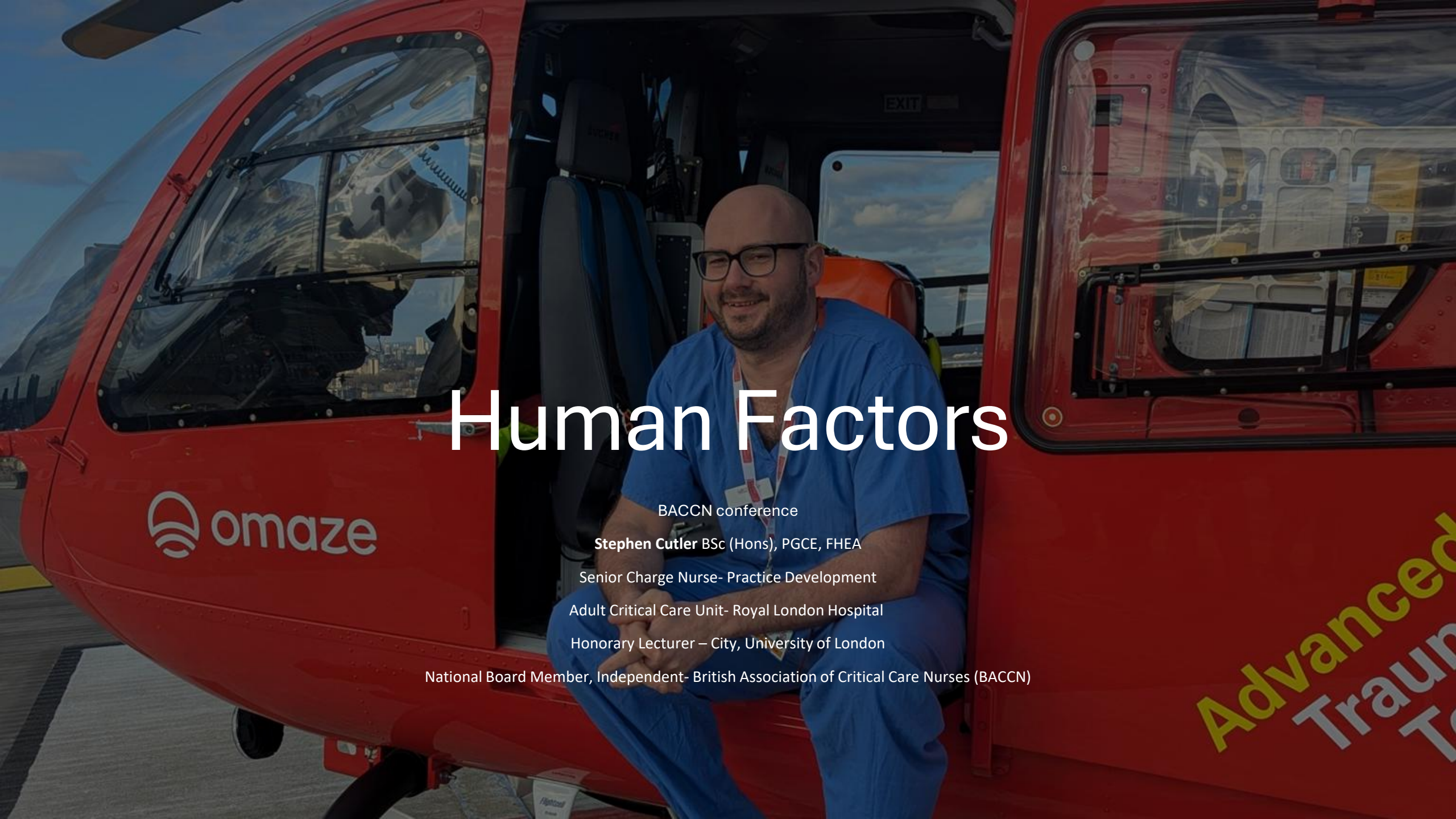


# Human Factors

BACCN conference

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Honorary Lecturer – City, University of London

National Board Member, Independent- British Association of Critical Care Nurses (BACCN)

# What we will look at

- Human factors in our day-to-day life
- Human factors at work
- The System Engineering Imitative for Patient Safety model
- Scenario

How did we all get here?

