

NHS EDUCATION FOR SCOTLAND SAFETY, SKILLS & IMPROVEMENT

Improving System Performance and Human Wellbeing

Human Factors in Healthcare: The UK Response to COVID-19

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CIEHF Response and Leadership



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About this site

The pandemic has brought human factors issues to prominence. The CIEHF and its members are responding rapidly to current challenges by providing expert guidance and help wherever it's needed most. This site gives details and links to new guidance documents developed and published by us and matches human factors expertise to those needing assistance.

About us

The CIEHF is a professional member organisation for ergonomists and human factors specialists, uniquely providing a route to Chartered status. We accredit education and training courses and our activities raise awareness about the broad scope and positive impact of the discipline in all aspects of life and work. Find out more and how to join us.

<https://covid19.ergonomics.org.uk/>

Silver Team Members

(Chartered Ergonomists: healthcare expertise)

(Clinical Experts)

(Academics and Researchers)

(Human Factors Consultancies with medical device experience)

(Consultancies with other sector experience)

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Creating a Safe Workplace

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User-Centred Design of Work Procedures

- Highly problematic risk & safety issue
- advice and guidance on the design of work procedures, e.g. written instructions, protocols, SOPs, checklists, flow charts
- support the design and re-design of care services and new ways of working
- safer and easier to use procedures, to support how people work and reduce risks to themselves, patients, carers etc.
- rapid development process 65++

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About the Guidance: 3-Level Interactive Infographic

Level 1

Essential steps to design work better

What is a work procedure?
A logical step-by-step way of doing things, e.g. using written instructions, checklists or flow charts.

Why are they important?
Work procedures are essential to help ensure better care, efficient and person-centred care.

What are the challenges?
Work procedures can often highlight or problems when things go wrong. You often they are hard to write, understand or not correct, relevant or not needed at all.

How to improve the design of work procedures

01 Create

- Ensure it's needed
- Involve the whole team at every stage
- Identify hazards
- Capture everyone's work in really clear
- Ensure it's easy to follow

02 Test

- Ask people who will use it to test it
- Use feedback to improve it
- Repeat until everyone is happy with the procedure

03 Use

- Train people in its use
- Spread ideas pointing it into practice
- Make sure it's easy to find
- Show it with others

04 Review

- Review regularly
- If it's not being used, understand why
- Update it if it no longer reflects how you really work

For more visit the 10 key steps or designing work better practice journey

Visit the full course on human-centred design of work procedures

Level 2

Ten key steps to design work better

Make your work procedures safe and easy-to-use for person-centred care

The work procedure process journey

- 1 What's a work procedure?
- 2 Ensure a procedure is needed
- 3 Involve the whole team
- 4 Identify the hazards
- 5 Capture work-as-done
- 6 Make it easy to follow
- 7 Test it out
- 8 Train people
- 9 Put it into practice
- 10 Keep it under review

Level 3

Guidance to help design effective and usable work procedures for health and social care teams

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COVID-19 Risk Assessment and Control Guidance Package for Scottish General Medical Practices

A 5-Step Guide to Risk Assessment in General Practice Environments

KEY POINTERS

- To identify, assess and control safety risks, the care team should think about what could go wrong in their own practice.
- Risk assessment should be iterative, it should be done in identifying possible scenarios in your practice (e.g. those associated with infection control in their usual working systems).
- You will already be taking steps to identify and control risks, but a more formal assessment will help you to prioritise and decide whether you have covered all that you need to.
- Qualitative definitions:
 - Minor: Anything that can cause harm.
 - Risk: The chance of that harm or using harm.
 - Minor: Anything that you will not do for happens to your patient, your home or yourself.
 - Then check that over time.
 - Minor: What has gone wrong in the past?
 - Minor: What could go wrong currently?
 - Minor: What could go wrong in the future?
- The 5-Step Guide can help you look at risk and control measures in more detail with a view to improving them, where you think it is necessary.

COVID-19: Monitoring Risk and Improving System Safety (C-MoRISS) Checklist

About the checklist

- As part of our Covid-19 response, the checklist was co-designed by many different GP team members to help practices identify and check safety-critical issues of importance to the health and wellbeing of patients, visitors and care teams during this crisis period and as we return to new ways of working.
- It is important to note that it is not fully mandatory – but is a flexible guide that you can adapt to suit your local circumstances. Use your own judgement and apply your own common sense when determining the content and if you're fully compliant with each checklist issue.
- As far as possible the checklist development process was informed by human factors/systems thinking to make the content relevant and understandable and to cover all possible roles across the general practice workforce.

How to use the checklist

- Simply work your way through the checklist (it has been sub-divided to make it easier to follow and complete) and use a combination of checking and your own professional judgement to determine whether you are fully compliant with each of the issues outlined.

