MAIN PROCESS		PROCESS STEP		POSSIBLE FAILURE MODES	POSSIBLE CAUSES
I.	DETECTING AND APPROACHING A PERSON IN NEED OF HELP	I.1	Detecting a person in need of help	No detection occurs Detection occurs late	Human resource shortage High patient volume department Incomplete patient monitoring (either specialist/disease-specific/condition-specific) Unorganised patient monitoring Lack of equipment Devices not working properly Incorrect detection or assessment of monitoring parameters Carelessness, negligence Infrastructure features (architectureal design) Event occurs in an outlying location They do not think about potential sickness of realtives/workers Etc.
		I.2	Assess the site	Assessing does not take place Assessing is done incorrectly Assessing is done late	Lack of knowledge Lack of practice Stress situation
		I.3	Alert to secure the site	Alarm does not happen Alarm does not happen in the right way Alarm happens late Not alerting the right person	Lack of knowledge Lack of practice Stress situation
		I.4	Securing the site	Securing the site does not happen The site is not secured according to the relevant knowledge The site is not secured by a person with the right expertise	Lack of knowledge Lack of practice Stress situation

MAIN PROCESS	PROCESS STEP		POSSIBLE FAILURE MODES	POSSIBLE CAUSES
	II.1	**Testing responsiveness**	Tesing the responsiveness does not happen Assessment of responsiveness is incorrect (both ways) The examination process is unprofessional The testing is slow	Lack of knowledge about the performing and content of testing responsiveness Lack f knowledge about the assessment of signals Lack of practice Stress situation
	II.2	**Shouting for help**	The shouting for help does not happen The shouting for help is not timely (early or late) The shouting for help is not loud enoigh The shouting for help is not precise enough (attention, location, etc.) Direction of the shouting for help is incorrect The shouting for help has no recipient	Lack of knowledge about the content and performing of shouting for help Lack of practice Stress situation Noisy environment The physical limitations of the first responder (e.g. no or only a low voice) The first responder does not dare to shout Lack of knowledge about the local area Lack of nurse call, other signaling Infrastructure features
	II.3	**Patient positioning**	Patient positioning dos not happen Patient positioning is late Patient positioning is not done professionally (inappopriate position achieved or technique of execution)	Lack of knowledge about the performing andcontent of patient positioning Lack of practice Stress situation
	II.4	**Testing basic life functions**	Basic life functions are not assessed The assessment of the signals received is incorrect (in both direction) The assessment process is unprofessional The assessment is slow	Lack of knowledge about the performing and content of testing basic vital functions Lack f knowledge about the assessment of signals Lack of practice Stress situation
	II.5	**Detecting the arrival of a helper**	The arriving helper is not detected Misjudging the competence of the helper	Lack of practice Stress situation
	II.6	**Notification of professional staff**	Notification does not happen The notification is not timely (early or late) The notification is not loud enough The notification is not precise enough (attention, location, etc.) Direction of the notification is incorrect The notification has no recipient	Lack of knowledge about the correct way of indication, content and performing of notifying professional staff Lack of practice Stress situation Noisy environment Lack of knowledge about the local area Lack of nurse call, other signaling Infrastructure features
	II.7	**Assessing the need for one-minute CPR (adult/child)**	The assessment does not happen The assessment ends with an incorrect result The assessment is slow	Lack of knowledge about the content and performing of the assessment Lack of knowledge about the assessment of signals Lack of practice Stress situation
	II.8	**Starting the specific CPR**	Starting the specific CPR does not happen Starting the specific CPR is late The CPR is not professionally adequate: parts of the CPR or its execution are inappopriate Devices and materials for CPR are missing Devices and materials needed for CPR are inadequate	Lack of knowledge about the need and cases of starting resuscitation Lack of knowledge about the content, method and technique of performing resuscitation Lack of devices and materials needed for resuscitation Lack of regular monitoring of resuscitation equipment and materials
	II.9	**Accessing a team alerting device in case of a helper**	The team alerting device is not being accessed Accessing the team alerting device is late The team alerting device is not accessed in time	The alerting device is not known The place of the alerting device is not known The alerting device is not in place The correct procedure of resuscitation is not known

MAIN PROCESS		PROCESS STEP		POSSIBLE FAILURE MODES	POSSIBLE CAUSES
II.	STARTING CPR AND ALERTING THE TEAM	II.10	Accessing the team by the alerting device in case of a helper	The team is not being accessed Accessing the team is late Not the right person(s) is (are) accessed Not all persons to be alerted are accessed	The alarm call number/code/etc is not known The person to be alerted is busy The person to be alerted does not answer the call The alerting device is not in use (e.g. out of battery, switched off, etc.) The alerting device is at another person Noisy environment Overload Carelessness Misdialing the wrong number/code Stress situation Lack of practice
		II.11	Handover of the alarm message in case of a helper	The content of the alert message is incomplete A misunderstanding occurs during the handover The handover of the alarm message takes too long	Lack of knowledge of the content, method of the handover of the alarm message (articulation, volume, use of handover technique) Lack of practice Stress situation The alerting device is discharged or malfunctioning The handover of alarm message is interrupted Technical obsatcles make it difficult to receive the message (e.g. line chatter, low volume setting, etc.)
