Hounslow and Richmond Community Healthcare NHS Trust

TITLE: **Learning from Deaths Policy**

VALID FROM: **February 2018**

END DATE: **January 2020**

This is a new procedural document

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Review date: 2 years maximum for clinical guidelines 3 years maximum for other documents	January 2020 (The timescale reflects the changing nature of guidance in this area)
Target audience	All clinical, management and supporting administrative staff

Version Control Sheet

Version	Date	Author	Status	Comments
1	August 2017	Dr Tony Snell	Draft	Sent to stakeholders for comment
1.1	September 2017	Dr Tony Snell	Draft	Feedback from QSC and QGC
1.2	September 2017	Patricia Wright and Donna Lamb	Draft	Feedback from Executive Committee
2.0	September 2017	Dr Tony Snell	Final	
2.1	October 2017	Dr Tony Snell		Following feedback from the Mortality Review Group
2.2	January 2018	Dr Tony Snell		Slight change to wording on page 13 of policy as agreed by that Mortality Review group on 12 December 2017
2.3	February 2018	Therese Singh	Draft	

CONTENTS:

1. Introduction

Last year 495,309 deaths were registered in England. Of these, 232,442 (47%) people died in hospital, with even more dying while receiving services provided by NHS trusts as an outpatient or from community services. Recent investigations and reports have highlighted the importance of reviewing how care is delivered to dying people including the experience of their family and carers.

2. Aims and objectives

2.1 This policy is aligned to NHSI's 'National Guidance on Learning from Deaths', published in March 2017 which states, 'community trusts should ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trust should also ensure that they share and act upon any learning derived from these processes.'

2.2 The principle objectives of learning from deaths are:

- All deaths are appropriately reviewed to assess if there is potential for organisation learning
- All deaths are reviewed using the agreed organisational screening tool by senior registered clinicians and a subset of these reviews will require additional investigation.
- The review and investigation of deaths will adopt principles of openness and transparency, and learning rather than blame.
- The review and investigation of deaths will include the involvement of families and those close to the deceased where this is possible and appropriate. This includes (but is not limited to) our duty of candour.
- Learning from deaths is a key priority for the Trust Board, with an identified senior clinical executive and non- executive lead.

3. Definitions and explanation of any terms used.

- Mortality Review –The process of reviewing the quality of care and assessing if the incident of patient death was avoidable.
- Patient Safety Incident -Any healthcare related event that was unintended, unexpected and undesired and which could have or did cause harm to patients as defined in the Serious Incident Policy (which is available on the Policies and Procedures pages of the HRCH Intranet).
- Serious Incident -Is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:
  - Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
  - Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
  - A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/ organisational information, damage to property, reputation or the environment, or IT failure; Allegations of abuse; adverse media coverage or public concern about the organisation or the wider NHS; One of the core set of Never Events defined by the National Patient Safety Agency (NPSA) as 'a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'. The NPSA maintained and published a list of never

events: http://www.nrls.npsa.nhs.uk/resources/ (from 2015 the revised Never Events Policy and Framework is the responsibility of NHSI)

- Serious Incidents are subject to more rigorous scrutiny in terms of reporting, investigation and learning. They are reported on the Strategic Executive Information System (STEIS) which is a national system that enables electronic logging, tracking and reporting of SIs. When an incident is entered on STEIS it alerts NHS England who manage the system. The commissioning body of the service where the incident happened also have access, as do the CQC.
- Duty of Candour is defined in The Francis report: "The volunteering of all Candour relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."
- Being Open Described by the National Patient Safety Agency in 2009 as discussing patient safety incidents promptly, fully and compassionately' adding that this 'can help patient and professionals to cope better with the after effects".

