# Mortality Review Procedure

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<tr>
<th>Date approved</th>
<th>5 June 2017</th>
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<tbody>
<tr>
<td>Approved by:</td>
<td>Yvette Oade, Chief Medical Officer</td>
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<tr>
<td>Version</td>
<td>Version 1</td>
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</tbody>
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| Governance Group  | Mortality Improvement Group |
| Review Date       | 31 May 2018          |
| Link to Policy    | N/A                  |
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Mortality Review Procedure

STAFF SUMMARY

This procedure sets out the process to be followed in the Trust to ensure all deaths undergo an initial review and, where appropriate, a further more in-depth review. A flow chart of the process can be seen on page 4.

Each specialty will have a mortality review meeting (which may be part of their routine governance meeting) at which mortality data, and in-depth review of individual deaths, will take place. Learning will be identified and shared with other specialties where appropriate.

Outcomes from specialty mortality review meetings will be reported to the clinical service unit governance meeting and from there to the Trust’s Mortality Improvement Group.

Mortality data from across the Trust, and any mortality alerts from external organisations, are reviewed by the Mortality Improvement Group and in-depth reviews initiated to identify what action needs to be taken.
Leeds Teaching Hospitals NHS Trust - Specialty Mortality Review Process

In-Hospital Death

Recorded on PAS

Informatics generate reports by specialty

All deaths have mortality screening tool completed on PPM

Specialties with >60 deaths/year

Specialties with <60 deaths/year

All cases

Screened positive cases

At least 5 cases per month to undergo case note review, by consultant (or ST4+) not involved in care of patients

(SJR or Interim Case Record Review Proforma)

Outcomes discussed at next Specialty Mortality Meeting and Escalation Process Followed as Appropriate

Record of meeting held on G-Drive

Report from specialty M&M → CSU Governance
(Could be the meeting record)

CSU Reviews learning at Governance Meeting

CSU Routinely Reports Learning to Mortality Improvement Group

Escalation if Overall Care Score of 1 to Deputy CMO. Score 2 re-review by independent reviewer within specialty

Additional reviews completed as required

Report on Datix as appropriate, and fully investigate
1. PURPOSE

This procedure sets out the process to be followed in the Trust to ensure all patient deaths undergo appropriate review, and learning is acted upon to improve the care and experience of our patients.

Mortality review is a means of identifying problems in healthcare and identifying areas of care which could be improved such as early recognition and escalation of the deteriorating patient, and appropriate and timely end of life care. Reviews often highlight aspects of excellent care also, and it is important that learning from both areas of excellence, as well as those in need of improvement, is shared across the Trust.

National Guidance on Learning from Deaths was published by the national Quality Board in March 2017, and Leeds Teaching Hospitals has piloted the use of the structured case note review tool¹, which is a core element of the guidance.

This document sets out how we conduct mortality review in this trust.

2. PROCEDURE TO BE FOLLOWED

The procedure for mortality review can be seen in the flow chart on page 4.

The process consists of the following stages:
- Screening of all deaths
- Case Record Review - detailed review of selected cases
- Mortality Review Meeting discussion within each specialty
- Escalation where significant concerns are identified
- Reporting of outcomes and sharing of learning

2.1 SCREENING OF ALL DEATHS

All deaths will be reviewed by the consultant responsible for the patient’s care, using the screening tool at Appendix A, to help identify those deaths where there were problems in healthcare and require further review. This can be done by a nominated junior doctor following discussion with a consultant.

Those deaths that meet any of the criteria in the screening tool require Case Record Review and discussion at the specialty mortality review meeting. The Screening Tool covers the following issues:
- Unexpected deaths
- All cardiac arrests which fail to lead to spontaneous circulation
- Absence of end of life care or absence of a DNACPR form where a death was expected
- Concerns that the death may have been avoidable
- Death subject to a level 2 or level 3 Datix investigation
- Complaints made regarding the patient’s care
- Elective admissions
- Deaths reported to the coroner
- Patients with learning disabilities
- Patients where a safeguarding concern was raised
- A death where there are important lessons to be learned for the team or department (these lessons may be areas of excellence as well as areas to improve)

More than one box may be ticked on the screening form, and there is some overlap between the different questions asked.

