The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Learning from Deaths Policy

Primary Intranet Location	Version Number	Next Review Year	Next Review Month
Trustwide	2	2020	Mar

Current Author	Trudy Taylor
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Department	Operations
Approved by	Clinical Governance
Date	04/02/19
Ratifying / Monitoring Committee	Trust Executive Committee
Ratified Date	05/02/19
Owner	Nick Lyons
Owner's Job Title	Medical Director

It is the responsibility of the staff member accessing this document to ensure that they are always reading the most up to date version - this will always be the version on the intranet

Related Policies and Procedures	Procedures to follow in the event of adult patient death Guidance for Doctors completing MCCD Nov 2013 Verification of Death 2013 10 Lessons Learnt Policy 2020 01 Openness and Candour Policy and Procedure V2 2020 08

	Deceased and Bereaved 2018 05 Policy for Dealing with Death in Theatre v2 2020 08 Mortuary Viewing Policy v3 2020 12 Maternal Death Care of the Dying Baby Death of a Child or Young Person Diagnosis and Management of Intra-Uterine Fetal Death When a baby dies booklet Guidelines for Supervisors of Midwives on Maternal Death Quick reference guide on the products of conception Disposal of Fetal Tissue Palliative Care Guidelines Organ Donation policy

Stakeholders	The Chaplaincy team All healthcare professionals involved in direct patient care The Mortuary department The Coroner PALS department

Version	Date	Author	Author's Job Title	Changes
V1	01/9/2017	Trudy Taylor	Head of Business Support	Initial development
V2	04/02/2019	Trudy Taylor	Head of Business Support	Update

Summary of the guidance
This document outlines the Trust's policy on learning from deaths

Key words to assist the search engine
Learning from deaths, mortality surveillance group,

CONTENTS

Learning from Deaths Policy

1 INTRODUCTION

The Trust is required to demonstrate how it responds to, and learns from, deaths of people who die while in our care. Our aim is to continue to build upon an open and transparent culture by developing our mortality governance so that our staff are supported to review and learn from deaths and then take effective action to make improvements. We recognise that we cannot do this alone And that we need the support of our community to help us in providing us with feedback. We also need the wider health and social care system to work with us in developing the system wide capacity to work together when it is necessary to do so. This document describes our agreed approach. In addition to the process and reference documents described here, all staff and stakeholders should demonstrate commitment to our quality objectives and overarching governance pertaining to; Serious Incident Reporting, Duty of candour, End of life care, Care of the Bereaved, and all other related policies.
Once we have launched this document and established the processes, we will adopt a continuous improvement approach to implementing it.

1.1 Background

Concern about patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures that have taken place over the last few years. There is an increased drive for NHS Trust boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

In March 2017, the National Quality Board issued a guidance document which sets out the framework for NHS Foundation Trusts. In the foreword, it states;

"Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This policy is our response to the publication of this framework.

We intend to use the four levels of scrutiny that we can apply to the care provided when someone dies. These are;

1. Review of Death Certificates
2. Initial screening
3. Case Record Reviews
4. Recommendations from investigations using the serious incident framework.

We are keen to implement a standardised approach to help us identify learning and make improvements in collaboration with our staff and patients and the wider system.

1.2 Scope

This policy and supporting processes applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

This policy provides a method of implementing national guidance for learning from deaths and whilst the cases will span clinical specialties, the case note reviews are distinct from any specialty reviews which are undertaken by clinicians for the purpose of education and outcomes of care. Therefore it is likely that specialty groups may still wish to meet to discuss cases, however, this does not preclude the requirement for the clinical staff to complete a Mortality Review as per this policy.

It is intended that as our process embeds and matures that we will become adept at undertaking multidisciplinary reviews where senior nurses and others will be expected to make judgements on the overall quality of nursing care and patient experience using the agreed methodology that follows.

It will be applied to all adult in-hospital deaths defined as 'in scope' and work will commence with our partners to better understand deaths occurring within 30 days of discharge.