		II.12	Perfoming the one-minute resuscitation	The one-minute CPR does not happen The one-minute CPR is late The one-minute CPR is not professionally adequate: parts of the CPR or its execution are inappopriate Devices and materials for CPR are missing Devices and materials needed for CPR are inadequate	Lack of knowledge about the need and cases of starting one-minute CPR Lack of knowledge about the content, method and technique of performing resuscitation Lack of devices and materials needed for resuscitation Lack of regular monitoring of resuscitation equipment and materials
		II.13	Accessing a team alerting device in without a helper	The team alerting device is not being accessed Accessing the team alerting device is late The team alerting device is not accessed in time	The alerting device is not known The place of the alerting device is not known The alerting device is not in place The correct procedure of resuscitation is not known
		II.14	Accessing the team by the alerting device without a helper	The team is not being accessed Accessing the team is late Not the right person(s) is (are) accessed Not all persons to be alerted are accessed	The alarm call number/code/etc is not known The person to be alerted is busy The person to be alerted does not answer the call The alerting device is not in use (e.g. out of battery, switched off, etc.) The alerting device is at another person Noisy environment Overload Carelessness Misdialing the wrong number/code Stress situation Lack of practice
		II.15	Handover of the alarm message without a helper	The content of the alert message is incomplete A misunderstanding occurs during the handover The handover of the alarm message takes too long	Lack of knowledge of the content, method of the handover of the alarm message (articulation, volume, use of handover technique) Lack of practice Stress situation The alerting device is discharged or malfunctioning The handover of alarm message is interrupted Technical obsatcles make it difficult to receive the message (e.g. line chatter, low volume setting, etc.)
		II.16	Continuing the specific CPR	Continuing of CPR does not happen Continuing of CPR is late The CPR is not professionally adequate: parts of the CPR or its execution are inappopriate Devices and materials for CPR are missing Devices and materials needed for CPR are inadequate	Lack of knowledge about the need and cases of specific CPR Lack of knowledge about the content, method and technique of performing resuscitation Lack of devices and materials needed for resuscitation Lack of regular monitoring of resuscitation equipment and materials

MAIN PROCESS	PROCESS STEP		POSSIBLE FAILURE MODES	POSSIBLE CAUSES
	III.1	**Ensuring continuity of patient care in the department of CPR**	Continuity of patient care is not ensured Continuity of patient care is late Continuity of patient care is not provided according to professional standards Ensuring continuity of patient care is not based on department-specific care arrangements and options	Lack of knowledge about the local patient care process and protoxols Lack of knowledge about the local area and care management Lack of practice Stress situation There is no responsible person for ensuring the continuity of care in acut situations
	III.2	**Ensuring continuity of patient care in the department of the team**	Continuity of patient care is not ensured Continuity of patient care is late Continuity of patient care is not provided according to professional standards Ensuring continuity of patient care is not based on department-specific care arrangements and options	Lack of knowledge about the local patient care process and protocols Lack of knowledge about the local area and care management Lack of practice Stress situation There is no responsible person for ensuring the continuity of care in acut situations
	III.3	**Assembling of the resuscitation team**	The resuscitation team is not assembled The resuscitation team is assembled late The resuscitation team is not made up of the right people	The members of the actual resuscitation team are not assigned, the roles, responsibilities are not clear The team menbers are far apart Not all the team members have been notified The team members are carrying out patient care activities that cannot be stopped immediately Human resource shortage Inadequate communication between team members Stress situation Lack of practice
	III.4	**Deciding who and where to pick up the resuscitation bag/tray**	Decision on picking up the resuscitation bag/tray does not happen Decision on picking up the resuscitation bag/tray is late The result of the decision is incorrect	Lack of knowledge about the relevant tasks, responsibilities Lack of knowledge about the relevant resuscitation process Stress situation Lack of practice
