Queen Victoria Hospital
NHS Foundation Trust

Responding to and Learning from Patient Deaths Policy

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2			**K Carter-Woods**
3	**2021**	**Updated to reflect current processes**	
4		**Updated to reflect Trust Mortality Surveillance Group process and Medical Examiner Role.**	**A Munday**

Executive Summary

The Queen Victoria NHS Foundation Trust (QVH) is committed to identifying, reporting and learning from deaths which occur in our care or following interventions and to enhancing the learning in this field through engagement with carers and families and with our clinicians.

For many people, death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death.

'*National Guidance on learning from Deaths*'[1] outlines the principles that healthcare staff should use when a patient dies whilst in the care of the Trust or within 30 days following discharge or an Outpatient procedure. This should include all deaths where families/carers or staff have raised a significant concern about the death, all deaths of those with learning disabilities or severe mental illness and all deaths in areas where people are not expected to die (e.g. elective procedures).

It supports a culture of openness, honesty and transparency[2], incorporating the 'Duty of Candour' which was made a contractual obligation in April 2013 and reinforces the fundamental obligation to be open and honest in the event of an incident where patient harm has occurred.

It is not intended to replace the Serious Incident (SI) Framework; this process will affect a much broader range of cases than SI investigations, which will continue to be carried out in line with the existing *National Serious Incident Framework*[3] until the implementation of the Patient Safety Investigation Response framework (PSIRF)

Case record reviews will be required to determine whether there were any problems in the care provided to the patient who died and, if there were, whether the death is likely to have happened as result of those problems - i.e. whether it was a potentially avoidable death.

Reviews should be carried out using an evidence-based methodology such as the 'Structured Judgement Review' (Royal College of Physicians 2018): the guidance further specifies that case

record reviews should, wherever possible, be conducted by clinicians who were not directly involved in the deceased's care.

The purpose of reviews and investigations of deaths, which problems in care might have contributed to, is to learn in order to prevent recurrence, and enable the duty of candour with bereaved families.

Involving families / carers

The other key message from the new framework is that Trusts must make it a priority to work more closely with the families/carers of patients who have died to ensure meaningful support and engagement at all stages, from notification of the death right through to actions taken following investigation.

The guidance sets out key principles for Trusts to follow, including the need to treat bereaved families/carers as equal partners and recognising that paying close attention to what families/carers say can offer an invaluable source of insight to improve clinical practice.

[1]National Quality Board, March 2017 (First Edition)
[2]NPSA/2009/PSA003 19th November 2009 Being Open
[3]NHS England 'Serious Incident Framework': Updated March 2015

Contents

Section		Page
	Executive Summary	2
1	Introduction	5
2	Purpose	5
3	Scope	6
4	Duties	6
5	Review and Investigation	9
6	Engagement with family and carers	10
7	Supporting and Involving Staff	11
8	Training and awareness	12
9	Equality	12
10	Review	12
11	Monitoring Compliancy with Policy	12
12	References	16

Appendices

Appendix 1	Mortality Review Flowchart	17
Appendix 2	Preliminary Mortality Review Screening	18
Appendix 3	Structured Judgement Review Proforma	21
Appendix 4	Bereaved Families and Carers – Key Principles	33

1. Introduction

This policy was originally developed in direct response to the National Quality Board report: '*National Guidance on Learning from Deaths: a framework for NHS Trusts and Foundation Trusts on identifying, Reporting, Investigating and Learning from Deaths in Care'*, published 4th April 2017:

The focus of the recommendations within the report is improving clinical governance processes around patient deaths and ensuring the families / carers of patients who have died are fully involved at every stage of the investigation procedure.

1.1 The Queen Victoria NHS Foundation Trust (QVH) has a responsibility to ensure that the death of any patient within their care, or within thirty days of discharge or an Outpatient procedure is reviewed and, if appropriate, fully investigated with the inclusion of relevant parties such as family / carers.

1.2 QVH has a responsibility to ensure that appropriate and sufficient employees have access to adequate information, training and supervision to be competent to undertake such review and investigation thoroughly and to an acceptable standard.

