

Conducting Perinatal Mortality Reviews using the National Perinatal Mortality Review Tool (PMRT):

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Guideline to be followed by (target staff): Obstetricians, Midwives, Neonatologists			
To be read in conjunction with the following documents: Updates as per MBRRACE - UK			
Are there any eCARE implications? No			
CQC Fundamental standards: Regulation 9 – person centered care Regulation 10 – dignity and respect Regulation 11 – Need for consent Regulation 12 – Safe care and treatment Regulation 13 – Safeguarding service users from abuse and improper treatment Regulation 14 – Meeting nutritional and hydration needs Regulation 15 – Premises and equipment Regulation 16 – Receiving and acting on complaints Regulation 17 – Good governance Regulation 18 – Staffing Regulation 19 – Fit and proper			

Disclaimer -

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

The national PMRT tool allows for a national systematic approach to reviewing cases that qualify for review.

Executive Summary

The concept and principles for a national Perinatal Mortality Review Tool (PMRT) were established by a stakeholder group convened by the Department of Health and the stillbirth and neonatal death charity, Sands in 2012 (Figure 1). The PMRT has been designed following these principles.

Figure 1. Principles for the conduct of local perinatal mortality reviews

- There should be comprehensive and robust review of all perinatal deaths from 22⁺⁰ days gestation until 28 days after birth*; excluding termination of pregnancy and those with a birth weight <500g if the gestation at birth is not known;
- Such reviews should be conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes;
- A multidisciplinary group should review each case at a meeting wheretime is set aside for doing the work;
- There should be scope for parental input into the process from the beginning;
- An action plan should be generated from each review, implemented and monitored;
- The review should result in a written report which should be shared with families in a sensitive and timely manner;
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements;
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning

*The PMRT has subsequently been designed so that the death of any baby who dies following care on a neonatal unit regardless of their age at death can be reviewed using the PMRT and the age of death is not limited to 28 days after birth

1.0 Roles and Responsibilities:

It is the Lead Bereavement Midwife, Lead Midwife for Risk, Obstetricians' and Neonatologists' responsibility to ensure they are conversant with the contents of this guideline and how they access it.

2.0 Implementation and dissemination of document

This document can be accessed via the Trust's Intranet.

3.0 Processes and procedures

3.1 The babies whose care should be reviewed using the PMRT

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22⁺⁰ to 23⁺⁶;
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22⁺⁰ to 28 days after birth;
- All post-neonatal deaths where the baby is born alive from 22⁺⁰ but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

- The PMRT is not designed to support the review of the following perinatal deaths:
 - Termination of pregnancy at any gestation;
 - Babies who die in the community 28 days after birth or later who have not received neonatal care;
 - Babies with brain injury who survive.

3.1.1 Review of the care of babies who have been transferred

Where babies were transferred (either in utero or after birth) and received care in more than one hospital we strongly recommend that the care across all hospitals should be reviewed by the teams involved in the care at each hospital and this should be carried out as a joint activity wherever possible.

The Trust/Health Board where the baby died is responsible for leading the review but all units involved in the care should be part of the review group to ensure that all aspects of the care are considered. Examples of where this did not occur for the deaths reviewed in the perinatal Confidential Enquiries illustrate the inappropriate conclusions which can be reached when limited aspects of care are reviewed in isolation (1) (see Appendix A).

The organising joint meetings will be complex, and not possible in all instances, but the use of video conferencing for joint discussions will be considered for all meetings.

In the event that it is not possible to organise a joint review it is better that care is reviewed separately than not at all and that all units review the part of the care pathway they were involved in providing.

3.1.2 Deaths that should be reviewed first

The aim is that the care of all the babies who die, as listed above, is reviewed. The deaths of all term intrapartum stillbirths and intrapartum related neonatal and post-neonatal deaths will be reviewed.

3.2 Multidisciplinary reviews

Reviews will be carried out using a multidisciplinary approach. As identified in the Confidential Enquiries the quality of the local review is much higher when a multidisciplinary group conducts the review compared with a single individual or just one or two members of staff. Appendix A illustrates the limitations of review by a single individual.

Figure 2. Nationally recommended composition of the local perinatal mortality review group

Core membership	Additional members
<p>Roles within the group:</p> <ul style="list-style-type: none"> • Chair and Vice-Chair • Scribe/Admin support • PMRT/Maternity Safety Champion <p>Minimum of 2 of each of the following:</p> <ul style="list-style-type: none"> • Obstetrician • Midwife • Neonatologist and Neonatal Nurse: <ul style="list-style-type: none"> -All cases where resuscitation was commenced -All neonatal deaths • Bereavement team (1 acceptable) • Risk manager/governance team member (1 acceptable) • External panel member (1 acceptable) • Other members as appropriate to the organisation of care in the Trust/Health Board e.g. service manager 	<p>Named and invited to attend or contribute where applicable:</p> <ul style="list-style-type: none"> • Pathologist • GP/Community healthcare staff • Anaesthetist • Sonographer/radiographer • Safeguarding team • Service manager • Any other relevant healthcare team members pertinent to case

Terms of reference and conduct of review meetings - Please see Appendix B

3.3 Organisation and preparation for review meetings

Members of the review group need to have sufficient time allocated to attending meetings and for carrying out the preparatory tasks ahead of the review meeting. This time should be included in medical job plans and membership of the group should form part of the identified roles of other staff.

