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| **Author:** | James Neil, Learning from Deaths Lead & Kirsty Foskett, Head of Clinical Governance, Quality and Patient Safety Specialist. | | | |
| **Scope:** | Trust Directors, Senior Managers and all staff groups | | | |
| **Replaces:** | 2.0 | | | |
| **To be Read in Conjunction with the Following Documents:**  **(list related policies)** | Patient Safety Incident Response Policy  Patient Safety Incident Response Plan | | | |
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**LEARNING FROM DEATHS POLICY INCLUDING MEDICAL EXAMINER SERVICE**

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# INTRODUCTION

The Trust is committed to making patient safety a priority and to doing its reasonable best to prevent injury, ill-health and harm to patients, staff and visitors. It would therefore stand to reason that the Trust would review the care provided to people who have died to with a view to making improvements where possible. The Trust will do this by:

* Identifying problems associated with poor outcomes.
* Working to understand how and why these occur.
* Ensuring lessons are learned.

The Trust has in place policies and processes for learning from incidents which includes those that may have arisen in connection with the death of a patient. This policy aligns with those processes but incorporates the recommendations made in the [CQC’s report of December 2016](https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf).[[1]](#footnote-1)

Under the ***National Guidance on Learning from Deaths***, published by the National Quality Board in March 2017, trusts are required to:

* Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients who die under their management and care, including:
  + how their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child death, a stillbirth or a maternal death
  + their evidence-based approach to undertaking case record reviews
  + the categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed)
  + how the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations
  + how staff affected by the deaths of patients will be supported by the trust.
* Collect specific information every quarter on:
  + the total number of inpatient deaths in an organisation’s care[[2]](#footnote-2)
  + the number of deaths the trust has subjected to case record review (desktop review of case notes using a structured method) (NB: information relating to deaths reviewed using different methodologies – eg inpatient adult deaths, child deaths, deaths of patient with learning disabilities – may be separated in the report to provide distinction/clarity where required)
  + the number of deaths investigated under the Patient Safety Incident Response Framework (PSIRF).
  + of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care
  + the themes and issues identified from review and investigation, including examples of good practice
  + how the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken, and progress in implementation.
* Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

This policy sets out the Trust’s approach to meeting these requirements.

# PURPOSE AND SCOPE

## **Purpose**

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

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in its care.

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

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

This policy should be read with the Trust’s Patient Safety Incident Response Policyand Patient Safety Incident Response Plan.

# Scope

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

# DEFINITIONS

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

|  |  |
| --- | --- |
| Death certification | The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner. |
| Case record review | A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care. |
| Mortality review | A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.  A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as ‘cause of death’). The term ‘avoidable mortality’ should not be used, as this has a specific meaning in public health that is distinct from ‘death due to problems in care’. |

|  |  |
| --- | --- |
| Death due to a problem in care | A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as ‘cause of death’). The term ‘avoidable mortality’ should not be used, as this has a specific meaning in public health that is distinct from ‘death due to problems in care’. |
| Patient Safety Incident Response Framework | Any patient death where acts or omissions have occurred and are thought to have contributed to a patients death under the Patient Safety Incident Response Framework (PSIRF) will require a full Patient Safety Incident Investigation to be undertaken.  For more guidance, the steps in the below policies are to be followed:  [Patient Safety Incident Response Policy - Percy (interactgo.com)](https://rjah.interactgo.com/Interact/Pages/Content/Document.aspx?id=7172&SearchId=647315)  [Patient Safety Incident Response Plan - Percy (interactgo.com)](https://rjah.interactgo.com/Interact/Pages/Content/Document.aspx?id=7173&SearchId=647319) |
| Quality improvement | A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures. |
| Patient safety incident | A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care. |

# ROLES AND RESPONSIBILITIES

This section includes the roles and responsibilities of individuals and committees or groups relevant to this policy.