1.4 This Policy is intended to:

- Provide information and guidance to staff to enable them to assist the Trust in analysing and investigating patient deaths in a systematic way
- Inform staff of the agreed procedures to follow when a patient dies in our care or within thirty days of discharge
- Outline requirements for engagement with bereaved families and carers
- Ensure that lessons are learned and appropriate action is taken, monitored and evidenced following a patient death to prevent, as far as is possible, a recurrence

1.5 This policy should be read in conjunction with the 'Duty of Candour Policy', 'Risk Management Policy, Incident Reporting and Investigation Policy' and 'Bereavement and Care after Death Policy' at the Queen Victoria Hospital, all available on Qnet.

2. Purpose

In December 2016 the Care Quality Commission published the report, '*Learning Candour and Accountability'*, a review of the way NHS Trusts review and investigate the death of patients in England; this was an NHS England commissioned review into the how NHS trusts investigate deaths across acute, community and mental health settings.

<u>The review made 8 recommendations across five key areas</u>:

- **Involvement of families and carers**
- **Identification and reporting**

- **Decision to review or investigate**
- **Reviews and investigations**
- **Governance and learning**

3. Scope

This policy applies to all workers of the Trust in all locations including temporary employees, locums and contracted staff, plus Non-Executive Directors.

4. Duties

The list below includes individual responsibility for responding to and learning from the death of a patient in our care, or within thirty days of discharge.

4.1 All Staff: (including: Trust bank, locum or agency staff, visiting consultants)

All staff have a responsibility to:

- contribute to the identification, reporting and where required investigation of such deaths
- familiarise themselves with relevant policies and maintain an awareness of relevant updates;
- be responsive to and share lessons learned from patient deaths

4.2 The Medical Practitioner who is requested to complete a Medical Certificate of Cause of Death for a patient who dies at QVH

If the Medical Practitioner cannot sign the Medical Certificate of Cause of Death due to not being confident as to which illness caused the patient's death then the case must be referred to the Coroner;

- There are several other types of death that must always be reported:
- All deaths of children and young people under 18, even if due to natural causes. This is for safeguarding purposes.
- Deaths within 24 hours of admission to hospital
- Deaths that may be linked to medical treatment, surgery or anaesthetic
- Deaths that may be linked to an accident, however long ago it happened
- Deaths that may be linked to drugs or medications, whether prescribed or illicit
- If there is a possibility that the person took their own life
- If there are any suspicious circumstances or history of violence
- Deaths that may be linked to the person's occupation, for example if they have been exposed to asbestos
- All deaths of people who are in custody or detained under the Mental Health Act, even if due to natural causes
- Some unusual illnesses including hepatitis and tuberculosis.

4.3 Medical Examiner (ME)

All QVH inpatient deaths which do not meet the criteria for referral to the Coroner should be referred to the QVH ME. Please refer to the Bereavement and Care After Death Policy for guidance as to how to do this.

Medical Examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties.

They are trained in the legal and clinical elements of death certification processes.The purpose of the ME system is to:

- Provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the Coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data.

4.4 Medical Director

The Medical Director, (or the Deputy Medical Director in the Medical Director's absence) as Executive Patient Safety Lead is the nominated executive lead with overall responsibility for ensuring the trust responds to and learns from patient deaths; undertaking all preliminary reviews and SJR's – or delegation of the task to an appropriate clinician. This responsibility is alongside a named non-executive director who has a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny

4.5 Quality & Compliance Team

This team receive mortality data monthly: including patients who have died within 30 days of being an inpatient, day case or having received an outpatient procedure.
This is reviewed monthly in arrears and the team:

- Inform the relevant consultant, speciality governance lead, Medical Director, Chief Nurse and Head of Risk & Patient Safety
- Ascertain and report, where possible, cause and place of death. This is from either the GP or Coroner.
- Provide statistical information annually to the Medical Director confirming the total number of deaths in the Trust's specified scope (as a minimum, all adult inpatient deaths), total number of deaths subject to a case record review / SJR / SI
- Report mortalities in the Clinical Indicator Report (CIR) and distribute to a defined list of clinicians and relevant staff

4.6 Risk & Patient Safety Team

The main duties of the team, including the Head of Risk & Patient Safety, in relation to this policy are as follows:

- Supporting staff involved in the investigation
- Coordinating reviews and full investigations as required
- Where case review identifies a problem that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS) until the implementation of the national 'Learn from Patient Safety Events' system (LFPSE)
- Ensuring that, where there is organisational learning as a result of investigations, this is part of robust clinical governance processes and structures, and disseminated to all relevant staff and teams; including but not restricted to Joint Hospital Clinical Governance Group.