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There may be occasions that reviewing substantial numbers of cases may require the organising of the review process as a series of stages outlined in Figure 3 and illustrated in Appendix C. Alternatively with very few cases and appropriate preparation, the review process may be completed at a single meeting, which will be the aim.

Prior to the review starting and within 72 hours of the death a rapid review will enable identification of any immediate safety concerns and escalation to moderate harm and serious incident if required. The PMRT can still be used for review as part of a serious incident investigation.

Figure 3. Stages of the review conducted as a multi-stage process

What	Who
Rapid review to identify any immediate safety concerns	Senior clinician and risk midwife
Enter basic case notification into the PMRT to open the case for review	Designated member of the perinatal mortality review group e.g. clerical support
Preparatory activities	Clerical support staff and clinical staff e.g. risk midwife
Initial review	Two clinical staff members from the perinatal mortality review group
Full (first) review	Perinatal mortality review group
Further review – may be required if information is still pending (e.g. post mortem findings) or new information comes to light	Perinatal mortality review group

3.3.1 Preparation for review meetings

A number of preparatory activities can be carried out ahead of the meeting such as:

- Agree appropriate dates, time and venue
- Ensure the meeting room has appropriate facilities including IT as needed
- Identify cases for each review meeting
- Collect relevant notes, statements, results of any follow-up investigations and other information as needed
- Gather the parents' perspectives of their care and any questions they have
- Enter the 'factual' information into the PMRT
- Complete a timeline of the events
- Invite any additional group members who need to attend or contribute

3.3.2 The initial review stage

Once the preparation is complete an initial review can be carried out by two members of the review group e.g. the risk midwife and an obstetrician in the case of a stillbirth. The purpose of this stage is first, to double check that the factual information already entered into the PMRT is correct. The second purpose is to start the 'review' with initial consideration of the care provided. By answering questions which result in only further relevant questions in the PMRT being presented, this initial review will speed up the full review process and enable the full review group to concentrate on the relevant aspects of care without being distracted by irrelevant questions. This initial review stage also enables a check that all the relevant information needed for the full review has been collated. For example, should ultrasound images require review, this can be carried out during the initial review stage so that information about the quality of the ultrasound images is available at the full multidisciplinary review meeting.

3.4 Parents' perspectives and concerns about their care

The review is the opportunity to consider the views and any concerns parents have about the care they received. In order for their perspectives to be considered they need to know that a review will take place and also have had the opportunity to express their views and any concerns they have about the care they and their baby received.

In some cases the fact that a review will take place will be included in a formal 'Duty of Candour' discussion. For other parents, where specific 'Duty of Candour' discussions will not take place, they also need to be informed that a review will take place. Whilst their consent is not required for their care to be reviewed since this is part of standard NHS care, it is nevertheless appropriate that they are told that a review will occur and that they will be invited to discuss the findings.

It goes without saying that the process of telling parents that a review of the care and that of their baby will be carried out needs to be handled sensitively. This discussion does provide, probably the first opportunity to seek any views they have about the care they received. However, the appropriate timing for a discussion to seek their views will vary from parents to parents, and from circumstance to circumstance. Asking them immediately following the death is likely to be too soon for many parents. They may also need more than one opportunity to express their views with time to reflect on what has happened to them and their baby.

3.4.1 The legal basis for processing data as described by the national PMRT Group:

"Parents' consent is not required to enable a review to be carried out. However, using the PMRT means that their confidential identifiable information is being included in a database which is held by the University of Oxford. We consulted with our stakeholder group of ~25 mother and baby charities about whether Trusts/Health Boards should seek parent consent for the use of the PMRT as the 'legal basis' for including confidential patient information in the PMRT. These stakeholders strongly expressed their belief that the vast majority of parents would support the work of the PMRT and MBRRACE-UK, since both are designed to prevent avoidable deaths in the NHS, without the need to obtain the consent of individuals. It is only possible to use personal identifiable information in this way, without obtaining consent, following a successful application to the Confidentiality Advisory Group for England and Wales, and the Public Benefit and Privacy Panel for Health & Social Care

in Scotland. For the purposes of the PMRT we have made these applications which have been approved: 17/CAG/0150 (England and Wales) and 1718-0249 (Scotland).

