<table>
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<th>Causal Factor</th>
<th>Questions / Factors to consider</th>
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| Communication / Teamwork      | • Communication with patient and family  
  o Was patient-provided information reconciled with family?  
  • Were there issues related to continuity of care?  
  o Was patient-provided information reconciled with previous providers?  
  • Was communication between team members adequate?  
  o available when needed?  
  o accurate?  
  o complete?  
  o Unambiguous?  
  • Does the medical record documentation adequately provide a clear picture of what happened?  
  • Are there barriers to communication?                                                                                                                                 |
| Environment                   | • Was the environment assessed for ligature risks?  
  • Were mitigation measures put in place to reduce risk of ligature points?  
  • How often is the physical environment assessed?  
  • Was a search for contraband completed?  
  • What family/peer interactions took place at the time of event or leading up to the event?                                                                                                                                 |
| Equipment / Technology        | • Did alarms, monitoring systems function properly?  
  • Is there a specific code or alarm indicating life-threatening emergencies to differentiate from general calls for assistance?  
  • Did ligature resistant equipment and/or fixtures function as anticipated?  
  • Were any additions, corrections, or alterations made in the medical record?                                                                                                                                 |
| Task / Process / Policies     | • Was a validated tool used for suicide risk screening and/or assessment?  
  • Did suicide risk assessment process include evaluation of:  
  o stated intent  
  o withheld intent  
  o reflected intent  
  o individual risk factors (static and dynamic)  
  o situational stressors  
  o availability of supports/protective factors  
  • What policies or procedure relate to the level and frequency of observation and monitoring?  
  o Did the level and frequency of patient observation or monitoring meet standard of care?  
  • What issues relating to philosophy of care or care planning had an impact on this case?                                                                                                                                 |
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| Staff Performance / Training | • Was staff properly qualified and currently competent for their responsibilities?  
• Were the results of training monitored over time?  
• Was the training adequate? If not, consider the following factors:  
  o supervisory responsibility  
  o procedure omission  
  o flawed training  
  o flawed rules, policy, or procedure  
• Did any human performance factor contribute to the event?  
  o Boredom  
  o Failure to follow established policies/procedures  
  o Fatigue  
  o Inability to focus on task  
  o Inattentional blindness/confirmation bias  
  o Personal problems  
  o Lack of complex critical thinking skills  
  o Rushing to complete task  
  o Substance abuse  
  o Trust  
• Was staff trained on identification of environmental risk factors?                                                                                                                                                      |
| Organization / Culture | • Was staffing appropriate to provide safe care?  
• Did actual staffing deviate from the planned staffing at the time of the event or during key times that led up to the event?  
• Was there an overall management plan for addressing risk and assigning responsibility for risk?  
• Did management have an audit or quality control system to inform them how key processes related to the adverse event were functioning?  
• Had a previous investigation been done for a similar event?  
  o Were the causes identified?  
  o Were effective interventions developed and implemented?  
• Would this problem have gone unidentified or uncorrected after an audit or review of the work process/equipment/area?  
• Was required care for the patient within the scope of the facility's mission, staff expertise and availability, technical and support service resources? |