4.7 Patient Experience Manager

- To ensure that any patient death reported as a complaint or claim is notified to the Risk and Patient Safety Team through the Trust's electronic reporting system, if not already completed.
- To be a consistent point of contact available to bereaved families following any death, or during any investigation.

4.8 Administrative staff

Any member of staff could be informed of a patient's death prior to the monthly CIR being produced.

1. Staff should record on Patient's Evolve Record
   - date of death
   - who has notified them of the death.
   - Cause of death from Death certificate/Postmortem finding etc if available

   If they are unable to do so they should forward the information to the Health Records Team who will undertake this element.
2. The Clinical Audit team should be notified; qvh.clinicalaudit@nhs.net
3. A Datix should be completed.
4. Date of death should also be added to Patient Centre record

4.9 Committees and Groups with Overarching Responsibilities

The QVH Board of Directors is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, taking into consideration the views of the board of governors.

The Quality & Governance Committee (Q&GC) has delegated authority from the board as defined in the trust 'Reservation of powers and scheme of delegation' document. It will seek assurance that the policy and processes involved in Responding to and Learning from Patient Deaths are robust and complete.
It will receive a quarterly report from the Chair of the Clinical Governance Group (Medical Director) detailing the numbers of deaths, the numbers subject to case review and the numbers subject to 'Structured Judgement Review'.
Where there is any likelihood that care has contributed to the cause of death or significant learning has been identified, the Committee will ensure that an investigation has been completed. It will review the findings and may well make recommendations to the Board about actions required or strategic review if indicated following conclusion of the investigation.
The Trust Mortality Surveillance Panel (see below) will ensure progress of investigations.

5. Review and Investigation

- All patient deaths within the QVH, along with those notified as being within thirty days of discharge from our care or Outpatient procedure, will be subject to an initial preliminary review (complete proforma Appendix 1). This will be completed by the Medical Director/ Head of Quality and Compliance and reviewed by the Trust Mortality Surveillance Panel (TMSP)
- Where possible and appropriate the bereaved family and / or carers will be contacted by the Medical Director in relation to all deaths, with their views or concerns being sought to help inform the decision as to whether an investigation is appropriate.
- If the TMSP identify issues/ potential concerns about care requiring a Trust internal investigation or declaration of a SI then this will be coordinated and reported externally if required by the Trust's Risk & Patient Safety Team
- If the TMSP assess the Preliminary Review as raising issues not requiring formal investigation but requiring further review then a SJR will be requested from the relevant specialty
- Investigation through Structured Judgement Review in the first instance, is recommended in following circumstances;
    - Unexpected death, for example in elective surgery
    - Any paediatric death
    - Any death of a patient with learning difficulties or serious mental health disease
    - Patients who are not under the care of QVH at the time of death but where another organisation suggests that the Trust should review the care provided to the patient previously.
    - All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
    - All deaths where concerns have been raised internally or externally about the quality of care, or where service improvements are in progress
- All on-site deaths at QVH will be subject to a SJR.
- All completed SJRs will be approved by the TMSP.
- Completed internal formal investigations/ SI's will be reviewed and approved through Trust governance processes as per the QVH Incident Reporting & Investigation Policy
- Any identified learning from formal investigations/ SI's/ SJRs will be addressed by an action plan. This action plan will be tracked by the specialty through the TMSP, providing

assurance to the CGG and Q&GC that these actions to address any learning have been embedded in practice.

Upon death of patient / notification of death:

- Notify the Medical Director (or Deputy)
- Consider Duty of Candour requirements: complete Duty of Candour proforma if applicable and follow the guidance on the proforma; please refer to the Duty of Candour Policy
- Obtain / secure the notes for initial preliminary review; these notes must be kept and not sent for scanning onto the Evolve system.
- As early as possible, engage meaningfully and compassionately with bereaved families and carers, liaising with the Patient Experience Manager; see Appendix 4 for key principles.
- Regardless of the circumstances, any significant concern raised by families/carers should always trigger a case review
- Inform the patient's GP and any other interested parties i.e. referring acute trust patient came from / community trust / nursing home or any other relevant establishment: this should be discussed and agreed with the bereaved family / carers and a coordinated approach established.
- Medical Director/ Head of Quality and Compliance complete the preliminary review
- Preliminary review is reviewed by the Trust Mortality Surveillance Panel
- If on reviewing Preliminary Review the TMSP identifies that a SJR (Appendix 2) formal internal Trust investigation/ SI needs to be undertaken then this will be delegated by the Medical Director as appropriate if not undertaking it personally.
- Where a preliminary review reveals potential deficiencies in care or significant learning then those should be reported by the Datix system and be investigated as per the Incident Reporting and Investigation Policy.
- Where a SJR concludes that it is considered likely that any deficiencies in care have significantly contributed to the patient's death, or there is a greater than 50% possibility that the death could have been avoidable, then this should be treated as a Serious Incident; requiring full formal investigation, duty of candour and external reporting to commissioners and the CQC.
- The numbers of case reviews, SJRs, resultant incident reporting and SI's should be reported to Board by the Medical Director as part of the quarterly report, along with a log of actions required and completed.
- No SJR's or investigation reports are to be sent externally without having been approved by the Trust as per the Incident Reporting & Investigation Policy