4. Policy - Learning from Deaths

4.1 For all patients who die whilst in the care of HRCH:

- Community contacts range from seeing one Health Care Professional, (HCP), once every few months to weekly or even daily contact with a range of Health Care Professionals. Community patients will also be receiving services from their GP and primary care team and may be receiving care from other NHS and non NHS providers in the region.
- The focus of the mortality review for community teams should be based on the care the patient received from HRCH.
- Whilst undertaking the review, the reviewing team may observe issues that might have led to an avoidable death by another provider; these should be reported on the Trust's (Datix) Incident reporting system.
- All reviews of mortality must be reviewed against the Trust's policies and procedures and be completed at the next multidisciplinary team or within one month of the patient death, but before the patient's physical notes are removed, where physical notes are still in use
- HRCH will consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death - for example, for older people with dementia and frailty receiving frequent input from their GP and from community mental health nurses.
- The review and investigation of deaths will adopt principles of openness and transparency, and learning rather than blame.
- The reviewers to determine and inform any service within the organisation about the death and any other organisation who may have an interest, including the deceased person's GP.

4.2 Involvement of Families

- The review and investigation of deaths will include the involvement of families and those close to the deceased where this is possible and appropriate.
- The Trust is committed to the involvement of families and carers when reviewing or investigating the circumstances that lead to a death, and in any learning that results from that investigation. This includes (but is not limited to) our duty of candour.
- Duty of candour should include informing the family/carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Initial contact with families/carers is often managed by the clinicians responsible for the care of the patient. Consideration is to be given as to whether an independent third party should undertake this role.

- Offer guidance, where appropriate, on obtaining legal advice for families, carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by providers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates.

- Bereaved families and carers:

    - should be treated as equal partners following a bereavement
    - must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
    - should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
    - should be informed of their right to raise concerns about the quality of care provided to their loved one
    - views should help to inform decisions about whether a review or investigation is needed;
    - should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
    - should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
    - who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to.

4.3 **Learning from Deaths**

- The Trust will adopt a proactive, proportionate approach to learning from mortality across the services delivered by the Trust. The Trust uses a mortality review tool that has been adapted for HRCH.

- The policy should be read alongside the Serious Incident Policy.

- All mortality reviews will be discussed in the mortality review group, quarterly. The discussion will focus on individual cases, seek to identify learning points, consider any changes required, and actively promote engagement with families and carers.

- The number of deaths and the proportion of reviews carried out will be: reported to the Board at the public section of the meeting; incorporated into the monthly performance reports with data suitably anonymised; and learning outputs from the mortality governance process, having been reviewed by the mortality review group quarterly will be reported through the medical director's report to the Board.

- The Medical Director will be accountable for reporting back the result of the more in-depth reviews and any themes that emerge from the broader organisational discussions. All inpatient deaths and deaths of patients in the community meeting the criteria described below will be screened and reviewed using the Mortality Review template. These reviews will consider opportunities for learning and the conclusions shared with the Quality Improvement team for further dissemination across the Trust and or externally. The deaths of patients with learning disability will be investigated as per the LeDeR programme (see below) and any learning disseminated across the service and organisation.

- HRCH will attempt to arrange joint case record reviews or investigations for patients where more than one organisation is routinely providing care at the time of death for example, for older people with dementia and frailty receiving frequent input from their GP and community mental health nurses.

- A process of analysis and learning then follows, whether this is as part of wider system external review processes, or through our own internal processes.

- Any learning from deaths is fed back via Ops Governance and unit meetings. Community nursing through team meetings to disseminate through to teams. The RRRT and ICRS through their governance meetings. Adult Specialist services through QSC to all Service Governance leads via an annual analysis of any potential themes".

5. Duties

- The Trust Board has overall responsibility for ensuring compliance with all legal, statutory, best practice including having an overview of this mortality review process and has knowledge of the learning that emerges from the reviews that drive improvements to care.
- The Chief Executive has ultimate responsibility for ensuring that the Trust has robust policies and procedures in place for reviewing all incidents of mortality.
- The Chairperson of HRCH is the identified non-executive lead for overseeing the implementation of the National Guidance.
- The Medical Director is responsible for ensuring that there is a comprehensive mortality policy, ensuring that all incidents of mortality are appropriately reviewed and where required appropriate actions are taken and learning disseminated.
- The Governance Manager is responsible for ensuring there are arrangements for reviewing all incidents of patient mortality and for working with team leaders to ensure reviews are completed.
- Service Managers must make arrangements for case notes to be reviewed.
- All staff must inform their service manager when it comes to their attention that a patient has died in order for the team leader to make arrangements to commence the mortality review process, where appropriate.

