mental and physical workload, decision-making, time pressure, attention levels, distractions and interruptions, volume and complexity of tasks; and interacting medical device, tools and technology issues such as their availability and usability).

Environment Factors (e.g. organisational issues such as how work is done, teamwork, verbal & written communication; staff levels, skill mix & shift patterns; information flow; leadership, management and supervisory issues; physical environment factors such as lighting, noise levels, workspace layout and design; prevailing safety culture & priorities; polices & standards; financial resources; and external pressures).

Think in-depth about the **interactions** between people, the activity you were undertaking and the immediate and wider healthcare systems and environment that you work in).

3. Lessons Learned

What lessons have been learned from the analysis of this event (as appropriate):

- At the individual level?
- At a care team level?
- At an organisational level?
- At the interface of primary and secondary health care?
- At the interface between health and social care?

4. Action Plan for Improvement

What action has been taken to-date to minimise the chances of this event happening again?

What further action do you plan?

(Outline your Action Plan for Improvement and how and when you will implement it together with the role and contribution of the wider care team where appropriate. Also consider how you might share any interface issues or external factors that have contributed to this event but which you deem to be out with your control. Think again about taking a systems approach to improvement and consider the complex interactions between People, Activity and Environment already identified.
If you judge that no action is necessary please justify why this is the case).

Who is responsible for ensuring that these actions are implemented and how will these be monitored and sustained in practice?

(Outline your role and contributions and those of the wider care team where appropriate).

If you did not have the opportunity to analyse this event with colleagues, what were the barriers?

(Please complete where applicable).

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