## **4.1 Individual Responsibilities**

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| --- | --- |
| **Individuals** | |
| **Chief Executive** | The Chief Executive has overall responsibility for the safety of the Trust’s patients, staff and visitors. The systems and process management responsibilities for learning from deaths are delegated by the Chief Executive as follows: |
| **Non-Executive Directors** | The Non-Executive Directors are responsible for:   * understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny * championing quality improvement that leads to actions that improve patient safety * assuring published information; that it fairly and accurately reflects the organisation’s approach, achievements and challenges |
| **Chief Nurse and Patient Safety Officer** | The Chief Nurse (jointly with the Chief Medical Officer) is responsible for patient safety in the organisation.  Further, the Chief Nurse has responsibility for overseeing the quality of the Patient Safety Incident Response Plan of which unexpected death investigations will form a part. |
| **Chief Medical Officer** | The Chief Medical Officer (jointly with the Chief Nurse) is responsible for patient safety in the organisation.  The Chief Medical Officer is the Executive Lead with overall responsibility for the learning from deaths agenda and the implementation of this policy to support the Trust’s work and learning in this area. |
| **Learning from Deaths Lead** | The Learning from Deaths Lead will chair the Mortality Steering Group and provide reports from this to the Patient Safety Committee and further reports to the Quality and Safety Committee and the Board.  The Learning from Deaths Lead will provide a synopsis / attend the Clincal Governance Meeting (see below) in the weeks that a death has occurred. |
| **Head of Clinical Governance & Quality** | The Head of Clinical Governance and Quality is responsible for the following:   * supporting the Chief Medical Officer and Learning from Deaths Lead with the implementation and adherence to this policy * ensuring alignment of the learning from deaths investigations with the incident management and PSIRF policies * ensuring liaison with external bodies in relation to an unexpected death takes place as required. * ensuring the mechanisms in place to support staff and families involved in a patient death are implemented |
| **Investigation Lead (in the event of an unexpected death)** | The Investigation Lead will be responsible for identifying all staff, departments and key teams who have some involvement in the incident and for informing all appropriate managers of the investigation. The responsibility for the investigation and identification of all corrective action rests with the Investigation Lead.  The Investigation Lead will determine from whom statements are required, and from whom an interview is more appropriate, and request these Trust staff involved and the line management for the staff to enable release of time Statements should be provided within 10 working days, and staff released for interview within 30 working days of the incident occurring at a mutually convenient time with the investigator (s), unless there are exceptional circumstances which must be agreed with the Chief Nurse or Chief Medical Officer  Where the incident is also an inquest, statements must be provided within 10 working days Notes should be taken from the interview, and shared with the interviewee to ensure factual accuracy.  The Investigation Lead will receive and review reports associated with the investigation and will ensure that reports are factual, legible, signed and dated.  The investigation lead will conduct the investigation in line with the following policies:   * + - Patient Safety Incident Response Policy     - Patient Safety Incident Response Plan   Following the ratification of the investigation report at the Trust Board, the Investigation Lead will feed back findings to those involved in the incident. |
| **Family Liaison Lead (in the event of an unexpected death)** | The Family Liaison Lead will be appointed during the 72 hour scoping review and will:   * ensure that the family or next of kin is informed of the incident and is kept informed during the investigation process to ensure that Duty of Candour is followed. However, the Consultant in charge of the patient’s care will be responsible for giving this information where appropriate. * ensure that should the family or next of kin so wish, they are provided with a copy of the final report upon conclusion of the investigation within 10 working days of sign off of the investigation report. * facilitate a face to face meeting and / or a response to any queries with the family or their next of kin |
| **PALS/Bereavement team and Ward Manager** | Responsible for the co-ordination of the certification of the patient death, including liaison with the clinical team involved, family, coroner and undertaker as necessary. |
| **All Managers** | Line Managers are responsible for ensuring staff can access support following a patient death, should this be required, including giving the employee details of the Employee Assistance Service.  The Line Manager has a responsibility to seek advice from the HR department if there are any concerns about the psychological impact of a patient death on a member of staff.  Line Managers should encourage staff involved in patient deaths and particularly those that were unexpected to record as much detail as they can as soon as possible after the incident in order to maximise recall.  Line Managers are required to support the release of staff to provide statements or attend interviews or meetings relating to the incident investigation. |
| **All Staff** | All staff have a responsibility to report via Datix Web all incidents and near misses, both patient safety and non-patient safety and this includes unexpected patient deaths.  All staff are required to co-operate with Patient Safety Incident Investigations (PSII) or learning from death reviews i.e provide any requested information, including statements and attend interviews when required.  All staff are expected to support colleagues who have been involved in a patient death. |