Under the General Data Protection Regulation (GDPR) the legal basis for processing identifiable data is:

Article 6 (1) (e) processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the data controller.*

and

Article 9 (2) (i) processing is necessary for reasons of public interest in the area of public health, in ensuring high standards of quality and safety of health care.”

3.5 The PMRT in action

Using the PMRT to support a systematic and standardised approach to the review of care

The PMRT broadly presents three types of 'questions':

- **Notification of death details** referred to as 'core demographics'. These questions are designed to log within the PMRT the fact that there has been a death which requires review and enables a review to be started. Notification also allows the data for the MBRRACE-UK perinatal mortality surveillance data to be entered.
- **Broadly factual questions.** These questions largely relate to 'factual information' about the mother and her pregnancy. These include for example, further demographic details such as her ethnic origin, employment and main support in pregnancy. Other examples include pregnancy and medical history questions which come from the booking and antenatal information.
- The third type of questions support the review of the care and involve **consideration of the care provided** and broadly ask the review group to consider whether the care provided was appropriate in the circumstances and met existing national or local guidelines and standards where these exist. These questions require the review group to make '**judgements**' about the quality of care provided.

3.5.1 Generation of issues

Particular responses to questions within the PMRT will generate 'issues' with the care provided. For example, if a mother met the national criteria for screening for gestational diabetes but she wasn't offered screening this will generate an 'issue'.

The issues generated will be listed at the end of the review and the review group will be able to identify the factors which contributed to this issue; a 'pick list' of contributory factors is offered for selection. The factors listed come from the National Patient Safety Agency Contributory Factors Classification Framework and it is possible to identify more than one contributory factor for each issue (the full list of contributory factors is given in Appendix C). You might find it helpful to print out the list of Contributory Factors for easy reference during the review meeting.

For each issue, the review group will also be asked to identify whether that issue was likely to have contributed to the outcome for the baby and/or the mother. The review group will then be asked to identify the action(s) needed to improve care as a consequence. All

the actions across all the issues identified will be summarised in an action plan which is generated as part of the final report. It is also possible to add issues which have been generated from the review discussion but have not been highlighted by the questions in the tool.

3.5.2 Grading of care

Towards the end of the review the review group will be asked to consider and grade the quality of care provided. Four levels of grading of care are offered for each of the following:

For stillbirths the care considered is:

- The care provided to the mother and baby up to the point that the baby was confirmed as having died;
- The care provided to the mother following confirmation of the death of her

baby. For neonatal deaths and later deaths the care considered is:

- The care provided to the mother and baby up to the point of the birth of the baby;
- The care provided to the baby from birth up to the death of the baby;
- The care provided to the mother following the birth of her baby.

3.5.3 Final report

Once the review is complete the PMRT will assist in the generation of a final report of the review. This consists of information which comes from the responses to the specific questions and also information which can be added into the tool as the review progresses. This information is added as free text into comment boxes on the right-hand side of the PMRT screen. Notes added as the review is carried out will appear in the final report as text which can be edited. So if short notes are entered into the text boxes these can be edited into prose for the final report by whomever is responsible for producing the final report.

A quarterly report will be generated and sent to the local Mortality Review Group (MRG) for review.

3.5.4 Communicating the outcome of the review with the parents

The PMRT has two over-arching purposes which follow from a high quality, standardised and systematic review of care having been conducted. The first, is to provide the parents with information about why their baby died, whether this might have been avoided and whether the death of their baby has any implications for future pregnancy plans. The review will have been conducted by the time that the parents come back for their follow-up visit at which the findings of the review can be discussed with them. The contents of the report will be discussed with them.

4.0 Statement of evidence/references

Statement of evidence:

National PMRT review tool

References:

1. Draper ES, Kurinczuk JJ, Kenyon S (Eds.) on behalf of MBRRACE-UK. MBRRACE-UK 2017 Perinatal Confidential Enquiry: Term, singleton, intrapartum stillbirth and intrapartum- related neonatal death. The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester: Leicester, 2017. ISBN: 978-09935059-7-3
2. Draper ES, Kurinczuk JJ, Kenyon S (Eds.) on behalf of MBRRACE-UK. MBRRACE-UK perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester: Leicester, 2015.
3. Royal College of Obstetricians and Gynaecologists. Each Baby Counts: 2015 Full Report. London: RCOG, 2017.
4. Kirkup B. The Report of the Morecambe Bay Investigation. An independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013. UK: The Stationery Office, 2015.

