

# The Shrewsbury and Telford Hospital

NHS Trust

Shelagh Hawkins  
Senior Assessment Manager  
Healthcare Commission

June 7 2007

Reference 0159/PP

Dear Ms Hawkins

Following your meeting with members of the Trust's Women's services, I am updating the Commission with the information you require, with the exception of the CTG audit which we will send to you by the end of July.

## **CTG Audit**

We have now established a mechanism whereby 10 random CTG's are audited each month by the lead Consultant for the Labour Ward. This audit will feature on the monthly agenda of the Obstetric Clinical Risk Group. The results of this audit will be fed back to staff by a number of established mechanisms. Including

- Newsletters,
- Labour Ward Forum and Maternity Governance Group
- Perinatal Mortality Meeting
- Consultant's Meeting
- Senior Midwives
- Local Supervisors of Midwives Meeting
- Joint Clinical Audit Meeting
- Multi disciplinary training day
- Maternity Guideline Group

as well as individually, as appropriate.

## **Lack of appropriate staff training**

### **▪ Skills Drills**

The skills drills offered to all staff on an annual basis include neonatal resuscitation, shoulder dystocia, breech delivery, massive postpartum haemorrhage and antepartum haemorrhage, cord prolapse and CTG interpretation.

Our standard is that all staff should attend these sessions each year as part of their mandatory training and we are meeting this standard. Each session is evaluated by all multi-disciplinary participants and Senior midwives and Supervisors of Midwives are involved in the teaching of the skills drills.

If a clinical incident occurs, staff members attendance at a skills drills session is checked. Supervisors of Midwives also check and document attendance by midwives during their annual supervisory interview.

We are planning to incorporate new skills into the drills in June 2007. These include, fundal height measurement (missed IUGR was recognised as a problem from Perinatal Mortality Meetings), and cell salvage procedures.

Evaluation of the effectiveness of the shoulder dystocia skills drill is to be achieved by comparing the ratio of Erbs Palsy (temporary and permanent) to the incidence of shoulder dystocia in 2004 and currently in 2007. However this work has not yet been undertaken. We will send you a copy of this work on completion.

### **Risk Management Systems**

All high risk cases are discussed at clinical risk meetings. Notes of discussion, categorisation of incident and lessons learned are taken contemporaneously.

If the incident is of a significant concern then a multi-disciplinary review is held with all involved clinicians invited to explain their role and involvement with care.

Action points are made for each case review and the Clinical Risk Manager keeps a register and ensures action points are fulfilled.

The Healthcare Commission's initial investigation covered incidents occurring in 2004. The management and recording of clinical risks and the subsequent action plans have developed considerably since then. The Healthcare Commission team were able to see examples of these action plans during their visit and we have included an additional example as discussed (Appendix 1).

### **Policies and Procedures**

In response to the recommendation that policies and procedures are rolled out to staff and reviewed in a timely manner, the Maternity Department has submitted sections from its Framework for the Development of Protocols and Guidelines.

Part of this framework explains the Maternity Guidelines Group and the flow chart (attached as Appendix 2) shows the system for developing or amending a clinical guideline.

#### **■ Maternity Guidelines Group**

The Maternity Guidelines Group is a sub-group of the Labour Ward Forum (LWF) and Maternity Governance Group (MGG) who ensures a systematic approach to the development and archiving of robust evidence-based multi-disciplinary clinical guidance.

The group have agreed Terms of Reference, minute the meetings and provide feedback to the LWF and MGG.

The Maternity Guidelines Group has responsibility for biennial review and distribution of Labour Ward Protocols and Maternity Guidelines for Practice.

The group monitor a cycle of audit of relevant clinical guidance, ensuring where appropriate, a guideline is audited within 3 years as specified by CNST.

The Project Midwife (Practice Facilitation) and the Antenatal Triage & Support Midwife are responsible for joint co-ordination of a planned review and distribution cycle of maternity guidelines for practice.

The Senior Midwife for Inpatient Services and Lead Obstetrician are responsible for a planned cycle of review and distribution for Labour Ward Protocols.

The Trust is corporately informed of guidelines that are developed within the Division. Once developed, the guideline is distributed as widely as possible using various methods:

1. Added to the intranet for access by ward-based computers.
2. Hard copies circulated to all wards and departments for inclusion in the Guidelines and Protocol folder. This will include all associated departments like gynaecology and accident and emergency departments.
3. The policy is also placed on the agenda of the Senior Midwives Group Meeting (monthly) and the Consultant Obstetricians and Gynaecologists Meeting (monthly).

New policies and amendments are listed in the staff governance news sheet, CRAWL and a memo is sent to all wards and departments to inform them that there is a new policy/guideline to raise awareness.

### **Clinical Governance**

The current clinical governance structure is attached (Appendix 3) for your information as requested.

### **Clinical Risk Advisor**

The management structure of the Trust is undergoing a major review. Once the new structure and managers are all in place, the governance structure will be reviewed to ensure it is aligned with the management structure to provide appropriate support.

Obviously, given the volume and complexity of work generated by a busy obstetric Unit, the staff in the Womens and Children's Unit would welcome the services of their own dedicated Clinical Risk Advisor. Currently there is 0.8 wte clinical risk advisor for Women's, Children's and Surgery.

The recommendations of the Healthcare Commission will be noted during the imminent discussions on future governance arrangements.

In conclusion, we would like to take this opportunity to reassure the Healthcare Commission that clinical governance underpins all our clinical and managerial activities within the Maternity Services.

Yours sincerely

Tom Taylor  
Chief Executive

**APPENDIX 1**

**Example of action plan following high risk case review  
Root cause analysis**

**Name** [REDACTED]

**Synopsis:** Waterbirth [REDACTED] baby born in poor condition. Transferred to RSH during extremely bad weather (Snow)-baby requiring resuscitation. Concerns re baby long term prognosis.

