SIQ   Contributing factors
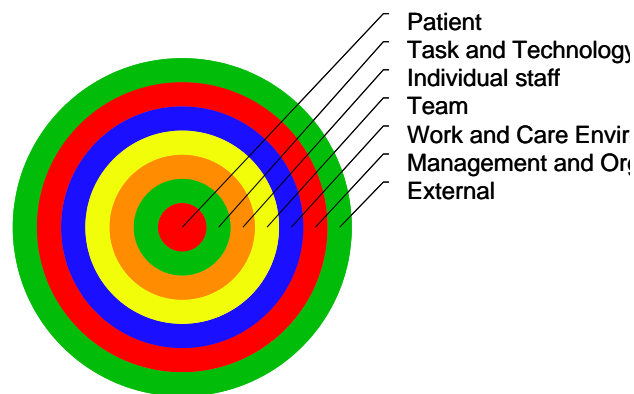
The factors that contribute to the SIQ (the 'contributing factors') should be identified.

- *Patient factors* – patients themselves can contribute to an incident by virtue of their clinical condition, personal characteristics or circumstances, and inter-personal relationships.
- *Task and technology factors* – the care tasks (e.g. as defined in care pathways or protocols) and technology involved, including medicines, can contribute to an incident.
- *Individual staff factors* – staff can contribute to an incident.
- *Team factors* – team aspects such as communication, supervision and leadership can contribute to an incident.
- *Work and care environment factors* – the working or care environment might contain deficiencies that can contribute to an incident.
- *Management and organisational factors* – shortcomings in the management and organisation of a hospital or department can contribute to an incident.
- *External factors* – finally, factors external to the organisation can contribute to the incident, such as regulatory or economic issues.

Patient
Task and Technology
Individual staff
Team
Work and Care Envir
Management and Org
External

SIQ   Contributory factors framework

Annex A provides a checklist of factors that can be used to help you establish the contributory factors that gave rise to patient safety event. Starting with the patient factors, and taking on board all that you have learned as a consequence of any investigation activity, systematically work thorough the contributory factors framework asking appropriate questions to arrive at a list of factors contributing to the incident.

Once you have determined the contributing factors, put the appropriate codes in the relevant categories.

SIQ Contributory factors framework and codes

				Code
Patient Factors	Clinical	☐	Known risks associated with treatment	101
		☐	Pre-existing co-morbidity	102
		☐	Complexity of condition	103
		☐	Seriousness of condition	104
		☐	Treatability of condition	105
		☐	Difficulty in diagnosis	106
		☐	Clinical/health history	107
		☐	Inexplicable/Unknown factors	108
		☐	Other	109
	Personal	☐	Personality	110
		☐	Physical state (e.g. malnourished, poor sleep pattern, etc.)	111
		☐	Cultural background	112
		☐	Religious beliefs	113
		☐	Language and communication	114
		☐	Social and family circumstances	115
		☐	External support	116
		☐	Stress	117
		☐	Disclosure of health history	118
		☐	Other	119
	Inter-personal	☐	Patient-staff relationship	120
		☐	Patient-patient relationship	121

				Code
Task and technology factors	Availability and use of protocols (including guidelines)	☐	Availability of protocols to staff	201
		☐	Use of protocols	202
		☐	Poor quality of information included in the protocol	203
		☐	Procedures for reviewing and updating protocols	204
		☐	Inappropriate use of protocol	205
		☐	Other	206
	Availability and accuracy of health Information, including medical record and test results	☐	Availability of information	207
		☐	Reliability of information	208
		☐	Information inaccessible to staff	209
		☐	Misinterpretation by staff	210
		☐	Disagreements regarding the interpretation of information	211
		☐	Inadequately flagged information/alert	212
		☐	Need to chase up information	213
		☐	Other	214
	Task design	☐	Relevance	215
		☐	Ease of task execution	216
		☐	Design deficiency	217
		☐	Other	218
	Decision making aids	☐	Availability, use and reliability of specific types of equipment e.g. CTG	219
		☐	Availability, use and reliability of specific types of tests, e.g. blood testing	220
		☐	Availability and use of a senior clinician	221
		☐	Other	222
	Medication-related	☐	Wrong medication	223
		☐	Adverse drug reaction	224
		☐	Miscalculation	225
		☐	Complicated dosage design	226
		☐	Mislabelling	227
		☐	Incorrect computer entry	228
		☐	Poor/ Similar packaging and labelling	229
		☐	Similar looking or sounding names	230
		☐	Other	231

				Code
Staff factors	Competence	☐	Inadequate knowledge	301
		☐	Inadequate skills	302
		☐	Inadequate experience	303
		☐	Other	304
	Compliance	☐	Failure to comply with policy/procedure/protocol	305
		☐	Intentional violation	306
		☐	Unintentional violation	307
		☐	Other	308
	Personal	☐	Personality	309
		☐	Stress	310
		☐	Fatigue	311
		☐	Distraction	312
		☐	Attitude	313
		☐	Inadequate motivation	314
		☐	Lapse of concentration	315
		☐	Mental impairment (e.g. illness, drugs, alcohol, pain)	316
		☐	Specific mental health illness (e.g. depression)	317
		☐	Domestic issues	318
		☐	Other	319
	Inter-personal	☐	Staff-patient relationship	320
		☐	Staff-staff/team relationship	321
		☐	Staff-organisation relationship	322
		☐	Other	323