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5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
1	06/2021	Emma Mitchener	New Document

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Maternity Guideline Review Group			25/06/2021	Approved	
Women's Health CIG			07/07/2021	Approved	

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board

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5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division		Department	
Person completing the EqlA		Contact No.	
Others involved:		Date of assessment:	
Existing policy/service		New policy/service	
Will patients, carers, the public or staff be affected by the policy/service?		Yes	
If staff, how many/which groups will be affected?		<i>For example: community midwives, phlebotomists, all staff</i>	
Protected characteristic	Any impact?	Comments	
Age	YES NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff	
Disability	YES NO		
Gender reassignment	YES NO		
Marriage and civil partnership	YES NO		
Pregnancy and maternity	YES NO		
Race	YES NO		
Religion or belief	YES NO		
Sex	YES NO		
Sexual orientation	YES NO		
What consultation method(s) have you carried out?			
<i>For example: focus groups, face-to-face meetings, PRG, etc</i>			
How are the changes/amendments to the policies/services communicated?			
<i>For example: email, meetings, intranet post, etc</i>			
What future actions need to be taken to overcome any barriers or discrimination?			
What?	Who will lead this?	Date of completion	Resources needed
Review date of EqlA			

Appendix A: An example vignette of a review of one aspect of care by a single healthcare professional

An example of the consequences of inappropriate conclusions being reached when limited aspects of care are reviewed in isolation by a single healthcare professional (1)

Vignette – review of only one aspect of care by a single health professional

- *A woman in her 20s in her first pregnancy was booked for antenatal care at 11 weeks. She was low risk and had an uneventful antenatal period.*
- *When she self-referred in labour at 40 weeks it was noted that there was blood stained liquor draining. This was not considered to be abnormal and the woman went on to labour in a birthing pool. Further documentation of blood loss was scant throughout the maternal record.*
- *There was a prolonged active second stage of labour with documentation of active pushing for three and a half hours without escalation or review. There was an absence of fetal heart rate monitoring in the 30 minutes preceding the birth of the baby, who was born in poor condition.*
- *Immediate care at birth was appropriate, although there was a delay in calling for the neonatal team and the baby was not intubated until five and a half minutes after birth.*
- *Following resuscitation the baby was transferred to the neonatal unit for cooling but some days later re-orientation of care was discussed with the parents and the baby died.*
- *Subsequent review by a single neonatal health care professional failed to review any of the care in the intrapartum period and categorised the death as 'expected'.*

Appendix B: Terms of reference

Perinatal Mortality Review Tool Group (PMRT) Terms of Reference

Background and Purpose:

The national Perinatal Mortality Review Tool was commissioned to improve the quality of the local review process to support a standardised, robust, and collaborative review process. The use of the tool will support the following:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the neonatal period having received neonatal care.
- A structured process of collaborative review, learning, reporting and actions to improve future care.
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a collaborative grading of the care provided.
- Active communication with parents to ensure they are told that a collaborative review of their care and that of their baby will be carried out and how they can contribute to the process.
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.

Membership:

The PMRT group will be chaired by the Bereavement Lead Midwife alongside the Lead Midwife for Risk. The meeting shall be deemed quorate with the minimum presentation of two midwives, one obstetrician and one neonatologist (for the review of cases involving a neonatal death) and well as the Bereavement Lead Midwife and / or Lead Midwife for risk.

Overall membership of this committee will be:

- Head of Midwifery, Gynaecology and Paediatrics
- Deputy Head of Midwifery
- Maternity Matrons
- Ward Managers / Labour Ward Coordinators
- Bereavement Lead Midwife
- Lead Midwife Risk
- Obstetric Team
- Neonatal Team
- External member from the local LMNS or Thames Valley Network.

Additional members as required:

- Anaesthetic Team
- Sonographer
- Pathologist
- Safeguarding Team
- Community Midwife

Frequency:

The PMRT group will meet weekly to discuss cases as they arise in order to meet the time frames to provide a quarterly report and update parents six weeks postnatally.

Due to the ongoing pandemic and facilitation of agile working the meeting will be held on Microsoft Teams and recorded to facilitate minute taking.

Responsibilities of the group:

- Robustly and comprehensively reviewing each case and the quality of care provided – recognizing that there will be occasions where a particular cause cannot be identified despite a full clinical investigation.
- Working through the care for each baby who died to identify contributory factors where issues are identified and assessing whether different care may have made a difference to the outcome (grading of care).
- Developing action plans that aim to address the contributory factors identified and achieve organisational change and service improvements.
- Recognising a 'just culture' of accountability for individuals and organisations.
- Incorporating the parents' perspective of their care and addressing any questions and concerns they have.
- Improving the care we provide for mothers, babies, and families in the future.

