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| **Guidance:** |
| * This form is designed to promote learning and improvement rather than blame. * Please complete this reflection honestly to help identify areas for development and system improvement. * Please feel free to seek support from your clinical supervisor if needed. * If required, please also discuss this incident as part of professional development and revalidation. |
| **Section 1: Details** |
| **Full Name:**  **Role:**  **Ward:**  **Date of Incident:** **Time of Incident:** **Location:** **Datix Number (if applicable):** |
| **Brief Description of the Incident:** (Provide a factual and objective summary of what happened) |
| **Type of Error (tick all that apply):** ☐ Absconding incident ☐ Skin or tissue damage ☐ Clinical error ☐ Slip, trips or fall  ☐ Communication  ☐ Documentation  ☐ Information Governance ☐ Patient behaviour ☐ Visitor behaviour  ☐ Equipment error ☐ Safer people handling ☐ Environment ☐ Laundry  ☐ Transport ☐ Other (please specify): \_\_\_\_\_\_\_\_ |
| **How was the error identified?** (What did you do once the error was identified?) |
| **Section 2: Reflection Using Gibbs' Reflective Cycle** |
| **1. Description**  What happened? Provide a detailed account of the incident. |
| **2. Feelings**  What were your thoughts and feelings at the time of the incident and after it occurred? |
| **3. Evaluation**  What was good and bad about the experience? What went well, and what could have been improved? |
| **4. Analysis and PSIRF (Patient Safety Incident Response Framework) Considerations**  Why do you think the incident happened? Consider factors below, such as workload, environment, communication, or system issues. Click on the check boxes below if a contributory factor applies to the incident and provide a brief explanation next to it.  **Tools & Technology:**  Characteristics such as:  Usability  Accessibility  Familiarity  Level of automation  Portability & functionality  Maintenance (outdated, malfunctioning)  **Tasks:**  Characteristics such as:  Specific actions within larger work processes  Includes task attributes such as:  Difficulty  Complexity  Variety  Ambiguity  Sequence  **Person:**  Individual characteristics such as:  Psychological Impact (e.g. frustration, stress, burnout)  Cognitive factors (attention, memory, confusion)  Preferences, personal goals  Knowledge, competence, skills  Psychological factors (e.g. illness, dehydration)  Sequence  Collective characteristics: team cohesiveness  **Organisation:**  Structures external to a person (but often put in place by people) that organise time, space, resources and activity  Within institutions:  Work schedules / staffing  Workload assignment  Management and incentive systems  Organisational culture (values, commitment, transparency)  Training  Policies / procedures  Resource availability and recruitment  In other settings:  Work schedules / staffing  Workload assignment  Management and incentive systems  Organisational culture (values, commitment, transparency)  Training  **Internal Environment:**  Physical environment such as characteristics of:  Ambient environment (lighting, noise, vibration, temperature)  Physical layout and available space  Housekeeping (clutter, organisation of, cleanliness)  **External Environment:**  Societal, economic, regulatory and policy factors outside the organisation |
| **5. Conclusion**  What could have been done differently? What have you learned from the experience? |
| **6. Actions**  What steps could you take to prevent a similar incident in the future? What support or training might you need? |
| **Section 3: Support and Feedback** |
| **Was a supportive debrief held?** ☐ Yes ☐ No |
| **Did you feel supported by your team/manager?** ☐ Yes ☐ No |
| **How can we support learning from this incident?** |
| **Section 4: Review and Sign-Off** |
| **Completed By (Staff Name):** **Date:** **Reviewer (Line Manager/Educator):** **Date:** |
| **Follow-up Actions/Support Provided:** (Line Manager, Clinical Supervisor, Clinical Educator to complete) |