## **4.2 Committee Responsibilities**

|  |  |
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| **Committee** | |
| **Trust Board** | The Chief Executive, Chief Medical Officer, Chief Nurse and other Executive Directors have a collective responsibility to ensure that this policy & procedure is effectively implemented. This includes ensuring that the required resources are available to facilitate the enactment of this policy and that the principles of a just culture are supported and maintained throughout the life of an incident investigation.  The Trust Board will:   * ensure the Trust has in place a nominated Patient Safety Director (Chief Nurse)and Learning from Deaths Director (Chief Medical Officer) * receive assurance regarding effective incident management and implementation of incident management policies and procedures from relevant Committees * receive mortality reporting in relation to deaths, reviews, investigations and learning with discussions held publicly * receive assurance that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reports on the same in annual Quality Accounts * ensure there are processes in place to offer timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death * ensure engagement with commissioners to review and improve their respective local approaches following the death of people receiving care from their services. |
| **Quality and Safety Committee (Q&SC)** | The Q&SC is a subcommittee of and accountable to the Trust Board.  The Q&SC receives assurance from the Delivery Units that appropriate systems of clinical governance are in place and that patient safety is ensured.  The Q&SC must be satisfied that this policy is effectively implemented and that learning from death reviews and investigations into unexpected deaths;   * are completed in a timely fashion * that all associated risks have been identified * that action plans to remove or minimise identified risks have been delivered * that lessons are learned in order to minimise the risk of similar incidents occurring in the future   The Committee will receive and consider a quarterly report on Learning from Deaths |
| **Patient Safety Committee**  **(PSC)** | The PSC, chaired by the Director of Nursing, ratifies the terms of reference and receives regular reporting on the learning from deaths review process via the Mortality Steering Group.  The PSC will also receive assurance, in respect of unexpected deaths, the sharing of lessons learned from Patient Safety Incident Investigations and Delivery Unit Reviews, through the Unit Clinical Governance Structure and associated assurance reports. |
| **Mortality Steering Group** | The Mortality Steering Group is a multi-disciplinary group responsible for overseeing the Trust’s Learning from Deaths Policy and its implementation across the Trust. It is chaired by the Learning from Deaths Lead.  The Mortality Steering Group will review all limited structured judgment reviews and root causes analysis reports in the event of death meeting the criteria of an SI. |
| **Weekly Governance Meeting** | This group is chaired by the Head of Clinical Governance and Quality and consists of the MSK and Specialist Clinical Governance Managers and Assistant Managers.  The meeting takes place weekly and will look at the incidents, inquests, complaints and claims that have occurred in the previous week. This will include any deaths that have occurred with either a brief report or attendance from the Learning from Deaths Lead as required.  On a bi-weekly basis this includes representation from the Delivery Unit Matrons, to discuss any moderate harm patient safety incidents or incidents of concern. |

# CERTIFYING, REPORTING AND INVESTIGATING A PATIENT DEATH

## **5.1 The Process for Certifying and Reporting a Patient Death in Care**

**5.1.1 Certification**

The registered medical practitioner in attendance during the patient’s last illness is required under the Births and Deaths Registration Act 1953 to certify the cause of death.

