Kent Community Health
NHS Foundation Trust

Mortality Review and Responding to Deaths Policy

Document Reference No.	QC035
Status	Approved
Version Number	1.5
Replacing/Superseded policy or documents	Version 1.4
Target audience/applicable to	Clinical Staff and Managers, Trust Board and Directors.
Author	Deputy Medical Director
Acknowledgements	Learning Disability Team
Equality Initial Screening Tool / full Equality Analysis (state which)	Full Equality Analysis
Contact Point for Queries	Medical Directorate 01622 211920
Date Ratified	July 2021
Date of Implementation/distribution	July 2021
Review date	July 2024
Has this document been adopted?	No
Where has this document been adopted from?	N/A

EXECUTIVE SUMMARY

This policy is based on National Guidance and describes how the Trust responds to and learns from deaths of patients who die under its management and care including the processes involved in responding to the death of a patient and undertaking case record reviews.

CONTENTS

		PAGE
	EXECUTIVE SUMMARY	2
1	Mortality Review and Responding to Deaths	2
1.0	Introduction	2
1.1	Family and Carer Involvement	3
1.2	Deaths in Scope for review	3
1.3	Death of a person with a Learning Disability	5
1.4	Mortality Review process	7
1.5	Mortality Surveillance Group	10
2.0	Training and Awareness	11
3.0	Roles and Responsibilities	12
4.0	Glossary and Abbreviations	13
5.0	Governance Schedule	14
Appendix 1	Mortality Review Forms	17
Appendix 2	Supplementary Guidance for Mortality Reviewers	24

1. Mortality Review and Responding to Deaths

1.0 Introduction

The Mortality Review and Responding to Deaths Policy has been developed following the recommendations made by the National Guidance on Learning from Deaths (2017). Other national publications have also been used to guide the content of this policy. The Mazars report provided an independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust from April 2011 to March 2015. A number of recommendations were made to improve the systematic management and oversight of deaths and investigations. These included best practice when working with families and carers and the processes by which lessons are learned and any resultant service change can be evidenced.

The Care Quality Commission (CQC) commenced a process in July 2016 specifically to ensure that NHS trusts have robust and effective mechanisms in place to investigate the deaths of patients/service users and that these mechanisms allow learning to be quickly embedded to improve care both within organisations and for the system as a whole. In response to this, the National Quality Board published the National Guidance on Learning from Deaths in March 2017.

In light of these publications, this policy was developed to provide guidance to clinicians and managers on how to review the care given to the patient before death

and to the family/carer after death. The policy also describes how we will identify and share learning with the wider Trust to ensure that the care received by people prior to death is of the highest standard.

1.1 Family and Carer Involvement

- All bereaved families and carers whose loved one has died in a community hospital will receive written guidance (available in Easy Read format) after the death of a loved one that sign-posts them to sources of support and will include an invitation to contact the Trust if they have any feedback they would like to give about the care their loved one received.
- A Bereavement Folder is provided which includes information and guidance for families along with a letter to advise that the family will be contacted at a later date to ask for feedback. The letter provides the option for families to decline being sent a survey. A bereavement survey will be sent to carers and relatives approximately 6 weeks following the death of a loved one which asks about their satisfaction with the care that was received and whether they have any concerns. This is also available on our public website. The Bereavement page on Flo provides information on the process, which includes advice for staff and a communication guide.
- When case record review highlights a concern triggering the patient safety review process we will proactively invite involvement of the deceased person's carers, following the Incident Policy. Staff should also refer to the Being Open Policy which incorporates Duty of Candour.
- At the time of case record review any feedback, concerns or complaints from carers and families will be included in the review

1.2 Deaths in scope for review

1.2.1 The mortality review process uses a modified structured judgment review (SJR) based on the Royal College of Physicians (RCP) methodology. NHS England has commissioned a National Mortality Case Record (NMCRR) Programme based on the RCP SJR to support the standardisation of, and learning from, mortality case note reviews in NHS Acute Trusts. Processes for review of deaths in community settings are not nationally well defined but adoption of a modified SJR format complies with national recommendations for use of evidence based methodology whilst enabling the Trust to reflect our individual service user and clinical circumstances.

1.2.2 The Trust will review the following cases via the mortality review process;

- all inpatient deaths in community hospitals
- The trust will, in addition, review the deaths of patients receiving community based treatment following the criteria below;
- all deaths of those with learning disabilities under our care
- all deaths of patients under our care with severe mental illness

- All deaths of patients where a complaint, significant concern about the quality of care provision or serious incident has been raised.
- all deaths of patients where queries have been raised by families in accordance with Trust guidance
- All deaths of patients where the need for mortality review has been raised by the Medical Examiner.
- All deaths where learning will inform the Trust's existing or planned quality improvement work.
- all deaths of patients receiving care from a service where an 'alarm' has been raised with the Trust through whatever means (for example via an elevated mortality alert, safeguarding enquiry, concerns raised by audit work, concerns raised by the CQC or another regulator). This will include situations where another organisation has reviewed a death and suggests that our Trust reviews its care processes.
- The Trust will fully cooperate with separate arrangements for the review (and where appropriate, investigation) of certain categories of deaths including suicides, homicides, and child and maternal deaths and safeguarding adults reviews according to national guidance.

1.2.3 It is common for more than one organisation to be involved in the care of a patient who dies. The Trust will work to develop working relationships with commissioners and other organisations to promote collaboration on case reviews and support the effective sharing of learning and concerns that arise from mortality reviews.

1.2.4 Reviews of deaths of those with learning disabilities will be conducted through the Trust Learning Disability mortality review process and National LeDeR programme as described in section 1.3

1.2.5 The National Quality Board guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) are subject to review. There is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder. For the purposes of this policy, all deaths of patients known to fulfil the above criteria will be reviewed. Where the review is led by another organisation the Trust will participate in the review as needed and share all learning obtained via the Mortality Surveillance Group (MSG).

