University Hospitals of Leicester NHS
NHS Trust

Learning from the Deaths
of Patients in our Care Policy

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Dec 17. Changes made::
3.7   Clinical Reviews – new category of review definition
3.8   Death Classification- changed from national to locally agreed criteria.
4.16f Structured Judgement Reviews not being undertaken by Consultants directly
          involved in deceased patient's care
5.10d Cases being fast tracked for review

KEY WORDS

Medical Examiner, Death Certification, MCCD, M&M, Mortality Screening, Structured Judgement Review, SJR, Death Classification, Learning from Deaths, Bereavement Support,

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1 INTRODUCTION AND OVERVIEW

1.1 UHL has had a standardised Mortality and Morbidity process since 2011 which has been reviewed and revised several times in response both national and local requirements.

1.2 In December 2016, the Care Quality Commission published its report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England[1].* The report identified that there were inconsistencies in the way Acute Trusts carried out mortality reviews and there was a need to improve learning from deaths reviewed.

1.3 The National Guidance on Learning from Deaths (Mar 17)[2] subsequently provided a framework for NHS Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. *Evidence shows that deaths caused by problems in care will occur in every single NHS trust and every hospital worldwide. The key is to learn from them as part of well-functioning governance processes.[3]*

1.4 This document provides details on how University Hospitals of Leicester NHS Trust (UHL) 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.

1.5 UHL's framework for 'Learning from Deaths' involves the:

- Medical Examiner Mortality Screening Process supported by the Bereavement Services Officers
- Bereavement Support Services
- Specialty Mortality & Morbidity process
- Structured Judgement Review and Death Classification Process
- Serious Incident Reporting Process

1.6 This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in our care and should be read in conjunction with the following supporting policies:

a) Last Offices and Care of the Deceased Patient Policy (B28/2010)
b) Medical Examiners' Process Policy (B49/2017)
c) Mortality & Morbidity Review Policy Policy (B48/2017)
d) Bereavement Support Service Guidelines (B4/2016)
e) Incident and Accident Reporting Policy (A10/2002)

1.7 This policy is also supported by the:

a) Death of a Child SUDIC Childrens Emergency Department UHL Guideline (C94/2006)
b) Guideline to be followed in the Event of an Unexpected Death of a Child (SUDIC) on Intensive Care, Inpatient wards and All Other Areas in UHL, Excepting ED (Appendix 25 of the Safeguarding Children Policies and Procedures) (B1/2012)
c) Safeguarding Children Policies and Procedures - Appendices 21 and 22 (B1/2012)

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d) Intrauterine Fetal Death in the Second Trimester and Stillbirth – Guideline for Management – Appendix 3 (C273/2016)
e) Maternal Death: Guidelines for the management of Maternal Death (C2/2007)

2 POLICY SCOPE

2.1 This policy applies to:
a) All deaths as inpatients and within the Emergency Department.
b) All adult, paediatric and perinatal deaths
c) Relatives and Carers who have been bereaved by a death in UHL

2.2 The principles of this policy and supporting guidelines also apply to deaths within 30 days of discharge from UHL.

2.3 This policy applies to:
a) All staff involved in the care of patients

and specifically

b) Bereavement Services Officers
c) Medical Examiners and Medical Examiner Assistants
d) Corporate Mortality and Morbidity Administrative Team
e) Doctors who have cared for deceased patients and who are eligible to complete the Medical Certificate of the Cause of Death (MCCD)
f) Mortality & Morbidity Leads
g) Mortality reviewers
h) Bereavement Support Nurses
i) Patient Safety Team

3 DEFINITIONS AND ABBREVIATIONS

3.1 **Medical Examiner** (ME) - This role is not the same as the proposed national role. The role of the UHL ME is to advise certifying doctors about the cause of death, undertake mortality screening (to include screening of the deceased's health care records and speaking to the bereaved relative/carer) and complete part 2 cremation forms (where applicable). Currently the UHL MEs predominantly cover adult deaths.

3.2 **Death certification** (MCCD) - 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.