This certification should preferably be carried out by a consultant or other senior clinician. Delegation of this duty to a junior doctor who was also in attendance should only occur if he/she is closely supervised.

The certifying medical practitioner must state the cause or causes of death to the best of his/her knowledge and belief. This may include a causal sequence of conditions with the disease of condition that led to directly to the death listed first. For example:

1 (a) Intracerebral haemorrhage

(b) Cerebral metastases

(c) Osteosarcoma

Part II should be used when one or more conditions have contributed to death but are not part of the main causal sequence leading to death.

This should be conveyed via the Governance/Bereavement team (location 41) to the Medical Examiner Service at SATH. (please see referral flow-chart and forms in appendix C and D).

## **5.1.2 Medical Examiner Service and the Medical Certificate of Cause of Death.**

The Royal Shrewsbury Hospital Bereavement Office now provides a Medical Examiner service to the county, which is a national system for reviewing deaths that occur in hospital. This service consists of senior level medical practitioners and support staff that have been independent from the care received. The Medical Examiner reviews all deaths within the hospital in order to establish a cause of death prior to issuing a Medical Certificate of Cause of Death (MCCD).

The identified next of kin will receive an initial telephone call from the Medical Examiner or a qualified Medical Examiner Officer, the nature of which is to discuss the nursing care, medical treatment and provisional cause of death.

Following this telephone conversation the Medical Examiner will instruct for the treating doctor to write the MCCD.

Once the MCCD has been completed, the Bereavement Service will send this electronically to the Registry Service.

In some cases, the Medical Examiner or treating doctor may need to speak to the coroner before proceeding

**5.1.3 Internal Reporting of the Patient Death**

All patient deaths are recorded on the Trust’s Datix system and then reported via the Trust’s performance data to the Trust Board and external agencies as required (For a list of the external agencies, please refer to Appendix A). This includes deaths that are reported into the Trust from other agencies.

For unexpected deaths which meet the criteris for a PSII these are reported under the Patient Safety Incident Response Policy.

[Patient Safety Incident Response Policy - Percy (interactgo.com)](https://rjah.interactgo.com/Interact/Pages/Content/Document.aspx?id=7172&SearchId=647315)

[Patient Safety Incident Response Plan - Percy (interactgo.com)](https://rjah.interactgo.com/Interact/Pages/Content/Document.aspx?id=7173&SearchId=647319)

In addition there are deaths of certain groups of patients which require additional external reporting and these are outlined later in this section.

**Timeline for Reporting**

|  |  |
| --- | --- |
| **Timeline** | **Action** |
| **Within 24 hours of the patient death** | Death to be reported via Datix Web and decision to be made whether the incident has potential to meet the criteria under PSIRF.  Screening tool to be completed (Appendix A) |
| **Within 48 hours of the incident report** | A limited structured judgment review to take place. |

# 5.1.4 External Reporting of the Patient Death/Coroner

**(Please Liaise with Medical Examiner Service via PALS/Bereavement team before referral).**

**01691 404606 or Location 41.**

**Reports to the Coroner**

A death should be referred to the coroner if;

* The death may be due to an accident (whenever it occurred)
* The death may be due to self-neglect or neglect by others
* The death may be due to an industrial disease or related to the deceased’s employment
* The death may be due to an abortion
* The death occurred during an operation or before recovery from the effects of anaesthetic • the death may be suicide
* The death occurred during or shortly after detention in police or prison custody.
* The cause of death is unknown
* The deceased was not seen by the certifying doctor either after death or within 14 days before death
* The death was violent or unnatural or was suspicious

In addition to this list, the registrar of births and deaths is required to report to the coroner any death for which a duly completed medical certificate of cause of death is not obtained.

**Patients with Learning Difficulties**

All deaths of people with learning disabilities aged 4 years and over to be reported to the Learning Disabilities Mortality Review (LeDeR) programme which will then follow the process below:



**Patients with Mental Health Issues**

All deaths relating to patients detained under the Mental Health Act must be reported to the Care Quality Commissioner and Commissioning Body without delay. These cases must also be automatically referred to the Coroner.