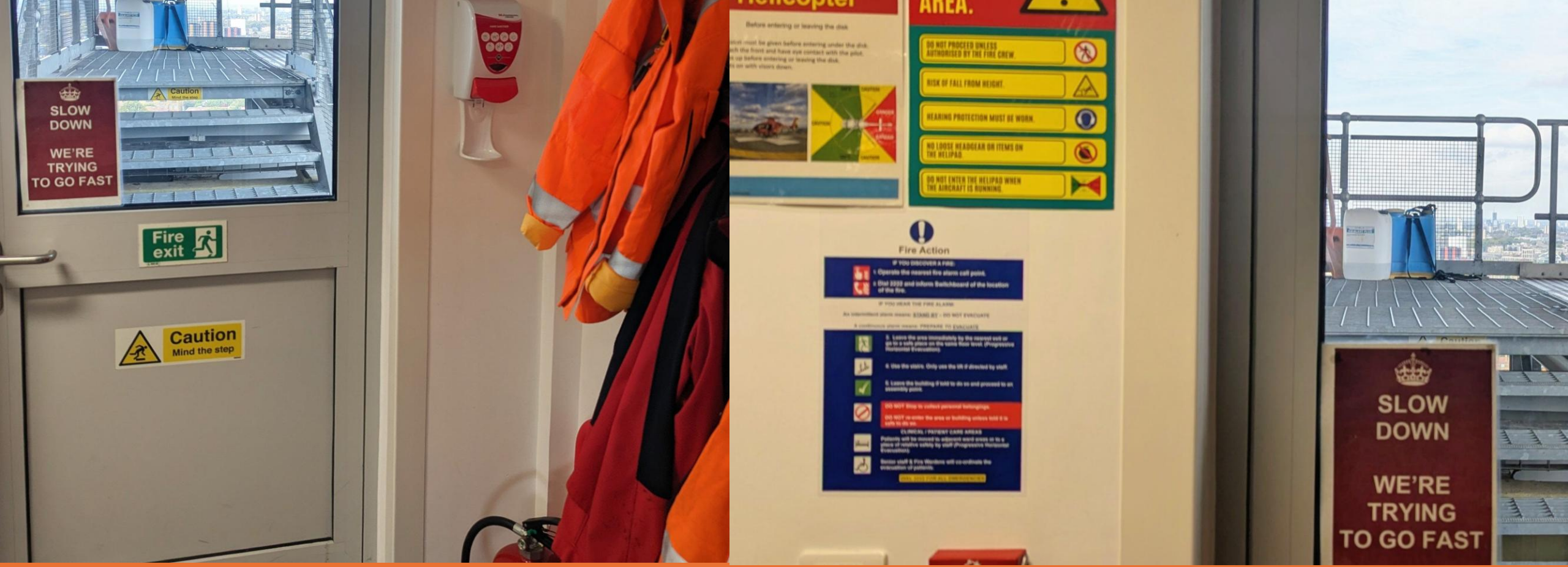
Have you met anyone new at conference yet?


STANDBY
79
91
125/2
(43)
0

# ‘To err is human, to forgive divine’

Alexander Pope (1688-1744)

Human Factors can go wrong!




from the HEMS control room

Congratulations!

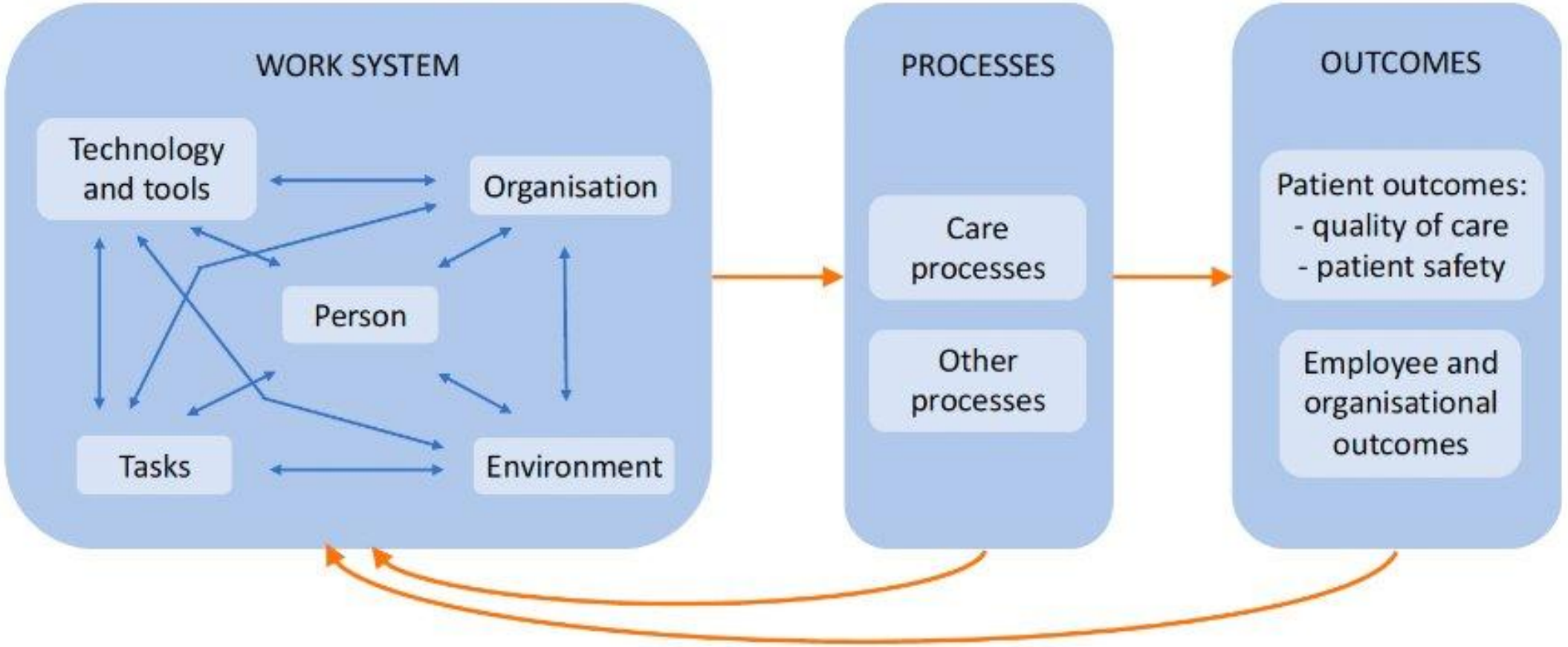
You are all now ***honorary*** provisional band 7 Practice Development Nurses!

