Resources and further reading

Learning to be safer and human factors

Patient safety in general

Reason, James, 2000. “Human error: models and management” *BMJ*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117770/pdf/768.pdf

Vincent, Charles and Amalberti, René, 2016. *Safer Healthcare: Strategies for the Real World.* Open Access http://link.springer.com/book/10.1007%2F978-3-319-25559-0

Book: Syed, Matthew, 2015. *Black box thinking.*

Quality improvement

***Video*:** Quality improvement in healthcare https://youtu.be/jq52ZjMzqyI

West of England AHSN, 2016. Guide to Quality Improvement. www.weahsn.net/qiguide

Human factors

Video: Just a Routine Operation. https://vimeo.com/970665

Video: The Human Factor: Learning from Gina’s Story. https://youtu.be/IJfoLvLLoFo

Human Factors 101 https://humanfactors101.com

Clinical Human Factors Group, 2016. *Human Factors in Healthcare: Common Terms.* http://chfg.org/wp-content/uploads/2016/03/chfg-human-factors-common-terms.pdf

Book: Rosenorn-Lanng, Debbie, 2014. *Human Factors in Healthcare: Level One*

Book: Rosenorn-Lanng, Debbie, 2015. *Human Factors in Healthcare: Level Two*

Supporting staff and patients involved in incidents

Video: Dr Mike Evans: What can you do to get through a crap week? https://youtu.be/o_X0K4ZrvFQ

Video: Circle of Care https://vimeo.com/166819236

Harrison, Lawton and Stewart. 2014. “Doctors’ experiences of adverse events in secondary care: the professional and personal impact.” *Clinical Medicine.* http://www.clinmed.rcpjournal.org/content/14/6/585.full

Medically Induced Trauma Support Services. Supporting a Colleague http://www.mitsstools.org/how-to-support-a-colleague.html

North Bristol NHS Trust
NHS Bristol Clinical Commissioning Group
NHS England
West of England Academic Health Science Network
Published: November 2016

NHSLA Saying Sorry http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

Wu and Steckelberg, 2012. “Medical error, incident investigation and the second victim: doing better but feeling worse?” *BMJ Quality and Safety* http://qualitysafety.bmj.com/content/21/4/267.extract

NPSA, 2008. *Examples of James Reason’s ‘three bucket’ model.* http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60160

Investigating incidents using human factors approach

Learning from Excellence http://learningfromexcellence.com/

Meadows, Baker and Butler. The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents http://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf

NHS Scotland Enhanced Significant Event Analysis http://www.qihub.scot.nhs.uk/safe/patient-safety/enhanced-significant-event-analysis.aspx

NPSA Significant Event Analysis Guidance for Primary Care Teams http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61501

Yorkshire and Humber AHSN Yorkshire Contributory Factors Framework http://www.improvementacademy.org/documents/Projects/safety_incidents_framwork/YCFF%20-%20Diagram.pdf

Yorkshire and Humber AHSN: Significant Event Analysis in Primary Care http://www.improvementacademy.org/tools-and-resources/significant-event-audit-in-primary-care.html

Behavioural change

Video*:* All washed up. https://youtu.be/osUwukXSd0k

Behavioural Insights Team, 2015. *EAST: Four simple ways to apply behavioural insights.* http://38r8om2xjhhl25mw24492dir.wpengine.netdna-cdn.com/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf

Yorkshire and Humber AHSN ABC for Patient Safety Toolkit http://www.improvementacademy.org/tools-and-resources/abc-for-patient-safety-toolkit.html