**Death of a Child**

Infant or child (under 18) death reviews are mandatory and must be undertaken in accordance with Working Together to Safeguard Children (2015). These deaths will be investigated under a different process e.g. Child Death Overview Panel. However, the Learning from Deaths Review Group will review the outputs from the Child Death Overview Panel to ensure any learning is embedded within The Trust. These cases must also be automatically referred to the Coroner.

## 

## **5.2 The Selection of Deaths for Case Review**

The Trust has taken the view that given the small number of deaths that occur amongst patients under its care that it will review all inpatient deaths, although SI process may superceed the need for this. In addition the Trust will review all post-operative deaths which occur within 30 days of discharge where possible.

**Fig. 1 Death Review Process**

24 Hours

Patient Death

National Quality Board Guidance on Learning from Deaths

Death certification takes place via Medical Examiner service.

Liaison with the family

Liaison with the Coroner if required

Liaison with other external bodies as required

Completion of Screening Tool (Appendix A)

Was the death unexpected or did it occur whilst a patient was detained under the Mental Health Act??

48 Hours

Yes

No

Being Open Policy

Discuss with Line Manager and implement duty of candour / being open.

Escalate to:

PSIRF Policy

Relevant Unit Clinical Governance Manager to arrange STEIS Report and PSII process to commence to include Learning from Deaths Lead

Yes

No

Does the incident meet the criteria for a PSII

Limited Structured Judgement Review

Liaise with Chief Nurse who will:

* Conduct criteria test and decide if incident is an SI
* Liaise with the Commissioner as required
* Authorise submission via STEIS
* Identify an appropriate specialist or clinician to conduct an initial incident review

Obtain all relevant physical, scientific and documentary evidence

Head of Clinical Goverance and Quality

Unit Clinical Governance Managers

## **5.3 Case Review Methodology**

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

The methodology used for each type of review is set out at Appendix B.

## **5.4 Involving and Supporting Those Affected**

The needs of those affected should be a primary concern for those involved in the review and any subsequent investigation of a patient death. It is important that affected staff and patients’ families and carers are involved and supported throughout any review and investigation.

**5.4.1 Involving and Supporting Bereaved Families and Carers**

The Trust is committed to involving the patient’s family/carers in any review or investigation and the subsequent learning process and recognises that in the event of shortfalls being identified this begins with a genuine apology.

All staff involved in liaising with and supporting bereaved people must have the necessary skills, expertise and knowledge of the patient’s care in order to be able to respond to any questions, fully and compassionately. With this in mind, the Ward Manager will be the primary point of contact for a bereaved family. In the event that an untoward incident is identified and a full investigation instigated, an appropriate Patient Liaison Lead will be appointed. This can include clinicians involved in the incident but this is not always appropriate and will be considered on a case-by-case basis.

An early meeting will be offered to the family to explain what action is being taken, how they can be informed, what support processes have been put in place and what they can expect from the investigation. This must set out realistic and achievable timescales and outcomes.

All staff involved in supporting bereaved families are expected to:

* Adopting an open and honest approach including early apology and implementation of duty of candour if appropriate
* Include the family / carers in all appropriate aspects of the investigation including setting the terms of reference and explain the purpose of the investigation i.e. to identify learning so that improvements can be made
* Keep the family/ carers informed throughout the process
* Offer the opportunity for the family / carers to ask questions, raise concerns and provide evidence
* Ensure that a coordinated approach is undertaken if the investigation involves a number of agencies.
* Provide the family / carers with the outcome of any review or investigation

**5.6.1 Involving and supporting staff**

The Trust recognises that patient deaths can have a significant impact on staff who were involved in the patient’s care and that like the patients and families they will want to know if there is anything they could have done differently.