1.2.6 The process for reviewing child deaths precedes this policy and will continue. All child (under 18) deaths are investigated by a multi-disciplinary group involving Kent and Medway Local Safeguarding Children Multiagency Partnerships (KSCMP). This provides a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child giving an overview of all child deaths in the KSMP area. Learning from all child deaths will be shared with the Mortality Surveillance Group (MSG).

1.2.7 The Trust is not a provider of Maternity services but will participate in any maternal death review process if appropriate and share all learning obtained via the MSG.

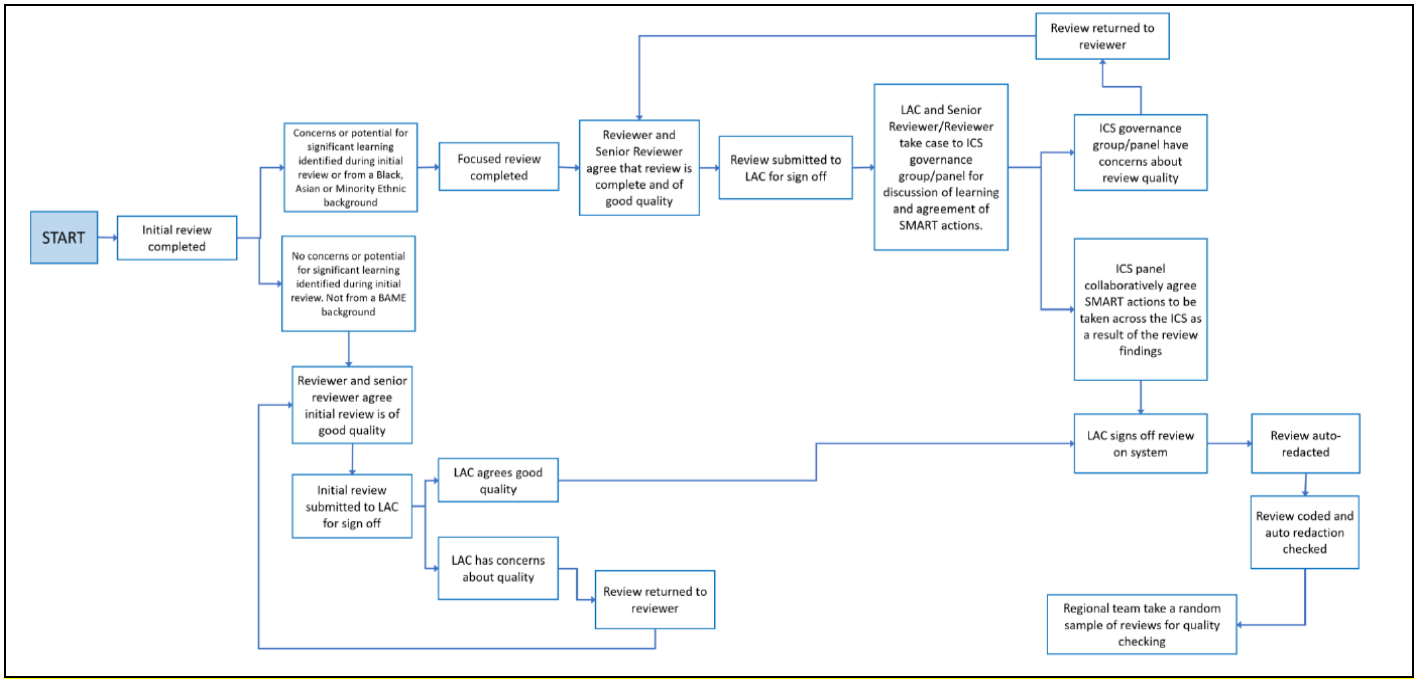
1.3 Death of a person with a Learning Disability

1.3.1 Any death of a person with a Learning Disability or serious mental illness whilst on the caseload of KCHFT services must be reported on Datix. For these specific patient groups reporting is irrespective of whether the death is expected, sudden, unexpected or suspicious. All Datix reports are received by the Mortality Review Project Lead and the Learning Disabilities Mortality Reviewer, ensuring all reports are processed and passed for review. Any community deaths where the patient had a Learning Disability and was receiving input from a KCHFT service, but was not necessarily on the Learning Disabilities caseload, will also be picked up in this way. This ensures compliance with Mazars recommendations (see report here).

1.3.2 In addition to this, all deaths of a person with a learning disability and or Autism are reported to the Learning from the lives and deaths of people with Learning Disability and Autism (LeDeR) Programme, which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. This is a national initiative. For more information please visit the LeDer LeDeR - Home which includes the process of how to report deaths to LeDeR.

1.3.3 The LeDer team will review all reported deaths. The process, including governance arrangements for this can be seen in the table below.

1.3.4 If a mortality review identifies a case that meets the criteria for a Safeguarding Adult Review, this will be flagged and the Trust Request for Safeguarding Adult Review (SAR) Guidance followed, which is available on Flo.