Case review meeting 23/3/07

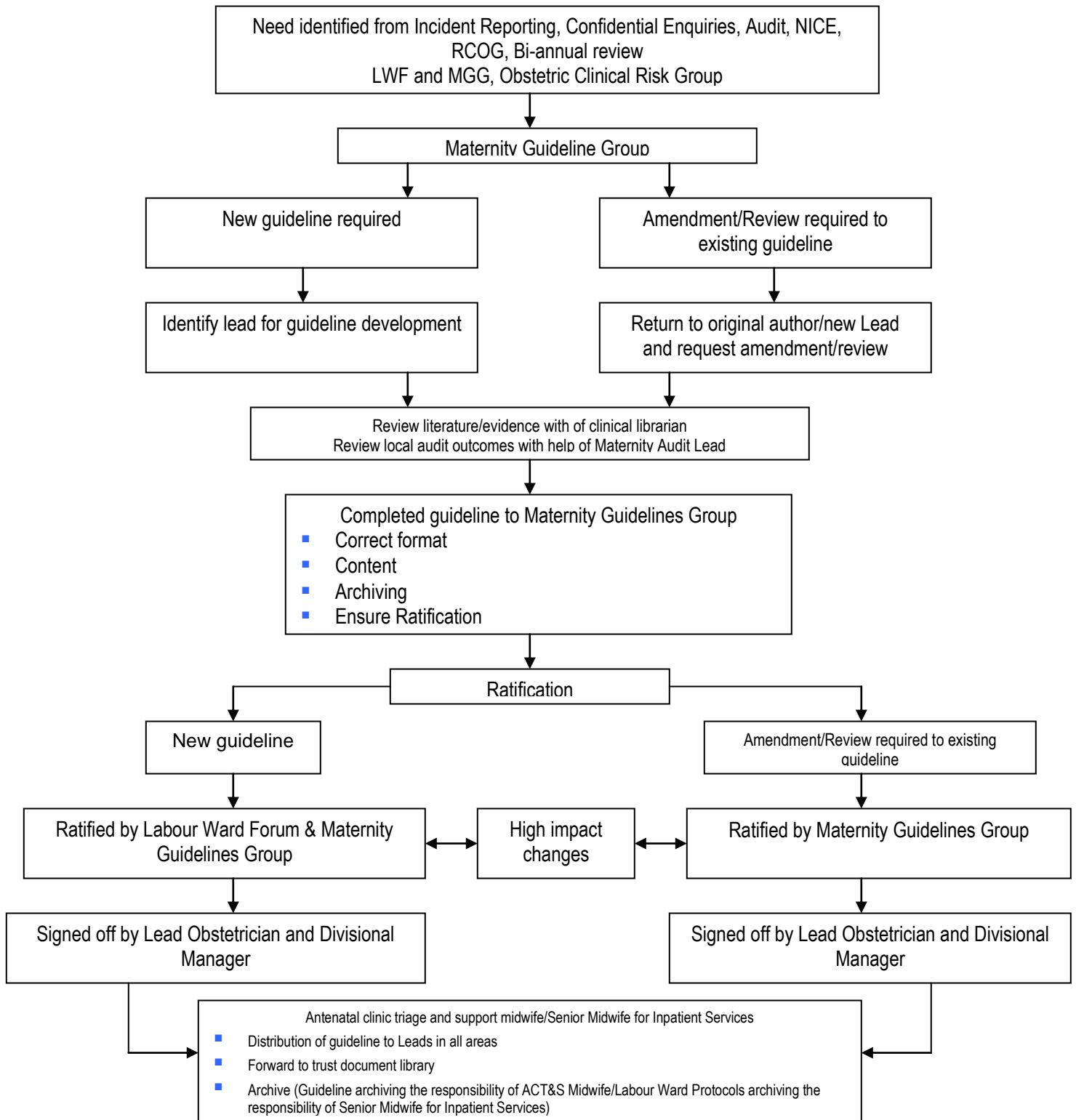
	<b><u>Issue</u></b>	<b><u>Action required</u></b>	<b><u>Individual responsible</u></b>	<b><u>Date completed</u></b>
<b><u>Individual factors</u></b>	Supervisory investigation undertaken re individuals involved.	Supervised practiced recommended	AH	April 07 Completed
<b><u>Team factors</u></b>	<b>No issues</b>			
<b><u>Task factors</u></b>				
<b><u>Guidelines/policies</u></b>	Placenta not sent  Guidance that cord can be clamped at either end and sent to consultant unit for taking cord PH	Re view current protocol  To circulate via senior midwives	JL	April 07 Completed  Completed
<b><u>Work environment</u></b>				
<b><u>Design of equipment</u></b>	Water birth pool -investigate cost for rigid pool . Birthing box cheaper but not so robust		AGP	On going
<b><u>Patient factors</u></b>		Parents have been offered debrief and have been seen by AT		29.3.07 Completed
<b><u>Organisational factors</u></b>	NO ISSUES			

Clinical risk advisor 23/3/07

Updated 11/4/07

**APPENDIX 2**

**System for Developing New Guidelines or Amendment/Review of Existing Clinical Guidance**



N.B. Where possible implementation date agreed. New guidelines should be implemented/circulated during the bi-annual review. This enables inclusion in index and folders. Where this is not possible, a copy must be emailed to the Co-ordinator of the protocol/guideline folder.

## WOMEN'S SERVICES

# RISK MANAGEMENT STRATEGY

Date: April 2004  
Amended: June 2004  
June 2005  
June 2006  
Jan 2007

Review: Jan 2008                      Responsible Officer:              Divisional Manager

Authors:              Divisional Manager (Women's Services).  
Practice Development Midwife.  
Head of Governance.  
Clinical Risk Advisor.

<b>Approved by:</b>	<b>Version</b>	<b>Issue Date</b>	<b>Review Date</b>	<b>Lead</b>
Strategic Governance Group Approved by 08.07.04.	3	July 2004	June 2005	Medical Director
<b>Reviewed by:</b>	<b>Version</b>	<b>Issue Date</b>	<b>Review Date</b>	<b>Lead</b>
Labour Ward Forum and Maternity Governance Group.	3a	29.06.05	June 2006	Divisional Manager
Labour Ward Forum and Maternity Governance Group (LWFMGG)	3b	20/9/06	10 January 2007	Divisional Manager
L.W.F. & M.G.G.	3c	10/01/07	Jan 2008	Divisional Manager

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## **1.0 Statement of Philosophy**

All staff working within Women's Services are expected to incorporate the essence of risk management into every aspect of their working lives. Women's services embrace a proactive approach to risk management to identify and minimise all risk including clinical, non-clinical and corporate. The management and reduction of risk will be considered as part of the decision making process and if risks are identified or incidents occur a structured review will be undertaken and recommendations implemented. Risk management should be incorporated into every decision and when sub-optimal processes or outcomes are identified, a structured review should be undertaken to ensure lessons are learnt.

The Women's Services risk management framework reflects the Trusts framework. Support for individual staff members is implicit in our approach, with disciplinary action only being considered in the exceptional circumstances of a criminal act, gross professional misconduct or repeated errors.

Women's Services recognises that to ensure comprehensive risk management there must be links between risk management and the systems for complaints, clinical audit and the other strands of clinical governance, including 'Standards for Better Health'.

## **2.0 Aim**

The aim of this strategy is to provide a framework for a safe environment for patients, mothers and babies, their families, members of the public and staff, and support a high quality services.

Where an adverse or potentially adverse outcome occurs, there is a working structure for early identification, investigation, action, feedback and appropriate notification of events.

## **3.0 Objectives**

- To promote safe, high quality care by preventing the recurrence of problems identified both locally and nationally through risk assessment, investigation, audit, implementation of guidelines and education. (Domain 1: Safety standards C1a; D1).
- To reduce the number of clinical risk incidents by appropriate assessment, training and feedback. (Domain 1: Safety standard C1a).
- To disseminate to a wide audience clinical incidents and the measures taken to reduce them. (Domain 1: Safety standard C1a, D1).
- To facilitate early identification of adverse incidents to minimise effects and ensure good communication with the patient and/or family. (Domain 1: Safety standard C1a).
- To ensure prompt gathering of information on those identified incidents, as close to the event as possible. (Domain 1: Safety standard C1a).

- To utilise and implement best practice identified from both internal and external sources e.g. confidential enquiries, NICE guidance, clinical audit and Health Commission Reviews. (Domain 1: Safety standard C16).
- To implement and work within the Corporate Policies relating to risk. This should include working within the Trust's major internal incident policy. (Domain 3: Governance Standards C7C).
- To ensure there is a framework for communication throughout the service for principles and practices of Clinical Risk Management. Information will be easily accessible to all members of the team on topics relating to changes in practice, new guidelines, areas of good practice and local and national statistics. (Domain 1: Safety Standards C1aD1).
- To ensure that Clinical Risk Management is an integral part of the day-to-day activity of Women's Services Division. (Domain 1: Safety Standards C1aD1).
- To maintain and monitor a Women's Services Risk Register, which will inform the Corporate risk register. (Domain 3: Governance Standards C7C).

This strategy applies to all employees of Women's Services, whether salaried or honorary. It is particularly relevant to line managers who are responsible for risk management and quality. This strategy covers all risk including clinical, operational, financial, and health and safety in line with corporate principles and systems. This document must be read in conjunction with the linked Trust policies including:

- Risk Management Strategy.
- Incident Reporting and Root Cause Analysis Policy.
- Internal Major Incident Policy.
- Health and Safety Policies.
- Manual Handling Policy.
- Infection Control Policies.
- Fire Policy.
- Security Policy.
- Personnel Policies.
- Staff Induction Policy.
- Policy for written patient information.
- Medical Devices Policy.
- Whistle blowing Policy.
- A SaTH framework for the development of policies, protocols and guidelines for health care professional.
- A framework for the development of protocols and guidelines in maternity.

## **4.0 Responsibilities**

### ***Chief Executive***

The Chief Executive is accountable on behalf of the Trust Board for managing all risks (corporate, clinical and non clinical) within the Trust.

### ***Medical Director***

On the Chief Executive's behalf, the Medical Director who is supported by the risk management structure leads the implementation and management of the Trust risk management strategy.

The management of risks within Obstetrics and Gynaecology is the responsibility of the Women's Services. The Division will report to the SaTH Business Meeting and the Trust Clinical Governance Executive.