6. Engagement with family and carers

Staff must engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death, following the principles in Appendix 3 in addition to:

- Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients; openness, honesty, and transparency should also be applied in all dealings with bereaved families and carers

- Communication at the time of a death, and afterwards, should be clear, sensitive and honest; Bereaved families and carers should be given as much information as possible and every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions.

- Involvement of bereaved families and carers begins with empathy and, where appropriate with a genuine apology; saying sorry is not an admission of liability, it is the right thing to do and, when appropriate, explaining what went wrong promptly, fully and compassionately and encouraging questions from the family / carers.

Where a preliminary review, or subsequent SJR concludes that the healthcare provided may have contributed to the death, then a more formal duty of candour meeting should be held as soon as possible with the bereaved family or carers to explain the process. This should include how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes; as per Duty of Candour requirements, they should be provided with a named person as a consistent link throughout the investigation and should:

- have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process

- have an opportunity to respond on the findings and recommendations outlined in any final report

- be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

7. Supporting and involving staff

The Trust recognises that Staff can be affected by the death of patients in different ways and is fully committed to supporting them.

Staff should be encouraged to talk to their line manager/ educational supervisor.

After Action Reviews should be facilitated for staff if those involved in the patients care feel that this would be helpful.

Occupational Health provides ‘an ‘Employee Assist Program’ for QVH staff; Care First is a confidential and professional service that provides impartial advice and support 24 hours a day, 365 days a year.

The Trust’s Psychology Service can provide appropriate support to individuals and/or teams as required.

8. Training and Awareness

This policy will be circulated to all ward managers and clinicians and be available on the Trust intranet for all staff.

9. Equality

This policy and protocol has been equality impact assessed in accordance with the Trust's impact assessment toolkit. Completed assessments are available upon request from qvh.eqia@nhs.net.

10. Review

This policy will be reviewed in 3 years: earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

11. Monitoring Compliance and Assurance

All hospital deaths are reviewed at the TMSP, presented at specialty governance meetings by the appropriate Clinical Governance Lead, CGG and other forums as appropriate. Under the new framework, Trusts are now also required to comply with new data reporting requirements relating to patient deaths.

This includes publishing the following information each quarter:

- total number of deaths in the Trust's specified scope (as a minimum, all adult inpatient deaths),
- Total number of deaths subject to a case review

Activity being monitored	Methodology to be used for monitoring	Responsibility for monitoring	Frequency of monitoring and reporting	Process for review and improvement
Mortalities within QVH	Data produced by Informatics and Quality and	Quality & Governance	Monthly report sent to CGG and clinicians.	• Preliminary Review (MD/ Head of Quality & Compliance) • Review by TMSP • SJR if required

	Governance			• Full investigation if required • Peer Review via JHCGM
Activity being monitored	**Methodology to be used for monitoring**	**Responsibility for monitoring**	**Frequency of monitoring and reporting**	**Process for review and improvement**
Mortalities elsewhere within 30 days of treatment (in/outpatient and day case)	Data produced by Informatics and Quality and Governance	Quality & Governance	Monthly report sent to CGG and clinicians.	• Preliminary Review (MD/ Head of Quality & Compliance) Review by TMSP • SJR if required • Full investigation if required • Peer review via the Joint Hospital Governance Meeting as required.
Learning Disabilities Mortality Review Programme (LeDeR)	Data produced by Informatics and Quality and Governance	Quality & Governance	Monthly sent to LeDeR by exception	Review by TMSP Peer review via the Joint Hospital Governance Meeting as required. Annual Report and Actions
Royal College of Physicians SJR	Data taken from clinician mortality reviews	Quality & Governance	Monthly report sent to CGG and clinicians as part of the CIR	Review by TMSP Clinical Governance Group (CGG)

The implementation of this policy, the reporting and subsequent review of deaths and the dissemination of learning will be monitored through the following internal and external groups and committees.