Other groups

Maternal deaths and deaths of children and young people under the age of 18 years are governed by the principles in this policy and we will continue to use our current processes to review each death. Learning and outcomes of these reviews will be shared with the Mortality Surveillance Group via a formal report.

When a child dies unexpectedly we will follow the Sudden Unexpected Death of an Infant or Child policy, contacting the police, the coroner, the safeguarding team and social services. For all child deaths we will contact the GP, the NHS safeguarding Team, community child health, named safeguarding lead (community) and the child death overview panel.

The Learning Disabilities Mortality Review (LeDeR) Programme for reviewing deaths in people with learning disabilities will be implemented alongside this policy. It is important to note that current guidance clearly states that there is an expectation that the organisation will continue to review deaths in this cohort of our population in accordance with local arrangements.

Scope of case note reviews

The following cases will be selected for review and these will be referred to as 'in scope' in board reports and other documents.

- All deaths where bereaved families and carers, or staff, have raised a concern about the quality of care provision. This to include intelligence from the safeguard modules for complaints and PALS.
- All inpatient deaths of those with a learning disability.
- All deaths in a service specialty, diagnosis or treatment group where an 'alert' has been raised. The inclusion criteria will be agreed with the Mortality Surveillance Group and reviewed on a monthly basis.
- All deaths under the care of a consultant Cardiologist
- All deaths under the care of a consultant Haematologist
- All deaths under the care of a consultant Oncologist
- All deaths in ITU
- Deaths where learning will inform our existing or planned improvement work.
- A further sample of deaths that do not fit the identified categories so that we can take an overview of where learning and improvement is needed most overall

Existing arrangements in Paediatrics and Maternity will be maintained.

1.3 Monitoring and Review

It will be necessary to monitor the impact of the process of the activity of the Business Unit Mortality Groups as it may need to evolve further.

This policy will be on a 3-year cycle for review.

The following people/groups have been consulted on this document and final sign off will be via the Medical Director using the trust approved process.

Non Executive Director
Head of Risk and Governance
Assistant Medical Directors
Director of Nursing
Divisional Operational Directors
Mortality Surveillance Group Members and Chair
Clinical Directors
Head of Midwifery and Gynaecology
Lead Clinician Paediatrics

Learning Disability Liaison Nurse

1.4 Trust Values

This Policy conforms to the Trust's values, caring well by providing compassionate care; providing dignity and respect for others at all times especially at the end of life; acting well and listening well, doing everything openly and honestly. The Policy incorporates these values throughout and an Equality Impact Assessment is completed to ensure this has occurred.

1.5 Glossary

The following terms and abbreviations have been used within this Policy:

Term Definition MSG Mortality Surveillance Group

2.0 PURPOSE AND SCOPE

2.1 Policy Objectives

The Queen Elizabeth Hospital will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedure for identifying, recording, reviewing and investigating the deaths of people in the care of The Queen Elizabeth Hospital.

It describes how The Queen Elizabeth Hospital will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust's care.

It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read with: Procedure following the death of an adult patient final version for Intranet June 2015; Guidance for Doctors completing MCCD Nov 2013; Verification of Death 2013 10; Deceased and Bereaved 2018 05; Policy for Dealing with Death in Theatre v2 2020 08; Openness and Candour Policy and Procedure V2 2020 08; Lessons Learnt Policy 2020 01

This policy sets out The Queen Elizabeth Hospital's approach to meeting these requirements.

2.2 Policy Definitions

MSG Mortality Surveillance Group

2.3 Responding to Deaths- our agreed principles and practice.

These are the standards we have agreed:

We will implement a framework for a comprehensive mortality review process which includes a scope for case selection as above.

Case note reviews will be undertaken to a consistent standard with reviewers adopting a comprehensive approach which looks at the care provided from admission to death.

We will devise a set of metrics to monitor that the reviews are progressing to plan and report this performance to the MSG on a monthly basis.