### ***Clinical Director (CD)***

The Clinical Director for Women's Services will have overall responsibility for Risk Management within the Division. The Clinical Director along with the Divisional Manager will be responsible for the management of risk at a strategic level. The Clinical Director will represent the division on the Clinical Governance Executive and work closely with the Clinical Risk Advisor on all aspects of risk management.

### ***Divisional Manager and Professional Lead***

Operational responsibility for risk management is delegated to the Divisional Manager for Women's Services, who is the nominated Professional Lead and is also responsible for health and safety within the Division.

The Divisional Manager will be responsible for ensuring that the divisional risk register is maintained, regularly reviewed and risks >15 are forwarded to the Trust Risk Register Group. Within this capacity, the Divisional Manager will attend the SaTH Business meeting and will work closely with the Clinical Directors, Clinical Leads, Directorate Managers and Senior Midwives/Nurses (for Obstetrics, Gynaecology, Fertility and Neonates) and those responsible for co-ordinating clinical risk. The Divisional Manager will also work with the Clinical Risk Advisor and Head of Governance.

### ***Relationship between Clinical Director and Professional Lead***

The Clinical Director of Women's Services and the Divisional Manager will work closely together and are jointly responsible for the implementation of this policy.

### ***Clinical Risk Co-Ordinators within Obstetrics and Women's Services.***

To ensure that Women's Services is fully represented, there are three Clinical Risk Co-Ordinators who provide the day-to-day management of risk. The co-ordinators receive and review all the incident forms, carry out risk assessment and implement appropriate action according to Trust Incident Reporting and Root Cause Analysis Policy. The Clinical Risk Co-Ordinators are responsible for ensuring communication and feedback relating to risk occurs.

The Clinical Risk Co-Ordinators will work closely with the Clinical Risk Advisor, Divisional Manager (Professional Lead) for Women's Services and the Clinical Director and Clinical Leads.

- I. Clinical Risk Co-Ordinator (Consultant and Telford based Women's Services) provides the co-ordination role for: -

- Consultant Unit.
- Royal Shrewsbury Hospital and Wrekin Antenatal Clinics.
- Pre-Natal, antenatal day assessment (PANDA).
- Wrekin antenatal day assessment (WANDA).
- Ultrasound Scanning Department.
- Wrekin midwifery led unit.

II. Clinical Risk Co-Ordinator (Community based services excluding Telford) provides the co-ordination role for: -

- Ludlow Midwifery Led Unit
- Oswestry Midwifery Led Unit
- Bridgnorth Midwifery Led Unit
- Royal Shrewsbury Hospital Midwifery Led unit
- Shropshire Community Midwifery Service

III. Clinical Risk Co-Ordinator (Gynaecology and Fertility services) provides the co-ordination role for: -

- Gynaecology Inpatient and Outpatient Service for Shrewsbury and Telford Hospital NHS Trust.
- Early Pregnancy Assessment Unit (E.P.A.S.) at Royal Shrewsbury and Princess Royal.
- Shropshire and Mid-Wales Fertility Service.

The Divisional Manager supported by the Clinical Risk Co-ordinators and Clinical Risk Advisor will be responsible for the operational management of clinical risk within the division.

The scope of this responsibility includes:

- Managing the Division's clinical incident reporting systems.
- The achievement of the CNST maternity standards.
- Co-ordinating implementation of recommendations arising from the National Confidential Enquiries, Health Circulars, and other relevant reports.
- Reporting Serious Untoward Incidents to the Clinical Risk Advisor in line with the Trust Policy, including completing required investigations and documentation.
- Actioning recommendations from investigations of clinical risk incidents.
- Feedback and education resulting from clinical risk incidents or investigations.

*Clinical Risk Advisor (Women's, Children's & Surgical Services)*

This post is a corporate appointment. The advisor will:

- Support the Professional and Medical leads and Clinical Risk Co-ordinators in delivery of the clinical risk agenda within the Division.
- Provide a link between the Division and the Trust Risk and Governance agenda.
- Ensure Trust Policies and information from external agencies relating to risk e.g. NPSA, NHSLA, is communicated for implementation where appropriate within the Division.
- Support the Clinical Risk Co-ordinators with the investigation of serious untoward events.

***Clinical Risk Advisor (Women's Services), extension 1448.***

Contact Supervisor (Shropshire)

Supervision is an important aspect of the clinical risk structure. It is essential that Supervisors of Midwives are an integral part of this strategy. Good communication is vital to influence risk management effectively and ensure safe practice. The Contact Supervisor for Shropshire will co-ordinate the communication, ensuring supervision is used appropriately for the benefit of patients and their families.

### ***Clinical Leads***

The Clinical Director is the senior medical lead for clinical risk in the Women's Services. He represents the Division on the Clinical Governance Executive. The Clinical Director is supported in this work by: -

- Gynaecology Clinical Lead.
- Obstetric Clinical Lead.
- Lead Anaesthetist for Obstetrics
- Lead for Fertility Services

The clinical leads for Women's Services will play an active role in the implementation of the risk strategy and are a valuable asset and ambassadors for the achievement of the Women's Services objectives.

## **5.0 Implementation & Co-Ordination**

The Division will undertake a planned and systematic approach to managing and minimising risk. Risk assessments will be used to decide priorities, implementation times and resource allocation.

The Division will maintain a risk register incorporating operational and strategic risks, including risks to achievement of standards for better health. These risks will be identified through a regular programme and linked to the business planning cycle through the Performance Framework. The maintenance and monitoring of the Divisional Risk Register will be through the Divisional Women's Risk Register Group (terms of reference Appendix 4). The Divisional Risk Register will be actively reviewed and high-scoring risks will be forwarded to the Trust Risk Register through the Trust's Governance Structure.

The provision of Women's Services has many complexities. Services are provided on more than one site and for obstetrics it extends countywide incorporating the community services and peripheral units. To meet the individual requirements of the three main services – Obstetrics, Gynaecology and Fertility, the Clinical Risk Management Strategy has evolved according to each services need.

### **Obstetric Incident Flow Chart (*Appendix 1*):**

All incidents will be reported to the appropriate Clinical Risk Co-ordinator within the service using the Trust format. The Clinical Risk Co-ordinators will manage these incidents according to Trust Policy. There are two main working groups responsible for clinical risk within obstetrics.

In the event of an internal major clinical incident, defined as any aspect of clinical management involving one or more patients in an event likely to produce legal, media or other interest, which could damage the Trust's reputation or assets.

(This could include screening errors, radiation dosage error, HIV positive staff etc). The Medical Director or his deputy should be informed immediately and the internal major clinical incident policy followed. This is in addition to the normal process of Managing Clinical Risk and Serious Untoward Incidents.

Some incidents may score highly and a review of those medical records will be part of the Obstetric Clinical Risk Group. A decision is made as to whether a full high risk case review is required. High risk case reviews may also be instigated for other events that might lead to a claim. A guide to this process is identified in Appendix 9. A case review is always held following a maternal death.

### **Obstetric Clinical Risk Group (*Appendix 2*):**

On a monthly basis the Obstetric Clinical Risk Group will meet to actively discuss incidents that have occurred and consider and implement appropriate action e.g. High Risk Case Review, Maternal Death Review, issue for multidisciplinary training day, audit or new guidelines. The incidents may be highlighted via clinical incident, the "purple card system" from the community, patient accidents or medical equipment alerts. The Professional Lead will raise risks that have been identified from the Complaints, Patient Advice Liaison Service and Legal Systems. On a quarterly basis a report analysing the incidents will be generated and actions followed up. The report is made available on the Clinical Risk intranet web page and synopsis in C.R.A.W.L. (Clinical Risk and Women's Lives).

Where necessary issues will be taken to other appropriate Groups and Committees within the organisation by the Professional Lead and/or the Clinical Director e.g. Business Meeting, Clinical Governance Executive, Health and Safety Committee, Risk Register Group and other Divisional Governance Groups. Feedback will be to the appropriate groups within the Obstetric Service including: -

- Labour Ward Forum and Maternity Governance Group
- Perinatal Mortality Meeting
- Consultant's Meeting
- Senior Midwives
- Provision of Patient Information Group
- Nursing and Midwifery Board
- Local Supervisors of Midwives Meeting
- Joint Clinical Audit Meeting
- Maternity Services Liaison Committee
- Multi disciplinary training day
- Maternity Guideline Group

### **Labour Ward Forum and Maternity Governance Group (*Appendix 3*):**

This group meets on a quarterly basis to review management and communication throughout the key stages of labour.

