Integrating Human Factors and Ergonomics into Health and Social Care

Abstract

Healthcare is a safety critical industry and yet the inclusion of human factors training has not been considered to a mandatory level. It has been suggested that punitive approaches to safety investigations such as root cause analysis, apportioning of blame and misconceptions of incident reporting systems do not always encourage a positive safety culture to grow [1,2]. At South Tees University Hospital, extensive work has been carried out by a small faculty who have developed strategies, teaching resources and processes with the intention to support staff in their approach to assessing and managing risk and safety.

In this presentation we discuss the necessity and methods by which one Foundation Trust in the North East of England has created and delivered training sessions to improve baseline understanding of Human Factors principles to begin the journey of engendering positive culture change.

1Peerally MF, Carr S, Waring J, Dixon-Woods M. The problem with root cause analysis. BMJ Quality & Safety [internet]. 2016 Jun 23;26(5):bmjqs-2016-005511. Available from: <https://qualitysafety.bmj.com/content/qhc/26/5/417.full.pdf>

2Mathis T. Safety and Performance Excellence: Does Root Cause Analysis Stifle Safety Innovation?. Proactsafety [internet]. 2017 Jun. Available from: <https://proactsafety.com/articles/does-root-cause-analysis-stifle-safety-innovation>