An **unexpected death** may be defined as follows:
- The cause of death was not clear
- Although the diagnosis was clear and the patient was treated, the patient died without there being clear prognostic factors that indicated death was likely
- There were concerns over the standard of care provided
- The patient died suddenly and unexpectedly without adequate time for end of life care planning or consideration of a DNACPR order

An **avoidable death** is very difficult to define, but if there are any concerns that a death may have been avoidable than it should be referred for further review.

When considering whether a death was “Expected” it may be worth considering the GMC categories for ‘last year of life’: People are approaching the end of life when they are likely to die within the next 12 months. This includes people whose death is imminent (expected to die within a few days or hours) and those with:
- Advanced, progressive, incurable conditions
- General frailty and coexisting conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events (GMC 2010; NICE 2011)
- Children and young people with life limiting conditions and uncertain prognosis where there is an acute deterioration in their condition

### 2.2 CASE RECORD REVIEWS

Specialties with five or fewer deaths per month are expected to review the case notes of all deaths using either the Interim Case Record Review Proforma (Appendix B) or the Structured Judgement Review Proforma (Appendix C). By April 2018 we expect all specialties to be using the Structured Judgement Review proforma.
Specialties are expected to use these methods for reviewing deaths. If there is a very clear need for a specialty to adapt the Interim Case Record Review Proforma or Structured Judgement Review (SJR) Proforma, then this request should be submitted to the Mortality Improvement Group (MIG) for review.

Structured judgement reviews require completion by a trained reviewer. All mortality leads are expected to become trained reviewers, and each specialty is expected to contribute to producing structured judgement reviews, which may be used for thematic analysis of deaths, and are recommended for use nationally.

If the specialty has more than 60 deaths a year, then all cases screened as requiring a Case Record Review should be reviewed using either the Interim Proforma or Structured Judgement Review Proforma. If less than 5 deaths a month are identified as requiring a Case Record Review using this process, then a random sample of deaths should be selected for Case Record Review so that at least 5 cases a month are reviewed. If more than 5 deaths are identified per month as requiring a case record review then the mortality lead may need to prioritise which 5 will be reviewed and minute the rationale for the prioritisation.

If the only trigger for a Case Record Review is that the case had been referred to the Coroner, and the Coroner has accepted the cause of death and is not going to take the case forward, a Case Record Review is not necessary.

Case Record Reviews should be carried out by a consultant, or senior trainee (ST4+) under consultant supervision, that has not had significant involvement in the care of the patient. This is to ensure that deaths are reviewed independently of the parent team. It is recognised that in certain small specialties, or specialties where it is commonplace for several teams to look after a patient, then independent review may not be possible.

More junior trainees may also be involved in mortality review, but where this takes place it should clearly be for educational purposes, and a consultant must jointly review the details of the case, and be responsible for analysis of the case.

If the Screening Tool has identified that a Case Record Review is required then this should happen in a timely way (usually within the following month) and the results of this must be discussed at the relevant specialty mortality review meeting.

Detailed case note reviews may be used in the following ways:
- As a framework for discussion at a mortality review meeting
- To explore where there are patterns of good care, or suboptimal care, within a department, and across the organisation
- To review quality of care for specific patient groups e.g. patients admitted with sepsis, or those that have a cardiac arrest.

2.3 MORTALITY REVIEW MEETINGS

Specialty mortality review meetings should take place regularly, usually monthly, for
specialties that have deaths most months. If deaths are less frequent than this, then a mortality review at a mortality review or governance meeting should take place in a timely fashion to ensure that learning takes place as soon as possible after the death, and no later than 3 months after the death has occurred. Mortality review meetings may include review of morbidity (M&M meeting), and in specialties with very few deaths may be part of the specialty governance meeting.