6. Consultation Process

- The following stakeholders were consulted in the creation of this policy and comments incorporated as appropriate:
  - Performance Executive Committee
  - Executive Team Meeting
  - Quality and Safety Committee
  - Quality Governance Committee
  - Trust Board

7. Approval and Ratification Process

The final draft of this policy was sent to the Performance Executive Committee on 15 August 2017, Quality & Safety Committee on 4 September 2017, the Executive Committee on 18 September 2017 and was approved at the Trust Board on 27 September 2017.

Final approval was given on 28 September 2017 through PRG Chair's action which will be confirmed by the Policy Ratification Group (PRG) on 17 October 2017.

8. Dissemination and Implementation

This document will be placed on the intranet by the Quality team. It will be therefore be available to all staff via the Trust intranet. Furthermore

The document will be circulated to all managers who will be required to cascade the information to members of their teams and to confirm receipt of the procedure and destruction of previous procedures/policies which this supersedes. Managers will ensure that all staff are briefed on its contents and on what it means for them.

The communications department will be asked to communicate a summary of the key issues to all staff.

9. Archiving

The QCE team will undertake the archiving arrangements.

10. Training requirements

Specific training will be provided for staff involved in the screening and review process referred to in appendix C.

11. Monitoring and Auditing Compliance with the Procedural Document

A full compliance monitoring table is provided at appendix A

12. Review arrangements

This procedural document will be reviewed in 6 month's time (April 2018). It will be reviewed by the Medical Director. Changes will be made earlier if the learning from the process suggests it should be.

13 References

National Guidance on Learning from Deaths. National Quality Board March 2017
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning- from-deaths.pdf

14. Associated Documentation

1. Mortality: Quality of Care Review Template tool (Appendix C)
2. Mortality: Case Note Review document (Appendix D)
3. Duty of Candour (Being Open) Policy
4. Serious Incident Reporting Policy and Procedure
5. Verification of Death policy

15. Appendices

Appendix A - Monitoring and compliance tool.
Appendix B - Equality impact assessment tool
Appendix C - Process for identifying deaths, arranging screening and reviews
Appendix D - Mortality: Quality of Care Review Template tool
Appendix E - Mortality: Case Note Review document
Appendix F - HRCH Mortality Review Algorithm

Appendix A

Compliance Monitoring Table

Element to be monitored *Which aspect of the policy will you monitor?*	**Lead**	**How Trust will monitor compliance** *For example via an audit or the use of data*	**Frequency of monitoring**	**Reporting arrangements** *Which committee will the audit be reported to*
Mortality Review data and learning. Dissemination of any learning	Dr Tony Snell	Scrutiny and assurance at the Quality Governance Committee	Quarterly Annual	Quality and Safety Committee Report by Medical Director to Board Annual report by Medical Director to Board

Appendix B

Equalities Impact Assessment Pro Forma

Learning from Deaths Policy

Manager's name	Dr Tony Snell
Directorate	Corporate
Date	17 August 2017
Function, strategy, policy or service	Policy
Main aims, purpose and outcomes of the function, strategy, policy, service or work	Learning from deaths of patients on our caseload
How will these aims affect our statutory duty to: 1. Advance equality of opportunity? 2. Eliminate unlawful discrimination, harassment and victimisation? 3. Foster good relations between different groups? 4. Protect and promote human rights?	 NA Any evidence of this may show in any mortality investigation NA Any evidence of this may show in any mortality investigation
Associated frameworks/NHS Operating Framework mention e.g. national targets NSFs	National Guidance on Learning from Deaths, published in March 2017
Who does it affect? *e.g. staff, patients, carers*	Patients, staff, families, carers
Engagement and consultation process carried out *(state who was involved, how and when they were engaged and the key feedback)*	Performance and Executive Committee 15 August 2017 Trust Board 27 September 2017
What aspects of the policy, including how it is delivered, or accessed, could contribute to inequality?	Learning from deaths may demonstrate inequalities in care
What different needs, experiences or attitudes are particular communities or groups likely to have in relation to this policy?	Some individuals or ethnic groups may have negative attitudes to being asked to participate in any review post mortem

Please complete the screening assessment grid below for equality groups listed within the Equality Act (2010) and highlight the evidence underlying your assessment.