Committee	Responsibility
Trust board	The *National Guidance on Learning from Deaths* places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the *National Guidance on Learning from Deaths.* The Trust Lead for Mortality Surveillance and Review supported by the Quality and Compliance Team will report annually to the Clinical Quality Review Group. This report will address any specific questions raised by the Quality and Governance Committee prior to the annual report, along with updates on the: - Overall Trust level mortality - Thematic learning from the mortality deaths and the sharing/implementation of change based on this learning - Engagement in LeDeR project and sharing of learning from these reviews - Involving bereaved families and carers following a death - Deaths where initial review indicated that more formal RCA/SI review was required - Deaths where problems in healthcare contributed to the death
Quality and Governance Committee	The Trust Lead for Mortality Surveillance and Review supported by the Quality and Compliance Team will report quarterly to the Trust Board Quality and Governance Committee. This report will detail the following: - Overall Trust level mortality - Number of deaths reported at the Trust - Number of deaths identified for more detailed SJR and/or FII/SI review, and the reasons for that - Number of detailed SJR completed and FIIs /SIs undertaken - Thematic learning from the mortality deaths and the sharing/implementation of change based on this learning

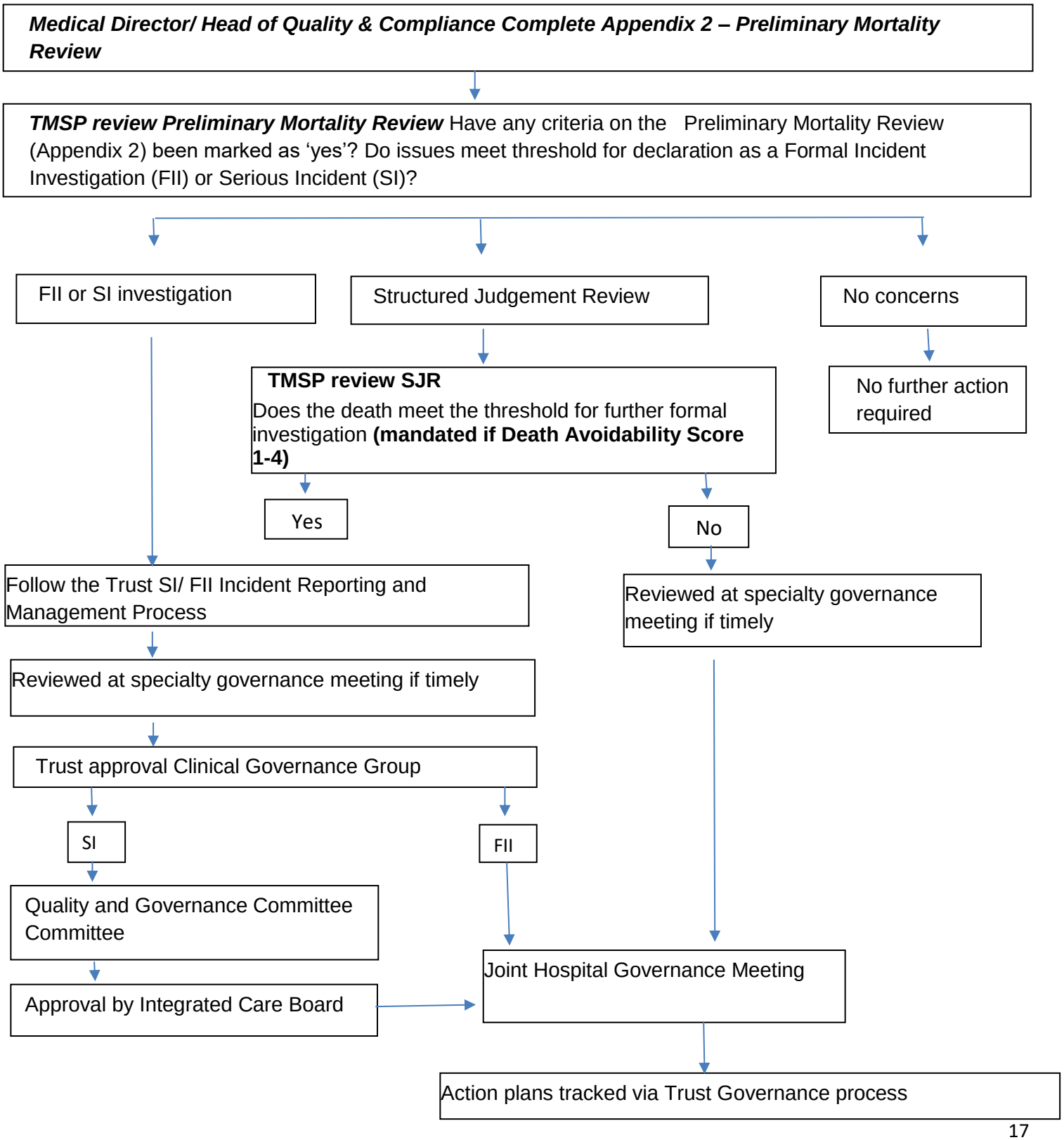
Clinical Governance Group	The specialities will present any SJRs to enable peer review at a Trust level following discussion at the speciality Mortality and Morbidity Meeting and review at the TMSP Each speciality will be invited to present their progress with their Learning from Deaths action plan on a rolling basis. Review Quarterly Mortality Report prior to submission for assurance at Q and G Committee
Trust Mortality Surveillance Panel (TMSP)	This panel will oversee, monitor and support the Specialties with the implementation of the Responding and Learning from Deaths policy. Compliance/ progress with detailed SJR, RCA and/or SI reviews will be monitored by the TMSP, and escalated to the CGG and Quality & Governance Committee as necessary. Ensure that any deaths requiring reporting externally is completed in a timely way. Report monthly update to CGG with a quarterly report, including mortality avoidability score
Speciality Mortality and Morbidity Meetings	Review completed SJRs to enable peer review at Local/ Speciality Governance Meetings prior to submission to the TMSP Track any actions identified through SJRs/ FIIs/ SIs