Mortality Review Meetings should meet the following processes:\(^3\,^4\):

- Be led by the designated mortality lead, responsible for the organisation of the meeting
- Be multi-disciplinary, with attendance from consultants, junior doctors, nurses, therapists, and other staff where appropriate.
- Where necessary, be held jointly on a regular basis with other specialties e.g. anaesthetists and surgeons
- Be chaired by the mortality lead or a nominated deputy
- Facilitate an open, honest and constructive discussion of cases with a no-blame culture
- Commence with a summary and update from action points that arose from the previous meeting
- Review, and seek to understand, the numbers and causative factors of deaths in the specialty, looking at recent data and trends.
- Review individual deaths that have been identified in advance as requiring further review from the Mortality 1 Screening Tool.
- Mortality Review Meetings should adopt the following good practice:
  - More time should be allocated to those cases with most learning and, typically, up to 5 cases should be discussed.
  - If more than 5 cases have been identified as requiring a Case Record Review, then some deaths may be discussed in less detail if there are few points for discussion. If there are more than 5 cases identified as needing significant discussion at the meeting, then adequate time should be allowed for this, and on some occasions may mean postponing discussion until the following month. Routinely discussing large numbers of cases in detail where there are few discussion points or learning points is unlikely to be a valuable use of time.
- The Mortality Lead and the person conducting the Case Record Review should decide which deaths should be allocated the most time for discussion.
- Cases should be presented by a consultant, or senior trainee (ST4+) under consultant supervision, that has not had significant involvement in the care of the patient. More junior trainees may sometimes be invited to present cases as an educational experience, but this should have been prepared jointly with a consultant. If there are sensitive issues to discuss such as possible avoidability of death or problems in care provided to the patient, then the case should be presented by a consultant.
- Cases should be presented using Powerpoint slides following a standard
format, to ensure a consistent approach, which includes:

- Phases of care; admission, ongoing care, peri-operative care (if appropriate), end of life care
- Highlighting areas of good practice/excellence
- Identifying areas for improvement
- Use of literature review, where appropriate
- Identifying points for discussion
- Identifying potential learning points
- Initial recommendations by reviewer
- Opened up for discussion of potential action points

The patient should only be identified by age, sex and hospital number

The clinicians involved in/responsible for the patient's care should either not be identified, or alternatively identified only after the discussion of the case has taken place, to clarify points and answer questions, rather than steering the discussion. It is recognised that in small teams or memorable cases, the identity of the patient and/or clinicians may be clear but the approach involved should focus on a discussion of the relevant factors for learning and care provided to the patient, rather than the individuals involved.

- Openly ask the questions "What did we do well?" and "What could we have done better?" to encourage discussion.
- After discussion, action points should be made with clear timeframes, and allocated to specific individuals.

2.4 RECORDING, REPORTING, AND SHARING OF LEARNING

Specialty mortality review meetings should have meeting notes, summarising the cases discussed, whether they were SJRs, the main discussion points, and learning points and action points, and stored on the G Drive.

- A register of attendance should be collected and stored with, or as part of, the meeting notes to provide evidence of who was present at the meeting.

A summary of learning from specialty mortality review meetings will be presented to CSU governance meetings. Learning from the CSUs will be presented to the Mortality Review Group. A reporting template can be found in appendix F.

2.5 ESCALATION AND DUTY OF CANDOUR

If there are serious concerns identified regarding the treatment and care of the patient, consideration should be given to a subsequent investigation and discussion with the patient’s family. Such cases should be discussed with the Deputy Chief Medical Officer and Associate Medical Director (Risk).

When using the Case Record Review Tools, the Overall Care score should be used to prompt the escalation process in Appendix D.
3. ROLES AND RESPONSIBILITIES

3.1 DEPUTY CHIEF MEDICAL OFFICER

The Deputy Chief Medical Officer is responsible for oversight of this procedure, and is the Chair of the Trust’s Mortality Improvement Group.

3.2 CLINICAL DIRECTORS

Clinical Directors are responsible for:

- ensuring the specialty mortality review processes, as described in Section 2 of this procedure, are in place within their CSU, and
- ensuring that learning from specialty mortality review meetings is reported and discussed at the CSU governance meeting and a summary provided to the Mortality Review Group.