Conduct of the perinatal Mortality Review Group

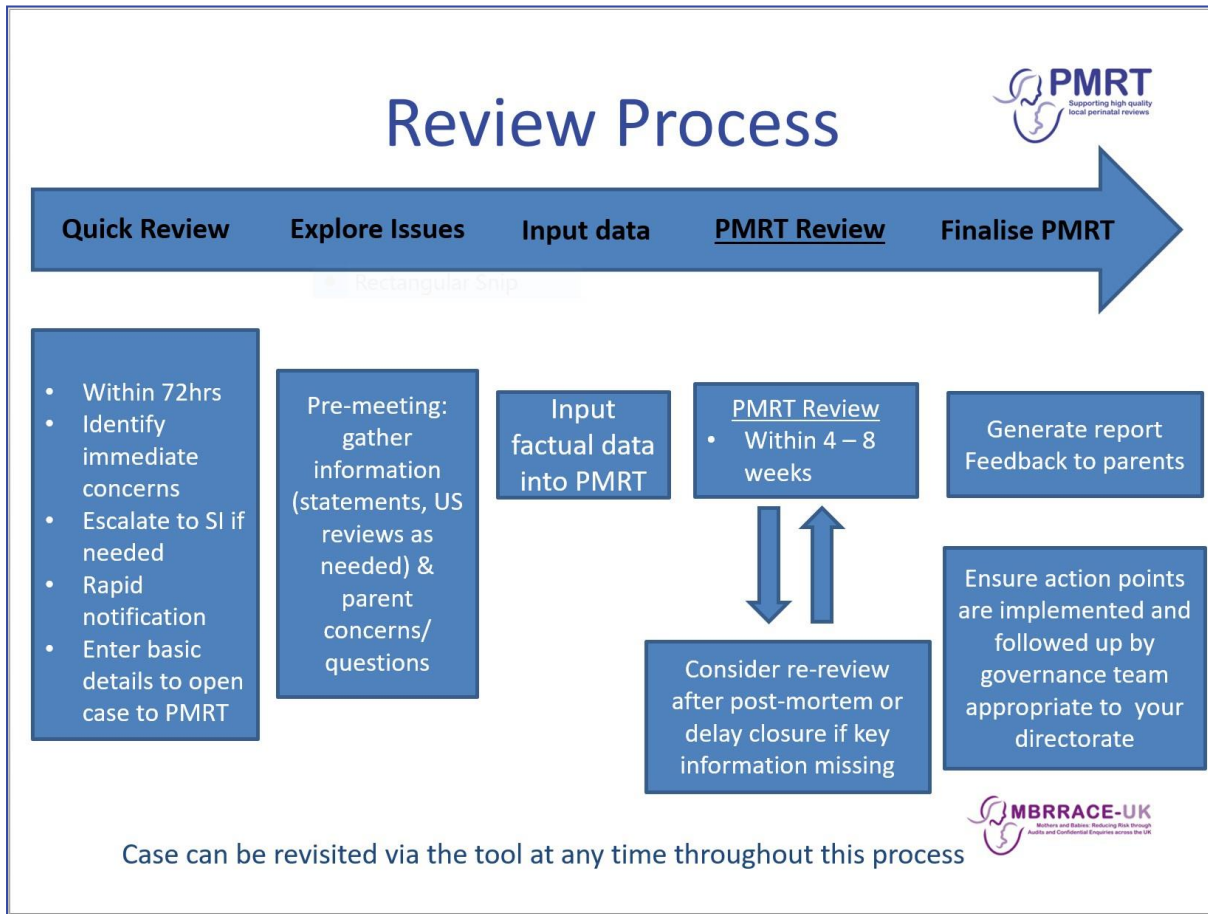
- Making every effort to gather the relevant information/evidence about each death in advance of the meeting.
- Attending and arriving on time to the meeting.
- Participating actively in discussions.
- Respecting everyone's ideas and way of expressing them.
- Accepting robust discussion and disagreement.
- Agreeing to be comprehensive, open and transparent throughout.
- Trying as much as possible (recognising this can be challenging) to accept that your own actions can be questioned.

- Respecting the confidentiality of the documents and discussions that take place during the meetings and record/dispose of them appropriately.
- If gaps are identified in the information there may be a need to go away and gather more information before completing the review.
- Using the national Perinatal Mortality Review Tool (PMRT) to support the conduct of each review.

Review

PMRT group terms of reference to be reviewed annually.

