Evaluation Form

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medhub

Human Factors Peer Review

Evaluator: _____

Evaluation of: _____

Date: _____

Select Yes or No.
For "Yes" responses add an explanation.

Acts, Errors, Skill-based errors

1. Inadvertent Operation - Factor when an individual's movements or actions inadvertently activate, deactivate or alter the function of equipment, controls, or devices when there is no intent, or lack of adequate training as to their regulation and function.

☐ No
☐ Yes

Example: Connections or settings to IV pumps, ventilators, cardiac monitors, etc.

Comments:

2. Checklist Error - Factor when the individual, either through an act of commission or omission makes a checklist error or fails to run an appropriate checklist and this failure results in an unsafe situation.

☐ No
☐ Yes

Example - Central line checklist, foley catheter insertions/maintenance/removal, intubation set up and backups, etc.

Comments:

3. Procedural Error - Factor when a procedure is accomplished in the wrong sequence or using the wrong technique.

☐ No
☐ Yes

Example - Errors in line placement or selection, suture selection, technique, method, etc.

Comments:

Acts, Errors, Judgment and Decision Making Errors

4. Risk Assessment - During Treatment -Factor when the individual fails to adequately evaluate the risks associated with a particular treatment plan of action, and this faulty evaluation leads to inappropriate actions and decision making.

☐ No
☐ Yes

Example - Anticipation of hemodynamics following intubation, fluid responses in septic heart failure patients, BP control with MIs, etc

Comments:

5. Task Misprioritization - Factor when the individual does not organize, based on accepted prioritization techniques, the tasks needed to manage the immediate condition and stabilization.

☐ No
☐ Yes

Example - Hemodynamic control prior to airway stabalization, etc.

Comments:

6. Rushed Necessary Management - Factor when the individual takes the necessary action as dictated by the situation but performs the action too quickly resulting in an unsafe situation.

☐ No
☐ Yes

Example - Failing to maintain adquate needle control during central line placement and losing access

Comments:

7. Delayed Necessary Management - Factor when the individual selects a course of action but elects to delay execution of the actions and the delay leads to an unsafe situation.

☐ No
☐ Yes

Example - Delaying intubation expecting clincal improvement, but delaying definitive management

Comments:

8. Ignored Factors - Bias - Factor when a symptoms, situation, or warning is perceived and understood by the individual but is ignored by the individual leading to an unsafe situation.

☐ No
☐ Yes

Example - Diagnostic momentum, failing to consider alternative diagnosis or pathology

Comments:

9. Decision Making - Factor when the individual through faulty logic selects the wrong course of action.

☐ No
☐ Yes

Comments:

Acts, Errors, Perception Errors

10. Error due to Misperception - Visual, auditory, or cognitive misperception; cognitive or attention failure.

☐ No
☐ Yes

Example - misheard the nurse call out of medication dose

Comments: