

STeLI

Simulation Technology-enhanced Learning Initiative



***Patient Safety Human
Factors Training***

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The logo for 'STeLI Brief' features the text 'STeLI' in a stylized font where 'e' is lowercase and 'LI' is uppercase, followed by the word 'Brief' in a bold, sans-serif font. The text is positioned over a series of five circles: a solid light purple circle, a white circle with a light purple outline, a solid light purple circle, a white circle with a light purple outline, and a solid light purple circle.

STeLI Brief

- Half a day exploring the generic principles of Human Factors and Patient Safety, **placing particular emphasis on Crisis Resource Management and generic capabilities.**
- Half a day designed to support individual London NHS Trusts to incorporate **National Patient Safety Agency (NPSA) advice or guidance and/or reviews of their own Serious Untoward Incident (SUI) or Critical Incident Reporting (CIR) data.** A review of relevant interventions or operational guidelines should be incorporated into the Training Programmes for their Trust.

The logo for 'STeLI Brief' is positioned at the top left. It features the text 'STeLI' in a stylized font where 'S' and 'L' are blue, 'T' is green, and 'e' is yellow. The word 'Brief' is in black. To the right of the text are three circles: a solid light purple circle, an outlined light purple circle, and another solid light purple circle.

STeLI Brief

- The final programme should be a flexible training module highlighting key areas of Human Factors, Patient Safety issues whilst **adapting to a Trust's specific patient safety needs or requirements.**



Consultation group

- Kings Health Partners Simulation Centre faculty
- Head of Clinical Communications, KCL
- Secondary School Teacher
- Head of Training, NPISA
- MA Clinical education group
- King's Learning institute

Learning outcomes



- To understand the main principles of Human Factors and how they relate to Patient Safety
- To explore the core issues of Crisis Resource Management
- To gain an awareness of the NPSA
- To utilise the information and ideas presented during the day to think how they might be applied to own working environment and improve patient outcomes

Numbers

- Candidates

- 20 – 30

- Mixed group of Health professionals

- Mixed levels of seniority

- Faculty

- Minimum of 2 faculty

Band 2 - Management

FY1's - Consultants

Dr's OT's
Nurses
Physios
Radiographers
Ward Clarks



Structure

- 1 day's training, modular format (0900 – 1630)
- 4 sessions
 - Each decreasing in duration
- 4 Scenarios
 - 2 based around a Serious untoward Event from the delivering hospital
 - 2 based around a simulation/DVD/scripted scenario

Structure

Mix of educational modalities

Small group work



Interactive quiz

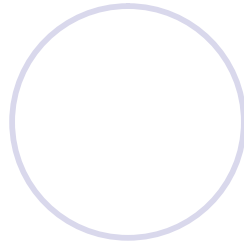
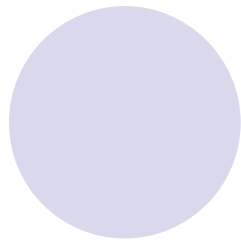
Video clips



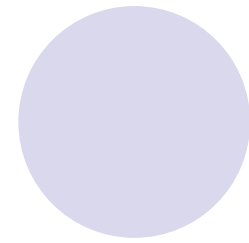
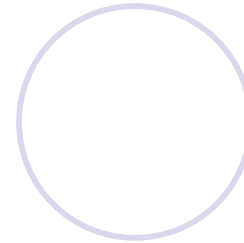
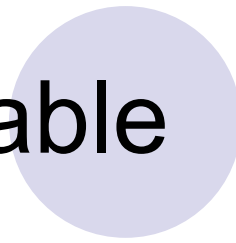
Lectures



Worksheets



Timetable



Session A (2hrs)

09.00- 11.00

Intro

15 mins



Martin Bromily video

15 mins



Discussion

30 mins



NPSA interactive quiz

25 mins



Pt safety in your environment

30 mins

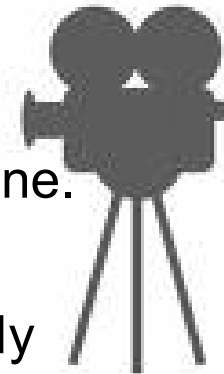
Group discussion



Content – Session A

● Martin Bromily

- Awareness of how the day is relevant to practice of medicine.
- Impact of patient care on the public
- Introduction to the idea that Human Factors training already exists in other industries e.g. Airline
- <http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/Campaign-support/human-factors/>



● Interactive quiz on the NPSA

- What is the NPSA and what do they do?
- Why is patient safety such an important topic?