START
Initial review completed
Concerns or potential for significant learning identified during initial review or from a Black, Asian or Minority Ethnic background
No concerns or potential for significant learning identified during initial review. Not from a BAME background
Focused review completed
Reviewer and Senior Reviewer agree that review is complete and of good quality
Review submitted to LAC for sign off
LAC and Senior Reviewer/Reviewer take case to ICS governance group/panel for discussion of learning and agreement of SMART actions.
Review returned to reviewer
ICS governance group/panel have concerns about review quality
ICS panel collaboratively agree SMART actions to be taken across the ICS as a result of the review findings
Reviewer and senior reviewer agree initial review is of good quality
Initial review submitted to LAC for sign off
LAC agrees good quality
LAC has concerns about quality
Review returned to reviewer
LAC signs off review on system
Review auto-redacted
Review coded and auto redaction checked
Regional team take a random sample of reviews for quality checking

1.4 Mortality Review Process

When a death occurs in one of the Trust's community hospitals, a Datix notification will alert the Mortality Review Project Lead, who will arrange for the notes to be made available for mortality review. Deaths of people with a learning disability, a serious mental illness, all deaths of children and all sudden, unexpected or suspicious deaths must also be reported by Datix if the patient is on the KCHFT caseload. There is also a requirement to Datix any death that is referred to the Coroner or if a Coroner's statement is later requested. If communication is received from the Coroner the legal team must be contacted at kcht.legal@nhs.net in order to assist with the request

1.4.1 With the exception of children and learning disability patients which are subject to separate processes, these Datix reports will also be received by the Mortality Review Project Lead and added to the list of deaths for review. A Reporters Guide to Reporting Patient Deaths on Datix authored by the Risk Team is available on Flo. A detailed Standard Operating Procedure for administration of reviews is saved locally within the Medical Directorate.

1.4.2 A structured case review (SJR) will be completed an allocated clinician. The completed SJR will be presented for review and closure at a mortality review meeting led by a senior trained clinician and attended by Quality Leads, senior nursing and clinical staff, pharmacy and legal teams and the lead practitioner for palliative and end of life care.. Members of the Mortality Surveillance group including Patient and Public Representatives are invited to attend mortality review meetings in an observer capacity. The Non-Executive Director for mortality reviews aims to attend either the Mortality Surveillance Group or a Virtual Mortality Review session on an approximately quarterly basis.

1.4.3 If at any stage of a mortality review there are any additional concerns requiring further investigation as a possible serious incident, the Patient Safety Team will be contacted. In line with Trust policy all unexpected deaths would have received an initial review in the first instance to clarify if a serious incident has occurred, as all Datix reports are sent to the relevant manager who must complete their initial investigation within 10 days.

1.4.4 During mortality reviews, any safeguarding concerns should be considered against the Safeguarding Adults Review (SAR) criteria which can be found in the Supplementary Guidance for Mortality Reviewers (appendix 2) and in the Request for Safeguarding Adults Review Guidance on Flo.

1.4.5 Any "Regulation 28 Report on Action to Prevent Future Deaths" from the coroner will also be integral to a provider's systems to support learning within and across their organisation and local system partners.

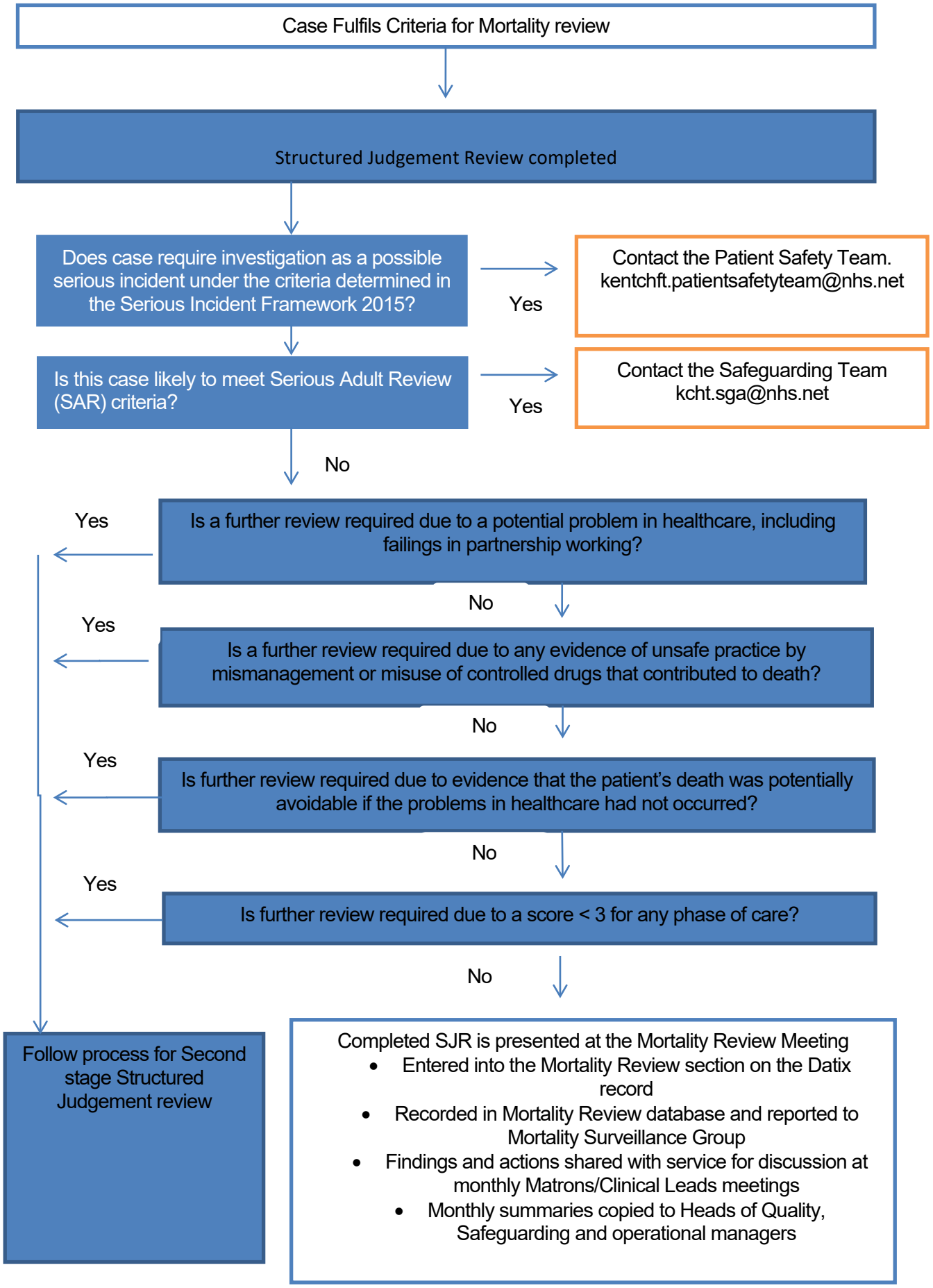
Mortality review process in reference to COVID-19 or other pandemic scenarios