3.3 **Mortality Screening** - refers to the reading through of deceased patients' clinical records (electronic and paper) with a view to identifying if there are potential problems in care or lessons to learn. Mortality Screening by MEs will also include speaking to a bereaved relative/carer, usually the 'next of kin'.

3.4 **Case Record Review** – review of a case record carried out by clinicians to determine whether there were any prolems in the care provided to a patient.

3.5 **Structured Judgement Review** (SJR). A detailed review of the medical record, normally undertaken by a senior doctor in the same medical specialty as that

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responsible for the deceased's final care. It is 'structured' because it follows an approach defined by the Royal College of Physicians.

3.6 **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.

3.7 **Clinical Review** - for the purpose of this policy this refers to where a clinician is requested to review a specific aspect of care and to reflect on whether there is any learning or actions required.

3.8 **Death Classification** – Locally agreed 5 point scale applied to cases subject to a Structured Judgement Review:

1	Problems in care thought more likely than not to have contributed to death
2	Problems in care but unlikely to have contributed to death
3	Problems in care but very unlikely to have contributed to death
4	No problems in care
5	Good or Excellent Care.

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3.9 **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').

In UHL such deaths would be given a Death Classification of 1.

3.10 **Patient Safety Incident** (PSI) – Any unintended incident which could have led or did lead to harm for one or more patients receiving NHS care.

3.11 **Serious Incidents** (SI) - Adverse events in healthcare, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified.

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3.12 **Investigation** – Systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided.

3.13 **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.

3.14 **Bereaved Relatives and Carers** (Bereaved) – Someone who has a relative or close friend who has recently died.

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3.15 Severe Mental Illness (SMI) - there is currently no single nationally agreed definition of which conditions/criteria would constitute SMI. For the purpose of this policy SMI will include psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

3.16 **The National Quality Board** (NQB) provides coordinated leadership for **quality** on behalf of the **national** bodies: Department of Health, Public Health England, NHS England, Care **Quality** Commission, NHS Improvement, and the **National** Institute of Care Excellence.

3.17 'Fast Tracking cases for review' for the purpose of this policy 'fast tracking cases for review' is where a Structured Judgement Review is urgently undertaken by the relevant Specialty M&M because the outcome of the review and death classification is needed to support a Coroner's Inquest or meeting with the Bereaved Relatives/Carers.

4   ROLES AND RESPONSIBILITIES

4.1   Board Level Lead - Medical Director
   a) Overall responsibility for the Learning from Deaths Framework within UHL and for the Trust's adult and child mortality review processes

   b) Ensuring reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the mortality review process.

   The Deputy Medical Director will have delegated responsibility for the above.

4.2   Non Executive Director - Chair of Quality and Outcomes Committee
Responsible for having oversight of the Trust's Learning from Deaths policy to include:
   a) Understanding the review process
   b) Ensuring robust processes are in place for the review and learning from deaths and for the taking forwards quality improvement actions to improve patient care
   c) Seeking assurance that the UHL's published mortality information accurately reflects the organisation's approach, achievements and challenges

4.3   Mortality Review Committee (MRC)
Oversee all work-streams and governance processes related to mortality and the Learning from Deaths framework within UHL

4.5   Head of Outcomes & Effectiveness (HOE)
The HOE is the Operational Lead for the Learning from Deaths framework within UHL and is responsible for development and implementation of this policy and the
   • Medical Examiner Process Policy (ME Policy)
   • Mortality & Morbidity Review Process Policy (M&M Review Policy)
   • Bereavement Support Service Guidelines (BSS Guidelines)

4.6   Head of Chaplaincy and Bereavement Services is the
Lead Officer for the Last Offices and Care of the Deceased Patient Policy (Last Offices Policy)

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Senior Manager for Bereavement Services

4.7   Senior/ Bereavement Services Officers are responsible for:
Being aware of the requirements of this policy and supporting implementation of the Medical Examiner Process
Implementation of the Last Offices Policy

4.8   Senior Patient Safety Manager
Lead Officer for the Incident and Accident Reporting Policy (Incident Policy)

4.9   Patient Safety Team are responsible for
Being aware of the requirements of this policy and implementing the Incident Policy

4.10   Senior/Medical Examiners and Medical Examiner Assistant are responsible for:
Being aware of the requirements of this policy
Implementation of the ME Process Policy Standards

4.11   Corporate M&M Administrative Team is responsible for:
Supporting implementation of this policy and the standards in the ME Policy and M&M Review Policy.

