

Human
Factors
Reflections



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The Safety Culture Series

Evaluating Incidents & Best Practice.

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Let's talk about the Manchester Patient
Safety Framework...





The Safety Culture Series

What is 'Evaluating Incidents & Best Practice'?

How are incidents evaluated?

What recognition is there of safe practice?

How is the resultant data used?



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The Safety Culture Series

Levels of Culture

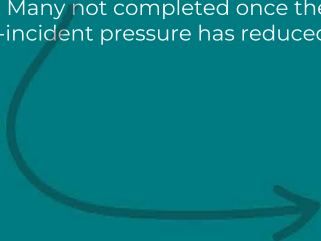
1. Pathological

- . Incidents are swept under the carpet
- . Superficially investigated
- . Focus on 'closing the book'
- . Focus on 'hiding the bad event'
- . Little action taken, and when taken is usually disciplinary focused
- . Has little recognition of good practice



2. Reactive

- . Investigations focus on damage limitation
 - . Staff are seen as the cause of the event
 - . Investigations limited in depth and detail
- . Quick fix solutions proposed- Many not completed once the post-incident pressure has reduced



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The Safety Culture Series

Levels of Culture

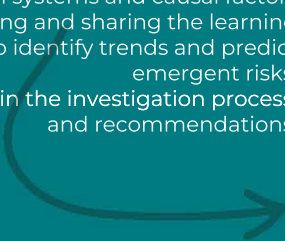
3. Bureaucratic

- . Senior managers are involved in investigations
- . Investigations are often narrow and focus on the individual, with some awareness of system factors.
- . There is a detailed investigation procedure- often paper work heavy and focused
- . Investigations often conducted so the organisation can say they investigated
- . Focus of action often on procedures and policies.



4. Proactive

- . Organisation is open to inquiry and welcomes external involvement to improve independence.
 - . Investigations focus on systems and causal factors
 - . Focus is on learning and sharing the learning
- . Incident data is analysed to identify trends and predict emergent risks.
- . Patients and families are involved in the investigation process, and recommendations.



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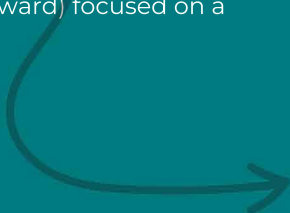


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Levels of Culture

5. Generative

- . Internal and external independent investigations conducted.
- . Staff, patients, carers and families fully engaged in investigation process
- . Investigations are seen as learning opportunities, focused on improvement.
- . Staff involved in regular data analysis
- . Learning and best practice shared throughout the organisations regularly.
- . All levels of staff (Board to ward) focused on a learning culture.



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How does your team and organisation fair?

Use these characteristics to reflect on:

- . What's your team's local culture (or climate) like?
- . What's the organisation's culture like?
- . How is it changing over time?

As a service user:

- . What evidence of these do you see in the services you use?



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Culture is critical!

Building a strong culture is critical,
but can take a long time.

If you would like advice and support
on improving your culture, comment
below and we'll be in touch

References

- Parker, D and Hudson, P. (2007) Understanding your culture, Shell International Exploration and Production.
Westrum, R. (1992) Cultures with Requisite Imagination in Wise, J., Hopkin, D and Stager, P. (eds.), Verification and validation of complex systems: human factors issues (pp. 401-416), Berlin: Springer-Verlag.
PARKER, D. (2009), Managing risk in healthcare: understanding your safety culture using the Manchester Patient Safety Framework (MaPSaF). *Journal of Nursing Management*, 17: 218-222. <https://doi.org/10.1111/j.1365-2834.2009.00993.x>