The forum will work closely with the Obstetric Clinical Risk Group and receive feedback of trends of incidents and action taken or required. The forum's prime function is to review all aspects of Labour Ward activity, including reviewing clinical and organisational issues. The agenda for this forum will include: -

- User Involvement.
- Feedback from incidents, claims and complaints.
- Actioning of recommendations from audit.
- Responding to National Recommendations e.g. National Institute for Clinical Excellence, NCE (National Confidential Enquiries), Health Care Commission Review etc.
- Ratification and review of guidelines.
- Review and monitoring of training for the department.
- Review of Divisional Risk Register.

### **Maternity Guidelines Group (*appendix 8*):**

The Maternity Guidelines Group is a sub-group of the Labour Ward Forum and Maternity Governance Group, who will ensure a systematic approach to the development and archiving of robust evidence-based multi-disciplinary clinical guidance.

The group will have agreed Terms of Reference, minute the meetings and provide feedback to the Labour Ward Forum and Maternity Governance Group.

The Maternity Guidelines Group will have responsibility for bi-annual review and distribution of Labour Ward Protocols and Maternity Guidelines for Practice.

The group will monitor a cycle of audit of relevant clinical guidelines, ensuring where appropriate a guideline is audited within the minimum 3 year period required by CNST.

The Practice Development Midwife will be responsible for ensuring a planned approach to the implementation of the guidance is achieved.

### **Women's Risk Register Group (*appendix 4*):**

This group meets on a monthly basis to review and maintain an up-to-date risk register for the division. It works closely with all groups within the division ensuring that identified risks are being overseen and to provide information to the corporate risk register group. An electronic risk notification is available to forward issues to the group for consideration for inclusion onto the Women's Risk Register.

### **Perinatal Mortality Meeting:**

This multidisciplinary meeting is held on a minimum basis of bi-monthly to review all cases of perinatal mortality.

### **Consultants' Meeting:**

Monthly meetings chaired by the Clinical Director with management representation. The prime function of this meeting is to encourage good communication and teamwork within the consultant team.

### **Senior Midwives:**

Monthly meetings chaired by the Divisional Manager or deputy. The prime function of this meeting is to encourage a consistent good practice approach to all aspects of midwifery care.

### **Provision for Patient Information Group (*Appendix 5*):**

To establish a group with appropriate membership that will develop a “provision for patient information framework”. This will provide women with up to date evidence based information to make informed health care decisions during their contact with Women’s Services. Meetings are held quarterly.

### **Nursing and Midwifery Forum:**

Strategic and operational group promoting good practice through nursing/midwifery policies. Monthly meetings with Women’s Division representation via the Divisional Manager and Directorate Manager Gynaecology.

### **Local Supervisors of Midwives Meeting:**

Local supervising authority strategy and guidance are circulated to Shropshire Supervisors of Midwives via the contact supervisor of midwives for Shropshire.

The local supervisors of midwives meetings are chaired by the contact supervisor, with a minimum of six meetings per year. Local issues relating to clinical risk and governance are discussed at these meetings, and action taken as necessary.

### **Joint Clinical Audit/Governance Meeting:**

This multidisciplinary meeting is held at least quarterly and is open to all clinical staff of Women’s Services and where appropriate a wider audience. The meeting discusses the audit programme as well as receiving feedback from clinical incidents, complaints, Patient Advice and Liaison Service (PALS) and patient surveys. The findings of Confidential Enquiries and other reviews are also presented at this meeting.

### **Multi Disciplinary Training Meeting:**

This multi disciplinary meeting is held at least quarterly and is open to all clinical staff (and a wider audience where appropriate). These meetings provide training updates and feedback on practice issues. This has proved to be a useful arena for both proactive and reactive training, supporting good practice.

### **Maternal Deaths:**



All maternal deaths are reported to Confidential Enquiry into Maternal and Child Health (CEMACH) and a local case review is held. Each death is also recorded in the Divisional maternal death register

### **Gynaecology Clinical Governance Group (*Appendix 6*):**

Similar to Obstetrics the incidents are reviewed and actioned according to Corporate Risk Management Policies by the Clinical Risk Co-ordinator for Gynaecology and Fertility. On a monthly basis the Gynaecology Clinical Governance Team meets to review all incidents raised. The Group also logs all complications of procedures by operator, to monitor outcomes of surgery. Each death that occurs is also individually reviewed.

### **Fertility:**

The HFEA issues a Code of Practice for centres carrying out licenced treatments. The purpose of the Code of Practice is:

- To give guidance to centres about implementing the Act.
- To raise the standards at all centres to those of the best.
- To provide a framework for good practice.

A specialist team inspects every licenced centre annually; this team is made up of HFEA members/inspectors and selected professionals from other fertility centres, including clinicians, scientists and nurses. This team examines practices/ protocols in the centre and assesses the competence of staff through extensive interview/ assessment. They then report back to a licence committee and make recommendations or conditions that must be complied with before the licence is granted.

The centre takes great care to ensure that all the regulations laid down in the Human Fertilisation and Embryology Act 1990 and the Code of Practice are adhered to.

In order to achieve this the centre maintains standard operating procedures, which are submitted to the HFEA annually as part of the licence application. These are so detailed that every aspect of work at the centre should be reproducible from them with no prior knowledge. In addition all staff performance is individually monitored with regard to treatment outcomes by regular audit of treatment statistics.

All staff keeps records of their continuing professional development and these are submitted to the inspection team if requested. The centre is expected to maintain up to date training for all clinical staff. The HFEA have the power to refuse a person's inclusion on the treatment licence if they feel the individual is not fully qualified for the job. All staff with access to confidential identifying information on patients must be included on the license in order to practice legally. The centre has been commended twice in the last three years for its compliance with regulations.

Clinical governance is integral to the work of all staff within the Fertility Centre. Clinical incidences are discussed at the Gynaecology Clinical Governance and at the Fertility Management Meetings (at least quarterly). Other Governance issues are referred to the larger Gynaecology Clinical Governance Group as appropriate. Both the Clinical Risk Co-Ordinator (Gynae/Fertility Services) and Clinical Risk Advisor (Women's, Children's and Surgical Services) attend both Groups.

## **6.0 Feedback**

Ensuring all staff has easy access to information is a vital part of the Risk Management Strategy. Information to staff will be communicated by the following systems: -

- Reports and staff leaflets are available on the Women's Risk page (*appendix 10*).
- For urgent/immediate information this will be via the Corporate Clinical Risk Alert System.
- Feedback and update changes in practices, education, training, new guidelines etc. to staff meetings e.g. Senior Midwives, Consultant Meetings and cascaded through these channels, co-ordinated by the Practice Development Midwife.
- Local and national statistics are presented at the start of the Perinatal Mortality Meeting.
- C.R.A.W.L. A quarterly newsletter (Clinical Risk and Women's Lives) summarises incidents, actions, new guidelines, and changes in practice.
- Quarterly Obstetric and Gynaecology Clinical Audit/Governance meeting to feedback incidents, complaints, changes to practice presentation of audits.
- Joint Anaesthetic and Obstetric Audit Meeting.
- Corporate 'Governance Gazette'.
- Designated Clinical Risk Notice Boards.
- Quarterly multi-disciplinary training sessions.

## **7.0 Monitoring, Review and Feedback**

Continuous review of risk is undertaken by the division via the meetings outlined in this strategy.

Issues for the Divisional Risk Register will be co-ordinated and monitored by the Divisional Risk Register Group.

Feedback to divisional staff as highlighted in this strategy by meetings and other mechanisms as identified in 6.0 Feedback.