When a death occurs, the clinical coding team will identify if the death is 'in scope' and will attach a structured judgement review form (appendix 1) to the notes. The reviewer will be notified by e-mail that they are required to complete a full review. The Trust Mortality Surveillance will be copied into the notification thereby triggering the review process.

All other deaths will be sent to the owning clinician with a form requesting review of the diagnosis and procedures recorded and requesting that the clinician score based on the updated learning from deaths scoring (previously scored by NCEPOD).

When someone who has a learning disability dies we will implement the LeDeR process and also include the case in our scope of reviews.

When a maternal death occurs, the Head of Maternity will implement the agreed process for reporting and investigating the case and will ensure that a mortality review is undertaken as part of this process.

When an infant or child dies the Clinical Director for Paediatrics will implement the agreed process for reporting and investigating the case and will ensure that a mortality review is undertaken as part of this process.

We will invite other providers to inform us of deaths which may have been influenced by the care we gave.

We will undertake periodic reviews of the cases of people who were expected to die to understand the quality of the experience and identify any learning.

We will keep clear and transparent records of our decisions to review or not.

We will communicate with openness and transparency with bereaved families and carers: ensuring engagement is meaningful and compassionate at every stage; from notification of death to the investigation report, lessons learned and actions implemented.

We will collect specific information every quarter on:

- the total number of inpatient deaths in our care
- the number of deaths we have subjected to a structured judgement review
- the number of deaths we have reported to LeDeR
- the number of deaths investigated under the Serious Incident framework (and declared as Serious Incidents)
- of those deaths subject to structured judgement review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
- the themes and issues identified from review and investigation, including examples of good practice
- how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation
- Publish this information on a quarterly basis from April 2019 by taking a paper to public board meetings

3.0 RESPONSIBILITIES

This section describes the specific responsibilities of key individuals and of relevant committees under this policy.

Roles and responsibilities for incident management, complaints handling and Serious Incident management are detailed in relevant policies

Role	Responsibilities
Chief executive	overall responsibility for implementing the policy
Non-executive director	• understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny • championing quality improvement that leads to actions that improve patient safety • assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.
Medical director	•Will provide assurance to the Board of Directors that

	there are effective arrangements for learning from deaths in place and that the mortality review process is functioning correctly. •Will ensure that there is a clear process through which delegated leaders hold reviewers to account for their performance regarding the quality and timeliness of the reviews and the implementation of learning actions. • Chair the Mortality Surveillance Group.
The Mortality Surveillance Group	• Oversees specialty mortality review structure, process and actions •Captures and responds to external and internal mortality trends •Ensures cross divisional learning from mortality review •Informs the Board of Directors of mortality outcomes and trends using the agreed reporting framework. •Administer the relevant documentation to support the mortality review process. •Offering training and advice to colleagues involved with the mortality review process •Keep copies of all mortality review forms for audit purposes. •Receive feedback and learning points from CBU and ensure learning outcomes and action points are included in the specialty governance audit plans as appropriate •Support and monitor the timely investigation of mortality alerts, reporting delays and or barriers to the CBU chairperson. •Ensures that any actions identified in relation to mortality reviews are recorded, progressed and monitored appropriately • Organising an annual audit of post mortem certificates which results in agreed improvements where identified.
The Head of Risk & Governance	•Monitoring recommendations from Serious Incident Investigations and makes reports them to the Mortality Surveillance Group for information, discussion and agreed actions. •Reviewing reports from speciality morbidity and mortality meetings CBU) to capture learning from mortality review within specialities •Raises any identified risk onto the Trust Risk Register

