# Maternal morbidity review template

# Case summary template

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| NHI: |
| LMC at registration: ☐ Midwife ☐ GP ☐ Private obstetrician ☐ DHB care  |
| If transfer of clinical responsibility: from LMC to… Date + gestation: |
|  |  | Age: G: P: EDD:Ethnicity: BMI: (*if not recorded, work out from height and weight or say not available*) |
|  | **Med Hx** |  |
|  | **Smoking status** | Yes/No |
|  | **Meds** |  |
|  | **Allergies** |  |
|  | **Obs Hx** |  |
|  | **Social Hx** | *If available* |
|  | **Booking visit/ bloods****Gestation** |  |
|  | **USS Gestation** | *Findings* |
|  |
| **Date + gestation:** | **LMC:**  | *History leading to the event. Where unrelated to antenatal care, summarise antenatal care such as registered, gestation, number of antenatal visits, any referrals such as referred at 36+4 with reduced FM, findings were: CTG normal, good fetal movements and discharged home.**Leave a blank box between different assessment time periods as below.* |
|  |
| **Date + gestation:** | **Clinician/ status/time/****gestation:*****eg,******LMC midwife******Core m/w******LMC Obs******O&G Reg******ICU SHO******O&G Cons*** | *Document and summarise the event: what happened and when? Include observations, assessments, medications, fluids, referrals, operation note.**If the anaesthetic record is complicated, include a copy of it instead of writing it up.**Document transfusion details and EBL so that there is a contemporaneous record of blood loss, blood products and fluids given and a* ***total*** *of all blood products and fluids given (where PPH is the event).**Include delivery details – time of birth, Apgars, birthweight and any other neonatal information* ***if*** *pertinent to the case.**(illegible) – Use for incredibly bad hand writing.****Record results in bold******Imp: Record in bold******Plans***1. ***Record plans in bold.***
2. ***Number points where possible for clarity.***
 |

**Other relevant background**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Staffing numbers: *AM/PM/N* | Variance: *AM/PM/N* | Code red:[[1]](#footnote-1) Yes/No Times:  |
| ☐ Standard weekday |  |  |  |
| ☐ Holiday weekday |
| ☐ Weekend |
| ☐ Holiday weekend |
| Other staffing issues (eg, sickness/roster short): |
| Overtime or no meal breaks claimed (acuity demand): |
| Extra SMO/MW educators working on floor:  | Second team called in: ☐ Yes ☐ No |
| Hours at work of responsible clinician at time of event:  |
| Baby’s weight, Apgars and significant issues: |
| Contraception discussion and prescription: |

**Additional information**

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| --- |
| **Pregnancy status at discharge from hospital (check boxes)** |
| **< 20 weeks** | **> 20 weeks** |
| ☐ Ongoing (still pregnant) | ☐ Ongoing (still pregnant) |
| ☐ Miscarriage | ☐ Termination of pregnancy |
| ☐ Ectopic | ☐ Live birth |
| ☐ Termination of pregnancy | ☐ Still birth |
| *If birth –* gestation at birth: |  |
| *If neonatal death –* age of neonate (days): |  |
| **Referrals at discharge** (eg, maternal mental health) |
| **Woman’s narrative available:** ☐ Yes ☐ No |

# Maternal morbidity review tool

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| --- | --- | --- |
| Date review started: | Date review completed: | Event date:  |
| Name: | Parity: | Ethnicity: |
| NHI: | Age: | Birth location: |
| Place booked:  | Event location: |

**Presenter: Describe what happened and give the timeline (5 minutes)**

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**Contributory factors**

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| --- | --- | --- | --- |
| **Organisation or management factors identified**  | **Contributory factor code (eg, 1B)** | **Comments** | **Opportunity for improvement** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Personnel factors identified** | **Contributory factor code (eg, 2B)** | **Comments** | **Opportunity for improvement** |
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|  |  |  |
|  |  |  |
| **Access and engaging with care** | **Contributory factor code (eg, 3B)** | **Comments** | **Opportunity for improvement** |
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**Did you find inequities in relation to the maternal morbidity? If so, how were these created, maintained or increased?**

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**Overall, what were the main issues and/or concerns identified in the review? (summarise)**

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**What are the opportunities for recommendations and quality improvement? (Add more items as needed.) Use this information to fill in the standardised DHB action template or the action template included in this document.**

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| --- |
| 1. |
| 2. |
| 3. |

**Identify what went well**

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**Review outcome: Was the episode potentially avoidable?**

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| --- | --- | --- | --- | --- | --- | --- |
| ☐ Yes – if Yes, which contributory factor or factors were absent that, if present, might have made the morbidity potentially avoidable?

|  |  |
| --- | --- |
| ☐ | Organisation and management |
| ☐ | Personnel |
| ☐ | Access to care or influences from the woman’s context |

 |
| ☐ No– if No, what aspects of care could have been improved (if any)? |

**After review, should this have been rated SAC 1 or 2?** Yes/NoIf Yes, forward to DHB adverse event process after first notifying the woman and immediate clinicians involved.