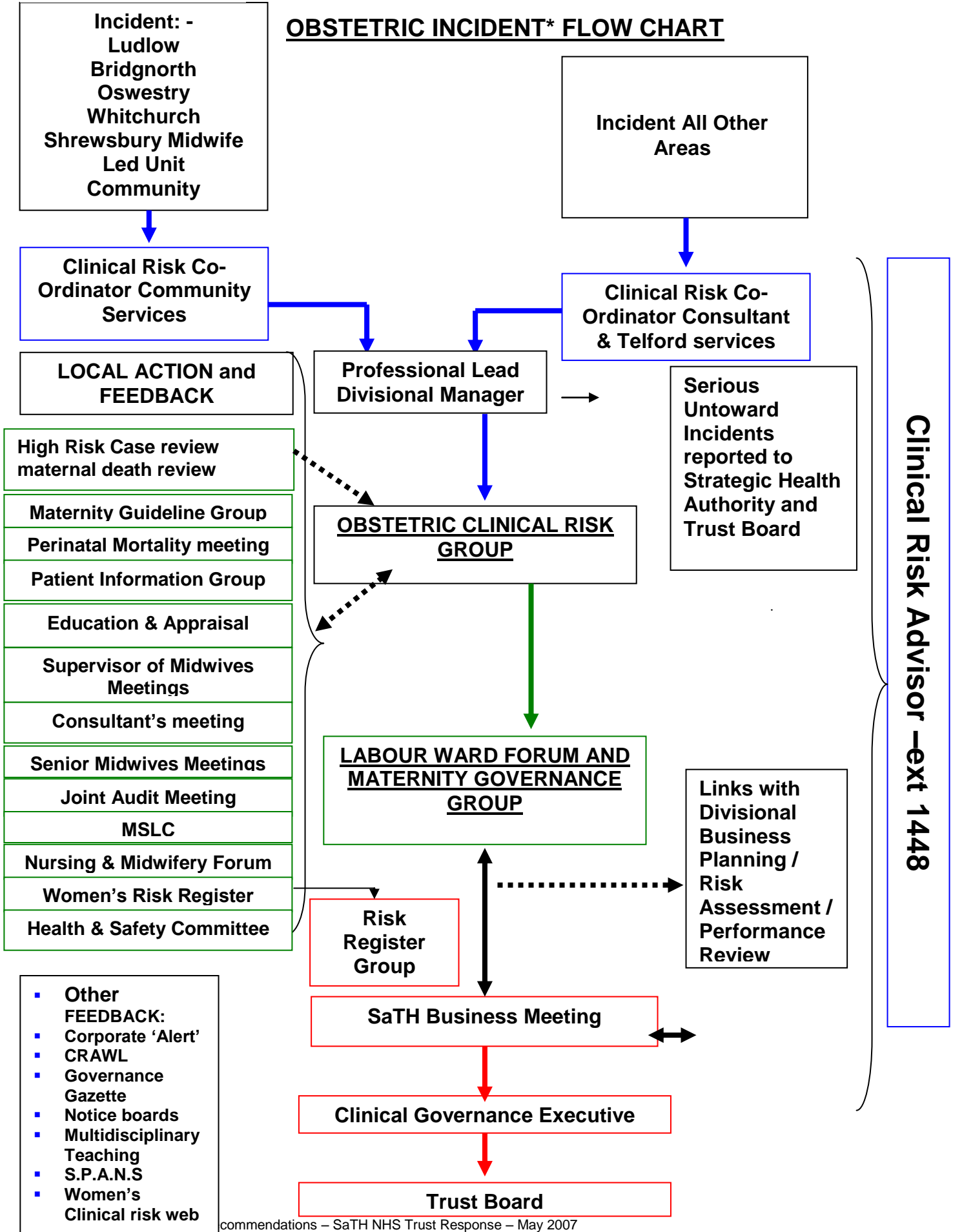
The clinical risk advisor provides feedback and updates to all midwives via a yearly programme of midwifery training days.

Risk management will form an agenda item at the business review meetings with the Trust Executive.

This strategy will be reviewed annually or earlier if the outlined processes need to change to accommodate Trust re-structuring.

This strategy is intended to be a dynamic document reflecting Risk Management Developments within the Women's Services Division.

**OBSTETRIC INCIDENT\* FLOW CHART**



**Terms of Reference and Membership  
Obstetric Clinical Risk Group  
(O.C.R.G.)**

**Terms of reference:**

**Key Aim:**

To co –ordinate and implement the monitoring and review of clinical risk incidences in accordance with the Risk Management Strategy (Women’s Division). Providing feedback to the Labour Ward Forum and Maternity Governance Group.

**Objectives:**

1. To monitor numbers and trends of reported incidents and complaints.
2. To actively review in detail the more significant clinical risk incidences.
3. To promote good practice by identifying risks through investigation and audit.
4. To decide appropriate action necessary to reduce future risk of reoccurrence.
5. To monitor the implementation of any action plans including guideline development and education.
6. To ensure feedback is generated to all appropriate personnel and departments including via the CRAWL (clinical risk and women’s lives) newsletter.
7. To provide minutes and feedback to the Labour Ward Forum and Maternity Governance Group.

The objectives link to Domain 1 of standards for better health (safety).

The Group will meet on a monthly basis. A quorum of at least the Divisional Manager (Professional Lead) or the Clinical Director, Obstetrics and Gynaecology must be present with a total of a least 5 members to ensure an adequate review is achieved.

**Membership**

Clinical Director, Obstetrics and Gynaecology
Clinical Risk Advisor (Women’s Services)
Clinical Risk Co-Ordinator Consultant & Telford Women’s Services (Consultant inpatient, antenatal, intrapartum and postnatal)
Clinical Risk Co-Ordinator Community Women’s Services (Low Risk Units, intrapartum, postnatal and community)
Contact Supervisor of Midwives
Divisional Manager (Professional Lead managing obstetric ultrasound)
Lead Consultant Anaesthetist for Obstetrics
Lead Consultant Obstetrics
Practice Development Midwife
Lead Neonatologist

Ratified June 2004

**Terms of Reference and Membership  
Labour Ward Forum and Maternity Governance Group  
(L.W.F. AND M.G.G)**

**Terms of reference**

**Key Aim:**

To review all aspects of Labour ward activity in order to promote good practice in accordance with the Risk Management Strategy (Women’s Division).

**Objectives:**

1. To review clinical and organisational issues impacting on Labour ward activities.
2. To receive a summarised report of from the Obstetric Clinical Risk Group in order to monitor numbers and trends of reported incidents and complaints including action taken.
3. To actively review in detail issues referred by the Obstetric Clinical Risk Group and develop an action plan and monitor its implementation.
4. To encourage and promote good inter-professional communication and team work.
5. To effectively communicate decisions made by the group.
6. To promote good practice by identifying and minimising risks through review of National Confidential Enquires, relevant investigation, audit, Department of Health guidance or reports.
7. To monitor the implementation of any action plans including guideline development and training.
8. To ratify labour ward guidelines.
9. Approve relevant midwifery guidelines prior to their ratification in accordance with the Trusts framework for development and ratification of nursing and Midwifery guidelines.
10. To ensure feedback is generated to all appropriate personnel and departments.
11. To provide minutes and feedback to the Obstetric Clinical Risk Group.
12. To refer issues as necessary to the most appropriate group including the Risk Register Group, Operational Governance Group and Strategic Governance Group.

The objectives link to Domain 1 of Standards for Better Health (safety).

The Group will meet at least four times a year. A quorum of at least 7 members must be present to ensure the effectiveness of the group. Where possible, individuals should send representatives to attend in their absence. As a minimum each key member\* or a representative must attend four meetings per year.

**Membership**

Clinical Director, Obstetrics and Gynaecology
* Lead Consultant Obstetrics
* Clinical Midwife Manager/ Senior Midwife Consultant Services
* Clinical Midwife Manager/ Senior Midwife Community Services
* Obstetric Anaesthetist
* Neonatologist/Neonatal Paediatrician
* Risk Manager/Clinical risk Advisor (Women’s Services)
* Junior Medical Representative
* Junior Midwifery Representative
* Consumer Representative
* Supervisor of Midwives
Divisional Manager (Professional Lead)
Practice Development Midwife

**WOMEN'S RISK REGISTER GROUP  
(W.R.R.G.)**

**TERMS OF REFERENCE**

<b>MEMBERS</b>
Divisional Manager
Directorate Manager
Clinical Risk Advisor
Project Midwife (Audit and I.T.)