	via the Mortality Surveillance Group where it will be reviewed as part of the risk management process
The Clinical Business Units	•Supporting clinical staff to speak openly and raise any concerns regarding the care of someone who has died and inform the Trust Mortality Surveillance Group so that the case can be considered for review. •Promoting an enabling culture by training and supporting staff to positively communicate with the bereaved and, where necessary, take timely effective action to address any specific concerns/complaints. •Monitoring the performance of Specialty Mortality Groups within the division by reviewing attendance and performance on at least an annual basis. •Establishing a governance process for receiving regular mortality reports from specialty mortality groups and ensuring that learning is captured and improvement actions progressed and so demonstrate compliance with Care Quality Commission (CQC) Regulation 17 'Good Governance' • Disseminating this policy to new starters and making sure all staff know of and positively support our commitment to learn from deaths. •Enabling people, including staff to contribute to a review when this is indicated. •Ensuring that the findings from mortality review are reported and discussed as part of the divisional clinical governance process.
Learning disability lead	•Identify and report learning disability deaths to LeDeR. •Participate in mortality reviews as requested by LeDeR or the trust.
Head of maternity/maternity lead	•Investigate all perinatal deaths using the new perinatal mortality review tool https://www.npeu.ox.ac.uk/pmrt

Paediatrics/children and young people	•Reviews of these deaths are mandatory and should be undertaken in accordance with *Working together to safeguard children* [1] (2015) and the current child death overview panel processes https://www.gov.uk/government/publications/working-together-to-safeguard-children
The Clinical Governance Committee	•Receive CKI's and reports from the Mortality Surveillance Group •Reviews and monitors action plans action plans where appropriate.
CBU Chair	•Each CBU Chair will provide a template report to the MSG. This will inform a performance dashboard giving MSG transparent and reliable data on case note reviews allocation, completion and learning outcomes.
Mortuary Service Manager	•Help identify cases where the bereaved relatives/ carers have implied that they have a concern about the quality of care- and that consent is sought to share this so that the case can be considered for review.
Head of Business Support	•Provide monthly mortality trend data to the MSG •Map monthly patient level data against the mortality indicators and ensure that possible signals are reported to the MSG •Provide mortality data and prepare reports to meet the Trust's board, divisional, performance and commissioner reporting requirements.
Clinical staff of all disciplines	•Review the cases allocated within the agreed timescales using the proforma template, seeking advice from other specialties and disciplines if appropriate. •Use the Trust incident reporting system (Datix) to report incidents identified during mortality review to enable review as part of the risk management process. •Take advantage of opportunities to engage with clinical coders and work in partnership to develop knowledge and expertise. •Work collaboratively across specialty boundaries in the interest of identifying areas for improvement.

4 LEARNING FROM DEATHS

Implementing this policy and the accompanying process documents will provide us with high quality, reliable, intelligence on the outcome of the care we provide so that we can celebrate what is good and make improvements where we have not met the standard expected. Once we have launched this document and established the processes we will adopt a continuous improvement approach so that, overtime, we build strong relationships with all stakeholders, especially the bereaved, so that we can support people to raise concerns and have them addressed at a level as close to satisfaction as we can get.

A quarterly summit is planned where learning from deaths can be communicated to clinical team to ensure future improvements.

The Lessons learnt policy captures our process for escalating and sharing learning within the organisation.

5 TRAINING

There is no particular training required for this policy however clinical staff completing the structured review can request advice from the Mortality Surveillance Group; its members will be available to discuss with interested groups when required.

6. DEFINITIONS

The National Guidance on Learning from Deaths includes a number of terms. These are defined below.

Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review

A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review

A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident

Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.[2]

Investigation

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care

A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in

care'.

Quality improvement

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident

A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

7. THE PROCESS FOR RECORDING DEATHS IN CARE

All inpatient deaths are recorded on the Patient Administration System as soon as possible but at least within 24hours of the event. The patient's GP will be advised of their death via the discharge letter.

Where the death occurs outside of the hospital and the trust is informed of the death from other sources e.g. family or care home. A death notification form will be completed and passed to the Information Team who will register the death on the Patient Administration System.