3.3 LEAD CLINICIANS

Lead Clinicians are responsible for:

- ensuring the specialty mortality review processes, as described in Section 2 of this procedure, are in place within their specialty, and
- ensuring that learning from their specialty mortality review meetings is reported to the CSU governance meeting.

3.4 SPECIALTY MORTALITY LEAD

Each specialty will have a named person who may perform the role of Mortality Lead alongside other clinical governance duties.

Mortality Leads are responsible for:

- Co-ordinating the two stage mortality review process outlined in Section 2, within their specialty
- Running the specialty mortality review meeting and identifying, in advance, which deaths will be discussed at the meeting
- Ensuring cases where poor care is identified are escalated appropriately

All specialty mortality leads should become trained in performing structured judgement review and use this process to analyse a sample of their deaths.

Mortality leads should ensure that at least 1 case per month is reviewed using structured judgement review.
3.5 CONSULTANTS

Consultants are responsible for:

- Reviewing the deaths of patients whose care they were responsible for, using the screening tool at Appendix A, to help identify those deaths where there were problems in healthcare and require further review.
- Carrying out Case Record Reviews of patients whose care they have not had significant involvement in, at the request of the Lead Clinician or Mortality Lead
- Supervising senior trainees (ST4+) who carry out Mortality Case Record Reviews
- Ideally being trained in performing structured judgement review and contributing to this process.

3.6 SPECIALTY MORTALITY MEETINGS

See 2.3 above

3.7 CSU GOVERNANCE MEETINGS

CSU governance meetings will review learning from specialty mortality review meetings, and agree appropriate action and sharing of learning.

3.8 MORTALITY IMPROVEMENT GROUP

The Mortality Improvement Group has delegated authority from the Quality Management Group to:

- Oversee and monitor the development of the Trust’s mortality improvement strategy and to manage the mortality work programme on an on-going basis.
- Oversee the implementation of any actions relating to mortality outlier alerts, the bi-annual review of CSU and specialty mortality data, the capture of evidence relating to mortality, and sharing learning outcomes from mortality reviews.
- To periodically review the specialty level mortality review meetings to assure consistency and high standards for effective review processes.

3.9 INFORMATICS AND CODING DEPARTMENTS

To be inserted

4. LINKS TO OTHER DOCUMENTS

None

5. MONITORING ARRANGEMENTS
See monitoring table attached

6. REFERENCES


## PROCEDURE MONITORING TABLE

<table>
<thead>
<tr>
<th>Procedure element to be monitored</th>
<th>Standards and Performance indicators</th>
<th>Process for monitoring</th>
<th>Individual or group responsible for monitoring</th>
<th>Frequency of monitoring</th>
<th>Responsible individual or group for development of action plan</th>
<th>Responsible group for review of assurance reports and oversight of action plan</th>
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<tbody>
<tr>
<td>Mortality Screening</td>
<td>All in-hospital deaths will undergo a Screening Review using the template provided in Appendix A</td>
<td>Report to be pulled from PPM+</td>
<td>Quality Governance Team</td>
<td>Quarterly</td>
<td>Mortality Improvement Group</td>
<td>Mortality Improvement Group and summary report to Quality Assurance Committee</td>
</tr>
<tr>
<td>Mortality Case Record Review</td>
<td>All screened positive deaths to undergo Mortality Case Record Review</td>
<td>Report to be pulled from PPM+</td>
<td>Quality Governance Team</td>
<td>Quarterly</td>
<td>Mortality Improvement Group</td>
<td>Mortality Improvement Group and summary report to Quality Assurance Committee</td>
</tr>
<tr>
<td>Specialty Mortality Review Process</td>
<td>All specialties will have a mortality review process, meeting the requirements set out in section 2.3</td>
<td>Annual review of specialty's process</td>
<td>Quality Governance Team, in conjunction with PSQMs and Leadership Fellows</td>
<td>Annually</td>
<td>Mortality Improvement Group</td>
<td>Mortality Improvement Group and summary report to Quality Assurance Committee</td>
</tr>
<tr>
<td>Recording of Specialty Mortality Review meetings</td>
<td>Minutes from Specialty Mortality Review Meetings will be held on G Drive</td>
<td>Six-monthly review of G Drive folders</td>
<td>Quality Governance Team</td>
<td>Six monthly</td>
<td>Mortality Improvement Group</td>
<td>Mortality Improvement Group and summary report to Quality Assurance Committee</td>
</tr>
<tr>
<td>CSU Reporting</td>
<td>All CSUs to provide reports on their mortality review activity and learning six-monthly to MIG with summary data and learning provided quarterly</td>
<td>Review of CSU reports to MIG</td>
<td>Quality Governance Team</td>
<td>Six monthly</td>
<td>Mortality Improvement Group</td>
<td>Mortality Improvement Group and summary report to Quality Assurance Committee</td>
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Mortality Review Screening Tool