Equality group	**Positive impact**	**Neutral impact**	**Negative impact**	**Reason/comment/evidence/ necessary action planning following equality analysis screening**
Age *Consider and detail (including any source of evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*	Families/carers may feel positive about being involved or receiving a report into the mortality investigation			National Guidance on Learning from Deaths', published in March 2017
Disability *Consider and detail on attitudinal, physical and social barriers.*		x		
Gender Reassignment *Consider impact on transgender and transsexual people. This can include issues such as privacy of data and harassment.*		x		
Marriage and civil partnership		x		
Pregnancy and maternity *Consider and detail on working arrangements, part-time working, infant caring responsibilities*		x		
Race *Consider and detail on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*		x		

Religion/belief (including lack of belief) *Consider and detail) on people with different religions, beliefs or no belief.*		x		
Sex (i.e. gender) *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*		x		.
Sexual Orientation *Consider and detail) on heterosexual people as well as lesbian, gay and bi-sexual people*		x		
Others *(e.g. carers, homeless people, sex workers)*		x		

Appendix C

Process for identifying deaths, arranging screening and reviews:

- The following processes do not apply to patients with Learning Difficulties. A separate process is described later.

- All unexpected deaths will be logged on Datix immediately - the Datix entry to include the outcome of the screening review- i.e. case closed or further in-depth review carried out Datix. All deaths to be to be recorded on Datix with discharged reason as "death".

- Datix will add a field that asks whether the patient who has died had an on-going mental health issue.

- The review template to be put on to SystmOne in an appropriate area to capture whether reviews take place and that the family have been notified; GP to be sent a copy of discharge note and cause of death.

- Acute hospital to be advised if death within 30 days of discharge from that hospital and that a review needs to take place.

- If categorised as a potential SI the unexpected deaths will follow the Trust's SI process. The service notifies the death to the patient safety team and an SI panel is convened within 48 hours from the time services became aware of the death.

- If the SI panel agrees that the death is an SI – then an investigation will proceed as per current Policy.

- The service also commences the Mortality Review process using the Mortality Tool and notifies the family that a review is under way.

- The Mortality tool will be used in all cases and will supplement other SI documentation, NOT replace it, NOR be replaced by it.

- All reviews of mortality must follow the Trust's policies and procedures and be completed at the next multidisciplinary team or within one month of the patient death, but before the patient's physical notes are removed, where physical notes are still in use.

- This screening and any subsequent reviews will be undertaken by 2 senior registered HCPs, one of whom must minimally work at a band 7. In circumstances where a band 6 is working as a service leader or deputy ward manger, this role can be delegated to a band 6 by a clinical manager. The output of these reviews will be periodically reviewed by the Clinical Governance Manager to ensure suitable levels of objectivity. Further training will be required for these staff members (see Training).

- If problems were identified or the death was thought to be avoidable the screener would alert the Medical Director who would be expected to carry out the detailed review that sits within the Mortality Review template.

- The output of the screening is reported weekly to the Clinical Governance Manager. Any screening that identifies that a more in-depth review is required is to

be carried out by the Medical Director. These reviews will include whether there is a need for further investigation via the SI process.

- Timescales for the preparation of the Mortality Review process:
  - A week for completing of quality of care review template
  - 30 days for the case note review
  - Monthly to QSC
  - Quarterly to QGC and Board
  - Yearly Annual Report

The following section sets out operating principles for all the services within HRCH.

Adults Services

- All deaths of patients in our inpatient care or who have been recently discharged within 30 days are to be screened once the service becomes aware of the death.