The process for certification and registration of deaths is detailed in the procedure following death of adult patient final version for Intranet June 2015

Certain types of deaths are governed by specific recording processes and the following guidance should be followed using this link: https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/

- people with learning disabilities: refer to Annex D of the National Guidance on Learning from Deaths; all deaths to be reported to the Learning Disabilities Mortality Review (LeDeR) programme.
- children and young people: refer to Annex F of the National Guidance on Learning from Deaths.
- maternity: refer to Annex G of the National Guidance on Learning from Deaths.

8. SELECTING DEATHS FOR CASE RECORD REVIEW

This section relates to case record review and not to patient safety incidents or incidents that fall under the Serious Incident framework.

All inpatients recorded on the Patient Administration System (Patient Centre) will be considered eligible for selection for case record review in the event of their death.

Specific categories of deaths as mandated in the Learning from Deaths framework will be subject to specialist review as detailed in this policy.

deaths of people with a learning disability

infant or child deaths

stillbirths

maternal deaths.

With due regard to the categories listed in the National Guidance on Learning from Deaths the trust will carry out structured judgment reviews on the following categories:

- All deaths where bereaved families and carers, or staff, have raised a concern about the quality of care provision. This to include intelligence from the safeguard modules for complaints and PALS.
- All deaths in a service specialty, diagnosis or treatment group where an 'alert' has been raised. The inclusion criteria will be agreed with the Mortality Surveillance Group and reviewed on a monthly basis.
- All elective care deaths
- All deaths under the care of a consultant Cardiologist
- All deaths under the care of a consultant Haematologist
- All deaths under the care of a consultant Oncologist
- All deaths in ITU
- Deaths where learning will inform our existing or planned improvement work.
- A further sample of deaths that do not fit the identified categories so that we can take an overview of where learning and improvement is needed most overall

The trust will provide input to requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death. The trust will collaborate with others to carry out reviews and investigations when a person has received care from several health and care providers.

9. REVIEW METHODOLOGY

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

Patient Group	Methodology	Frequency	Where stored
Adult Inpatient	Modified SJR (Scoring) SJR	Monthly as occurring	Clinical Coding
Child (under 18)	Working together to safeguard children (2015) and the current child death overview panel processes.		
Learning disability	Flagged via Patient Centre Reported to LeDer SJR		
Perinatal and maternity	Perinatal Mortality Review tool Serious Incident protocol		

10 EQUALITY IMPACT STATEMENT

This policy has been subject to an equality impact assessment

11 REFERENCES

National Guidance on Learning from Deaths.
National Quality Board, March 2017
Learning Disabilities Mortality Review (LeDeR) Programme NHSE. 2015

The Mortality Governance Guide NHSE 2016 Learning, candour and accountability.
Care Quality Commission. December 2016 National Mortality Care Record Review Programme, Royal College of Physicians 2016
Learning Disabilities Mortality Review (LeDeR) Programme NHSE. 2015

12 DISSEMINATION OF DOCUMENT

This document will be distributed to relevant staff by publication on the intranet under policies and procedures and be notified to CBU by presentation at the next monthly meeting following ratification. .....

13 MONITORING COMPLIANCE

Key Elements	Process for Monitoring	By Whom (Individual/ Group/ Committee)	Responsible Governance Committee	Frequency of Monitoring
Review of death certificates	Audit of all notes coded to identify % completion. 20% compared to coded record	Clinical Coding	MSG	Quarterly
Review of post mortems	Comparison of pm to the last episode of hospital care	Clinical Coding	MSG	Quarterly
Assurance of scoring using the decision tree	Audit of a sample of completed structured judgment forms	MSG	Clinical Governance	Quarterly

Appendix 1

EQUALITY IMPACT ASSESSMENT

STAGE 1 - SCREENING

Name & Job Title of Assessor:	**Date of Initial Screening:** **Date of Review:**
Policy or Function to be assessed:	

		Yes/No	Comments
1.	**Does the policy, function, service or project affect one group more or less favourably than another on the basis of:**		
	• Race & Ethnic background	No	
	• Gender including transgender	No	
	• Disability:- This will include consideration in terms of impact to persons with learning disabilities, autism or on individuals who may have a cognitive impairment or lack capacity to make decisions about their care	Yes	Patients with a learning disability will have a further review using the LeDer system
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	Yes	Children will be subject to a national review
2.	**Does the public have a perception/concern regarding the potential for discrimination?**	No	

If the answer to any of the questions above is yes, please complete a full Stage 2 Equality Impact Assessment.