12. References

Document title	Publisher	Date	Comments
Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers	National Quality Board	2018	Supporting and involving carers and families
Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England	Care Quality Commission	2016	Throughout the policy
National Guidance on Learning from Deaths (1st Edition)	National Quality Board	2017	Throughout the policy
NHS England 'Serious Incident Framework'	NHSE	Updated 2015	
NPSA/2009/PSA003 'Being Open'	NPSA	2009	
Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study.	British Medical Journal	2012	Introduction
Using the structured judgement review method; A guide for reviewers	Royal College of Physicians	2016	
Severe Mental Illness; Health outcome indicator	Department of Health	2000	Mandated reporting group
The national medical examiner system	NHSE		ME system (4.3)

Appendix 1

Mortality Review Flow Chart



Appendix 2

Preliminary Mortality Review Screening

PRELIMINARY MORTALITY REVIEW FOLLOWING PATIENT DEATH AT QVH, WITHIN 30 DAYS OF TREATMENT/ INPATIENT EPISODE

Guidance for all staff following:

1. The death of a patient in our care
2. Notification that a patient has died within thirty days of being discharged from our care or after an Outpatient procedure

Patient Name			Date of Birth		
Hospital No.			NHS No.		
Date of Death		Age at Death		Date of admission Or Outpatient Appointment	
Speciality		Index Consultant			
Cause of Death					
Place of Death					
Preliminary Review by				Date	

If the initial screening below meets even one of the criteria provided in the list below, it is mandatory to conduct a detailed case review (SJR)

	Criteria	Yes	No	Comments
1	Inpatient death at QVH			
2	Referral to coroner: deaths that cannot be readily certified as being due to natural causes			
3	Was Sepsis recorded on either 1a, 1b, 1c or part 2 of the death certificate?			
4	All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision			
5	All deaths of patients subject to care interventions from which a patient's death would be wholly unexpected, for example in relevant elective procedures			
6	Children and Young People Mortality Review Process			
7	Maternity Mortality Review Process			
8	Inpatients detained under Mental Health Act (1983) or with severe mental health needs			
9	Patients known to have learning disability Action: Please ensure that this case was referred to the LeDeR team in Bristol (web address: http://www.bristol.ac.uk/sps/leder/) – 0300 777 4774			
10	Transfer to intensive care or high dependency unit or monitored beds from a ward			
11	Any interventional procedures (chest drain, lumbar puncture, liver biopsy, abdominal paracentesis, endoscopy etc.)			
12	Any other problem related to treatment and management plan e.g. cardiac or peri-arrest call made, fall resulting in injury etc.			