1.4.6 Deaths of patients where nosocomial COVID-19 infection has occurred will be reviewed using the Trust Mortality Review process and will also be further assessed in accordance with Trust guidance for the reporting and investigation of nosocomial infection

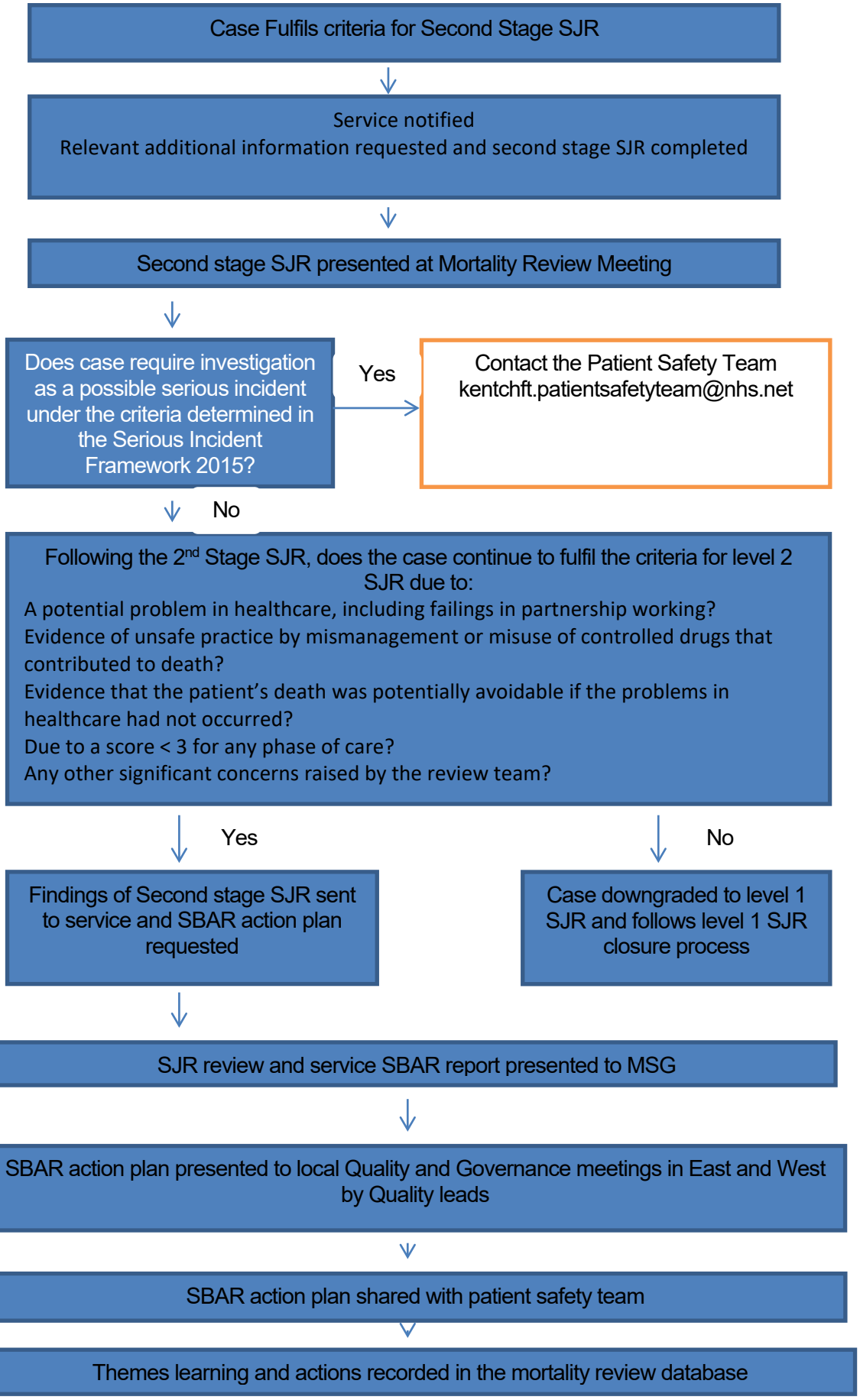
1.4.7 The Trust will endeavour to provide a full mortality review for all inpatient deaths during periods of higher death rates related to pandemic conditions. However where death rates

and other exceptional clinical pressures arise temporary adaptations may be required. Any time limited changes would be subject to approval by the Trust Executive with assurance oversight from the Quality Committee. All inpatient deaths would continue to undergo initial Datix investigation in accordance with existing Trust policy and an initial case review. Any concerns regarding potential Serious Incidents arising from Datix investigation follow the Serious Incident review process. In accordance with current national statutory guidance, for all other inpatient deaths, mortality reviews using the structured judgement review (SJR) process are conducted for any cases where a concern has been raised about the quality of care provision, all unexpected community inpatient deaths, deaths of people with severe mental illness and deaths where an SJR is recommended by the Medical Examiner or where learning will inform our existing or planned improvement work. Cases will also be randomly sampled in order that a minimum of 5 cases per month will continue to receive a full SJR.

Mortality Review Process Flow Chart



Mortality Review Process for Second Stage Structured Judgement Review (SJR)



1.5 Mortality Surveillance Group (MSG)

1.5.1 The MSG meets bi-monthly to oversee process of the mortality review, discuss sample mortality reviews, scrutinize learning from deaths and triangulate shared learning, good practice and concerns.