**Systems review: contributory factors and codes for potential avoidability (laminate for repeated use at meetings)**

Contributory factors may be highly specific to the morbidity experienced by the woman or generalised to the system(s). Identifying contributory factors that occur, and are inherent, in the system is an important part of the review. These factors are commonly classified into: organisational; personnel; and those relating to the woman’s perspective, such as factors throughout her pregnancy journey, which may include accessing or engaging with care.[[2]](#footnote-2)

***HEAT questions 1–3:[[3]](#footnote-3)***

When considering the range of factors that may have contributed to the woman’s morbidity, the panel should apply the HEAT to consider whether inequities existed in the woman’s care, how and why these were created and maintained, and how they could have been reduced. The review panel should ask the following questions:

1. What inequities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?

***Organisational factors***

|  |  |
| --- | --- |
| 1A | Organisational arrangements of staff – *eg, acuity at the time, adequate skill mix rostered, TrendCare data, fatigue of staff* |
| 1B | Clinical and organisational knowledge of staff available during episode of care – *eg, locum, junior or new staff* |
| 1C | Policies, protocols or guidelines (accessible, used, up-to-date, multiple versions) |
| 1D | Appropriate number of staff to respond to fluctuating department acuity and demand |
| 1E | Access to and responsiveness of senior clinical staff  |
| 1F | Treatments and diagnostics – *eg, appropriate treatment or diagnostic, timely treatment, timely referral, timely identification of deterioration, timely caesarean, follow best practice* |
| 1G | Responses in emergency – *eg, timely call for HELP instigated* |
| 1H | Systems and processes for sharing of clinical information between services  |
| 1I | Access to test results or inaccurate results |
| 1J | Access to appropriate equipment – *eg, available equipment, adequate maintenance, quality of equipment, in-service training for new equipment* |
| 1K | Building and design functionality – *eg, space, privacy, ease of access, lighting, noise, power failure, operating theatre in distant location, woman in appropriate clinical setting* |
| 1L | Other – please provide full details in comments |

***Personnel factors***

|  |  |
| --- | --- |
| 2A | Clinical and organisational knowledge of staff available during episode of care – *eg, locum, junior or new staff* |
| 2B | Responses in emergency – *eg, timely call for HELP instigated by health care providers* |
| 2C | Up-to-date practice, knowledge and skills  |
| 2D | Communication – *eg, between providers, departments, hospitals, the woman; clear chain of responsibility* |
| 2E | Sought help or supervision  |
| 2F | Followed recommended best practice, protocols, policies, guidelines |
| 2G | Recognition of complexity or seriousness of condition by health care provider  |
| 2H | Documentation – *eg, clear decision-making, rationale for actions* |
| 2I | Other – please provide full details in comments |

***Access and engaging with care***

| 3A | Engaged with antenatal care |
| --- | --- |
| 3B | Infrequent care or late booking |
| 3C | Declined treatment or advice (informed decision made and clearly documented) |
| 3D | Maternal co-morbidities that impacted on delivery of optimal care – *eg, obesity on ultrasound scanning*  |
| 3E | Substance use (including tobacco) may have influenced engagement  |
| 3F | Family violence may have influenced engagement |
| 3G | Woman or family did not recognise complexity or seriousness of her condition |
| 3H | Co-morbidities – *eg, mental health, diabetes* |
| 3I | Cultural factors and/or other beliefs influenced care decisions |
| 3J | Communication challenges – *eg, interpreter requirements, NZ sign language* |
| 3K | Unable to access free care |
| 3L | Ability to access care impacted by social determinants – *eg, food and housing security, race and gender, income and work* |
| 3L | Environment – *eg, isolated, distance to specialist care, weather prevented or delayed transport, no seat belt* |
| 3M | Other – please provide full details in comments |

**Action template[[4]](#footnote-4) (or use standardised DHB template)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Identified what went well** | **Plan for sharing (eg, other DHBs, Health Quality & Safety Commission)** | **Consent from clinicians/woman** | **Shared local** | **Shared regional** | **Date of completion** |
| Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Statement 1** | **Solutions and quality improvement**  | **Action strength** | **Responsibility for action** | **Measure of compliance** | **Date of completion** |
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| **Statement 2** | **Solutions and quality improvement**  | **Action strength** | **Responsibility for action** | **Measure of compliance** | **Date of completion** |
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| **Statement 3** | **Solutions and quality improvement**  | **Action strength** | **Responsibility for action** | **Measure of compliance** | **Date of completion** |
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| **Statement 4** | **Solutions and quality improvement**  | **Action strength** | **Responsibility for action** | **Measure of compliance** | **Date of completion** |
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1. Code red refers to high acuity where the service is challenged to meet the clinical demand. In some DHBs this will be referred to using different terminology. [↑](#footnote-ref-1)
2. Taylor-Adams S, Vincent C. 2004. *Systems Analysis of Clinical Incidents: The London Protocol*. London: Faculty of Medicine, Imperial College London. URL: [www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/528](http://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/528/).
Vincent C, Amalberti R. 2015. *Safer Healthcare: Strategies for the Real World.* Oxford: Springer Open.
Perinatal and Maternal Mortality Review Committee maternal death classification form. [↑](#footnote-ref-2)
3. [www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf](http://www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf) [↑](#footnote-ref-3)
4. This template is also available as an Excel spreadsheet: [www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/3510](http://www.hqsc.govt.nz/our-programmes/mrc/pmmrc/publications-and-resources/publication/3510) [↑](#footnote-ref-4)