				Code
Team factors	Verbal Communication	☐	Communication between junior and senior staff	401
		☐	Communication between professions	402
		☐	Communication outside of the ward/department etc.	403
		☐	Inadequate hand over	404
		☐	Communication between staff and patient	405
		☐	Communication between specialists and departments	406
		☐	Communication between staff of the same grade	407
		☐	Voicing disagreements and concerns	408
		☐	Communication between staff and relatives or carers	409
		☐	Other	410
	Written communication	☐	Incomplete/absent information (e.g. test results)	411
		☐	Incomplete/ absent information (e.g. test results, handover)	412
		☐	Discrepancies in the notes/documentation	413
		☐	Incomplete documentation	414
		☐	Illegible	415
		☐	Missing signature	416
		☐	Poor quality of information in the notes/documentation	417
		☐	Inter-dept communication	418
		☐	Communication with MoH/other hospitals/agencies	419
		☐	Misinterpretation	420
		☐	Other	421
	Supervision and seeking help	☐	Decision/willingness of staff to seek help	422
		☐	Unavailability of staff to help	423
		☐	Responsiveness of staff to help	424
		☐	Other	425
	Congruency/ consistency	☐	Definition of tasks between professions	426
		☐	Definition of tasks between different grades of staff	427
		☐	Definition of tasks between same grades of staff	428
		☐	Other	429
	Leadership and Responsibility	☐	Ineffective leadership	430
		☐	Unclear definitions of responsibility	431
		☐	Other	432
	Staff colleagues response to incidents	☐	Inadequate support by peers after incident	433
		☐	Inadequate support by staff of comparable grades across professions e.g. senior nurse and junior	434

				Code
		☐	doctor	
		☐	Other	435

				Code
Work and care environment	Building and design	☐	Maintenance management	501
		☐	Functionality (ergonomic assessment e.g. lighting, spaces, etc.)	502
		☐	Other	503
	Physical environment	☐	Housekeeping	504
		☐	Control of the physical environment (e.g. temp, light, etc.)	505
		☐	Movement of patients between wards/sites	506
		☐	Storage	507
		☐	Other	508
	Equipment/ supplies	☐	Malfunction/failure/reliability	509
		☐	Unavailability	510
		☐	Maintenance management	511
		☐	Functionality (e.g. ergonomic design, fail-safe, standardisation)	512
		☐	System design	513
		☐	Other	514
	Information technology	☐	Malfunction/failure/reliability	515
		☐	Unavailability	516
		☐	Maintenance management	517
		☐	Functionality (e.g. ergonomic design, fail-safe, standardisation)	518
		☐	System design	519
		☐	Other	520
	Staffing	☐	Unavailability	521
		☐	Allocation of staff	522
		☐	Recruitment	523
		☐	Other	524
	Education and training	☐	Induction/orientation	525
		☐	Ongoing and refresher training	526
		☐	Other	527
	Workload/ Hours of work	☐	Inadequate regular rest breaks	528
		☐	Heavy workload	529
		☐	Long working hours	530
		☐	Other	531
	Service	☐	Delay	532

	delivery			
		☐	Missed	533
		☐	Inappropriate	534
		☐	Other	535

				Code
Management and organisational factors	Leadership and governance	☐	Leadership presence	601
		☐	Leadership style	602
		☐	Governance arrangements	603
		☐	Other	604
	Organisational structure	☐	Hierarchical arrangement of staff within the organizational context	605
		☐	Span of control	606
		☐	Unclear roles/ responsibility	607
		☐	Other	608
	Objectives, policies and standards	☐	Management arrangements (function)	609
		☐	Operation (e.g. Facility Management, Materials Management, Contract Management)	610
		☐	Human resources policy	611
		☐	Financial policy	612
		☐	Information policy	613
		☐	Risk management (e.g. incident reporting, investigation and analysis, safety culture)	614
		☐	OSH management	615
		☐	Other	616
	Resources and constraints	☐	Human resources	617
		☐	Financial	618
		☐	Other	619
	Safety culture and priorities	☐	Inadequate safety culture	620
		☐	Wrong priorities	621
		☐	Other	622

				Code
External factors	Political	☐	Goals	701
		☐	Perceptions	702
		☐	Other	703
	Economic	☐	Climate	704
		☐	Other	705
	Regulatory	☐	Laws and regulations	706
		☐	Ministry of Health requirements	707
		☐	Requirements of other regulatory agencies/bodies	708
		☐	Other	709
	Partnership working with external organisations	☐	Governance arrangements	710
		☐	Management arrangements	711
		☐	Contractual arrangements	712
		☐	Communication	713
		☐	Other	714