LEEDS TEACHING HOSPITALS NHS TRUST

NAME:  DOB:  GENDER:  NHS NUMBER:  ADDRESS:

In March 2017 the Department of Health issued 'National Guidance on Learning from Deaths' which mandates that certain criteria are present, NHS organisations must undertake a case record review of a patient's care, with a view to develop an understanding of themes relating to mortality, in order to drive quality improvement work.

The mandatory criteria indicating case record review is necessary are present in the fields below.

If 'Yes' is selected, your specialty Mortality Lead will be informed and this will trigger a case notes review. Thank you for your help.

For further guidance click here

Specialty
Please select a Specialty:
Responsible Clinician:

It is MANDATORY that this form is completed following discussion of the criteria in relation to the case, with a Consultant. Please select below the name of the consultant that this form was discussed with.
Consultant:

Cause of death:
1 a
b
c
2

Criteria for Case Record Review

<table>
<thead>
<tr>
<th>Criteria for Case Record Review</th>
<th>Yes</th>
<th>No/ N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you believe the death unexpected? (There will be some patients with frailty and multiple comorbidities in whom death was not unsurprising to the clinical team - these do not require case record review unless other concerns are present.)</td>
<td></td>
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<tr>
<td>Was the patient subject to a cardiac arrest call which failed to lead to return of spontaneous circulation?</td>
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<tr>
<td>If the death was expected, was there an absence of end of life care planning or DNACPR form?</td>
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<tr>
<td>Are you concerned that any problems in healthcare occurred? (A problem in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard and led to harm'. E.g. Avoidable healthcare associated infection, avoidable acquired pressure ulcer, failure to respond in a timely manner to deterioration etc.)</td>
<td></td>
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<tr>
<td>Have you any concerns that this death was avoidable? (Even if you have slight concerns that this death was avoidable, you should refer for Case Record Review)</td>
<td></td>
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<tr>
<td>Is this case subject to an investigation (internal or external)? (I.e. When an incident with moderate harm or above has been reported on Datix)</td>
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<tr>
<td>Did the family/carers have significant concern regarding the quality of care</td>
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<tr>
<td>8.</td>
<td>Was the patient admitted for an elective procedure?</td>
<td>☐ ☐</td>
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<tr>
<td>9.</td>
<td>Was this death reported to the coroner? (Including if the patient died whilst sectioned under the Mental Health Act). Excluding when reporting industrial diseases</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>10.</td>
<td>Did this patient have a learning disability?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>11.</td>
<td>Was a safeguarding concern raised?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td></td>
<td>For Case Record Review? (If yes to any of the above then case note review is required) You may wish to put this case forward for Level 2 review for another reason. If so please expand here:</td>
<td>☐ ☐</td>
</tr>
<tr>
<td></td>
<td>If a Case Record Review is not required are there any aspects of excellent care or compliments received you wish to highlight?</td>
<td></td>
</tr>
</tbody>
</table>

Many thanks for the time you have spent completing this form. The data you have provided will be used to help the Trust develop an understanding of themes relating to mortality, in order to drive quality improvement work.

