The Dudley Group NHS Foundation Trust

LEARNING FROM DEATHS POLICY		
	DOCUMENT TITLE:	**LEARNING FROM DEATHS POLICY**
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	Relevant Documents /Legislation/Standards	*National Guidance on Learning from Deaths (March 2017)*
	The electronic version of this document is the definitive version	

CHANGE HISTORY

Version	Date	Reason
1	**September 2017**	**This is a new document**

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

Policy on Learning from Deaths

Contents

THE DUDLEY GROUP NHS FOUNDATION TRUST

POLICY ON LEARNING FROM DEATHS

1. INTRODUCTION

This policy is developed from the "policy for review of inpatient deaths" which was introduced in April 2010. That policy had improved the accuracy of information the Trust held for internal assurance, and that submitted to outside organisations, and addressed the development of a new database of inpatient deaths which is automatically populated from OASIS so that a review of every death is recorded. The database is known as the Mortality Tracking System (MTS).

Following the publication of the National Guidance on Learning from Deaths (March 2017): https://improvement.nhs.uk/resources/learning-deaths-nhs/
the policy has been renamed and updated to refocus on learning and to ensure that the Trust's processes meet the standards required.

Significant parts of that guidance discuss the *selection* of cases for review; the Trusts position remains that all deaths should be reviewed and therefore selection of deaths to be reviewed is not part of this policy.

2. STATEMENT OF INTENT

The original processes addressed by the review of inpatient deaths policy remain; they were:

(i) To ensure that circumstances surrounding **all** inpatient deaths are peer reviewed, and thus:
- To learn from deaths
- To provide assurance at Board level of quality of final episodes of care.
- To provide Directorate leadership with information and assurance of quality of care and outcomes within their areas of responsibility
- To have in place a system that can immediately respond to mortality outlier information.

(ii) To ensure that the coding associated with inpatient death is as accurate as possible and to develop clinicians' understanding of the importance of the quality of data for which they are responsible.

2.1 This policy addresses further issues identified in *National Guidance on Learning from Deaths:*

- A requirement that opportunities for learning are always acted upon and that the learning is recorded
- Clear and documented attention to deaths of patients with Learning Disability
- A requirement that bereaved relatives have been invited to voice any remaining concerns, and that any review has taken such concerns into account. (This is in addition to the statutory Duty of Candour)
- Inclusion of deaths in ED into the remit of this policy (these are not admitted patients so have not previously been included in this policy)
- Integration of the review of both paediatric and perinatal deaths into the Trust wide review principle and mortality reporting process.

2.2 **Note: None of the above precludes the obligation to report a death via Datix as a serious incident if that is clinically appropriate (eg death potentially avoidable).** Finalised RCAs will be reviewed by the mortality panel (see below) .

2.3 Introduction of this policy will enable comprehensive reporting of learning from death.

3. DEFINITIONS/ABBREVIATIONS

MTS – Mortality Tracking System

Level 1 review – The first structured review by the department concerned using the MTS questionnaire (**Appendix 1)**

Level 2 review – The review performed by the Mortality Panel (see below) using "Structured case note review data collection" as advised by the *National Mortality Case Record Review Programme* (See references, Para 10)

Mortality Panel – A group of at least two consultants and a senior nurse that will carry out level 2 review independently from the level 1 reviewing department

LD Nurse - Liaison Nurse Learning Disabilities

4. DUTIES (RESPONSIBILITIES)

Chief Executive Officer
The Chief executive officer is responsible for ensuring there is a process in place for reviewing and learning from patient deaths.

Medical Director
The Medical Director and Deputy Medical Director are responsible for keeping under review the functioning of the process addressed by this policy.

Consultant Medical Staff
The Consultant Medical Staff are responsible for adhering to this policy.

Trust Clinical Audit Lead
The Trust Clinical Audit Lead is responsible for coordinating and monitoring the audit process.

Specialty Clinical Audit Leads
The Speciality Clinical Audit Leads are responsible for leading level 1 review of all inpatient deaths in their speciality; ensuring the MTS review tool is submitted and reporting actions on learning to the Medical Director's directorate (See 7. below).