**REMIT**

To work as a sub group to the LWF and MGG to monitor and maintain the Divisional Risk Register.

**RESPONSIBILITY**

1. To ensure the Division has an up-to-date accessible and complete risk register in place.
2. Individual risks are monitored via Divisional Risk Tracker form.
3. To validate and prioritise risks on the Division Risk Register.
4. To report to the Obstetric Clinical Risk Group, LWF and MGG to support reappraisal of any identified risks and the addition and deletion of risks.
5. To advise Divisional Manager of the status of Divisional risks (scoring 15 or above) to be notified to the Corporate Risk Register Group.
6. To support the requirements of the relevant Healthcare Standards and NHSLA.
7. To receive, record and feedback to staff members identifying risks for consideration for inclusion on Risk Register.

**ACCOUNTABILITY**

The W.R.R.G. is accountable to Divisional manager and Clinical Director.

The Divisional Risk Register progress reports will be presented to LWF and MGG and to appropriate corporate groups.

**REPORTING ARRANGMENTS**

To LWF and MGG.

**FREQUENCY OF MEETINGS**

Meetings will be held monthly.

**DATE TERMS OF REFERENCE APPROVED**

October 2006.

**DATE OF NEXT REVIEW**

October 2007.

## **Provision for Patient Information Group (Women's Services)**

### **Terms of Reference**

#### **Aim**

To establish a group with appropriate membership that will develop a “provision for patient information framework”. This will provide women with up to date evidence based information to make informed health care decisions during their contact with Women's Services.

#### **Objectives**

1. To meet four times a year with each member attending at least 50% of meetings. Meetings will be minuted.
2. To write and review a guideline for the production of Patient Information Leaflets for Women's Services.
3. To review and update the criteria for the ratification of Patient Information Leaflets including:
  - The risks associated with proposed treatments.
  - The benefits of the proposed treatment.
  - Consequences of treatment.
  - Alternative treatments available and their associated risks and benefits.
  - Consequences of not accepting the proposed treatment.
4. To establish an appropriate reading panel.
5. To initiate and review a system of archiving patient information.
6. To provide a system for obtaining in different languages and formats.
7. To ensure that all appropriate staff are aware of the framework.
8. To ensure the framework is congruent with the corporate Patient Information Policy.
9. To liaise with Departments and Agencies that influence the provision of care for patients accessing Women's Services.
10. To liaise with Corporate Provision for Patient Information Group.

The objectives link to Domain 4 of Standards for Better Health (Patient focus).

Community Midwife/NCT link (Chair)
Clinical Risk Advisor (Women's Services)
Senior Midwife Consultant Unit
Senior Midwife Community Women's Services
Directorate Manager Gynaecology
Research Midwife
Early Pregnancy Assessment Unit
Patient advice and liaison service.
Consultant Obstetrician and Gynaecologist
Minutes To Link Members

**Terms of Reference and Membership  
Gynaecology Clinical Governance Group  
Terms of reference**

**Key Aim**

To review all aspects of Gynae. Department activity in order to promote good practice in accordance with the Risk Management Strategy (Women's Division).

**Objectives**

1. To review clinical and organisational issues impacting on Gynae. Department activities.
2. To monitor numbers and trends of reported incidents and complaints
3. To actively review in detail the more significant clinical risk incidences.
4. To review the clinical care given following the death of Gynae. Patients within the Gynae. Department.
5. To promote good practice by identifying risks through investigation and audit.
6. To decide the appropriate action necessary to reduce future risk of reoccurrence.
7. To monitor the implementation of any action plans including guideline development and education.
8. To ensure feedback is generated to all appropriate personnel and departments including via the CRAWL (clinical risk and women's lives) newsletter
9. To encourage and promote good inter-professional communication and team work.
10. To effectively communicate decisions made by the group.
11. To promote good practice by identifying and minimising risks through review of National Confidential Enquires, relevant investigation, audit, Department of Health guidance or reports.
12. To ratify Gynae. Department guidelines.
13. Approve relevant nursing guidelines prior to their ratification in accordance with the Trusts framework for development and ratification of nursing and midwifery guidelines.
14. To provide and validate minutes of meetings held.
15. To refer issues to the Labour Ward Forum Governance Group and Patient Information Group as appropriate.
16. Operational Governance Group and Strategic Governance Group
17. Identify issues for the Women's Multidisciplinary Training Days

The Group will meet at least four times a year. A quorum of at least 4 members must be present to ensure the effectiveness of the group. Where possible, individuals should send representatives to attend in their absence. As a minimum each member or their representative should attend at 50% of meetings.

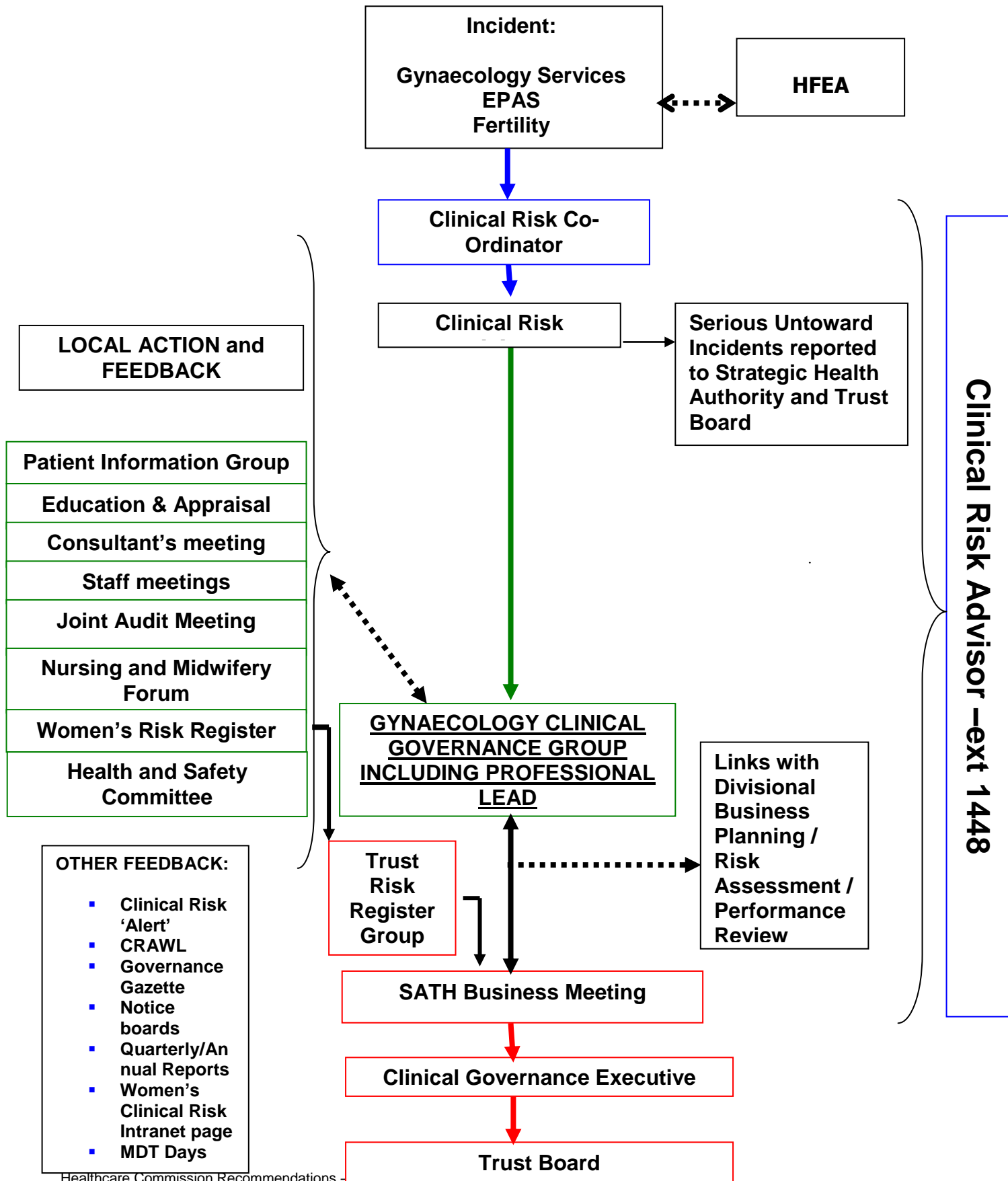
The objectives link to Domain 1 of Standards for Better Health (safety).