If you have selected “Yes” to any of the mandatory criteria above, your specialty’s Mortality Lead will be informed and this will trigger a case note review.
LEEDS TEACHING HOSPITALS NHS TRUST
Interim Mortality Case Record Review Tool

Specialty:

Date of death:

NHS Number:

**Why was this case chosen for Case Record Review?** - Please outline in box below

Eg Routine (either all deaths in specialty reviewed, or this case was sampled randomly),
or, Issue identified in part 1 of screening tool.

---

Name of Doctor completing this form

Grade

Date
Please review the patient’s background, admission, procedures and events leading to death. You may wish to consider the following issues but these are not intended to be exhaustive or exclusive:

Problems in assessment, diagnosis and management, including whether the patient had appropriate senior medical input

Timeliness of diagnosis, investigations, delivery of care/treatment

Appropriate monitoring and response to e.g. early warning scores, abnormal test results

Harms including (but not limited to) hospital acquired VTE/MRSA infection/C.difficile infection/inpatient fall/pressure ulcer/allergic reaction/incorrect medication

Appropriate escalation of care, including critical care outreach/HDU/ICU care

Communication between healthcare professionals, or with family

Quality of end of life care, including timely and appropriate DNACPR decision where appropriate:

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/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 identified as important to them should be involved in decisions about treatment and care to the extent that 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 & 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 consider (if applicable) whether GMC guidance has been followed regarding communication of cardiopulmonary resuscitation decisions with the patient and/or carer.

**Areas of excellent care**
Problems with care

Learning points
Action points (may be documented after a mortality meeting)

**Phase of care: Assessment of Care Overall**

We are interested in comments about the quality of care the patient received overall and whether it was in accordance with current good practise (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please comment on the overall care received by the patient, including anything particular you have identified.

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very Poor</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Excellent</td>
</tr>
</tbody>
</table>

Please Select:

Please rate the quality of the patient record in enabling good quality of care to be provided

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very Poor</td>
</tr>
<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Excellent</td>
</tr>
</tbody>
</table>

Please Select:

Does this case need to be reported on Datix? Yes/No
e.g. an adverse incident that has not previously been reported

Is there an issue relating to duty of candour? Yes/No

Are there areas of learning that need to be shared across the Trust and reported to the Mortality Improvement Group or EoLC Group? Please outline below
LEEDS TEACHING HOSPITALS NHS TRUST
Structured Judgement Review Tool

Introduction

Leeds Teaching Hospitals has piloted the use of structured judgement review (previously called Structured Case Note Review) as a means of reviewing deaths. This is a tool designed locally by the Improvement Academy which now forms the basis of a national programme for retrospective case record review. Structured judgement review has been used by several departments, including Elderly Medicine as a means for reviewing deaths, and is a valuable tool for identifying strengths and weakness in care delivered to patients. It involves trained clinicians reviewing phases of care and judging the quality of care provided using both ratings of quality for phases of care, and short, explicit judgement commentaries for safety and quality of care provided in each period.

Background

Specialties may use the phase of care scores from structured judgement review, and themes identified within these reviews, as areas for learning. Use of structured judgement review as a means to perform all mortality Case Record Reviews is regarded as best practice but requires training for all staff performing these reviews. Staff members wishing to be trained in structured case note review should contact Sarah.Braidford-Smith@nhs.net.
Structured Judgement Review Data Collection

Please enter the following:

Age at death (years):

Gender: M/F

First 3/4 digits of the patient’s postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:
Jan/Feb/Mar Apr/May/June Jul/Aug/Sept Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:
Guidance for reviewers

1) Did the patient have a learning disability?
   - No indication of a learning disability – proceed with this review.
   - Yes – clear or possible indications from the case records of a learning disability. Action: after your review, please refer the case to the hospital’s clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2) Did the patient have a serious mental health issue?
   - No indication of a severe mental health issue – proceed with this review
   - Yes- clear or possible indications from the case records of a severe mental health issues. Action: after your review, please refer the case to the hospital’s clinical governance group.

3) Is the patient under 18 years old?
   - No the patient is 18 years or older – proceed with this review.
   - Yes- the patient is under 18 years old. Action: after your review, please refer the case to the hospital’s clinical governance group for linkage with the Child’s Deaths review programme.
Structured judgement review data collection

Phase of care: **Admission and Initial Care (first 24 hours)**

We are interested in comments 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 important or relevant that you wish to comment on then please do so.