Staff involved in a patient death and any investigation of the same can expect to receive the followin

* the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services.
* information about the stages of the investigation and how they will be expected to contribute to the process.
* support with being justifiably held to account but in the knowledge that there is zero tolerance for inappropriate blame and that they will not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration by virtue of involvement in the investigation process.
* fair and consistent staff treatment within the Trust and from external organisations.

In the very rare circumstances where a member of staff has committed a criminal or malicious act, they will be advised at an early stage to enable them to obtain separate legal advice and/or representation.

## **5.7 Lessons Learned**

## **5.7.1 Process for Managing the Completion of Action Plans**

Evidence of delivery of the actions in the action plan will be held by the delivery units, who will then provide assurance of completion monthly Unit Governance Meetings. Reports on quality performance of the delivery unit is received a Quality and Safety Committee on a quarterly basis. However the Learning from Deaths Lead should include themes for shared learning within the quartely report to promote wider shared learning that is shared at Patient Safety Committee.

Where actions are identified following PSII’s, an annual assessment of trends and themes will be conducted by the Head of Clinical Governance and Quality at the end of each calendar year, with recommendations for improvement/learning identified.

## **5.7.2 Sharing of Lessons Learned**

The sharing of the lessons learned post investigation is a critical part of risk management, helping to reduce the risk of recurrence. The Trust considers learning from Patient Safety Incidents to be a collaborative, decentralised and reflective process that allows us to draw on experience, knowledge and evidence from a wide variety of sources. Sharing Learning should be multi-modal, to increase the likelihood of embedding learning into routine practice.

The Trust has a range of mechanisms to ensure that lessons have been learned as a result of an incident and that they are disseminated across the organisation. The investigation report will clearly specify which lessons are to be shared, within the department / division, across the wider organisation, and externally. These will be reviewed and agreed at the SI Panel. Key lessons for wider learning will be disseminated through the Trust Clinical Governance structure. These will be presented quarterly to the Patient Safety Committee. Assurance on learning shared via the Unit Clinical Governance structure will be given to the Quality and Safety Committee. Where necessary, lessons learned from the review, or required changes in individual practice, are discussed in supervision with individual practitioners.

Key learning requiring rapid dissemination from Patient Safety Incident Investigations, will be sent out as an SBAR alert, agreed at the weekly Clinical Governance Meeting and sent from the Chief Nurse and Chief Medical Officer as appropriate and the Unit Clinical Governance Managers, for dissemination to the appropriate staff within the delivery unit..

# IMPLEMENTATION

The Trust already has a PSIRF Policy and mortality review process in place but there will need to be education regarding the new process. The policy is to be circulated to the following groups / committees:

* Quality and Safety Committee
* Patient Safety Committee
* Mortality Steering Group

A copy of the policy will place on the Trust intranet and communications will go out via the weekly newsletter.

In addition the Trust will publicly publish the policy on its website.

# TRAINING

Root Cause Analysis Training is provided as required, in line with the Trust’s Training Needs Analysis.

All training is recorded on the Electronic Staff Record (ESR) from which the Learning and Development Team provide a monthly report to the relevant manager to enable monitoring of compliance

# REFERENCES AND RELATED DOCUMENTS

**8.1 References**

National Guidance on learning from Deaths – National Quality Board 1st Edition, (March 2017)

Implementing the Learning from Deaths framework: key requirements for trust boards -NHS Improvement (July 2017)

**8.2 Related Documents**

* + Incident Reporting Policy
    - Being Open Policy
    - Patient Safety Incident Response Policy
    - Patient Safety Incident Response Plan