1.5.2 The following reports will be submitted:

Report content	Person or team responsible
Any relevant shared learning from KSCMP reviews of children or the KMSAB (Kent and Medway Safeguarding Adult Board) adults reviews, in the form of an Action Tracker	Safeguarding Team
Child Death Overview Panel data	Head of Quality, Governance and Professional Standards for Children's Services
Update on mortality reviews of patients with Learning Disabilities and any emerging themes and trends	Learning Disability Service
Insight Report including crude and expected mortality rates and step-up and step-down volumes benchmarked against other community providers	Healthcare Insight Specialist from Dr Foster

1.5.3 If any mortality review reports are received from external organisations in relation to patients who were on a KCHFT caseload, these will be shared with the MSG.

1.5.4 The MSG will offer advice on changes in external guidance, training and development or any other improvements based on Mortality Review Process.

1.5.5 The MSG will have oversight of a sample of at least two mortality review forms at each meeting, as well as any cases where potential for cross-organisation learning has been identified. Any cases where there was limited assurance for any reason or concerns were raised will be prioritized for sampling, along with any deaths subject to a second stage review.

1.5.6 The MSG will provide a quarterly report to the Trust Board in January, May and July, with an annual report submitted in November. Each report will include:

- Number of deaths in scope in the reporting period
- Number of deaths reviewed in the reporting period
- Number of deaths subject to a second stage review
- Number of deaths considered more likely than not to be due to problems in care
- Details of any deaths investigated as a Serious Incident
- Themes and trends from reviews including good practice as well as learning and actions taken in response
- Relevant data from the latest Dr Foster benchmarking report submitted to MSG

2.0 TRAINING AND AWARENESS

2.1 The policy will be available for reference by all staff and the Trust will ensure that all staff involved in implementing it are provided with the appropriate training advice and support. Awareness of the policy will be additionally supported by the process for sharing learning across the Trust and wider health economy as previously outlined.

2.2 The involvement of staff in mortality reviews from across the Trust and in differing roles and bandings is encouraged, to widen participation and raise the profile of mortality review processes.

2.3 The MSG will oversee appropriate training for the delivery of the mortality review process as laid out in this policy.

2.4 The following training is available for mortality reviewers. All staff involved in mortality reviews are encouraged to complete the E-learning for Health training as a minimum, while staff who lead reviews such as geriatricians and Heads of Quality, Governance and Professional Standards are encouraged to attend face to face training where possible.

E-Learning for Healthcare by Health Education England
www.e-lfh.org.uk/programmes/learning-from-deaths

This e-learning takes approximately one to two hours and gives a thought-provoking overview of how trusts should learn from deaths against a backdrop of experiences from real people who have lost a family member in a hospital setting.

Royal College of Physicians National Mortality Case Record Review eLearning
https://lms.dayonetech.uk/spaces/nmcrr

This e-learning also takes no more than one to two hours and takes the learner through best practice for completing Structured Judgement Review forms. Although this form is more aligned to the one used by acute trusts, whereas the KCHFT form has been adapted for the community, it still provides useful principles for reviewers and an understanding of how a structured judgement works.

Face to face training provided by EKHUFT
These half-day sessions look at the purpose of Structured Judgement Reviews, how to complete the forms and a case study to practice with as a group, with interactive discussions to understand why people rate care differently. Please contact the Mortality Review Team for further information kentchft.mortalityreviews@nhs.net.

ESTHER Training provided by Kent County Council

These two-hour sessions look at the ESTHER philosophy of putting patients at the centre and asking “what matters **to** you?” rather than “what’s the matter **with** you?” Although not specific to mortality reviews, this is an overarching ethos that can be valuable when evaluating the care provided, and can translate into other areas of practice. Dates and information are available here:
https://designandlearningcentre.com/overview-of-our-work/esther-model-sweden-kent/

2.5 Supporting and Involving Staff

The Trust recognises that staff may be affected by the death of a patient who has been in their care, and support is available via line managers.

2.6 Supporting and Involving families and carers

The Trust recognises the need to support, communicate and engage with families following a death of someone in our care as described in the Trust Care after Death Policy (QC015).

3.0 Roles and responsibilities

Trust Board	Holds overall responsibility for ensuring compliance with all legal and statutory duties, along with best practice including having an overview of mortality review processes and knowledge of the learning emerging from reviews that drives improvements in care with reference to Annex A of the National Guidance on Learning from Deaths
Chief Executive	Holds ultimate responsibility for ensuring the Trust has robust policies and procedures in place for reviewing all incidents of mortality in line with national guidance.
Chairperson	Responsible for ensuring there is an identified Non-Executive lead for overseeing the implementation of the national guidance.
Non-Executive Lead	Responsible for ensuring the processes in place are robust and can withstand external scrutiny, by providing challenge and support. with reference to Annex B of the National Guidance on Learning from Deaths; •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	Is the Executive Lead responsible for ensuring there is a comprehensive mortality review policy in place, ensuring that deaths are reviewed appropriately, and where needed actions are taken and learning disseminated.
Community Services Directors and	Responsible for ensuring that teams

Heads of Service	regularly receive feedback from mortality reviews, for example at monthly Matrons Meetings, and ensure that actions and learning points from reviews are implemented.
Ward Managers and Community Team Leaders	Must ensure that patient notes are made available for mortality review meetings when requested.
Deputy Medical Director, Community Geriatricians and Heads of Quality, Governance and Professional Standards	Responsible for leading mortality review sessions or overseeing the review process if done by other trained senior clinicians on a rotational basis, extracting areas of good practice and areas for improvement and overseeing the process of feedback to teams involved in patient care.
Mortality Review Project Lead	Responsible for all administrative processes around mortality reviews, to include arranging and minuting mortality review meetings and the MSG, requesting patient notes in a timely manner, ensuring the mortality dashboard is up-to-date and themes, trends and actions are robustly recorded, and producing and sending feedback reports to Matrons Meetings, End of Life Steering Group and elsewhere as appropriate.
All healthcare professionals	Should be aware of the outcome of reviews and understand the importance of feedback for the purpose of fostering a culture of openness, learning and continuous quality improvement. Ward and community team staff may be invited to attend reviews or lead reviews in order to develop confidence in identifying areas of good practice and areas for improvement. All healthcare staff are expected to engage with the process and implement actions identified during reviews.