Summary of findings of Preliminary Review

Next steps

Structured Judgement View Required. Y/N	
Could this require a Trust formal Internal Investigation or Serious Investigation **If yes, please complete a Datix and immediately escalate to** • Patient Safety and Risk Team • Medical Director • Chief Nurse	

	Comments	Date
Reviewed by TMSP		

Appendix 3

Structured Judgement Review (SJR) Form

Hospital No.			NHS No.		
Date of Death		Age at Death		Date of admission/ outpatient appointment	
Speciality		Index Consultant			
Cause of Death (if known)	The certified cause of death (if known): 1a 1b 1c 2				
Did the patient have a Learning Disability?	Y**es** **No** **If yes** Action: Please ensure that this case was referred to the LeDeR team in Bristol (web address: http://www.bristol.ac.uk/sps/leder/) – 0300 777 4774				
Place of Death					

Summary of Case

Structured case note review data collection

Phase of care**; Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether this 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 important or relevant that you wish to comment on then please do so

Please rate the care received by the patient during this phase. 1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care Please circle only one score

Phase of care**; Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether this 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 important or relevant that you wish to comment on then please do so

Please rate the care received by the patient during this phase. **1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care** Please circle only one score

Phase of care: **Care during a procedure (excluding IV cannulation**

Please record your explicit judgements about the quality of care the patient received and whether this 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 important or relevant that you wish to comment on then please do so

Please rate the care received by the patient during this phase.
1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care
Please circle only one score

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether this 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 important or relevant that you wish to comment on then please do so

Please rate the care received by the patient during this phase.
1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care
Please circle only one score

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether this 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 important or relevant that you wish to comment on then please do so

Was the patient receiving palliative care?	No	Yes
Were they on an end of life care pathway?	No	Yes

Please rate the care received by the patient during this phase.
1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care
Please circle only one score

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received and whether this 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 important or relevant that you wish to comment on then please do so

Please rate the care received by the patient during this phase.
1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care
Please circle only one score

Please rate the quality of the patient healthcare record
1 = Very poor care 2 = Poor care 3 = Adequate care 4 = Good care 5 = Excellent care
Please circle only one score

Assessment of problems in healthcare

Were there any problems with the care of the patient?

If yes, did they lead to patient harm?

No (please move to next page) **Yes** (please continue below)

Problem types	**Yes/No**	**Did the problem lead to harm?**
Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)		No Probably Yes
Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic)		No Probably Yes
Problem related to treatment & management plan (including prevention of pressure ulcers, falls, VTE)		No Probably Yes
Problem with infection control		No Probably Yes
Problem related to operation / invasive procedure (other than infection control)		No Probably Yes
Problem in clinical monitoring (including failure to plan, undertake, recognize & respond to changes)		No Probably Yes
Problem in resuscitation following a cardiac or respiratory arrest (including CPR)		No Probably Yes
Problem of any other type not fitting the categories above		No Probably Yes

Avoidability of death judgment score

Action required	Avoidability Score	Definition	Please tick
If score 1-4, this case needs a Formal Investigation **immediately escalate to** • Patient Safety and Risk Team • Medical Director • Chief Nurse Log as an incident on Datix	**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)	
complete ACON Log (next page) to capture any learning	**Score 5**	Slight evidence of avoidability	
	Score 6	Definitely not avoidable	

Next steps;

1. Please explain your reasons for the death avoidability score along with any learnings and actions taken on the Areas of Concern Log (next page)
2. **Please forward all completed SJRs and ACON logs to the QVH Clinical Audit Inbox;** qvh.clinicalaudit@nhs.net

SJR Completed by	Electronic Signature	Date

	Comments	Date
Reviewed by TMSP		

Queen Victoria Hospital
NHS Foundation Trust

Mortality ACON (Areas of Concern) Log and Action Plan

Learning Point	Reviewed at	Action to be Taken	Responsible for Action	Target date for completion	Progress	Completion date
Detail the concerns raised from the SJR	*Detail where the death has been reviewed e.g. Divisional Mortality & Morbidity Group, including date*	*Detail actions taken Along with learning Points*	*Named person responsible for the action*			

Appendix 4

BEREAVED FAMILIES AND CARERS - KEY PRINCIPLES:

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