NPSA Quiz – Sample questions

- How many people are treated every day in the NHS?
- **Over 1 million**
- What percentage of patients admitted to NHS hospitals experience a patient safety event?
- **10% (900,000 on 2002/3 admission rates)**
- What percentage could have been prevented?
- **50%**
- What percentage of these contributed to the deaths of these patients?
- **8% (72,000)**

Content - Session A

- Patient safety in your environment
 - To consider when patient safety may be an issue at work
 - To think why unsafe incidents occur
 - To think about how these issues could be addressed



Timetable

Session B (1hr 45 mins)

11.15 - 1300

Hudson video

3 mins



Discussion

22 mins



Lecture – Human factors/error

30mins

Scenario 1

50 mins

CRM leadership and Followership

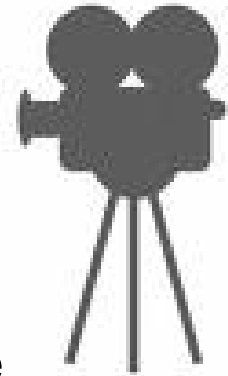
(5 mins Set up, 30 mins small group work, 15mins Feedback)



Content - Session B

- Hudson video

- To show how effective CRM teaching can be
- To demonstrate what we can learn from other industries
- To understand how human factors can effect performance
- <http://www.youtube.com/watch?v=imDFSnkIB0k>



- Human factors Lecture

- What are human factors / CRM
- How did it come into medicine
- What are the main key points in medical CRM



Small group work

- Session B, C, D



- Content alternates between local Serious Untoward Incidents (SUI's) and provided materials
- Materials can be delivered in three alternative methods
 - Human Patient Scenario
 - DVD
 - Scripted scenario.

Content



- 4 scenarios – 4 Human Factors Issues

Effective communication

Leadership and Followership

Calling for Help early

Knowing your environment

Timetable

Session C (1hr 30 mins)

13.45 - 15.15

Scenario 2

Effective Communication

(30 mins small group work – 15 mins Feedback)

45 mins



Scenario 3

Calling for Help Early

(30 mins small group work – 15mins Feedback)

45mins



Timetable

Session D (1hr)

15.30 -16.30

Video clip

5 mins



Scenario 4

Knowing your environment

(Small group work 20 mins – 10 mins feedback)

30 mins



Application

15 mins



Post course questionnaire and certificate

10 mins



Course Package for Facilitators

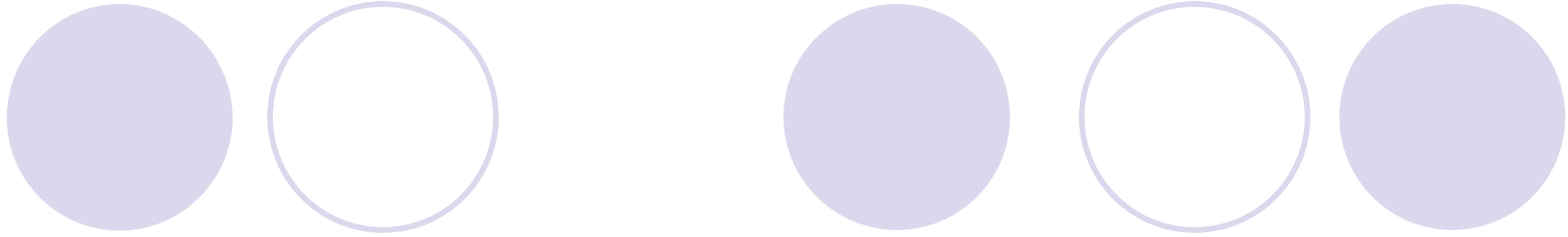
DVD / USB with videos and lectures and material to print out including:-

- Attendance sheets
- Timetable
- Worksheets
- Teachers notes for each activity
- Evaluation Questionnaires
- Certificates



Conclusion

- Inter-professional
- Modular
- Multiple teaching modalities
- SUI's and scenario based teaching



Questions?

Comments?

Feedback?