Appendix C: Stages of the Review Process



Appendix D: National Patient Safety Agency: Contributory Factors Classification Framework

Root Cause Analysis Investigation tools Contributory Factors Classification Framework

Patient Factors	Components
Clinical condition	<input type="checkbox"/> Pre-existing co-morbidity <input type="checkbox"/> Complexity of condition <input type="checkbox"/> Seriousness of condition <input type="checkbox"/> Limited options available to treat condition <input type="checkbox"/> Disability
Physical Factors	<input type="checkbox"/> Poor general physical state <input type="checkbox"/> Malnourished <input type="checkbox"/> Dehydrated <input type="checkbox"/> Age related issues <input type="checkbox"/> Obese <input type="checkbox"/> Poor sleep pattern
Social Factors	<input type="checkbox"/> Cultural / religious beliefs <input type="checkbox"/> Language <input type="checkbox"/> Lifestyle (smoking/ drinking/ drugs/diet) <input type="checkbox"/> Sub-standard living accommodation (e.g. dilapidated) <input type="checkbox"/> Life events <input type="checkbox"/> Lack of support networks / (social protective factors -Mental Health Services) <input type="checkbox"/> Engaging in high risk activity
Mental/ Psychological Factors	<input type="checkbox"/> Motivation issue <input type="checkbox"/> Stress / Trauma <input type="checkbox"/> Existing mental health disorder <input type="checkbox"/> Lack of intent (Mental Health Services) <input type="checkbox"/> Lack of mental capacity <input type="checkbox"/> Learning Disability
Interpersonal relationships	<input type="checkbox"/> Staff to patient and patient to staff <input type="checkbox"/> Patient engagement with services <input type="checkbox"/> Staff to family and family to staff <input type="checkbox"/> Patient to patient <input type="checkbox"/> Family to patient or patient to family <input type="checkbox"/> Family to family (Siblings, parents, children)

Staff Factors	Components
Physical issues	<input type="checkbox"/> Poor general health (e.g. nutrition, hydration, diet, exercise, fitness) <input type="checkbox"/> Disability (e.g. eyesight problems, dyslexia) <input type="checkbox"/> Fatigue <input type="checkbox"/> Infected Healthcare worker
Psychological Issues	<input type="checkbox"/> Stress (e.g. distraction / preoccupation) <input type="checkbox"/> Specific mental illness (e.g. depression) <input type="checkbox"/> Mental impairment (e.g. illness, drugs, alcohol, pain) <input type="checkbox"/> Lack of motivation (e.g. boredom, complacency, low job satisfaction)
Social Domestic	<input type="checkbox"/> Domestic problems (e.g. family related issues) <input type="checkbox"/> Lifestyle problems (e.g. financial/housing issues) <input type="checkbox"/> Cultural beliefs <input type="checkbox"/> Language
Personality Issues	<input type="checkbox"/> Low self confidence / over confidence (e.g. Gregarious, reclusive, interactive) <input type="checkbox"/> Risk averse / risk taker <input type="checkbox"/> Bogus Healthcare worker

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Cognitive factors	<input type="checkbox"/> Preoccupation / narrowed focus (Situational awareness problems) <input type="checkbox"/> Perception/viewpoint affected by info. or mindset (Expectation/Confirmation bias) <input type="checkbox"/> Inadequate decision/action caused by Group influence <input type="checkbox"/> Distraction / Attention deficit <input type="checkbox"/> Overload <input type="checkbox"/> Boredom
Task Factors	Components
Guidelines, Policies and Procedures	<input type="checkbox"/> Not up-to-date <input type="checkbox"/> Unavailable at appropriate location (e.g. Lost/missing/non-existent/not accessible when needed) <input type="checkbox"/> Unclear/not useable (Ambiguous; complex; irrelevant, incorrect) <input type="checkbox"/> Not adhered to / not followed <input type="checkbox"/> Not monitored / reviewed <input type="checkbox"/> Inappropriately targeted/focused (i.e. not aimed at right audience) <input type="checkbox"/> Inadequate task disaster plans and drills
Decision making aids	<input type="checkbox"/> Aids not available (e.g. CTG machine; checklist; risk assessment tool; fax machine to enable remote assessment of results) <input type="checkbox"/> Aids not working (e.g. CTG machine, risk assessment tool, fax machine) <input type="checkbox"/> Difficulties in accessing senior / specialist advice <input type="checkbox"/> Lack of easy access to technical information, flow charts and diagrams <input type="checkbox"/> Lack of prioritisation of guidelines <input type="checkbox"/> Incomplete information (test results, patient history)
Procedural or Task Design	<input type="checkbox"/> Poorly designed (i.e. Too complex; too much info.; difficult to conceive or remember) <input type="checkbox"/> Guidelines do not enable one to carry out the task in a timely manner <input type="checkbox"/> Too many tasks to perform at the same time <input type="checkbox"/> Contradicting tasks <input type="checkbox"/> Staff do not agree with the 'task/procedure design' <input type="checkbox"/> Stages of the task not designed so that each step can realistically be carried out <input type="checkbox"/> Lack of direct or understandable feedback from the task <input type="checkbox"/> Misrepresentation of information <input type="checkbox"/> Inappropriate transfer of processes from other situations <input type="checkbox"/> Inadequate Audit, Quality control, Quality Assurance built into the task design <input type="checkbox"/> Insufficient opportunity to influence task/outcome where necessary <input type="checkbox"/> Appropriate automation not available