- All deaths occurring while services were being provided in the carrying on of a regulated activity or have, or may have, resulted from the carrying on of a regulated activity (e.g. wrong dose of medication given) are to be screened once the service becomes aware of the death. (These deaths would be reportable to CQC)

- In addition to the mandatory list above the Trust intends taking a pragmatic approach to identifying other groups that would require review. This list is not exhaustive and may be added to at any time and does not exclude other examples or events. Front line clinicians and managers need to identify any case that might warrant review and where learning would be beneficial;

  Cases on the adult caseload where:
  - there is any concern that management could have been better compared to what we would expect for a relation of our own.
  - the GP, pharmacist or any other relevant health professional requests a review
  - patient family or friend raise issues or concerns
  - individual members of clinical team wish for a review to take place

- The Trust has determined that it will record the total number of deaths across the service that were currently on the services caseload, where we are informed of the death. These deaths may be entirely unrelated to the services the Trust provide, e.g. road traffic accident, deaths from unrelated causes, e.g. stroke in a wound management patient, etc. On reviewing this data in twelve months' time, the Trust will determine the workload resource associated with screening and reviewing these cases and what, if any, learning would be achieved by doing so.

- All deaths are reviewed via the mortality screening process (Appendix D) and reviewed using Mortality Review tool (Appendix E)

- If a patient who is under our care dies within 30 days of being discharged from an acute hospital, the Trust will notify the provider that the patient has died, as the provider may wish to report and investigate the death through their own mortality reporting system. However, the Trust will undertake case record review in accordance with the above criteria. Any learning which relates to the transition of care will be shared with the hospital provider

Palliative / End of life care

- All expected deaths in patients who have been receiving end of life care in the community setting are not part of this policy unless they meet the criteria set out in section 4.2. A sample of 25% of all expected deaths in patients who have been receiving end of life care in the community are audited through the Trust audit process

Children and Families

- All child deaths are recorded on the Trust incident reporting system (Datix) at the time the service becomes aware of the death. If a child death occurs and the child/young person is not known to HRCH children's services, the safeguarding nurses will report this on the Trust incident reporting system.

- A process of analysis and learning then follows, whether this is as part of wider system external review processes, or through our own internal processes. Our processes are designed to complement the inter-agency Child Death Overview Panel (CDOP) processes, including the Serious Case Review process

Adults with Learning Disabilities

- HRCH participates with the LeDeR programme which is an established and well-tested methodology for reviewing the deaths of people with learning disabilities.

- All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

- The standardised review process involves discussing the circumstances leading up to the person's death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

- A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. A full multi-agency review is recommended if there have been any concerns raised about the death, if any 'red flag alerts' have been identified in the initial review, or if the reviewer thinks that a full multi-agency review would be appropriate. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

- The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes. This enables an integrated approach to initial reviews of deaths of people with learning disabilities to be taken whenever possible, so as to avoid unnecessary duplication but ensure

that the specific focus of the different review or investigation processes is maintained. The reviews, once completed would be reported through the trust's mortality review group and reported to the Board six monthly and an annual Board summary report.

- Hounslow CCG is the lead agency for ensuring that a local mortality review group is in place for reviewing the deaths of adults with learning disabilities who are registered patients with their GP practices.

- Due to current commissioning arrangements, HRCH provides specialist Community Learning Disability Services to people who are registered with Hounslow CCG GP practices. The Trust is therefore a member of the CCG led, Hounslow learning disabilities mortality review group, where representation is made up by other local NHS Trusts and the London Borough of Hounslow who deliver services to/or support people.

- Hounslow CCG holds responsibility for being the 'local area contact' and they will allocate two 'reviewers' to each case who in turn, will follow the established LeDeR reviewer process.

Clinical staff from the Hounslow Community Learning Disability Team (CLDT) when allocated, will act as an LeDeR Reviewer and follow the established reviewer process.

- In addition, the Trust provides a range of community health services within the locality to which people with learning disabilities may access. The Trust will ensure that if required or called upon, its health care professionals (HCPs) will contribute to the wider LeDeR process in a supporting role (if required) by making the necessary information and clinical personnel available to the LeDeR case reviewers

- Hounslow CCG, as the lead organisation, will ensure that any learning from/or emerging themes are disseminated to the local health and social care economy to ensure that all learning is shared and any changes made are embedded locally.

- Hounslow CCG will also report to the Hounslow Safeguarding Adults Board on a six monthly basis any findings to date and will advise the board what local actions have been taken. The CCG will also report to a subcommittee of the CWHEE Collaborative with the same information, who in turn with give assurance to NHSE centrally.

- Richmond CCG is the lead agency for ensuring that a local mortality review group is in place for reviewing the deaths of adults with learning disabilities who are registered patients with their GP practices.