Definitions

- Mandatory** – where a legal, professional, contractual or regulatory obligation existed for the check to take place
- Essential** – where a failure to check the item would have the potential for harm to occur to patients, GP team members, or practice visitors, or impact negatively on the performance and reputational risk of the practice
- Advisable** – where periodic checking of the item would be a voluntary demonstration of high quality safe system practice

Category key: Mandatory ■ Essential ■ Advisable ■

Ten key steps to design work better

Make your work procedures safe and easy-to-use for person-centred care

The work procedure process journey

- 1 What's a work procedure?
- 2 Ensure a procedure is needed
- 3 Involve the whole team
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Systems Thinking and Capturing Organisational Learning



Mindset template

This is generic for the department/organisation and does not have to be completed every time. It can be filled in once and can then be reviewed periodically.

Mindset	Prompts	Description
1 Learning goals	<ul style="list-style-type: none"> What are our learning goals? Do we want to learn about protocols and safeguards? Do we want to learn about how to make the work more flexible and responsive? Do we want to learn about how technology can help or hinder us in becoming more efficient? 	
2 Learning to be resilient	<ul style="list-style-type: none"> What should be resourced? Have we identified everyone who might contribute or might be affected? Are we learning at team level, departmental level, organisational level or crosswide? How can we involve relevant people at all levels? 	
3 Learning speed and depth	<ul style="list-style-type: none"> Have we looked at a range of options for improvement? Do improvements have the feel of quick fixes? Have we challenged ourselves and our existing beliefs? 	
4 Learning from everyday work	<ul style="list-style-type: none"> Do we focus only on adverse events and what went wrong or could go wrong? Do we try to learn from everyday situations? Do we capture what went well and things we want to keep? 	
5 Learning to formal and informal	<ul style="list-style-type: none"> Is our learning narrowly confined to specific people or designated roles? How do we promote informal learning, eg spontaneously formed working groups? Do we give ownership for learning and improvements to a wide range of people? How do we establish psychological safety, i.e. at the personal level being free and safe to raise issues or challenge decision-making without fear of punishment or embarrassment for staff who contribute to change? 	

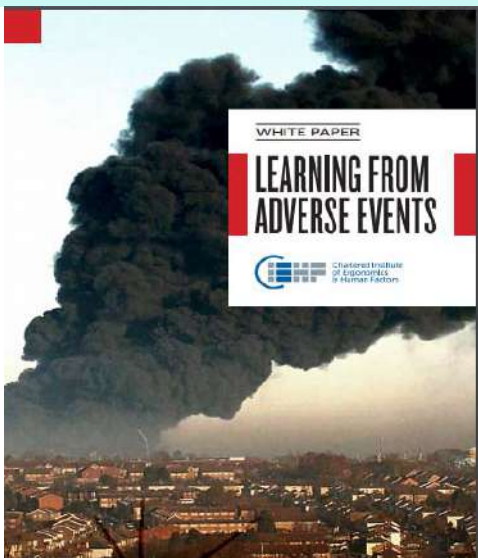
Action template

Think of a situation from which you want to learn, e.g. where you had to adapt systems, processes or behaviours to get jobs done, where you had to make trade-offs between competing priorities and demands, or where you anticipated that a change was necessary and then implemented it.


Action	Prompts	Description
1 Capture work as done	<ul style="list-style-type: none"> What was actually done? By whom? How, e.g. sharing of information, negotiation, delegation of tasks, etc? 	
2 Understand trade-offs and adaptations	<ul style="list-style-type: none"> What prompted the adaptation? How was the need for adaptation recognised? What purpose did the adaptation serve? What made it work/not work? 	
3 Drive learning to practical and meaningful	<ul style="list-style-type: none"> How does the adaptation relate to everyday practice? Who should know about the results? Who will be affected? Is it useful to make it standard practice? Are there any risks? What would help in the future? 	
4 Put commitment and resource into change	<ul style="list-style-type: none"> Who takes ownership of implementing changes? How do the changes require practice, e.g. does it require anticipatory adaptation, the ability to make trade-offs? What does one need to keep an eye on? 	
5 Monitor and feedback	<ul style="list-style-type: none"> What outcomes does one expect to happen? How do we involve people and enable them to provide feedback? How will we make further changes? 	

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CIEHF Good Practice Guidance in Learning from Adverse Events



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SIGNPOSTING RESOURCES

Team-Based Learning from Events - Safety Culture Cards - Systems Thinking Cards - HF and QI Tools - HF Teaching Resources and More


- **UK and International Community of Practice**
- **‘Go To’ Hub for Human Factors learning and resources to support Health & Social Care**

<http://www.knowledge.scot.nhs.uk/hfe.aspx>

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Thank You Very Much!



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