Signature of Assessor:_____ Date: 04/02/2019

Signature of Line Manager:_____ Date:

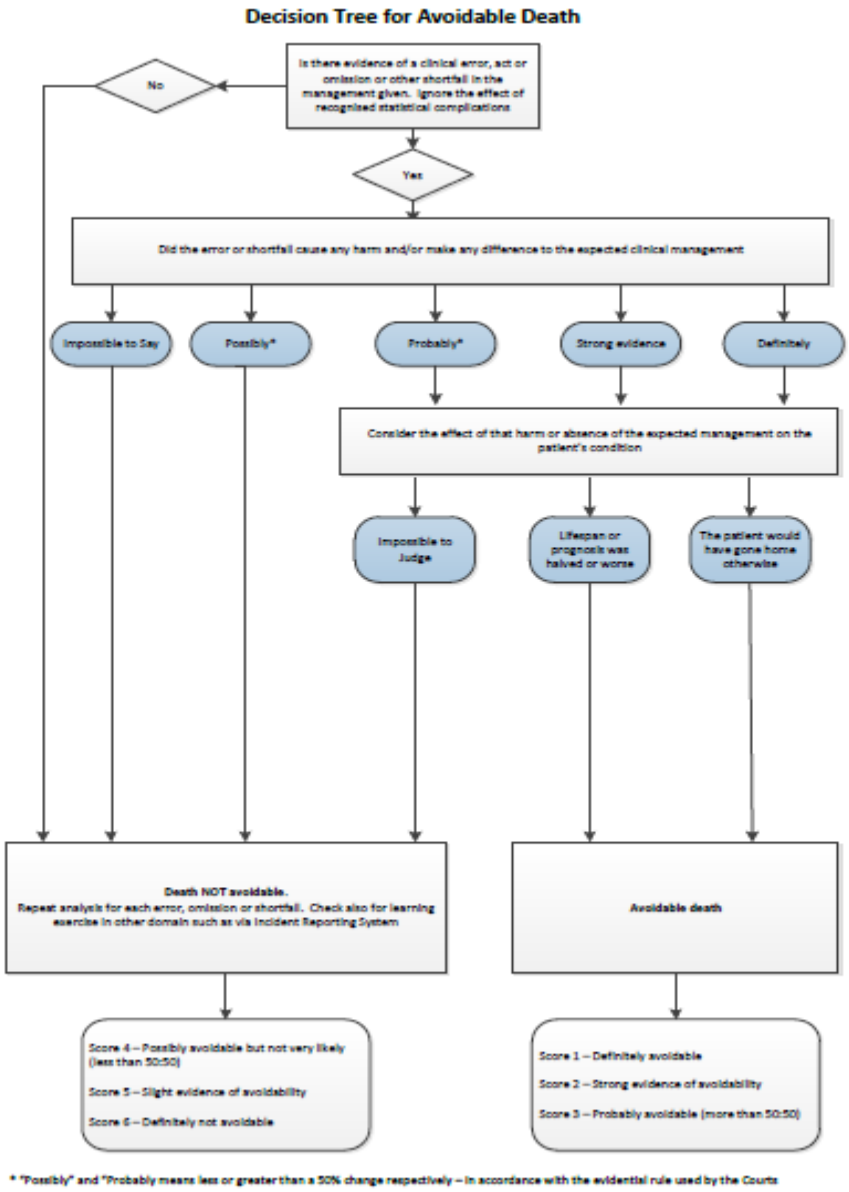
STAGE 2 – EQUALITY IMPACT ASSESSMENT

If you have indicated that there is a negative impact on any group in part one please complete the following, is that impact:

		Yes/No	Comments
1.	**Legal/Lawful under current equality legislation?**	Yes	
2.	**Can the negative impact be avoided?**	Yes	
3.	**Are there alternatives to achieving the policy/guidance without the impact?**	No	
4.	**Have you consulted with relevant stakeholders of potentially affected groups?**	No	
5.	**Is action required to address the issues?**	No	

It is essential that this Assessment is discussed by your management team and remains readily available for inspection. A copy including completed action plan, if appropriate, should also be forwarded to the Equality & Diversity Lead, c/o Human Resources Department.

