**Human Factors in anaesthesia | Te Āhua Tangata i te rehunga**

**Visual  
The video begins. The screen has a white background. In the middle of the screen are the words ‘Human Factors’ in large letters. Each letter of the word ‘Human’ is a different colour. The word ‘Factors’ is blue. Underneath that is a line, under which is written in smaller blue letters ‘Human Factors in anaesthesia.’**

**The screen changes and a te reo translation in the same style as the first screen appears. The words say ‘Te Āhua Tangata i te rehunga.’**

**We then see the outside of Auckland City Hospital. The shot is taken from below. Clouds swirl and the sky is blue. We see the words ‘main entrance’ and ‘emergency.’**

**The screen changes and a doctor dressed in blue scrubs sits beside a surgical incubator. He wears a blue surgical cap with his name sewn onto it. Below the word ‘Matt’ it says ‘Anaesthetist.’**

Audio  
[Matt] Kia ora, my name is Matt Drake. I’m a specialist anaesthetist. I’m the service clinical director for the National Women’s operating rooms and anaesthesia at Auckland City Hospital.

**Visual  
We see a close-up shot of three surgeons wearing caps, glasses and face masks.**

Audio  
[Matt] Human Factors are quite important in lots of ways across anaesthesia and theatres. So, for example, there are systems and processes, and the ways that the theatre is set up is very important in helping people to do a really good job.

**Visual  
We see the inside of an operating theatre followed by some empty hospital beds.**

Audio  
[Matt] So, just to give you an example, we have different connectors for different types of drugs, also our syringe labels in anaesthesia they will have a specific colour and for the type of drugs, so, for example, opioids are in blue and neuromuscular-blocking agents in red. So, as well as being able to read the name of the drug, you can see just by looking at the colour what type of drug it is. So, it kind of reduces the chance of you grabbing the wrong syringe in a crisis.

**Visual  
Matt is standing in front of a set of hospital drawers. He opens a drawer and takes out some different drugs and a syringe. We see shots of different drugs. The scene changes, and a clinician in a surgical gown puts on a blue rubber glove.**

Audio  
[Matt] You can see today that I’m wearing a theatre hat which has got my name and my role on, so when you’re in theatres and particularly if you’re in a new team, you don’t know everybody or you’re wearing a mask, it’s a bit more difficult to communicate and get your message across.

**Visual  
We see Matt working in a surgical theatre wearing his named blue hat.**

Audio  
[Matt] So, if you can say Matt, could you tell me what the blood loss is, and I can say yes, sure Steve, it’s 200 mls, then that’s a good way of having closed-loop communication within the theatre team.

**Visual  
Three clinicians’ faces are looking down in an operating theatre.**

Audio  
[Matt] The World Health Organization Surgical Safety Checklist is just another thing that probably everyone’s familiar with using now. It’s a fairly simple checklist. It has three parts that are done at three different parts of the surgery, and it’s led by three different disciplines.

**Visual  
A surgical safety checklist appears on screen. The background is blue and it has three sections with lists below each of them.**

Audio  
[Matt] So, there’s a sign-in at the beginning which the anaesthetist leads, there’s a time-out the surgeon leads and then there’s a sign-out at the end which the scrub nurse leads, and by delegating that checklist to three different people it flattens the hierarchy in the theatre. So, it empowers everybody to be able to notice things and speak up for safety if they need to.

**Visual  
Matt strides purposefully out of a hospital room. Two clinicians look at a screen. The scene changes to show surgeons in theatre with a machine monitoring vital statistics in the foreground.**

Audio  
[Matt] Some Human Factors, things can appear to be like common sense or things that are really obvious; however, they are things that can really make your day go better if you incorporate them in your day-to-day work, so they are really useful.

**Visual  
Inside an operating room, a surgery is taking place. Instruments are passed between surgeons.**

Audio  
[Matt] For example, when we do a general anaesthetic, for a caesarean section, these are really high-stakes emergency situations, and all of the things that you would normally do are quite straightforward, but there are 20 or so things you have to remember, and a checklist just makes sure that you can get all those things done really efficiently and you don’t forget anything.

**Visual  
An ambulance leaves the main entrance of Auckland City Hospital. We see close-up shots of surgeons performing an operation.**

Audio  
[Matt] There’s lots of evidence that Human Factors are really key to the way adverse events happen. In maternity, we have a tool which we use to identify all the different types of factors contributing to adverse events, and that looks at not just the adverse event but all of the factors that led up to the situation which allowed that event to happen.

**Visual  
Shots of beds in a hospital ward. Matt moves a large piece of medical equipment.**

Audio  
[Matt] So, it’s split into things like personnel factors, and patient factors and building and design factors, and so all of these can play a part in adverse events, and if you ignore the Human Factors aspects of adverse events, then you are much more likely to have those events recur.

So, it’s really important to address them when you do these reviews.

**Visual  
A doctor with a stethoscope around her neck bends over to examine a small baby wearing a white onesie. We then see a shot of clinicians in blue scrubs working in a hospital.**

Audio  
[Matt] Implementing Human Factor principles into our day-to-day work puts staff into a system that allows them to do their best work every day so that we can produce the best outcomes for our patients.

**Visual  
The video closes and credits roll.**