Using Human Factors tools in Clinical Governance within ODT

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Introduction
In 2016, the Care Quality Commission recommended to “move the focus of investigation from the acts or omissions of staff, to identifying the underlying causes of the incident” and “use Human Factors principles to develop solutions that reduce the risk of the same incidents happening again”.

Human Factors are how the people within the organisation interact with the hardware, software and each other when completing a task therefore “Day to Day Observations” was used to identify areas of good practice and where improvements could be made.

Following a trend of clinical incidents, where donor family letters were completed incorrectly, a new process had been implemented to reduce the risk of reoccurrence. Errors were subsequently still reported, therefore it was agreed to use a Human Factors approach particularly looking at external factors and influences.

Method
A human factors audit tool was devised, following training by NHSBT Continuous Improvement department. The group consisted of:
- 2 managers
- 2 administrators
- 2 independent observers

Twenty-one observations were carried out (maintaining a usual working environment) over three days to incorporate all administrator teams, by the 2 administrators and 2 independent observers.

<table>
<thead>
<tr>
<th>External influencing factors</th>
<th>Individual good practice</th>
<th>Work telephone calls</th>
<th>Personal telephone calls</th>
<th>Colleague distractions</th>
<th>Email distractions</th>
<th>Office environment</th>
<th>IT problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of observations recorded</td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>15</td>
<td>2</td>
<td>14</td>
<td>8</td>
</tr>
</tbody>
</table>

Results
The observations were pulled together and collated for each behaviour observed. This included a yes, no, not applicable and additional comments.

The table below demonstrates how Human Factors impact on the donor family letter process. The results highlighted areas of good practice on all observations. The findings also showed that additional steps were undertaken due to the lack of accurately documented information; this was in relation to donor keepsakes and family addresses.

Discussion
Following presentation of the results to DRD staff, a number of actions were identified to mitigate against the external influencing factors that were found:
- Changes were made to the SNF to DRD handover form, making communication clearer around donor keepsakes.
- The Donor Family Link Nurses within each region, shared the importance of clearly documenting the next of kin/primary contacts.
- The agile working environment was discussed at the Local Management Group meeting and with facilities to review centre guidance
- The delays unarchiving donor files on DonorPath were reported to IT and changes will be implemented as part of a wider DonorPath review.

Good practice was highlighted and shared, which has resulted in each of the cluster teams reviewing how they complete the process. It was acknowledged that external factors can influence on a task being completed accurately:

Due to the benefits obtained from this review, Human Factors observations will be rolled out in other areas of ODT to strengthen practice.

References

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