Appendix 2



The Mortality Surveillance Group are interested in your view on the avoidability of death in this case. Please choose from the following scale:

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Appendix 3

Departmental Mortality Case Review

Initials K number
Age at death (years):
Sex: M/F
First 3/4 digits of the patient's postcode:
Date of admission:
Time of admission:
Date of death:
Time of death:
Number of days between admission and death:
Specialty team at time of death:
Type of admission: 1 – Emergency, 2 – Elective, 3 – Day case
Terminal care status:

Reason for admission

Final diagnosis (if different were there any delays causing harm)

Recorded cause of death

Did the patient have a learning difficulty? Yes No
If yes: Alert the Mortality Surveillance group

Records review

Legible	Yes	No
Clear record of decisions	Yes	No
Clear record of family involvement	Yes	No
Entries signed and traceable	Yes	No
Early consultant input	Yes	No
Entry on death certificate recorded	Yes	No
Frailty assessment	Yes	No

Review of Care

Please record your judgements on the following areas about the quality of care received and whether it is in accordance with good practice and professional standards. Include other comments you feel relevant.

Admission and initial management first 24 hours
On-going care
Care during procedures (excluding iv cannulation)
Perioperative care
End of life care
Overall care

Narrative for review of care

Specific problems

Please add narrative to the box below if answer is yes

Failure in VTE assessment/diagnosis /prophylaxis/treatment	Yes	No
Insufficient fluids (oral or IV)	Yes	No
Electrolyte disturbance acted upon	Yes	No
AKI acted upon as per Trust guidelines	Yes	No
Oxygen therapy issues (e.g. supply stopped and not recognised)	Yes	No
Sepsis guidelines followed	Yes	No
Fall occurred	Yes	No
Pressure ulcers developed during admission	Yes	No
Infection control issues	Yes	No
EWS recorded and acted upon	Yes	No
Problem in resuscitation following cardiac or respiratory arrest	Yes	No
Other identifiable problems	Yes	No

Narrative for specific problems identified above and any harm caused

Specialty specific measures

Surgery

Unplanned returned to theatre	Yes	No
Unplanned admission to critical care	Yes	No
Major complication	Yes	No