# MONITORING COMPLIANCE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Area to be monitored** | **Methodology** | **Who** | **Reported to** | **Frequency** |
| The completion of action plans within the agreed timescale and organisational learning and dissemination | Patient Safety Incident Response Policy  Patient Safety Incident Response Plan | Head of Clinical Governance and Quality | Patient Safety Committee | Monthly |
| Unit Quality Reports | Unit Assistant Chief Nurse and Clinical Goverance Manager | Quality and Safety Committee | Quarterly |
| Sharing Learning assurance through reporting to Quality and Safety / Board of Directors | Learning from Deaths Lead | Quality and Safety Committee / Board of Directors | Quarterly |
| Quality of structured reviews | Quality assurance of all reviews to be conducted by the Learning from Deaths Lead | Learning from Deaths Lead | Patient Safety Committee | Quarterly |

# APPENDIX A – SCREENING TOOL

**ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST**

**Mortality Review Screening Tool**

|  |  |
| --- | --- |
| **Name:** |  |
| **Addresss:** |  |
| **D.O.B** |  |
| **Gender:** |  |
| **NHS No:** |  |
| **Ward (where death ccurred)** |  |

|  |
| --- |
| **Certified Cause of Death** |
| 1a |
| 1b |
| 1c |
| 2a |

|  |  |  |
| --- | --- | --- |
| **Criteria for Case Record Review** | **Y** | **N** |
| Do you believe the death was unexpected? |  |  |
| Was the patient subject to a cardiac arrest call which failed to lead to return of spontaneous circulation? |  |  |
| If the death was expected, was there an absence of end of life care planning or DNACPR form? |  |  |
| Are you concerned that any problems in healthcare occurred? If yes, please provide details below: |  |  |
| Have you any concerns that this death was avoidable?(Even if you have slight concerns that this death was avoidable, you should respond yes) If yes, please provide details below: |  |  |
| Is this case subject to an investigation (internal or external)? If yes please provide details below: |  |  |
| Did the family/carers have significant concern regarding the quality of care? If yes please provide details below: |  |  |
| Was the patient admitted for an elective procedure? |  |  |
| Was this death reported to the coroner? If yes please provide reason for reporting below: |  |  |
| Did the patient have a learning disability? If yes please provide details below: |  |  |
| Was a safeguarding concern raised? If yes please provide details below: |  |  |

Completed by:

|  |  |
| --- | --- |
| **Name:** |  |
| **Job Title:** |  |
| **Date:** |  |

# APPENDIX B – CASE REVIEW METHODOLOGY

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient group | Methodology | SRO | Frequency of review | Where info/outputs will be saved and shared |
| Adult inpatient | eg SJR, PRISM, other evidence-based method |  |  |  |
| Mental health | Trusts can use a modified SJR or another relevant method to review the care of those with severe mental illness. NHS England, NHS Improvement and the Royal College of Psychiatrists are developing a standardised methodology for case record review of the care of those who die with severe mental illness |  |  |  |
| Child (under 18) | Reviews of these deaths are mandatory and should be undertaken in accordance with [*Working together to safeguard children* [[3]](#footnote-3)](https://www.gov.uk/government/publications/working-together-to-safeguard-children--2) (2015) and the current child death overview panel processes. |  |  |  |
| Learning disability | All trusts should adopt the LeDeR method to review the care of individuals with learning disabilities, once it is available in their area.  Guidance for conducting reviews of deaths can be found [here](http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf).[[4]](#footnote-4)  Trusts must have systems to flag patients with learning disabilities so their care can be reviewed |  |  |  |

# APPENDIX C – Process Flowchart for Medical Examiner Service

# Graphical user interface, application, table Description automatically generatedAPPENDIX D – SATH ME Service Referral Form

Table

Description automatically generated

1. <https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf> [↑](#footnote-ref-1)
2. Trusts can define locally which patients are considered to be ‘in their care’ according to what makes sense for their services. At a minimum this must include all inpatients but, if possible, also patients who die within 30 days of discharge from inpatient services. Be aware that this means all inpatients are *in scope* for review, not that all inpatient deaths need to be reviewed. Mental health trusts and community trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by trusts needs to be published and open to scrutiny. [↑](#footnote-ref-2)
3. <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2> [↑](#footnote-ref-3)
4. <http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf> [↑](#footnote-ref-4)