- Richmond CCG holds responsibility for being the 'local area contact' and they will allocate two 'reviewers' to each case who in turn, will follow the established LeDeR reviewer processes.

- Due to current commissioning arrangements, HRCH does not provide specialist Community Learning Disability Services to people who are registered with Richmond CCG GP practices. However, the Trust does provide a range of community health services within the locality to which people with learning disabilities may access. The Trust will ensure that if required or called upon, its health care professionals (HCPs) will contribute to the wider LeDeR process in a supporting role (if required) by making the necessary information and clinical personnel available to the LeDeR case reviewers

Appendix D - Mortality: Quality of Care Review Template tool

Hounslow and Richmond Community Healthcare NHS Trust

Mortality - Quality of care review template[1]

This template is to be completed for all deaths on the community caseload (within 1 week of the patient's death)		
Date of Review		
Name of Reviewer and role		
Place of death and location		
Patient's Name		
Date of Birth		
Sex M/F		
Admission to caseload Date		
Reason for Admission (eg wound care, EOL etc)		
Date of Death		
Duration on caseload (in days)		
Was this death Expected or Unexpected. (See definition in guidance below)	(Note: If the death was unexpected then you must report it as an SI)	SI STEIS number
Cause of Death (from Death Certificate)		

"Mortality - Quality of care review template".					
Quality Domain				Total	Notes (please add details where appropriate)

[1] The **screening template** is intended to identify any evidence where the care of the patient may have been sub-optimal. The Trust Development Authority provide no definition of sub-optimal care. The TMH Mortality Working Group (at a meeting on 20th March 2014) determined that all patients should receive quality care whilst in TMH. If for any reason they do not receive quality care then that may signify that their care was 'sub-optimal' and this is the definition that the template supports.

Patient Safety	Were there any Datix Incident or Serious Incident reports in relation to this patient during their admission?	Yes = 1	No = 0		(Include Datix numbers) and brief details.
	Did the patient have a healthcare associated infection, acquired within HRCH? (# e.g. C. diff, ESBL, MRSA, MRA, VRE etc)	Yes = 1	No = 0		
	Did the patient develop an avoidable pressure ulcer or was there deterioration in a pressure ulcer during admission? (this should be recorded as an incident but check notes)	Yes = 1	No =0		
	Was the Malnutrition Universal Screening Tool (MUST) completed on admission?	Yes = 0	No = 1		
	Were the MUST management guidelines followed where appropriate?	Yes = 0	No = 1		
	Was the Waterlow Score completed on admission	Yes = 0	No =1		
Clinical Effectiveness	Was there a clear care plan for all aspects of care identified during assessment?	Yes = 0	No = 1		
	Did the patient's overall condition deteriorate while on the caseload?	Yes (as expected) = 0 Yes (this was unexpected) = 1	No = 0		
	Was the essential observation chart completed on admission?	Yes = 0	No = 1		
	Was the NEWS score (National Early Warning score) over >1	Yes = 1	No = 0		
	Was the care plan adhered to and clearly documented?	Yes = 0	No = 1		

Patient Experience	Any complaints or PALS made by patient or their relatives in relation to the care of the patient at any time during their stay?	Yes = 1	No = 0		(Include Datix reference numbers)
	Did the patient's representatives have any feedback about the patient's treatment or experience whilst on the caseload?	Yes = 1 (if has raised a concern)	No = 0		(Were they asked?)
			TOTAL		

During the process of completing this template were there any other issues, apart from those listed above that gave cause for concern or were below the standard expected? If yes then please list below. (Please add additional notes if needed). See guidelines.

1.
2.
3.

Examples of best practice / good care:

Where the total is ≥ 1 then a full case note review should take place to present at the Mortality Review Group. Please complete the Mortality case note review document.

 # *Clostridium difficile*, ESBL (Extended Spectrum Beta Lactamases), MRSA (Meticillin resistant *Staphylococcus aureus*), MRA (Multiple Drug Resistant *Acinetobacter* spp), VRE (Vancomycin-Resistant Enterococci)

NB. Patient falls, medication errors etc should all be captured in the incident reporting.