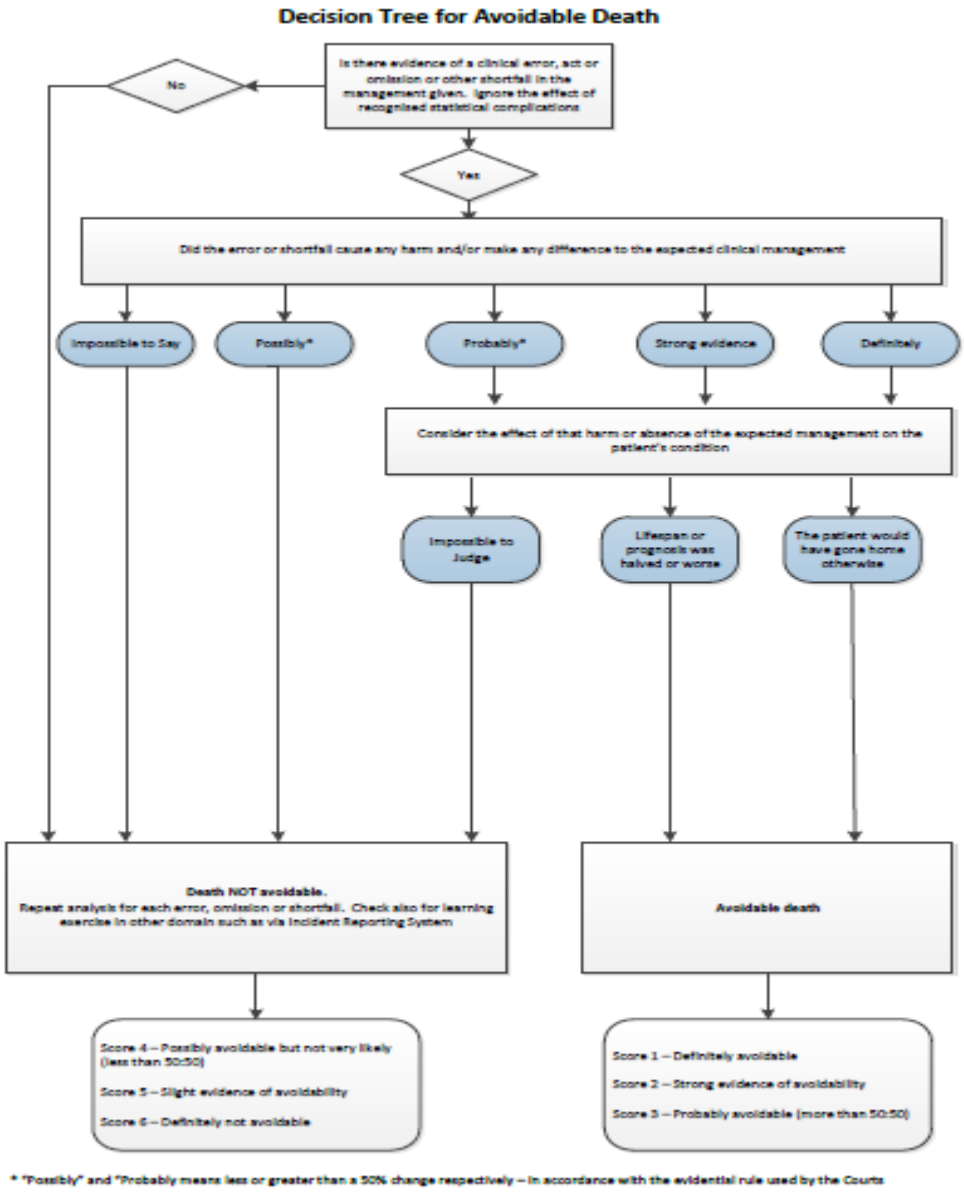
The Mortality Surveillance Group are interested in your view on the avoidability of death in this case. Please choose from the following scale.

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

Give reasons and learning points

All avoidable deaths must be referred to the Mortality Surveillance group

Decision Tree for Avoidable Death



Appendix 4

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

FINAL REPORT FOR PATIENTS IN HAEMATOLOGY DATABASE

A D D R E S S O G R A P H	HAEMATOLOGICAL DIAGNOSIS: Consultant: LJC/EG/JP/ML TRIAL: YES/NO (please circle)

Date of death: …… **Date form completed:** ……...

Autopsy performed: **YES/NO** **Death expected/unexpected**

Learning from deaths - avoidability score: **1 2 3 4 5 6**

Palliative Care:

Location of death:

☐ **Home** ☐ **Hospice**

☐ **Hospital** ☐ **Nursing Home**

☐ **Other (specify)** ☐ **Unknown**

……..…

……...

Cause of death: (most significant factor)

☐ **Advancing disease**

☐ **Treatment related complications: (specify) ……..**

☐ **Disease related complications: (specify) ……**

☐ **Unrelated cause: (specify) ……**

COPIES TO:

1. CLINICAL CODING:
   ☐

2. HOSPITAL NOTES
   ☐

3. **LINK WITH CANCER REGISTRATION FORM FROM YEAR DIAGNOSED IN CANCER**
   ☐
   REGISTRATION FOLDERS