<table>
<thead>
<tr>
<th>Please rate the care received by the patient during this phase.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = very poor care</td>
</tr>
</tbody>
</table>

Please circle only one score.
Phase of care: On-going Care

We are interested in comments about the quality of care the patient received and whether it was in accordance with current good practise (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.
We are interested in comments about the quality of care the patient received and whether it was in accordance with current good practise (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

We are interested in comments about the quality of care the patient received and whether it was in accordance with current good practise (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.
We are interested in comments 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).

You may find it useful to take into account the following 5 priorities which form the professional Standards for End of Life Care:

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/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 identified as important to them should be involved in decisions about treatment and care to the extent that 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 & 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 consider (if applicable) whether GMC guidance has been followed regarding communication of cardiopulmonary resuscitation decisions with the patient and/or carer.
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: Assessment of Care Overall**

We are interested in comments about the quality of care the patient received overall and whether it was in accordance with current good practise (for example, your professional standards). 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 overall 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 record.

1 = very poor  2 = poor  3 = adequate  4 = good  5 = Excellent

Please circle only one score.
**Assessment of problems in healthcare**

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

**Were there any problems with the care of the patient? (Please tick)**

No ☐ (please stop here)  Yes ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

**Problem types**

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)*
   - Yes ☐ No ☐
   - Did the problem lead to harm?  No ☐ Probably ☐ Yes ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*
   - Yes ☐ No ☐
   - Did the problem lead to harm?  No ☐ Probably ☐ Yes ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)*
   - Yes ☐ No ☐
   - Did the problem lead to harm?  No ☐ Probably ☐ Yes ☐

4. **Problem with infection management**
   - Yes ☐ No ☐
   - Did the problem lead to harm?  No ☐ Probably ☐ Yes ☐

5. **Problem related to operation / invasive procedure** *(other than infection control)*
   - Yes ☐ No ☐
   - Did the problem lead to harm?  No ☐ Probably ☐ Yes ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)*
   - Yes ☐ No ☐
   - Did the problem lead to harm?  No ☐ Probably ☐ Yes ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))*
   - Yes ☐ No ☐
   - Did the problem lead to harm?  No ☐ Probably ☐ Yes ☐

8. **Problem of any other type not fitting the categories above**
   - Yes ☐ No ☐
   - Did the problem lead to harm?  No ☐ Probably ☐ Yes ☐

Please summarise any actions and lessons learnt

Learning Points:

Action Points: (may be documented after a mortality meeting)
Does this case need to be reported? Please comment on the care received by the patient during this phase of care, including anything particular you have identified.

Is there an issue relating to duty of candour? Please comment on the care received by the patient during this phase of care, including anything particular you have identified.

Are there areas of learning that need to be shared across the Trust and reported to the Mortality Improvement Group, and/or End of Life care Group? Please outline below

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Avoidability of death judgement score
(Most appropriately used at second stage review, if required)

We are interested in your view on the avoidability of death in this case. Please choose from the following scale.

**Score 1**  Definitely avoidable

**Score 2**  Strong evidence of avoidability

**Score 3**  Probably avoidable (more than 50:50)

**Score 4**  Possibly avoidable but not very likely (less than 50:50)

**Score 5**  Slight evidence of avoidability

**Score 6**  Definitely not avoidable
Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular you have identified.

Please summarise any actions and lessons learnt from this case:
Leeds Teaching Hospitals NHS Trust
Mortality Case Record Review Escalation Process

Overall Assessment of Care Score

1 2 3 4 5

Review by Deputy Chief Medical Officer (DCMO) and next step confirmed

Friday Quality Meeting

Expert clinician to review notes and ask to score 1-5 for overall assessment and avoidability

DCMO to Review

Formal Investigation (Datix and Duty of Candour)

Specialty Review at M&M meeting with reflection, learning and actions minuted

Appendix D

Mortality Review Procedure - May 2017