

**A Framework for Patient Safety Incident Review**

**Yorkshire Contributory Factors Framework (YCFF)**



To support staff in applying the framework in practice it has been adapted to provide a pragmatic 2 page guidance document which suggests a series of prompting questions and examples of contributory factors that may be useful to assist reviewers in formulating questions relating to a review they are undertaking. The questions and examples of contributory factors are illustrative and can be tailored depending on the nature and context of the incident under review.

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| **Prompting Question** | **Relevant to Incident?** | CONTRIBUTORY FACTOR DOMAIN |
| **Situational Factors** |
| **Did the staff involved function as a team?** | Yes  Maybe  No | **Team Factors** – For example:   * Conflicting team goals * Lack of respect for colleagues * Poor delegation * Absence of feedback |
| **On the day of the incident, how did you feel?** | Yes  Maybe  No | **Individual Staff Factors** – For example:   * Fatigue * Stress * Rushed * Distraction * Inexperience |
| **Did the task features make this incident more likely?** | Yes  Maybe  No | **Task Characteristics** – For example:   * Unfamiliar task * Difficult task * Monotonous task |
| **Were there any reasons this incident was more likely to occur to this particular service user?** | Yes  Maybe  No | **Service User Factors** – for example:   * Language barrier * Uncooperative * Complex medical history * Unusual physiology * Intoxicated |
| **Prompting Question** | **Relevant to Incident?** | CONTRIBUTORY FACTOR DOMAIN |
| **Local Working Conditions** |
| **Did staff provision match the expected workload around the time of the incident?** | Yes  Maybe  No | Workload & Staffing issues- For example:   * High unit workload * Insufficient staff * Unable to contact staff * Staff sickness |
| **Did everyone understand their role?** | Yes  Maybe  No | **Leadership, Supervision & Roles** – example:   * Inappropriate delegation * Unclear responsibilities * Remote supervision |
| **Were the correct drugs, equipment and supplies available and working properly?** | Yes  Maybe  No | **Drugs, Equipment & Supplies** – example:   * Unavailable Drugs * Equipment not working * Inadequate maintenance * No supplies delivery |
| **Prompting Question** | **Relevant to Incident?** | CONTRIBUTORY FACTOR DOMAIN |
| **Latent/Organisational Factors** |
| **Did the ward environment hinder your work in any way?** | Yes  Maybe  No | **Physical Environment** – For example:   * Poor layout * Lack of space * Excessive noise/heat/cold * Poor visibility (e.g. position of nurses’ station) * Poor lighting * Poor access to service user |
| **Were there any problems from other departments?** | Yes  Maybe  No | **Support from other departments**  This includes support from IT, HR, porters, estates of clinical services such as radiology, phlebotomy, pharmacy, biochemistry, blood bank, physiotherapy, medical or surgical subspecialties, theatres, GP, ambulance …. |
| **Did any time of bed pressures play a role in the incident?** | Yes  Maybe  No | **Scheduling and Bed Management** - example:   * Delay in the provision of care * Transfer to inappropriate ward * Difficulties finding a bed * Lack of out-of-hours support |
| **Were there any issues with staff skill or knowledge?** | Yes  Maybe  No | **Staff Training and Education** – For example:   * Inadequate training * No protected time for teaching * Training not standardised * No regular/yearly updates |
| **Did local policies, protocols and Procedures help or hinder?** | Yes  Maybe  No | **Local Policies, Protocols or Procedures** – e.g.   * No protocol exists * Protocol too complicated * Lack of standardisation * Contradictory policies exist |
| **Prompting Question** | **Relevant to Incident?** | CONTRIBUTORY FACTOR DOMAIN |
| **Latent/External Factors** |
| **Is there any characteristic about the equipment, disposables or drugs used that was unhelpful?** | Yes  Maybe  No | **Design of Equipment, Supplies & Drugs** - e.g.   * Confusing equipment design * Equipment not fit for purpose * Similar drug names * Ambiguous labelling and packaging |
| **Have any national policies influenced this incident?** | Yes  Maybe  No | **National Policies** – For example:   * Commissioned resources * National Screening Policy * Interference by government organisations * National medical/nursing standards * National Performance Targets |
| **Prompting Question** | **Relevant to Incident?** | CONTRIBUTORY FACTOR DOMAIN |
| **General Factors** |
| **How would you describe the culture of you clinical/care areas in relation to service user safety?** | Yes  Maybe  No | **Safety Culture** – For example:   * Service User Safety awareness * Fear of documenting errors * Attitude to Risk Management |
| **Were the notes available, accurate and readable?**  **Did poor or absent verbal communication worsen the situation?**  **Acknowledgement: Yorkshire and Humberside Improvement Academy. Creative Commons Bradford Teaching Hospitals NHS Foundation Trust.** | Yes  Maybe  No | **Communication – Written and Verbal** e.g.   * Poor communication between staff * Handover problems * Lack of communication/notes * Unable to read notes * Inappropriate abbreviations used * Unable to contact correct staff * Notes availability |