The leading body for maternity and newborn safety investigations in England

March 2025

A monthly bulletin for stakeholders, clinical and non-clinical staff working in maternity, neonatal care and patient safety.

Introducing COMPASS: A new safety tool to help understand the impact of culture on patient safety

It's widely recognised that organisational culture has a high impact on patient safety. However, through our maternity safety investigations it has become clear that there is no consistent approach that supports safety organisations to understand the impact culture may have had on a patient safety incident.

To support our work, and ensure that we have a holistic understanding of all elements that may have contributed to a patient safety incident, we have developed COMPASS (Culture of Organisations and its iMpact on PatientS' Safety – Assessment). This tool has been developed by Chris McQuitty (Clinical Fellow) and Nicki Pusey (Maternity Investigation Team Leader) to provide a standardised process for our staff to articulate, analyse and feedback observations about organisational culture. We believe the tool will help our teams to reflect the cultural approach to safety investigations within trusts.
Later this month we will be launching a pilot for COMPASS within our own investigations and in partnership with 12 NHS Trusts.

Click here to read more about COMPASS

Sign up to our webinar series

Following the success of our recent webinar series we are delighted to announce the second series of MNSI webinars will begin in May 2025.

The next set of webinars will cover:

- **Exploring learning from MNSI safety investigations: What MNSI investigations tell us about neonatal resuscitation** ***In this webinar we will explore learning following a review of MNSI investigations where a baby has experienced a severe brain injury or died following labour in the first week of life.***
    - **Wednesday 7 May, 1pm-2pm (GMT)** Register here
- **Exploring learning from MNSI safety investigations: Birthing outside of guidance: Learning from MNSI investigations** ***In this webinar for healthcare professionals, we will explore how you can support women / birthing people who plan care outside of guidance so we can improve the outcomes and the experience of all mothers, birthing people and babies.***
    - **Tuesday 13 May, 1pm-2pm (GMT)** Register here
- **Exploring learning from MNSI safety investigations: Health Equity Warning Score (HEWS) Tool and the Health Equity Assessment and Resource Toolkit (HEART)** ***In this webinar we will explore MNSI's Health Equity Warning Score (HEWS) and the Health Equity Assessment and Resource Toolkit (HEART). Join this webinar to find out how these tools are impacting on MNSI's safety investigations***
    - **Thursday 22 May, 1pm-2pm (GMT)** Register here
- **Exploring learning from MNSI safety investigations: Factors affecting the delivery of safe care in midwifery units** ***In this webinar we will explore factors affecting the delivery of safe care in midwifery units following the analysis of 92 MNSI investigations where care had been given at some time during labour in a midwifery led setting.***
    - **Tuesday 3 June, 1pm-2pm (GMT)** Register here
- **Exploring learning from MNSI safety investigations: Umbilical cord management** ***In this webinar we will explore MNSI's findings following a systematic literature review analysing the research regarding cord management during neonatal transition and resuscitation.***
    - **Wednesday 18 June, 1pm-2pm (GMT)** Register here

Safety spotlight

A baby's heart rate was being monitored with a CTG abdominal transducer. The mother's heart rate was also being monitored using a finger probe pulse oximeter, attached to the CTG machine. The mother and baby's heart rates were displayed visually on the CTG machine and recorded on the CTG trace.

It was likely that the abdominal transducer lost contact with the baby's heart rate and recorded the mother's heart rate as shown on the CTG trace below.

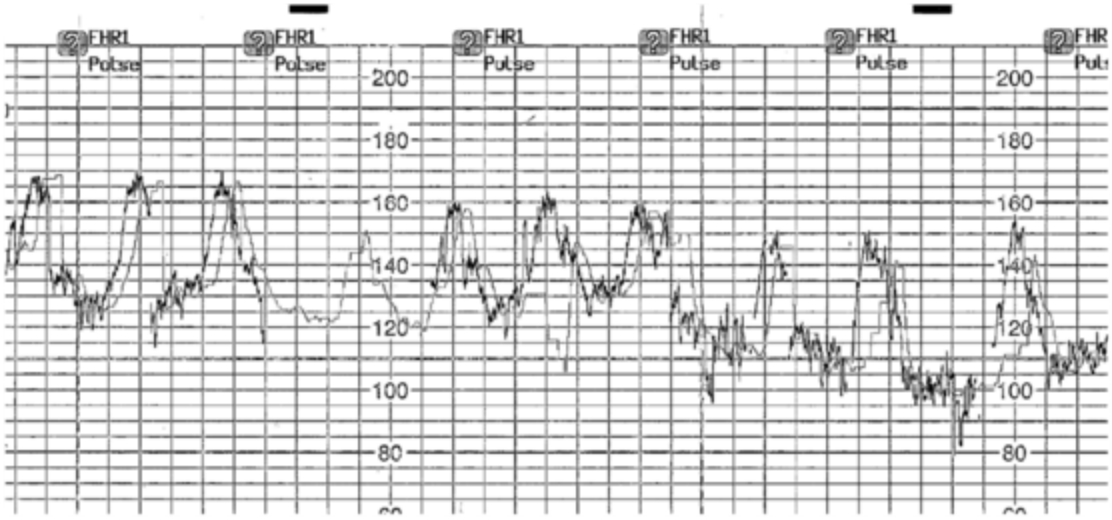
The average calculation time of the maternal pulse from a CTG's pulse oximeter finger probe can be different to the maternal pulse recorded by an abdominal transducer. This can lead to a delay in the calculation and the recording of the mother's heart rate, in this example, of up to 12 seconds.

This meant that there were two different values being shown on the CTG visual display and this reassured staff that there were two different heart rates being heard, when it was likely to be the mother's heart rate on both.

To prevent a mother's heart rate being inadvertently interpreted as a baby's heart rate it is worth considering the following questions:

- Does your training include functionality of the CTG machines used in your Trust including how the machines work and alarm functions?
- Does the manufacturer's guidance indicate a delay in the calculation and recording of the maternal heart rate for the CTG machines used by your trust?

Further reading can be found here



Dates for your Diary 2025

March

RCPCH Conference 2025 (Royal College of Paediatrics and Child Health), 26 March 2025 - 28 March 2025 | Glasgow, Scotland

April - June

BAPM Spring Conference 2025 (British Association of Perinatal Medicine), 1 - 2 April 2025, Leicester, England

RCM Annual Conference 2025 (Royal College of Midwives), 30 April - 1 May 2025, Birmingham, England

BMFMS Conference 2025 (British Maternal and Fetal Medicine Society), 8 May 2025, Belfast, Northern Ireland

RCOG World Congress (Royal College of Obstetricians & Gynaecologists), 23 - 25 June 2025, London, England

November

BICS Conference 2025 (British Intrapartum Care Society), 13 - 14 November 2025, Northern Ireland

Awareness Days

International day of the Midwife, Monday 5 May 2025

World Patient Safety Day, Wednesday 17 September 2025

Baby Loss Awareness Week, 9 - 15 October, 2025

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mnsi.org.uk