Mortality Panel
The Mortality Panel (panel of consultants) is responsible for level 2 review of adult deaths

- When the level 1 process has produced an alert
- If the patient had been reviewed by the LD Nurse
- When the death has been subject to RCA via Datix

5. PROCESS TO BE FOLLOWED

5.1 Mortality Tracking System

The MTS contains the Consultant recorded as responsible for the patient at the time of death, and will automatically email that Consultant when the notes are available for coding review.

5.2 Clinical Review of Coding of Notes

Clinical review of the coding of notes of deceased patients is required. Incomplete or inaccurate coding can lead to inaccurate submission of data. This review must take place as soon as possible, but in any case **within a month** of the death to allow resubmission of any coding change, and is **the responsibility of the Consultant in charge of the final episode of care.**

The primary code must indicate the MAIN condition actually being treated during the first inpatient episode – this might not be the condition first noted as an initial impression or provisional diagnosis, and it might not be the condition that caused death.

The coders can only code from what has been written in the notes and they cannot interpret results of tests, or speculative entries.

5.3 Process – Consultant Responsible For Last Episode of Care:

The Consultant responsible for the final episode of care or last episode prior to step-down, (as identified by the OASIS PAS System) must liaise with the Clinical Coding Co-ordinator or Clinical Coding Manager to review the clinical record to ensure:-

- Hierarchy of coding is correct, particularly the primary diagnostic code
- Administrative details are correct (admission method, Consultant responsible for the episode/s etc.)
- Diagnostic and procedural coding is accurate
- Co-morbidities, circumstantial codes (e.g. palliative care) are included where appropriate
- The notes indicate what was written on the certificate of death (See Verification and Certification of Death Policy) and whether the coroner was informed.
- Note: The cause of death on the death certificate is not necessarily the same as the condition referred to by the “primary code” on admission.

Additional notes:

- If a Consultant believes they are **not** responsible for the discharging episode (or episode before step-down (as identified by the OASIS PAS System), they must identify the responsible Consultant to the Coding Team.
- Consultants must not delegate this review process to junior members of their team as maximum accuracy is essential.

5.4 Subsequent Process For Assurance – Audit Of Final Episode Of Care

Audit leads will be automatically notified of deaths occurring in their departments via the database above. The notification will contain a link to the MTS audit tool. (**Appendix 1**)

Each Department must undertake a structured review, via the audit tool, of all deaths occurring under the care of their Consultants. The audit lead should aim to undertake the process and complete the audit tool within 6 weeks of the patient death. Both the clinician in charge and the audit lead will be sent a reminder at 6 weeks and subsequently at 8 weeks. A further reminder will be sent at 12 weeks by the Trust Audit Lead. At this point the Head of Service and Deputy Medical Director will also be notified.

The review should take place in a multidisciplinary forum. The audit tool must confirm that Consultants other than the Consultant responsible have contributed to the review. The tool allows free text and comments should be added at the time of the departmental review.

The tool MUST be completed on line and will be stored in the MTS.

The tool is structured to flag any issues of concern that may require further consideration, and such cases will automatically be referred on for a level 2 review by a Trust panel of Consultants. A Primary Care representative is invited to attend this panel meeting.

5.4.1 ALL DEPARTMENTS: *Clear and documented attention to deaths of Patients with Learning Disability (LD)*

Patients known to have LD are flagged on OASIS. The LD nurse will automatically be informed. As well as the standard audit, the LD nurse will review the notes and the case will automatically be subject to a Level 2 review

5.4.2 ALL DEPARTMENTS: *Bereaved relatives should have been invited to voice any remaining concerns (This is in addition to the statutory Duty of Candour)*

Even in cases where there is no statutory Duty of Candour, it should be considered and noted at the departmental audit that there is evidence that bereaved relatives have been invited to question or comment on any aspect of care, and that they have been satisfied with the information they have been given. Free text entry should reflect this. Information to this effect will also be given to relatives in the bereavement booklet "*For you in your loss*".

Note:

Good practice will always be that bereaved relatives have the opportunity to discuss concerns with the responsible consultant and this should be the norm.