System Engineering Initiative for Patient Safety (SEIPS)

Is the tool used within the Patient Safety Incident Response Framework (PSIRF)

*Describes how a work system can influence processes (work done), which in turn shapes outcomes (NHS England 2024)*

# System Engineering Initiative for Patient Safety (SEIPS)




NHS England 2024

# DATIX

An incident report has been submitted via the DATIX web form.

The details are:
Form number: W528
Incident Manager: BOBJON
Site: NHH
Exact Location: ICU
Severity: NOHARM
Description:

**Noradrenaline was bolused by a nurse through the central line which increased the patient blood pressure above the safe limits and decreased the patient heart rate below safe limits**

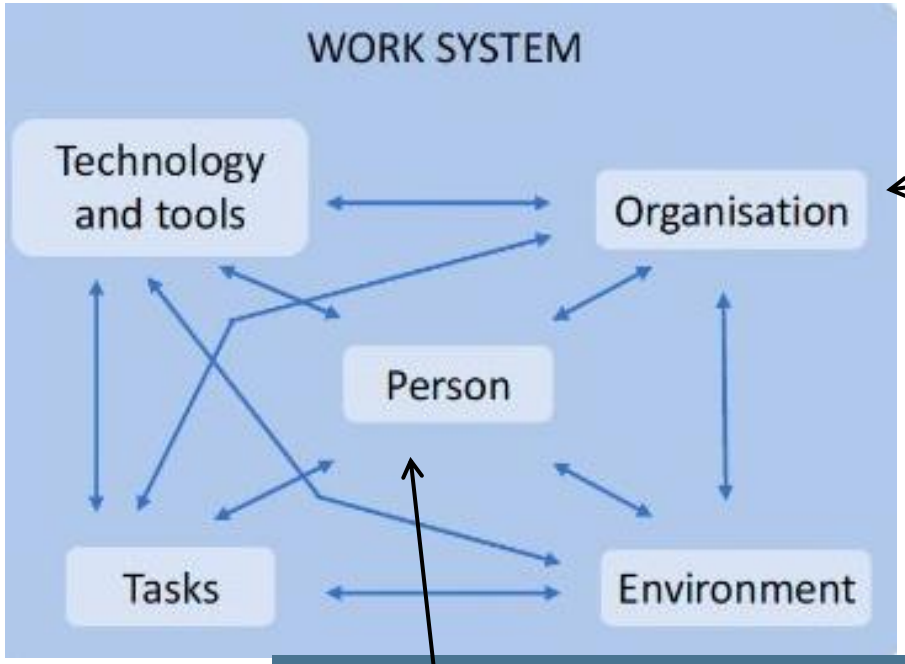
# What other information do we want?

