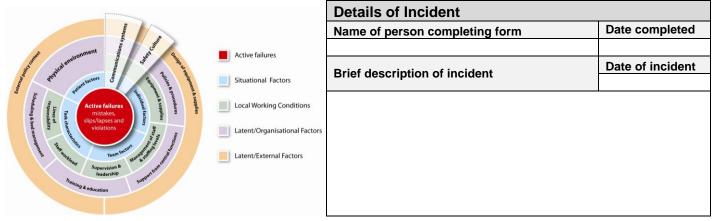
## Framework for Patient Safety Incident Investigation: Yorkshire Contributory Factors Framework (YCFF)

The Yorkshire Contributory Factors Framework



Domain 1: Situational Factors				
Team factors				
Was there any failure of team function?For example:• Conflicting team goals• Lack of respect for colleagues	Poor delegation Absence of feedback	Yes Maybe No	Notes	
Individual staff factors		NO		
Were there any reasons this incident was marticular staff involved?         For example:         • Fatigue         • Stress         • Rushed	ore likely to occur with the Distraction Inexperience	Yes Maybe No	Notes	
Task characteristics				
Did the task features make the incident mor         For example:         • Unfamiliar task         • Difficult task	<b>e likely?</b> Monotonous task	Yes Maybe No	Notes	
Patient factors				
Were there any reasons this incident was mean particular patient?For example:• Language barrier•• Uncooperative•• Complex medical history	ore likely to occur to this Unusual physiology Intoxicated	Yes Maybe No	Notes	
Domain 2: Local Working Conditions				
Workload and staffing issues				
Was there a mismatch between workload an time of the incident?         For example:         • High unit workload         • Insufficient staff	nd staff provision around the Staff sickness	<ul><li>Yes</li><li>Maybe</li><li>No</li></ul>	Notes	
Leadership, Supervision and Roles				
Was there any failure of team function?For example:Inappropriate delegationUnclear responsibilities	Remote supervision	<ul><li>Yes</li><li>Maybe</li><li>No</li></ul>	Notes	
Drugs, Equipment and Supplies				
Were there difficulties obtaining the correct equipment and/or supplies?         For example:         • Unavailable drugs         • Equipment not working	drugs and/or working Inadequate maintenance No supplies delivery	Yes Maybe No	Notes	

Domain 3: Organisational Factors				
Physical environment				
Did the ward environment hinder your work in any way? For example:	🗀 Yes	Notes		
<ul> <li>Poor layout</li> <li>Lack of space</li> <li>Poor visibility (e.g. position of nurses' station)</li> </ul>	Maybe			
<ul> <li>Excessive noise/heat/cold</li> <li>Poor lighting</li> <li>Poor access to patient</li> </ul>	🗆 No			
Support from other departments				
Were there any problems from other departments? For example:	Yes	Notes		
<ul> <li>This includes support from IT, HR, porters, estates or clinical services such as radiology, phlebotomy, pharmacy, biochemistry, blood bank, microbiology,</li> </ul>	Maybe			
physiotherapy, medical or surgical sub-specialities, theatres, GP, ambulances etc	🗆 No			
Scheduling and Bed Management	1			
Did any time or bed pressures play a role in the incident? For example:	🗆 Yes	Notes		
<ul> <li>Delay in the provision of care</li> <li>Transfer to an appropriate ward</li> <li>Difficulties finding a bed</li> <li>Lack of out of hours support</li> </ul>	Maybe			
Staff training and Education		Notoo		
Were there any issues with staff skill or knowledge? For example:	Yes	Notes		
Inadequate training     Training not standardised	Maybe			
No protected time for teaching     No regular/yearly updates	└── No			
Domain 4: External Factors				
Design of Equipment, Supplies and Drugs				
Was there any characteristic about the equipment, disposables or drugs that was unhelpful?	🗀 Yes	Notes		
For example:	Maybe			
<ul> <li>Confusing equipment design</li> <li>Equipment not fit for purpose</li> <li>Similar drug names</li> <li>Ambiguous labelling and</li> </ul>				
packaging	└── No			
National policies	1			
Have any national policies influenced this incident?		Notes		
For example:	Yes			
<ul> <li>Commissioned resources</li> <li>National screening policy</li> <li>National medical/nursing standards</li> </ul>	Maybe			
Interference by government         4 hour Emergency Department				
organisations target	└── No			
Domain 5: Communication and Culture				
Safety culture				
Did the lack of safety culture in your clinical area contribute to this incident?	Yes	Notes		
<ul> <li>Patient safety awareness</li> <li>Attitude to risk management</li> </ul>	Maybe			
<ul> <li>Fear of documenting errors</li> <li>Fear of documenting errors</li> </ul>	□ No			
Verbal and Written communication				
Did poor written or verbal communication worsen the situation?		Notes		
For example:	Yes			
<ul> <li>Poor communication between staff</li> <li>Handover problems</li> <li>Inappropriate abbreviations used</li> <li>Unable to contact correct staff</li> </ul>	Maybe			
<ul> <li>Handover problems</li> <li>Lack of communication/notes</li> <li>Unable to contact correct staff</li> <li>Notes availability</li> </ul>				
Unable to read notes	└─┘ No			
Summary				
Which are the most important contributory factors for this incident?				
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