2021 Annual SHOT Report – Supplementary information

Chapter 7: Human Factors in SHOT Error Incidents

Additional information not included in the main 2021 Annual SHOT Report.

Patient safety syllabus for all UK NHS staff

The five domains are shown in Figure 7.2 and in domain 3 - human factors, human performance and safety management – human factors and ergonomics is introduced with special relevance to patient safety. Within this domain there is a focus on task management, the role of humans in safety systems, communication and other non-technical skills. The importance of non-technical skills is apparent across multiple steps in the transfusion process where accurate communication is key. Transfusion is notorious for using acronyms, and these may not have universally agreed meaning, or a single acronym may have multiple meanings, for example 'Tx' might be interpreted as an acronym for transfusion or transplant or in different circumstances can mean treatment. The impact of ambiguous communication such as requesting a blood component 'as soon as possible' could lead to assumptions, and clearly stating the time that components are required is preferable to manage expectations between the clinical area and laboratory. Illegible handwriting is a reason for rejection of pre-transfusion samples by the laboratory, potentially requiring the patient to be re-bled and can contribute to delays in issuing components. Within healthcare and transfusion there is a need to recognise that improving non-technical skills helps to build safe systems to reduce errors, and despite sophisticated technology a back-to-basics approach incorporating training for this domain is recommended.

Figure 7.2: Five key domains in the patient safety syllabus (HEE 2021)