# After a short investigation, we find the following

- The incident happened at 0200 post admission from theatres
- The patient was experiencing a sudden hypotensive episode
- The bedside nurse was asked to  give a 250ml fluid challenge which was connected to the patient
- The patients systolic then escalated to 280/120
- The line was then fed back to the bag and found to be the noradrenaline infusion by the nurse in charge.
- All of the drug library's were labelled ***DRUG X l***
- lines were not labelled
- Insufficient handover from theatre staff on infusions connected
- Patient assessed by medical team  and sent for CT- pt was safe

# So what did that tell us?

Pumps were not labelled
*Lack of situation awareness*



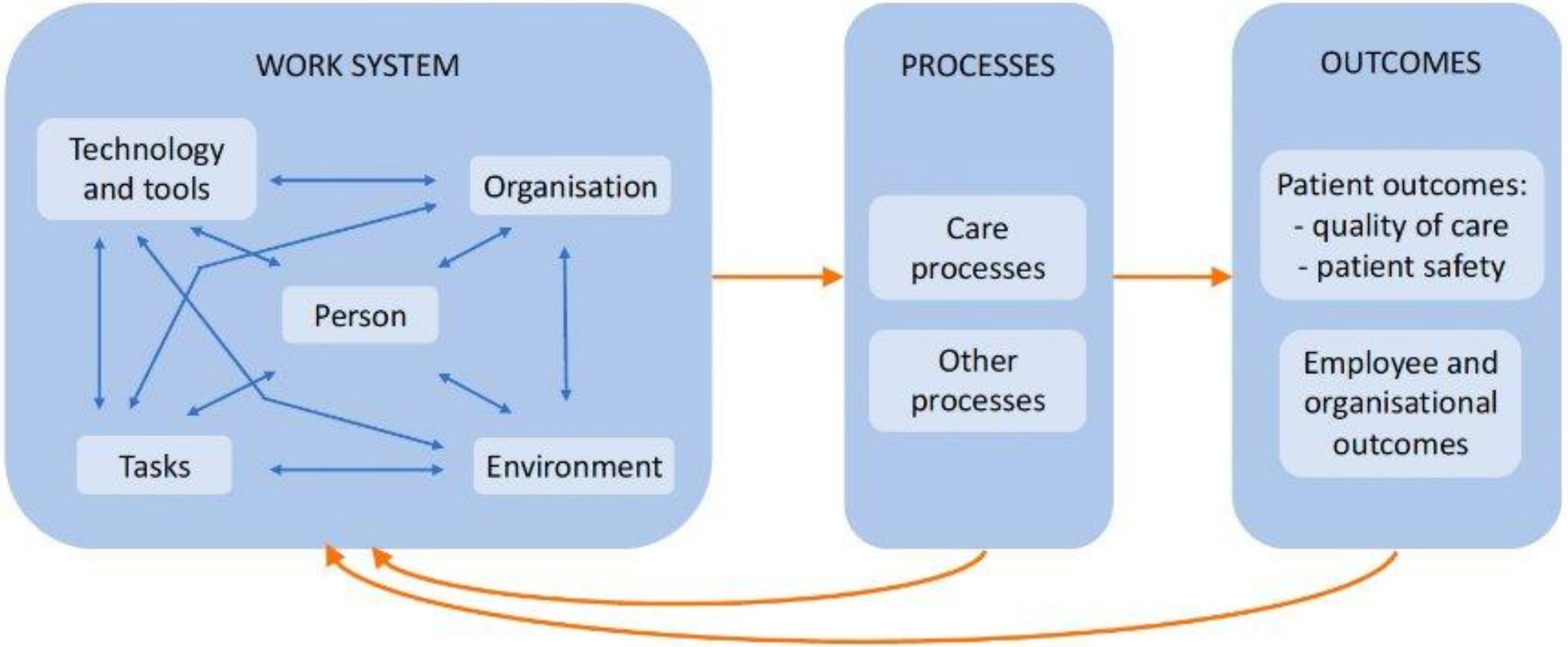

Worked out of policy as all lines and devices should be labelled
*Shows 'work as done instead of work the should be done'*

Lack of communication between nurse and theatre staff

Feels awful
***Lacks self care***
***Stressed***
*PT Was safe, Duty of Candor completed*

It was dark
Lack of ***situational awareness***

# System Engineering Initiative for Patient Safety (SEIPS)



# What suggested changes and feedback are we going to give to those involved in the incident?

- How to deal with stress
- Communication
- Situational awareness
- How to deal with stress
- Offer support
- Share the knowledge learned

Any questions?

# What we have covered

- How Human factors impact on our daily lives
- The impact they have on our working life
- How Human Factors interact with PSiRF
- Examples on how to overcome some Human Factors

Go meet people! Have fun!
Use your verbal and non verbal communications!