**Membership**

Clinical Audit Representative
Clinical Director, Obstetrics and Gynaecology
Clinical Risk Advisor (Women's Services)
Directorate manager Gynaecology
Divisional Manager (Professional Lead).
Gynae Ward Manager
Middle Grade Medical Representative
Lead Consultant Gynaecology



**GYNAECOLOGY INCIDENT\* FLOW CHART**



## APPENDIX 8

### Terms of Reference and Membership

#### Maternity Guideline Group

##### Terms of reference

###### Key Aim:

This group will ensure that clinical guidelines within Maternity reflects evidence-based multi-disciplinary practice and positively influence patients' outcome. The group will oversee the implementation of the Women's framework for the development of protocols and guidelines in Maternity, to ensure a systematic and formalised approach.

###### Objectives:

- To meet at least quarterly and provide representation from all areas utilising maternity guidelines.
- To co-ordinate a planned approach to bi-annual reviews of Labour Ward Protocols, Maternity Guidelines for practice.
- To co-ordinate a tri-annual audit cycle for relevant guideline.
- To ensure a formalised approach to literature search and review is adopted.
- Oversee the ratification of maternity guidelines.
- Ensure distribution of maternity guidelines is achieved to all relevant areas.
- Monitor the adoption of a systematic approach to guideline reviews.
- Ensure a formal approach to archiving of guidelines is adopted within the Division.
- Audit findings from clinical audit with influence guideline development.
- All meetings will be minuted.

The objectives link to Domain 1 of Standards for Better Health (safety).

##### Membership

Practice Development Midwife/Directorate Manager
Clinical Project Midwife/Contact Supervisor of Midwives
Senior Midwife Shropshire Community Services
Senior Midwife Telford Community Services
Senior Midwife for Consultant Labour Ward
Clinic Booking Co-Ordinator
Clinical Librarian
Clinical Risk Co-Ordinator
Project Midwife (Audit, IT, CNST)
Obstetric Audit Lead (Obstetrician)

Members to attend 50% of meetings and nominate a deputy.

## **Appendix 9**

### **Guidance for medical and midwifery staff dealing with serious clinical incidents, that might lead to a claim.**

This advice must be read in conjunction with other relevant Trust policies relating to incident reporting and management. Due to the uniqueness and sensitivity of the Women's specialty there are specific issues and additional information that need to be considered when investigating serious incidents.

Examples of serious clinical incidents that might lead to a claim, include the following:

- Baby delivered (after 37 weeks gestation) with persistent low Apgar scores (less than 6 at 5 minutes) and where there were also neonatal seizures (or cord pH of less than 7.1).
- Neonatal death where low Apgar scores were recorded on delivery.
- Baby shows signs of brachial plexus injury or other serious trauma e.g. fracture or any injury that is likely to lead to scarring or permanent injury.
- Intrapartum stillbirth.
- Maternal death.
- Any other incidents where circumstances suggest a claim may result (for example third degree tears and uterine rupture).

This list is neither prescriptive nor exhaustive and the following points should be considered for any case where a claim is likely.

Procedures to be taken following an incident that has the potential to lead to a claim:

- 1 A clinical incident form must be completed for all incidents listed above and any other serious incidents that might lead to a claim.
- 2 Staff must notify the clinical risk co-ordinator at the earliest opportunity. The clinical risk co-ordinator will notify the clinical risk advisor, litigation manager, divisional manager, lead clinician. A decision will be made on how and who will investigate. Through the incident reporting system the case will be reported, discussed and action plans monitored through the relevant groups in the Women's Risk Management Strategy and through the corporate governance structure as necessary.
- 3 Initiate a detailed investigation of the incident. This will include confirmation of timings in the records and brief FACTUAL statements from all health professionals involved in the perinatal care of mother and baby (including paediatricians, anaesthetists and student midwives). These should specifically exclude personal or professional opinion. It is particularly important to clarify the various timings set out in the notes and to ensure that any discrepancies are referred to in the brief factual statements. The notes themselves should not be altered retrospectively as this will lead to confusion in later years, should a claim be lodged. It is acceptable to allow staff late written entries to clarify the notes, but not to amend earlier notes. Further guidance on writing witness statements is provided in the claims policy and the clinical incident investigation toolkit. There is also a staff information

leaflet on the womens clinical risk management intranet site, with an electronic version of the witness statement form.

- 4 Preserve and file the factual information pending a possible claim. The record of the investigation should be retained with any other adverse incident reports. Despite the link to potential litigation, this information should be treated as disclosable and made available to the claimants representative if a request is made.
- 5 Copy\* and retain on file the CTG traces including later recordings (as a maximum, 2 to 3 hours prior to delivery) in all cases of:
  - Babies delivered (after 37 weeks gestation) with persistent low Apgar scores (less than 6 at 5 minutes) and where there were also neonatal seizures (or cord pH of less than 7.1).
  - Neonatal death where low Apgar scores were recorded on delivery.
  - Intrapartum stillbirth

And the following cases if thought to be relevant (Clinical advice (**must**) be sought)

- Baby shows signs of brachial plexus injury or other serious Trauma
- Maternal death
- Any other incidents where circumstances suggest a claim may result (for example third degree tears and uterine rupture)

**Ensure original CTGs are correctly filed in brown envelopes** as per the Trust policy as originals are prone to fade in a relatively short time.

\*(Copies of CTG traces are arranged through the litigation department).

- 6 The obstetric clinical risk group will actively review the root cause analysis, as detailed in the Trust investigation and reporting policy, including any issues of delay in attendance of health professionals.
- 7 The Labour Ward Protocol regarding the taking of cord blood analysis must be followed. This includes the taking of cord blood at delivery and securing the results in the notes. Part of the investigation and root cause analysis will include compliance with the protocol. The NHSLA advocates this is undertaken as soon as possible after delivery. Agreement between professionals should ensure that the procedure was undertaken in an accurate and timely fashion with both arterial and venous samples. This information will be important in establishing the cause of any subsequent damage, which may not be attributable to the original accident.

## 8 **Additional Information**

Where appropriate obtain additional information that could assist the Paediatric/Neonatal team in establishing the cause of any brain damage / birth trauma.

Examples:

- Placental examination and histology. (Please see Labour ward protocol for when placentas are kept and sent to Birmingham for Analysis). This could determine placental insufficiency, infection or early death of a twin.
- Infection in baby or mother
- Evidence of Intra Uterine Growth Retardation

***Further information is available in the Investigation and Reporting Policy and the Incident Toolkit both available on the clinical risk website.***

## **Appendix 10**

### **Additional Information**

The following leaflets are written specifically for healthcare staff in Shropshire's Maternity Services and can be found in all clinical areas.

- Women's Risk Management Strategy.
- Clinical Risk Management.
- Help! Something has gone wrong.
- Being open.
- Key points for consent.
- Key points for confidentiality.
- Writing a witness statement.
- Women's clinical incident investigation leaflet.
- Induction package.
- Death certification.
- Patient safety incident categories.
- Root cause analysis.
- Being open and honest.
- Guide to working with the coroner.
- Fetal remains handbook.

### **Supervision for Midwives**

Introduction to Supervision letter.

Standards and Guidelines for Supervisors of Midwives (West Midlands Consortium) May 2003.

What Supervision in Shropshire can do for you.

Guidelines for Record Keeping in the event of obstetric complications.

Supervisors for Midwives – How can we help you? (leaflet).

Web Sites:

[www.nhsla.com](http://www.nhsla.com) (Useful Information including CNST Standards), [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent),  
[www.npsa.net](http://www.npsa.net) (useful information including reporting systems and national risk issues).