Communication	Components
Verbal communication	<input type="checkbox"/> Inappropriate tone of voice and style of delivery for situation <input type="checkbox"/> Ambiguous verbal commands / directions <input type="checkbox"/> Incorrect use of language <input type="checkbox"/> Made to inappropriate person(s) <input type="checkbox"/> Incorrect communication channels used
Written communication	<input type="checkbox"/> Inadequate patient identification <input type="checkbox"/> Records difficult to read <input type="checkbox"/> All relevant records not stored together and accessible when required <input type="checkbox"/> Records incomplete or not contemporaneous (e.g. unavailability of patient management plans, patient risk assessments, etc) <input type="checkbox"/> Written information not circulated to all team members <input type="checkbox"/> Communication not received <input type="checkbox"/> Communications directed to the wrong people <input type="checkbox"/> Lack of information to patients <input type="checkbox"/> Lack of effective communication to staff of risks (Alerts systems etc)
Non verbal communication	<input type="checkbox"/> Body Language issues (closed, open, body movement, gestures, facial expression)

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Communication Management	<input type="checkbox"/> Communication strategy and policy not defined / documented <input type="checkbox"/> Ineffective involvement of patient/carer in treatment and decisions <input type="checkbox"/> Lack of effective communication to patients/relatives/carers of risks <input type="checkbox"/> Lack of effective communication to patients about incidents (being open) <input type="checkbox"/> Information from patient/carer disregarded <input type="checkbox"/> Ineffective communication flow to staff up, down and across <input type="checkbox"/> Ineffective interface for communicating with other agencies (partnership working) <input type="checkbox"/> Lack of measures for monitoring communication
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equipment	Components
Displays	<input type="checkbox"/> Incorrect information / feedback available <input type="checkbox"/> Inconsistent or unclear information <input type="checkbox"/> Illegible information <input type="checkbox"/> Interference/unclear equipment display
Integrity	<input type="checkbox"/> Poor working order <input type="checkbox"/> Inappropriate size <input type="checkbox"/> Unreliable <input type="checkbox"/> Ineffective safety features / not designed to fail safe <input type="checkbox"/> Poor maintenance programme <input type="checkbox"/> Failure of general services (power supply, water, piped gases etc)
Positioning	<input type="checkbox"/> Correct equipment not available <input type="checkbox"/> Insufficient equipment / emergency backup equipment <input type="checkbox"/> Incorrectly placed for use <input type="checkbox"/> Incorrectly stored
Usability	<input type="checkbox"/> Unclear controls <input type="checkbox"/> Not intuitive in design <input type="checkbox"/> Confusing use of colour or symbols <input type="checkbox"/> Lack of or poor quality user manual <input type="checkbox"/> Not designed to make detection of problems obvious <input type="checkbox"/> Use of items which have similar names or packaging <input type="checkbox"/> Problems of compatibility

Work Environment	Components
Administrative factors	<input type="checkbox"/> Unreliable or ineffective general administrative systems (Please specify e.g.: Bookings, Patient identification, ordering, requests, referrals, appointments) <input type="checkbox"/> Unreliable or ineffective admin infrastructure (e.g. Phones, bleep systems etc) <input type="checkbox"/> Unreliable or ineffective administrative support
Design of physical environment	<input type="checkbox"/> Poor or inappropriate office design (computer chairs, height of tables, anti-glare screens, security screens, panic buttons, placing of filing cabinets, storage facilities, etc.) <input type="checkbox"/> Poor or inappropriate area design (length, shape, visibility, provision of space) <input type="checkbox"/> Inadequate security provision <input type="checkbox"/> Lack of secure outside space <input type="checkbox"/> Inadequate lines of sight <input type="checkbox"/> Inadequate/inappropriate use of colour contrast/patterns (walls/doors/flooring etc)
Environment	<input type="checkbox"/> Facility not available (failure or lack of capacity) <input type="checkbox"/> Fixture or fitting not available (failure or lack of capacity) <input type="checkbox"/> Single sex accommodation limitation/breach <input type="checkbox"/> Ligature/anchor points <input type="checkbox"/> Housekeeping issues – lack of cleanliness <input type="checkbox"/> Temperature too high/low <input type="checkbox"/> Lighting too dim or bright, or lack of <input type="checkbox"/> Noise levels too high or low <input type="checkbox"/> Distractions