	III.5	**Going of the resuscitation team to the scene**	The resuscitation team does not arrive at the scene The resuscitation team arrives at the scene late The resuscitation team does not arrive at the right scene	Physical barriers (e.g.: closed door) Infrastructural features (e.g.: pavilion system, number of floors, dim lighting, etc.) Lack of knowledge of the path to follow Incorrectly provided/received information about location Lack of knowledge about the local are The resuscitation site is too far away Resuscitation team member(s) receive late or inaccurate information about the location Stress situation Lack of practice

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III.	ARRIVING OF THE RESUSCITATION TEAM AND BAG TO THE SITE	III.6	Picking up the resuscitation bag/tray by the team	The bag/tray is not picked up The bag/tray is picked up late The bag/tray is not picked up with the correct contents	There is no bag The bag is in a bad condition (difficult to mobilise, e.g. torn handle, bad zipper, etc.) The content of the bag are inadequate: incomplete and/or unchecked (in terms of functionality, expiry dates, etc.) The location of the bag is unknown Access path is not known The bag cannot be accessed (e.g. it is in a locked cupboard, the key is not available) The bag is not in place Lack of knowledge about the local area Carelessness Stress situation Lack of practice Lack of knowledge about the relevant tasks, responsibilities
		III.7	Getting to the place of the resuscitation bag/tray	The storage space of bag/tray is not being accessed Accessing the storage space of the bag/tray is late There is no resuscitation bag/tray	They did not think to put together a bag/tray No bag/tray due to funding reasons No person responsible for assembly and ongoing maintenance of the bag/tray The location of the bag/tray is not known Lack of knowledge about the local area Access paths not known Communication problem in finding and identifying the place The bag/tray is not in place Stress situation Lack of practice
		III.8	Accessing the resuscitation bag/tray	The bag/tray is not being accessed The bag/tray is accessed late	The bag/tray is locked, the access way is unknown Access is otherwise physically blocked The bag/tray is not in place Stress situation Lack of practice
		III.9	Carrying the bag/tray to the site	The bag/tray does not arrive at the scene The bag/tray arrives at the scene late The bag/tray does not arrive at the right scene The bag/tray does not arrive at the scene with the correct contents	Physical barriers (e.g.: closed door) Infrastructural features (e.g.: pavilion system, number of floors, dim lighting, etc.) Lack of knowledge of the path to follow Incorrectly provided/received information about location Lack of knowledge about the local are The resuscitation site is too far away No person responsible for assembly and ongoing maintenance of the bag/tray Stress situation Lack of practice

MAIN PROCESS		PROCESS STEP		POSSIBLE FAILURE MODES	POSSIBLE CAUSES
IV.	ACTIVITY OF THE RESUSCITATION TEAM	IV.1	Performing the CPR by the team	CPR does not happen CPR is not performed professionally CPR is not performed usng the right equipments or materials CPR is not performed in time CPR is not carried out in the desired teamwork	Lack of knowledge about the proper procedure and technique of CPR Lack of practice Lack of relevant training Relevant training gaps: in relation to content, teaching methods, regularity, monitoring, target group No person responsible for assembly and ongoing maintenance of the bag/tray There is no bag/tray No appopriate devices, tools for all age groups Lack of human resources Funding reasons, difiiculties Team members do not know each others Team members' attitude is not appopriate Communication between team members is inadequate Team direction is inadequate Stress situation
		IV.2	Final checking for spontaneous return of circulation	Checking of the spontaneous return of the circulation does not happen The assessment of the signals received is incorrect (in both ways) The examination process is unprofessional The examination is not timely	Lack of knowledge about the checking of the spontaneous return of the circulation Lack of knowledge about the assessment of signals Lack of practice Stress situation
		IV.3	Stopping CPR	Stopping CPR is not done in time Stopping CPR is not done professionally	Lack of knowledge about the indications, method and content of stopping CPR Lack of clarity about the related decision-making competences Lack of practice Stress situation
		IV.4	Initiating care for the dead	The care for the dead is not initiated The care for the dead is not initiated in time The care for the dead is not performed according to the correct professional procedures The care for the dead is not performed by the correct staff	Lack of knowledge about the indications, method and content of care for the dead Lack of clarity about the related decision-making competences Lack of practice Stress situation