Staff Information leaflet  
**Women's Services Investigation Into Cases That  
May Lead To A Claim**  
July 2007



**Related policies:**

Women Risk Management Strategy  
Trust Risk Management Policy  
Claims Policy

**CLINICAL RISK ADVISOR**

**EXT: 1448**

Due to the impact financially and through publicity and the uniqueness and sensitivity of the specialty there are specific issues that need to be considered when investigating serious incidents.

Where a serious clinical incident occurs in obstetrics the clinical risk coordinator should be notified immediately. If it is thought that the claim against the Trust may follow, the Litigation Manager should be notified immediately.

Examples of serious clinical incidents include the following: -

- Baby delivered (after 37 weeks gestation) with persistent low Apgar scores (less than 6 at 5 minutes) and where there were also neonatal seizures (or cord pH of less than 7.1)
- Neonatal death where low Apgar scores were recorded on delivery

- Baby shows signs of brachial plexus injury or other serious Trauma
- Intrapartum stillbirth
- Maternal death
- Any other incidents where circumstances suggest a claim may result (for example third degree tears and uterine rupture)

This list is neither prescriptive nor exhaustive and the following points should be considered for any case where a claim is likely.



## Key Issues to be considered Following an Incident that has a Potential to lead to a Claim:

1. A clinical incident form must be completed for all incidents listed above and any other serious incidents that might lead to a claim.
2. Staff must notify the Clinical Risk Coordinator at the earliest opportunity. The Clinical Risk Coordinator will notify the Clinical Risk Advisor, Litigation Manager, Divisional Manager, Lead Clinician. They will make the decision regarding the make up of group to lead on the investigation and the action following a serious incident. Through the incident reporting system the case will be reported and discussed through the relevant groups in the Women's Risk Management Strategy and through the Corporate Governance Structure as necessary.
3. Initiate a detailed investigation of the incident, to include confirmation of timing in the records and brief **FACTUAL** statements from all health professionals involved in the perinatal care of mother and baby (including paediatricians, anaesthetists and student Midwives) These should specifically exclude personal or professional opinion. It is particularly important to clarify the various timings set out in the notes and to ensure that any discrepancies are referred to in the brief factual statements.

The notes themselves should not be altered retrospectively as this will lead to confusion in later years, should a claim be lodged. It is acceptable to allow staff late written entries to clarify the notes but not to amend earlier notes.

Further guidance on writing witness statements is provided in the clinical incident investigation toolkit.

4. Preserve and file the factual information pending a possible claim. The record of the investigation should be retained with any other adverse incident reports. Despite the link to potential litigation, this information should be treated as disclosable.
5. \*Copy and retain on file the CTG traces including later recordings (as a minimum, 2 to 3 hours prior to delivery) in all cases of:
  - Baby delivered (after 37 weeks gestation) with persistent low Apgar scores (less than 6 at 5 minutes) and where there were also neonatal seizures (or cord pH of less than 7.1)
  - Neonatal death where low Apgar scores were recorded on delivery
  - Intrapartum stillbirth





And in the following cases if thought to be relevant (clinical advice **must** be sought)

- Baby shows signs of brachial plexus injury or other serious Trauma
- Maternal death
- Any other incidents where circumstances suggest a claim may result (for example third degree tears and uterine rupture)

•  
**Ensure original CTGs are correctly filed in brown envelopes** as per the Trust policy as originals are prone to fade in a relatively short time.

\*(Copies of CTG traces can be arranged through the litigation department).

6. The obstetric clinical risk group will actively review the root cause analysis, as detailed in the Trust incident reporting policy, including any issues of delay in attendance of health professionals.
7. The Labour Ward Protocol regarding the taking of cord blood analysis must be followed. This includes the taking of cord blood at delivery and securing the results in the notes. Part of the investigation and root cause analysis will include compliance with the protocol. This information will be important in establishing the cause of any subsequent damage, which may not be attributable to the original accident.

## Additional Information

8. Undertake an appropriate review of information that could assist the Pediatric team establishing the cause of any brain damage.

Important examples should be obtained:

-

- Placental examination and histology. The Labour ward protocol regarding when placentas are kept and sent to Birmingham for Analysis must be followed. This could determine placental insufficiency, infection or early death of a twin
- Infection in baby or mother
- Intra Uterine Growth Retardation
- When placentas are kept and sent to Birmingham for Analysis must be followed. This could determine placental insufficiency, infection or early death of a twin

***Further information is available in the incident reporting policy and the incident Toolkit both available on the clinical risk website.***

Please do not be afraid to ask for help and advice from the Senior Management Team in women's Services or contact

***Clinical Risk Advisor***  
01743 261448



Staff Information leaflet  
**Root Cause Analysis**  
 July 2006

It is recommended that for all high risk incidents an investigation is undertaken followed by a root cause analysis. This will help identify the systems that require improvement and help formulate the action plan. It is recommended that the root cause analysis is undertaken in a small group of appropriately experienced staff to ensure all issues are identified. Help and advice on undertaking an investigation and root cause analysis are available on the Clinical Risk web page under the investigating clinical incidents toolkit. Root cause analysis has been supported by the national patient safety agency and the format used in this Trust is from their recommendation. A root cause analysis reviews the incident under 6 key elements, with each having sub-divisions. They are:

**ROOT CAUSES – CONTRIBUTORY FACTORS**

**INDIVIDUAL FACTORS**

COMPETENCE	qualifications, skills, knowledge
Physical issues	physical health, disability
Psychological issues	stress, fatigue, depression, substance abuse, motivation

**TEAM FACTORS**

Verbal Communication – between: junior and senior staff, professional groups, staff and patients –

With; relatives and carers advocates and advisors  
 Hand over arrangements  
 Voicing of disagreement

**Written Communication**

Legibility, segregated notes, complete information, availability of records, Risk assessments

**Supervision**

Mentorship, availability of senior support, approachability, willingness of juniors/trainees to accept supervision

**Role Congruence**

Is there clarity of understanding, different perceptions of role?

**Support and Cultural**

Open or closed culture, learning or disciplinarian, support networks, Scapegoat culture

**TASK FACTORS**

Guidelines and policies – up to date, available, relevant, usage of guidelines and protocols.

Performance of Task and function – Particular steps in task not carried out, misinterpretation of results, difficulty in performing task (why), inability to obtain results



Decision-making aids – Availability of aids; access to senior advice, easy access flow charts  
Task Design – Do the guidelines enable one to carry out the task in a timely manner

Does staff agree with the task design

## **WORK ENVIRONMENT**

Administrative factors – Reliability of admin system, systems for requesting records, drugs

Design of environment – Ergonomics

Environment – Housekeeping issues, cleanliness, heat and light, noise

Equipment – Equipment functional, available, standardised, correctly maintained safety features

Staffing – Skill mix, numbers, leadership, temporary staff, turnover – i.e. fast or static, stuck in ways

Education / training Appropriately trained, appraisal mechanisms, Induction processes  
Statutory training, facilitated to attend training

Workload and hours – Duty rotas – adequate rest, meal breaks, dependency of patients, volume per trained person.

Time – Delays caused by system failure or design, pressure to do more/faster

## **PATIENT FACTORS**

Clinical Condition – Pre existing co – morbidity

Social factors – Culture, lifestyle, language, support networks

Physical factors – Malnourished/bariatric

Psychological factors – Motivation, stress, trauma, existing mental health disorder, intoxication

Interpersonal factors – Staff to patient, patient to staff, patient to patient, inter family.

## **ORGANISATIONAL FACTORS**

Organisational structure – Hierarchical, not conducive to discussion, tight boundaries of accountability, Clinical v Managerial model

Policy, standards, goals – ill defined, no document management systems, operation standards

Risk management systems, quality improvement, implementation of Health and Safety, Investment in education, Leadership skills.

Safety Culture – Ethos of organisation, 'Safety' or 'Target' driven

Once the Root cause has been completed an action is agreed and in implementation is monitored by the local Governance Group and on some occasions by the operational Governance Group.

Please never be afraid to ask for help and advice.