4.0 GLOSSARY AND ABBREVIATIONS

Abbreviation	Meaning
AIS	Accessible Information Standard
CQC	Care Quality Commission
CEG	Clinical Effectiveness Group
GP	General Practitioner
KCHFT	Kent Community Health NHS Foundation Trust
KSCB	Kent Safeguarding Children Board
LeDeR	Learning Disabilities Mortality Review
MDT	Multi-Disciplinary Team
MSG	Mortality Surveillance Group
SAB	Safeguarding Adults Board

5.0 GOVERNANCE SCHEDULE

Ratification process

Governance Group responsible for developing document	Medical Directorate / Mortality Surveillance Group
Circulation group	*Intranet, Policy Distribution*
Authorised/Ratified by Governance Group/Board Committee	Quality Committee
Authorised/Ratified On	July 2021
Review Date	*July 2024*
Review criteria	*This document will be reviewed prior to review date if a legislative change or other event dictates.*

KEY REFERENCES

These are key documents that the policy, guideline, SOP etc. relies on for best practice or national guidance or a legislative requirement. It is a list of those items that have been relied on for best practice and influence the requirements of the document.

Title	Reference
Mazars Report (2015)	
Learning Disabilities Mortality Review (LeDeR) Programme	
National Guidance on Learning from Deaths, National Quality Board	
Implementing the Learning from Deaths framework: key requirements for trust boards	
Using the Structured Judgement Review Method, Royal College of Physicians	

Has an Equality Analysis (EA) been completed?
No ☐ The document will have no impact on people with any of the nine protected characteristics
Yes ☒ The Equality Analysis for this policy is available upon request by contacting the Engagement Team via kchft.equality@nhs.net.
NOTE: *Kent Community Health NHS Foundation Trust is committed to promoting and championing a culture of diversity, fairness and equality for all our staff, patients, service users and their families, as well as members of the public.* *Understanding of how policy decisions, behaviour and services can impact on people with 'protected characteristics' under the Equality Act 2010 is key to ensuring quality and productive environments for patient care and also our workforce.* ***Protected characteristics:*** *Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.* *An equality analysis should be completed whilst a policy is being drafted and/or reviewed in order to assess the impact on people with protected characteristics. This includes whether additional guidance is needed for particular patient or staff groups or whether reasonable adjustments are required to avoid negative impact on disabled patients, carers or staff.* ***Equality Analysis*** *Liaise with the Engagement Team if support is required at kchft.equality@nhs.net*

DOCUMENT TRACKING SYSTEM

Version	Status	Date	Issued to/Approved by	Comments/Summary of Changes
1.0	Final	14 Sept 2017	Mortality Surveillance Group	Ratified
1.0	Final	12 Sept 2017	Quality Committee	Ratified
1.0	Final	28 Sept 2017	Trust Board	Ratified
1.1	Final	May 2018	Medical Director	Minor amendments
1.2	Final	November 2018	Medical Director	Amendments to reflect changes to review process in line with national guidance.
1.3	Draft	November 2019		Amendments to reflect changes to review process in line with national guidance.
1.4	Draft	August 2020	Quality Committee	Amendments to reflect changes to process due to Covid-19, which were approved by the Extraordinary Quality Committee on 3rd April 2020
1.5	Draft	April 2021		Amendments to reflect further changes to process during COVID-19 Amendments to reflect changes to bereavement and being open policies Amendments to reflect changes to review forms

				Amendments to reflect changes to comply with revised National LeDeR policy
1.5	Final	July 2021	Quality Committee	Ratified and published

Summary of Changes

a) *Executive Summary condensed*
b) *Order of sections rearranged for clarity*
c) *Detail around administrative processes removed from section 1.4 and added instead to locally saved SOP document*
d) *Amended Mortality Review Process flowchart to clarify that completed review forms are entered onto Datix*
e) *Additional information included for clarity in 1.4.3 around initial Datix investigations*
f) *Table inserted in 1.5 Mortality Surveillance Group for clarity around which reports are submitted and from whom*
g) *Information on available training for mortality reviewers added to 2.0 Training and Awareness*
h) *Table inserted in 3.0 Roles and Responsibilities for greater clarity*
i) *Amendment to 1.4.1 to clarify that all deaths of patients with Learning Disabilities should be Datixed even if not on Learning Disabilities service caseload*
j) *Amendments made to process flowcharts to include reference to Safeguarding referrals*
k) *Item 2.6 added to acknowledge importance of supporting and involving families and carers*
l) Amendments to reflect changes to process due to Covid-19, which were approved by the Extraordinary Quality Committee on 3rd April 2020
m) Appendix 5 added to show relevant details of process from COVID-19 SOP
n) *Links to bereavement pathway guidance and being open policy added*
o) *Item 1.3 update with NHS LeDeR policy*
p) *Appendix 5 to show relevant details of process from Covid-19 SOP removed*
q) *Mortality case review for added to appendix 1*
r) *Appendices 3 and 4 removed, bereavement letter and survey now accessible via hyperlink in section 1.1*
s) *Amendments added to comply with revised LeDeR policy 1st June 2021*

MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS POLICY

Policy Lead	Element(s) to be monitoring	Ensuring Implementation	Frequency of monitoring	Reporting arrangements
Medical Director	Deaths within community hospitals	Dr Foster benchmarking	Quarterly	Report to Mortality Surveillance Group

Medical Director	How many deaths have taken place, what proportion have been reviewed at what level, number of expected and unexpected deaths	Datix reporting and Dashboard	Bi-monthly	Dashboard to MSG, Quality Committee and Formal Board
Medical Director	Completed actions from reviews	Action plan monitoring	Bi-monthly	Spreadsheet to MSG, Quality Committee and Formal Board

Appendix 1

Mortality Case Review Form

Section 1 – Patient and Admission Details

Date of Birth	
NHS No.	
Age at death	
Gender	
Day and Time of arrival (please specify day of week)	
Date and time of death	
Number of Days Between Admission and Death	
Place of death	
Type of admission e.g. from acute/from home *(For community patients; GP, Hospital or other service referral)*	
Certified cause of death (if known)	
Was the death discussed with the coroner's office? (If yes, please give details)	
Did the patient have a learning disability?	Yes ☐ No ☐ If clear or possible indications of a learning disability, **please inform the LeDeR lead by contacting 03000419549 or** LeDeR - Home If no indication of learning disability, proceed with review.
Did the patient have a serious mental health issue? (refer to supplementary guidance for definition)	Yes ☐ No ☐
Have any complaints, concerns or potential SI's been reported for this patient at any time during their care at KCHFT?	Yes ☐ No ☐ If yes, please provide further details as part of your structured judgement.
Have the patient's family or carers given any comments or feedback about the care received?	Yes ☐ No ☐ If yes, please provide further details as part of your structured judgement.

Section 2 – Detailed Review of Phases of Care

Admission/First contact with Community Services and initial management (approximately the first 24 hours)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is relevant that you wish to comment on, please do so. *See supplementary guidance sheet for examples of narrative.*

Please rate the care received by the patient during this phase of care:

1	2	3	4	5
Very poor care ☐	**Poor care** ☐	**Adequate Care** ☐	**Good Care** ☐	**Excellent Care** ☐

Ongoing Care
(including any procedures that may have been carried out)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is relevant that you wish to comment on, please do so. *See supplementary guidance sheet for examples of narrative.*

Please rate the care received by the patient during this phase of care:

1	2	3	4	5
Very poor care ☐	**Poor care** ☐	**Adequate Care** ☐	**Good Care** ☐	**Excellent Care** ☐

End of Life Care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is relevant that you wish to comment on, please do so. *See supplementary guidance sheet for examples of narrative.*

Please specifically reference evidence of the priorities of care for the dying person

1. **Recognise: The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed reversible conditions considered and decisions revised accordingly**
2. **Communicate: Sensitive communication takes place between staff and the dying person and those identified as important to them**
3. **Involve: The dying person, and those important to them, are involved in decisions about treatment and care to the extent the dying person wants**
4. **Support: The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible**
5. **Plan and Do: An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion**

Please rate the care received by the patient during this phase of care:

1	2	3	4	5
Very poor care ☐	**Poor care ☐**	**Adequate Care ☐**	**Good Care ☐**	**Excellent Care ☐**

Overall Assessment Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is relevant that you wish to comment on, please do so. *See supplementary guidance sheet for examples of narrative.*

Please rate the care received by the patient during this overall phase:

1	2	3	4	5
Very poor care ☐	**Poor care** ☐	**Adequate Care** ☐	**Good Care** ☐	**Excellent Care** ☐

Please rate the quality of the patient record:

1	2	3	4	5
Very poor care ☐	**Poor care** ☐	**Adequate Care** ☐	**Good Care** ☐	**Excellent Care** ☐

Section 3 – Highlighting Overall Areas of Best Practice and Areas for Improvement

Considering the three phases of care, please identify areas of best practice and areas for improvement for feedback to the team. Feedback will be reported monthly to Heads of Service, Quality Leads and at Matrons Meetings and themes and trends will be monitored by the Mortality Surveillance Group.

Phase of care	Best Practice	Areas for Improvement
Admission & Initial Management		
Ongoing care		
End of Life Care		

Section 4 – Problems in Care

1. Do you believe that a more in depth review of this case is required due to a potential problem in healthcare, including failings in partnership working? *See supplementary guidance notes for definition of a problem in healthcare and Safeguarding Adults Review criteria from Safeguarding.*	Yes ☐ No ☐
2. In your judgement, is there any evidence of unsafe practice by mismanagement or misuse of controlled drugs that contributed to death?	Yes ☐ No ☐
3. In your judgement, is there some evidence that the patient's death was potentially avoidable if the problems in healthcare had not occurred? *See supplementary guidance notes for advice in determining avoidability* If answering yes to either 1, 2 or 3 above the additional Section "Detailed review of potential problems in healthcare" must be completed If answering no, complete the details of those involved in the review and record any problem types identified in the table below and finish the form at that point.	Yes ☐ No ☐

4. If yes to Question 3, please rate the avoidability according to the Royal College of Physicians scale:	**6** Definitely Not Avoidable ☐ **5** Slight evidence of avoidability ☐ **4** Probably avoidable but not very likely ☐ **3** Probably avoidable (more than 50-50) ☐ **2** Strong evidence of avoidability ☐ **1** Definitely avoidable ☐

Details of those involved in the review:

Date of Review

Name	Job Title	Base

Date of review:

Details of those involved in the Virtual Review:

Date of Virtual Review

Name	Job Title	Base

Case identifier			
Problem Types			
1. Problems in assessment, investigation of diagnosis Including assessment of pressure ulcer risk, VT risk, history of falls			No Yes
Did the problem lead to harm?	Yes	Probably	No
In which phase(s) did the problem occur?			
2. Problems with medication including administration of oxygen			No Yes
Did the problem lead to harm?	Yes	Probably	No
In which phase(s) did the problem occur?			
3. Problems related to treatment and management plan			No Yes
Did the problem lead to harm?	Yes	Probably	No
In which phase(s) did the problem occur?			
4. Problems with infection management			No Yes
Did the problem lead to harm?	Yes	Probably	No
In which phase(s) did the problem occur?			
5. Problems related to invasive procedure			No Yes
Did the problem lead to harm?	Yes	Probably	No
In which phase(s) did the problem occur?			
6. Problems in clinical monitoring			No Yes
Did the problem lead to harm?	Yes	Probably	No
In which phase(s) did the problem occur?			
7. Problems in resuscitation following cardiac or respiratory arrest			No Yes
Did the problem lead to harm?	Yes	Probably	No
In which phase(s) did the problem occur?			
8. Problems of any other type not fitting other categories			No Yes
Did the problem lead to harm?	Yes	Probably	No
In which phase(s) did the problem occur?			

Appendix 2

Supplementary Guidance for Mortality Reviewers

Notes for Section 1 – Patient and Admission Details

Review of deaths of patients with severe mental illness:

The NQB guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review. In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

The national bodies are working to clarify expectations about mortality review in mental health and community services in general. In the meantime, please use the above description of SMI. You can also review the care provided to patients with other significant mental health issues such as those mentioned above, where this can be done proportionately and effectively.

Notes for Section 2 – Detailed review of care

When completing a Mortality Review, please consider the following areas. Use this list as a series of prompts/triggers to ensure that all aspects of care are considered when making a judgement.

Admission/First Contact with Community Services and Initial Management

- Were all necessary assessments completed within 24 hours of admission?
- Was an SBAR/telephone handover/admission checklist received and appropriate reason for transfer given?
- Was there appropriate information gathering relevant to patient's circumstances?
- Were next of kin details completed with sufficient detail including phone numbers
- Was MCA/DoLs considered if appropriate?
- Was there a personal care plan
- Did staff explain the care plan to the patient and their relatives/carers?
- Were nutrition and hydration considered?
- Did the patient have a diagnosis of dementia?
- Was skin care considered?
- Was there a medication review?
- Were any safeguarding issues or concerns raised? If so, is there:
  - Reasonable cause for concern about how the Kent and Medway Safeguarding Assurance Board (KMSAB), members of it or other persons with relevant functions worked together to safeguard the adult, **and**
  - The adult has died and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

  If the above criteria are met, a Safeguarding Adults Review is required. Please contact the Safeguarding team for advice on 01233 667990.

Example Narrative:

Thorough admission clerking with clear, concise notes and management plan. Good background history obtained from patient and wife. Medical review took place within 24 hours of admission. It was documented that DNA CPR was in place but unfortunately no early discussion with patient and family was documented regarding escalation plans.

Please note: If referring to 'discharge' or 'transfer' in the narrative, please clarify where this was to and from. Ideally 'discharge' should be used to mean that the patient went home, while 'transfer' should be used for movements from one hospital to another.

Ongoing Care

- Was the current management plan reviewed?
- Were all appropriate observation charts completed and variations noted and acted upon?
- Have any complaints or concerns been raised during this period of care via PALs or Complaints team?
- Has any feedback been received from the family/carers via the Meridian survey?

Example narrative:

Good escalation of concerns when NEWS increased resulting in prompt administration of IV antibiotics and IV fluids. Patient catheterised which was adequately documented with catheter passport in situ. However despite increased confusion, team did not request medical review. Medication review not carried out and drug chart illegible.

End of Life Care

- Was the patient subject to any intrusive or invasive procedures not in their best interest at end of life?
- Was an advanced care plan in place?
- Were nutritional and hydration needs assessed?
- Were the patient's spiritual needs considered?
- Was there a signed DNA CPR in place?
- Was the patient's preferred place of death identified?
- Was there evidence of discussion of the likelihood of dying or were the reasons for not discussing documented?
- Was pain assessed and managed?
- Were crisis medications prescribed and dispensed?
- Was a syringe driver in place?
- Was there evidence of a documented End of Life Care plan?
- Was the End of Life tick box completed on CIS?
- Was verification of death documented correctly?
- Is there evidence that the family/carer has been supported during care at the end of life and after death? (including being given appropriate bereavement pack/information on what to do next)
- Have you considered the 5 Priorities of Care for the Dying Patient? Recognise; Involve; Plan & Do; Communicate, Support.

Example narrative:

It was noted that there was a delay in identifying patient was reaching end of life, resulting in a delay in DNA CPR being signed. Due to this, patient was unnecessarily cannulated on day of death. Appropriate pain relief prescribed and administered. Once identified, family were involved in supportive discussions around the patient's progression to end of life and were sensitively given bereavement pack after death.

Notes for Section 4

Defining problems in healthcare

A problem in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard and led to harm'. 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. Also consider any potential safeguarding concerns in your response.

Determination of avoidability:

The following questions can be useful in helping to identify avoidable deaths:

- Was the death expected or unexpected at the outset?
- Was the death related to a healthcare intervention rather than the natural progression of the patient's disease?
- Did any avoidable events cause harm to the patient
- Was there a deviation from the accepted norms of practice?
- Were there extenuating factors that reduce preventability (co-morbidity, nature of acute illness, urgency of situation)

- Were there mitigating factors which decrease preventability (appropriate use of pressure relieving mattress in case of pressure ulcer, evidence of falls prevention strategies)
- Consider if better care had a reasonable chance of preventing the patient's death
- Is there enough evidence to justify your decision?

Notes for completing Section 5
Detailed review of potential problems in healthcare

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.

Consider whether any of the following were potential contributory factors:
Patient
Staff
Team
Communication
Equipment
Work Environment
Organisational
Education and Training
Safeguarding Concern