Guidance Notes

1. The practitioner completing the template should be the senior nurse in the team.
2. **Unexpected Death** is defined (Policy & Procedure for the verification of expected death for adults by registered nurses; para 3.2) as "any death not due to a terminal illness or a death that the family were not expecting. It also applies to patients where the medical

practitioner has not attended within the previous 14 days." All unexpected deaths should be reported as a Serious Incident (SI) and a comprehensive investigation is carried out with a root cause analysis.

3. If following completion of the template a score of 1 or more is obtained then a full review of the case notes must be undertaken by the senior member of the medical or nursing staff.
4. Following the 'case note review', the reviewer should highlight any issues not previously identified and present a report to the Mortality Review Group for discussion

Appendix E - Mortality: Case Note Review document

Form B
Case Note Review document

Hounslow and Richmond Community Healthcare NHS Trust

HRCH Mortality: Case Note Review document

IMPORTANT: This document should be completed following the completion of the **HRCH Mortality: Quality of care review template** where the total score is ≥ 1 or, if during the completion of that template any issues gave cause for concern or were below the standard expected.

This case note review should be undertaken by a Senior member of the Medical or Nursing Staff.

The purpose of this process is to highlight any circumstances or events where the care of the patient fell below an acceptable standard. The reviewer should keep in mind the mission of HRCH - Did the care that was given to this patient meet our mission, to provide care and services that we and our families would want to use?

The Case Note Review should be undertaken in two steps.

Step 1.

Before completing the document, ensure you have all of the available documentation related to the admission.

- **All inpatient documentation including medical, nursing and therapy records**
- **Any GP referral letters or Acute transfer documentation related to the admission.**

Step 2.

- **Follow through the patient's progress from their admission to their death and consider if appropriate actions were taken along the patient's journey. Be open minded and take a holistic view of the care given to the patient.**
- **Use the 'Options for problems table' as a prompt to identify any 'problems in healthcare' (Attached at Appendix 1)**

Date of Review	
Name of Reviewer and role	
Place of death and location	
Patient's Name	
Date of Birth	
Sex M/F	
Admission Date	
Date of Death	
Duration on caseload (in days)	
Cause of Death (from Death Certificate)	
Family advised of review and date	

Please summarise in chronological order the background details of the admission, events leading up to the patient's death and cause of death, including any points where you have identified any problems in healthcare.

Background

Purpose of admission

Details of admission

Events leading to patient's death

Was the patient treated in the right place at the right time by the right person?

Please complete the following table

- **A problem in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard'.** To identify the **problems in healthcare,** consider what an acceptable standard of healthcare would be for this patient, and articulate how the healthcare they received fell below this acceptable standard (whether through omission, delay or incorrect actions). Include any problems in healthcare that occurred before the patient's final admission but were identified during it. **Only one problem should be entered per row.**
- It can be difficult to identify **contributory factors** (i.e. the underlying reasons ***why*** the problem in healthcare occurred) from case notes alone. If you can clearly identify any factors that contributed to each problem in healthcare please do so, but avoid making assumptions. **Contributory factor should refer to the problem described in the same row.**

Describe each problem in care in your own words. Please articulate what should have happened AND what did happen.
Example: "First dose of IV penicillin should have been given immediately but was not given until three hours after prescribed"

Mortality Review Group Discussion:-

Please summarise the outcomes of this review and the lessons that need to be taken forward into actions:

Patient initials and DOB

Issue identified for discussion in MRG	Discussion at MRG	Action required following MRG and by who	Update / Statement / Explanation / Information	Learning from this action at Mortality Review Group

Areas of good practice identified:

Using the following classification, the MRG should determine which category applies to the care this patient received

NCEPOD:
1 = Good practice: A standard that you would accept from yourself, your trainees and your institution.
2 = Room for improvement: Aspects of clinical care that could have been better.
3 = Room for improvement: Aspects of organisational care that could have been better.
4 = Room for improvement: Aspects of both clinical and organisational care that could have been better.
5 = Less than satisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.

Outcome and reasons for this decision:
(To be completed when MRG agree rating above)

Family notified of review with findings and date

Appendix F - HRCH Mortality Review Algorithm