4.12   Bereavement Support Nurses are responsible for:
Being aware of the requirements of this policy and implementation of the BSS Guidelines

4.13   Learning Disability Acute Liaison Lead Nurse Practitioner is responsible for:
Ensuring that the deaths of patients with Learning Disability are registered with the Learning Disability Mortality Review Programme (LeDeR)
Being a point of contact for advice and support in respect of reviewing the deaths of patients with a Learning Disability

4.14   CMG Management Teams are responsible for:
Ensuring relevant processes and resources are in place within their Service/Department/CMG to meet the requirements of this policy

4.15   Adult, Paediatric and Perinatal Specialty M&M Leads are responsible for
Being aware of the requirements of this policy and specifically for
   a) meeting the relevant Standards within the M&M Review Process Policy
   b) External reporting of child, perinatal and maternal deaths as set out in Section 2.4 above (where applicable)

4.16   Administrative Staff who support Speciality M&M Processes are responsible for
Being aware of the requirements of this policy and supporting implementation of the M&M Review Process Policy within their Specialty

4.17   Consultants, Ward Sisters and Matrons are responsible for:
   a) Being aware of the requirements of this policy
   b) Referring deaths for review by the Specialty M&M where potential problems in care identified or there could be lessons to learn

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c) Reporting of relevant potential patient safety incidents where these are identified through mortality screening or completion of SJR in line with the Incident Reporting Policy

d) Supporting implementation of relevant standards in this policy and in the policies listed in Section 1.6

e) Reflecting on the care provided to patients who die in our hospitals and learning from this to inform future practice

f) Supporting the implementation of actions identified from reviews or investigations

g) Consultants undertaking Structured Judgement Reviews must not have had either overall responsibility or substantial direct involvement in the deceased patient's care during their last admission

4.18   All Staff directly or indirectly involved in patient care are responsible for
   a) Participating in the process for Learning from deaths
   b) Being aware of learning from deaths identified as relevant to their specialty
   c) Supporting the implementation of actions in response to learning from deaths within their specialty
   d) Reporting patient safety incidents in line with the Incident Reporting Policy

5.   POLICY STANDARDS

The process for Learning from Deaths within UHL is set out in Appendix 1.

5.1   Recording Deaths in Care
All deaths within UHL will be recorded on the Trust's Patient Administration System (InPatients/Theatres) and NerveCentre (Emergency Department deaths). This data is then uploaded into the Trust's Hospital Information Services System (HISS).

5.2   Death Certification, Post Mortem and Coroner Referral
All adult deaths will be discussed with the Medical Examiner to confirm if cause of death known, post mortem indicated or whether referral to the Coroner is required, in line with the ME Policy and Consent to Hospital Post Mortem Examination Policy.

5.3   Mortality Screening
All Adult Deaths of patients under our care, either as an inpatient or in the Emergency Dept will be subject to 'mortality screening' as per the ME Policy.

5.4   Supporting and involving families and carers
   a) Bereaved Relatives/Carers of all adult and paediatric deaths should be informed and supported in line with the 'Last Offices' Policy.

   b) All Bereaved Relatives/Carers will be given an opportunity to raise concerns about the care provided to the deceased as per the BSS Guidelines and ME Policy

   c) Practical and emotional bereavement support will be offered to the bereaved relative/carer by the Bereavement Services and Bereavement Support Nurses (see Last Offices Policy and BSS Guidelines) or the Bereavement Midwife (Maternal and Perinatal deaths).