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Staffing	<input type="checkbox"/> Inappropriate skill mix (e.g. Lack of senior staff; Trained staff; Approp. trained staff) <input type="checkbox"/> Low staff to patient ratio <input type="checkbox"/> No / inaccurate workload / dependency assessment <input type="checkbox"/> Use of temporary staff <input type="checkbox"/> High staff turnover
Work load and hours of work	<input type="checkbox"/> Shift related fatigue <input type="checkbox"/> Excessive working hours <input type="checkbox"/> Lack of breaks during work hours <input type="checkbox"/> Excessive of extraneous tasks <input type="checkbox"/> Lack of social relaxation, rest and recuperation
Time	<input type="checkbox"/> Delays caused by system failure or design <input type="checkbox"/> Time pressure

Organisational	Components
Organisational structure	<input type="checkbox"/> Hierarchical structure/Governance structure not conducive to discussion, problem sharing, etc. <input type="checkbox"/> Tight boundaries for accountability and responsibility <input type="checkbox"/> Professional isolation <input type="checkbox"/> Clinical versus the managerial model <input type="checkbox"/> Inadequate maintenance <input type="checkbox"/> Lack of robust Service level agreements/contractual arrangements <input type="checkbox"/> Inadequate safety terms and conditions of contracts
Priorities	<input type="checkbox"/> Not safety driven <input type="checkbox"/> External assessment driven e.g. Annual Health checks <input type="checkbox"/> Financial balance focused
Externally imported risks	<input type="checkbox"/> Unexpected adverse impact of national policy/guidance (from Department of Health / Health authorities /Professional colleges) <input type="checkbox"/> Locum / Agency policy and usage <input type="checkbox"/> Contractors related problem <input type="checkbox"/> Equipment loan related problem <input type="checkbox"/> Lack of service provision <input type="checkbox"/> Bed Occupancy levels (Unplanned bed opening/closures) <input type="checkbox"/> PFI related problems (Private Finance Initiative)
Safety culture	<input type="checkbox"/> Inappropriate safety / efficiency balance <input type="checkbox"/> Poor rule compliance <input type="checkbox"/> Lack of risk management plans <input type="checkbox"/> Inadequate leadership example (e.g. visible evidence of commitment to safety) <input type="checkbox"/> Inadequately open culture to allow appropriate communication <input type="checkbox"/> Inadequate learning from past incidents <input type="checkbox"/> Incentives for 'at risk'/risk taking' behaviors <input type="checkbox"/> Acceptance/toleration of inadequate adherence to current practice <input type="checkbox"/> Ignorance/poor awareness of inadequate adherence to current practice <input type="checkbox"/> Disempowerment of staff to escalate issues or take action

Education and Training	Components
Competence	<input type="checkbox"/> Lack of knowledge <input type="checkbox"/> Lack of skills <input type="checkbox"/> Inexperience <input type="checkbox"/> Inappropriate experience or lack of quality experience <input type="checkbox"/> Unfamiliar task <input type="checkbox"/> Lack of testing and assessment
Supervision	<input type="checkbox"/> Inadequate supervision <input type="checkbox"/> Lack of / inadequate mentorship <input type="checkbox"/> Training results not monitored/acted upon

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Availability / accessibility	<input type="checkbox"/> Training needs analysis not conducted/acted upon <input type="checkbox"/> On the job training unavailable or inaccessible <input type="checkbox"/> Emergency Training unavailable or inaccessible <input type="checkbox"/> Team training unavailable or inaccessible <input type="checkbox"/> Core skills training unavailable or inaccessible <input type="checkbox"/> Refresher courses unavailable or inaccessible
Appropriateness	<input type="checkbox"/> Inappropriate content <input type="checkbox"/> Inappropriate target audience <input type="checkbox"/> Inappropriate style of delivery <input type="checkbox"/> Time of day provided inappropriate

Team Factors	Components
Role Congruence	<input type="checkbox"/> Lack of shared understanding <input type="checkbox"/> Role + responsibility definitions misunderstood/not clearly defined
Leadership	<input type="checkbox"/> Ineffective leadership – clinically <input type="checkbox"/> Ineffective leadership – managerially <input type="checkbox"/> Lack of decision making <input type="checkbox"/> Inappropriate decision making <input type="checkbox"/> Untimely decision making (delayed) <input type="checkbox"/> Leader poorly respected
Support and cultural factors	<input type="checkbox"/> Lack of support networks for staff <input type="checkbox"/> Inappropriate level of assertiveness <input type="checkbox"/> Negative team reaction(s) to adverse events <input type="checkbox"/> Negative team reaction to conflict <input type="checkbox"/> Negative team reaction to newcomers <input type="checkbox"/> Routine violation of rules/regulations <input type="checkbox"/> Lack of team openness/communication with colleagues <input type="checkbox"/> Inadequate inter-professional challenge <input type="checkbox"/> Failure to seek support <input type="checkbox"/> Failure to address/manage issues of competence (whistle blowing)