In cases where a level 2 review occurs the next of kin will be advised of this by letter and given a further opportunity to raise any concerns.

5.4.3 ALL DEPARTMENTS *A requirement that opportunities for learning are always acted upon and that the learning is recorded*

The responses to questions 8 and 9 on the first level audit require a specific response within the text field. In such cases, the departmental audit lead must with the Medical Head of Service, submit a brief note of the learning to the Medical Director. The note need not be a formal action plan, but must include "action by" dates. The note will then be recorded on the MTS

5.4.4 Inclusion of deaths in ED into the remit of this policy (these are not admitted patients so have not previously been included in this policy)

Deaths occurring in ED will be subject to a structured review. It is recognised that a modified audit tool may be more helpful/appropriate for ED deaths, and this is being developed in conjunction with the College of Emergency Medicine. Any questionable issues will be referred to second level review panel as with inpatient deaths.

5.4.5 Integration of the review of both paediatric and perinatal deaths into the Trust-wide review principle and mortality reporting process

5.4.5.1 Paediatric Deaths

Level 1 review recorded on MTS. MTS alerts leading to Level 2 review will work as with adult inpatients. In **all** cases bereaved relatives are offered a follow up meeting with Paediatric Consultant.

(Note, safeguarding reviews of all paediatric deaths take place as a matter of course, but by their nature would not necessarily identify problems in clinical treatment.

5.4.5.2 Neonatal deaths – level 1 review recorded on MTS. (included in perinatal meeting) Level 2 review provided by network review. In all cases bereaved relatives are offered a follow up meeting with Paediatric Consultant.

5.4.5.3 Stillbirths – Level 1 review at Departmental MDT (Perinatal Meeting). In all cases bereaved relatives are offered a follow up meeting with obstetric consultant.

Note: A new perinatal mortality review tool is in preparation for national roll out and will be taken up by DGH in due course.

6. REPORTING

Reporting on mortality and the learning from deaths will be considered

- at the Mortality Surveillance Group, particularly the detail of actions around learning provided by the departmental audit leads when appropriate
- at CQSPE to provide assurance of the application of this policy and its supporting processes with a focus on the learning and changes / improvements made
- at the appropriate Public Board meetings in a format compliant with all statutory responsibilities.

7. TRAINING/SUPPORT

The Information Department will provide advice and support.

8. PROCESS FOR MONITORING COMPLIANCE

See Table 1.

Table 1 - Compliance monitoring Checklist

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
The Compliance with the review of inpatient deaths policy	Deputy Medical Director	Mortality Tracking System (MTS) Dashboard	6 Monthly	Mortality Report	Trust Audit Leads and Clinical Directors	Mortality Surveillance Group

9. EQUALITY IMPACT ASSESSMENT

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

10. REFERENCES

National Guidance on Learning from Deaths:
A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (March 2017)

https://improvement.nhs.uk/resources/learning-deaths-nhs/

Using the structured judgement review method Data collection form (RCP)

https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources

Appendix 1- Mortality Tracking System Audit Tool

Question (Audit Form v4)
1) Is it clear from the notes that a plan of care was made on admission by a doctor of sufficient seniority?
2) Was there a delay in any investigation, procedure, operation or referral, or failure to respond to a result or report which affected outcome?
3) Were there any identifiable actions taken that could have contributed to death?
4) In your judgement, is there some evidence that the patients death was avoidable?
4.1) Has it been reported on Datix?
4.2) Is the RCA available?
5) In the opinion of the review team, was there a perceived deficiency of care from another department which may have contributed to death?
5.1) Is evidence available that it has been reviewed with the department involved?
6) Was the patient admitted <24hrs before death from a care home? (Please note care home in free text)
7) Was the patients' ward location appropriate?
8) Have any/all learning points from the review of this death been shared throughout your department?
9) Are there any learning points which should be shared more widely?
9.1) Has your department taken action to share these learning points more widely?
10) Was it recognised that the patient would die during this admission?
10.1) Was this documented?
10.2) Were there documented discussions with patient and family?
10.3) Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care?