		IV.5	Performing postresuscitation treatment	Postresuscitation treatment is not performed The treatment is unprofessional The treatment is not initiated in time The treatment is not provided by the right professionals	Lack of knowledge about the indications, performing and content of postresuscitation treatment Lack of knowledge about the related competencies Lack of clarity about the related tasks, responsibilities Lack of practice Stress situation
		IV.6	Checking the status	Status is not checked The checking is unprofessional The assessment of the signals received is incorrect (in both directions) The checking is not timely The checking is not performed by the right professionals	Lack of knowledge about the role, the performing and the content of checking the status Lack of knowledge about the assessment of signals Lack of knowledge about the related competencies Lack of clarity about the related tasks, responsibilities Lack of practice Stress situation

MAIN PROCESS		PROCESS STEP		POSSIBLE FAILURE MODES	POSSIBLE CAUSES
		IV.7	**Determining the location of further care**	The location of further care is not determined The location of further care is determined late The location of further care is determined incorrectly The location of further care is not determined by the right professional	Lack of knowledge about the factors needed to determine the further place of care Lack of knowledge about care management Lack of knowledge about the local area Lack of clarity about the related tasks, responsibilities Lack of practice Stress situation
		IV.8	**Deciding on transport need**	Decision on transport need does not happen Decision on transport need happens late Decision on transport need is incorrect	Lack of knowledge about the factors of decision on transport needs Lack of knowledge about care management Lack of knowledge about the local area Lack of clarity about the related tasks, responsibilities Lack of practice Stress situation
		IV.9	**Organising transport**	Organisation of transport does not happen Organisation of transport happens late The transport is not organised according to the right place of destination The transport is not organised according to the patient's condition The patient is not properly prepared for transport	Lack of knowledge about the organisation of transport Lack of knowledge about the local area Lack of clarity about the related tasks, responsibilities Lack of knowledge about preparing the patient for transport Health resource shortage, overload Lack of devices (for transport and for its organisation) Stress, exhaustion
		IV.10	**Documenting the CPR**	Documenting the CPR does not happen CPR is not documented in the right place (in the right documents) CPR is documented late CPR is incompletely documented CPR is incorrectly documented	No procedures for documenting CPR Lack of knowledge about the documentation requirements and performing of CPR Lack of devices (for documentation) Access to device is blocked Poles, responsibilities for documenting resuscitation are unclear The required documentation forms are not available Human resource shortage Fatigue, stress, overload
		IV.11	**Handing over the patient**	Handover does not happen Handover happens late Handover is not performed in the right way Handover is incomplete Handover is incorrect (wrong information, different patient, etc.)	Patient handover is not structured Lack of knowledge about the content, method and channels of patient handover Lack of clarity about the tasks, responsibilities realted to patient handover Human resource shortage Fatigue, stress, overload Inappopriate attitude
V.	**POST-RESUSCITATION ACTIVITIES**	V.1	**Discussing the case**	No case discussion takes place The case discussion is not conducted according to the right principles (willingness to improve, identification of mistakes, honest atmosphere, professionalism, etc.) The case discussion is only held as a formality The case discussion is held late The case discussion is not attended by all the stakeholders	Case discussion is not considered important Lack of knowledge about the significance, content, purpose, process and performing of case discussion Lack of interest Incorrect attitude Punitive culture Human resource shortage Fatigue, stress, overload
		V.2	**Team care**	Team care does not take place Team care happens late Team members are not involved in the process Team care is not professional	Team care is not considered important Lack of knowledge about the significance, content, purpose, process and performing of team care Lack of interest Incorrect attitude Human resource shortage Fatigue, stress, overload
		V.3	**Organising the replacement of team members**	Team members are not replaced Replacement is late Replacement of team membrs is not carried out according to the professional expectations Replacement of team membrs is not carried out according to the care procedures and possibilities specific to the department	Lack of knowledge about the local patient care process and protocols Lack of knowledge about the local area and care management Lack of practice Stress situation There is no responsible person for ensuring the continuity of care in acut situations