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5.5 Supporting and involving staff

Support will be available for staff; affected by the death of someone who has been in the trust's care, from;

• Clinical and Operational Managers and senior colleagues
• Medical Examiners
• Bereavement Services Office Staff
• Bereavement Support Nurses
• Head of Outcomes & Effectiveness
• Corporate Teams - Claims and Inquests, Patient Safety and Complaints)   see Policy for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims (B28/2007)
• AMICA Staff Counselling and Psychological support services (contact telephone no. 0116 254 4388)

5.6 Selecting deaths for case record review (Structured Judgement Review)

a) A Structured Judgement Review and Death Classification (SJR & DC) must be undertaken,by the relevant Specialty, of all:

• Infant and Child Deaths
• Maternal Deaths
• Deaths where the patient had a Learning Disability or Severe Mental Illness
• Deaths following an elective procedure
• Maternal Deaths

b) If Mortality Screening by the Medical Examiner (to include feedback from the Bereaved, members of the clinical team or case note screening) identifies potential problems in care in line with the Medical Examiner Process Policy criteria; a Structured Judgement Review (SJR) will be undertaken as per the Mortality & Morbidity Reviews and Death Classification Policy

c) Members of the clinical team or the Specialty M&M Lead may also select cases for SJR, either due to concerns raised directly to the team or for potential learning

d) In addition to SRJs being undertaken where referred by the Medical Examiner or due to meeting the national criteria (as set out in 5.6a above) SJRs will be undertaken of a random sample of deaths or all deaths in line with agreed Specialty M&M Terms of Reference

5.7 Learning Disability

a) The Trust's Special Register will be checked as part of the Mortality Screening process to identify deaths of patients with Learning Disability

b) All deaths of people with learning disabilities aged four years and older will be registered with the national Learning Disabilities Review Programme (LeDeR)

5.8 Severe Mental Illness

a) The NQB guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

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b) Where a patient is identified (either by the Medical Examiner screening process or the clinical team) as having a SMI (as defined in 3.14) which is requiring active treatment by a Mental Health Trust (which will usually by the Leicestershire Partnership Trust), the case will be referred for SJR.

5.9 Undertaking Mortality Reviews and Responding to Mortality Alerts
a) UHL's crude and risk adjusted mortality rates will be monitored by MRC
b) Mortality reviews will be undertaken of diagnosis/patient groups with a higher than expected risk adjusted mortality or a 'mortality alert' is received.
c) Mortality reviews may also be undertaken as part of a quality improvement inititive
d) Review findings, learning and actions will be reported to the relevant clinical team, Specialty M&M, CMG and MRC as applicable
e) Responses to mortality alerts will be overseen by MRC

5.10 Structured Judgement Review format (SJRs)
a) Where cases are referred for SJR, these will be undertaken in line with the SJR Policy

b) SJR Reviewers will use the UHL SJR template based on the national Royal College of Physicians' National Mortality Case Record Review tool (adult and paediatric deaths) or the UHL Perinatal Mortality Review template (stillbirths, neonatal deaths)

c) SJRs and Death Classifications will be completed within 4 months of the death (6 months where post-mortem result or coroner inquest outcome awaited)

d) SJRs will be 'fast tracked' where the outcome of the review and death classification is needed to support a Coroner's Inquest or meeting with the Bereaved Relatives/Carers.

5.11 Clinical Reviews
a) Where problems in end of life care or patient experience are identified, either by mortality screening or bereaved relatives/carers feedback, this will be shared with relevant teams for clinical review, learning and action as per ME Policy.

5.12 Compliments
a) Compliments received from the bereaved will be shared with the relevant clinical teams as per the ME Policy

5.13 Dissemination of Learning from Deaths
b) Dissemination of learning from SJRs and Mortality Screening will be via Specialty and Joint Speciality M&M meetings and also via the Trust-wide M&M Leads Forum

5.14 Learning from Deaths and other Organisations
a) Where other organisations requires a review of a UHL in-patient, ED or post discharge death, these will be screened by members of the Mortality Review Committee and referred for SJR by the relevant Specialty M&M as applicable.

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b) Where a mulit-agency review of a UHL in-patient, ED or post discharge death is indicated, these will be discussed at the Clinical Quality Review Group and the appropriate review panel and terms of reference agreed.

5.15 Trustwide Learning from Deaths
a) Mortality screening and SJR findings will be reviewed by the Mortality Review Committee to identify cross-specialty or trust-wide learning or themes.

b) Findings from mortality screening and SJRs will be used to inform the annual Quality Commitment 'improve patient outcomes' work programme

5.16 Sharing Mortality Review findings with Bereaved Relatives/Carers
a) Where bereaved relatives/carers request feedback following a clinical review or SJR, this information will be shared with them via the Bereavement Support Nurse

5.17 Selecting deaths for investigation
Where mortality screening or SJR identifies a problem in care that meets the definition of a patient safety incident this must be reported on Datix as per the **UHL Incident and Accident Reporting Policy** and Duty of Candour requirements met as per the Being Open (Duty of Candour) Policy.

5.18 Quality Improvement
a) Where a need for learning or action is identified via feedback from bereaved relatives/carers, ME mortality screening or the SJR process, this must be taken forward by the relevant clinical team / Specialty M&M

b) The UHL Way of implementing change should be used when developing quality improvement plans
http://insite.xuhl-tr.nhs.uk/homepage/working-life/uhl-way

c) Monitoring of actions resulting from SJR and M&M discussions will be via the Specialty M&M Action Tracker with oversight by the MRC

d) Monitoring of actions resulting from an SI investigation will be via the SI Tracker with oversight by the Adverse Events Committee.

5.19 Presenting UHL's mortality data
a) The outcomes of all mortality screenings, bereaved relatives/carers' feedback, SJRs, M&M discussions and mortality reviews will be recorded on the UHL Learning from Deaths Database

b) UHL's mortality data will be published via the Quarterly MRC report to the Trust Board and will include adult, child and infant, in-patient and ED deaths

c) Mortality data taken from the Trust's Learning from Deaths database which is held on the Shared M&M Drive

d) Data will be published in the quarter after that in which the death occurred and will include -
- number of deaths subject to case record review (desktop review of case notes using a structured method)

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- number of deaths investigated under the Serious Incident framework (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- themes and issues identified from review and investigation (including examples of good practice)
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- How many reviews or investigations are ongoing

e) UHL's mortality data and details of learning and actions taken will be published in the Trust's annual Quality Accounts

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Details of additional training or education requirements and provision of such are set out in the associated policies and guidelines

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead Officer / Clinical Lead	Tool	Frequency	Reporting arrangements
Completion of Learning from Deaths Dashboard	HOE/ Deputy Medical Director	LFD Database	Quarter	Mortality Review Committee Trust Board
Evidence of Learning and Actions	HOE/Deputy Medical Director	Quality Account	Annually	Mortality Review Committee

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

[1] **Learning, candour and accountability**; A review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission, December 2016

[2] **National Guidance on Learning from Deaths**, A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, National Quality Board, March 2017

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[3] **Implementing the Learning from Deaths framework**: key requirements for trust boards, NHS Improvement, July 2017

Template Learning from Deaths policy ; NHS Improvement Sept 2017

10   PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This Policy will be uploaded into the Policies and Guidelines Library on INsite and will be available on the Trust's website.

The Policy will be reviewed in June 2019 by the Head of Outcomes & Effectiveness with support from Mortality Review Committee members.

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LEARNING FROM THE DEATHS OF CHILDREN IN OUR CARE (0-18 YEARS) FLOW CHART

CHILD / INFANT DEATHS IN THE EMERGENCY DEPARTMENT	STILL BIRTHS, EARLY AND LATE NEONATAL DEATHS	DEATHS ON: GENERAL PAED ITU MEDICAL WARDS SURGICAL WARDS	DEATHS ON: CARDIAC PAED ITU CARDIAC WARDS	DEATHS ON: ADULT WARD

Death recorded on Patient Centre / Nerve Centre

Death Certificate Issued or Death Referred to the Coroner

SJR undertaken as part of the Paed ED M&M Process	Review undertaken by the Perinatal Mortality Review Group	SJR undertaken as part of the Paed ITU/Medical or Paed General Surgical M&M Process	SJR undertaken as part of the Paed Cardiac M&M Process	SJR undertaken as part of Spec M&M Process

Review completed and presented to Specialty M&M Group
- Death Classification Agreed as per Paed/Perinatal Mortality Review Policies
  - Where problems in care identified – Incident Reporting Policy requirements met
- Learning and need for Actions considered
- Action Leads and Timescales Confirmed

Learning Disseminated / (Cardiac - Discussed at QUICKA Meeeting)   Actions Tracked by Specialty M&M Leads

All Deaths in Children (0-18 years) reported to LLR Child Death Overview Panel (CDOP).
All Stillbirths, Deaths within 28 days of Life and Maternal Deaths (within 1 year of pregnancy, regardless of pregnancy outcome) reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquriies across the UK (MBRRACE-UK)

Updates on actions sought by Corporate M&M Team and inputted on LFD Database for monitoring of actions, theming, cross Specialty learning and reporting to Trust Board via the MRC Quarterly Report

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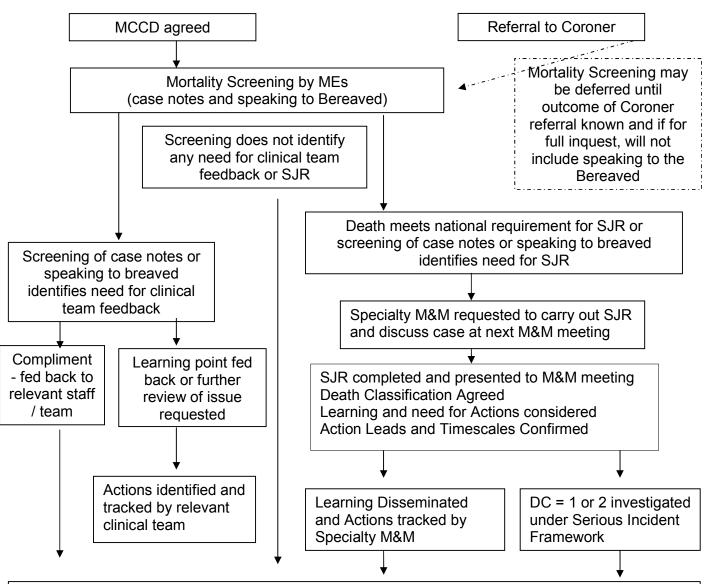**LEARNING FROM THE DEATHS OF ADULT PATIENTS IN OUR CARE FLOW CHART**

In Patient or Emergency Dept Death

Death recorded on Patient Centre/NerveCentre
'Notification of Death Form Completed by Nursing Staff and yellow copy taken to Bereavement Services Office

Bereavement Services liaise with Medical Team to confirm appropriate doctor to complete death certificate. Advise Bereaved about Bereavement Support Nurse and Medical Examiner

Certifying doctor discusses case and cause of death with Medical Examiner and advises if any concerns about patient's management plan or death
ME advises whether MCCD can be issued or whether requires referral to Coroner.

MCCD agreed

Referral to Coroner

Mortality Screening by MEs
(case notes and speaking to Bereaved)

Mortality Screening may be deferred until outcome of Coroner referral known and if for full inquest, will not include speaking to the Bereaved

Screening does not identify any need for clinical team feedback or SJR

Death meets national requirement for SJR or screening of case notes or speaking to breaved identifies need for SJR

Screening of case notes or speaking to breaved identifies need for clinical team feedback

Specialty M&M requested to carry out SJR and discuss case at next M&M meeting

Compliment - fed back to relevant staff / team

Learning point fed back or further review of issue requested

SJR completed and presented to M&M meeting
Death Classification Agreed
Learning and need for Actions considered
Action Leads and Timescales Confirmed

Actions identified and tracked by relevant clinical team

Learning Disseminated and Actions tracked by Specialty M&M

DC = 1 or 2 investigated under Serious Incident Framework

Updates on actions sought by Corporate M&M Team and inputted on LFD Database for monitoring of actions, theming, cross Specialty learning and reporting to Trust Board via the MRC Quarterly Report

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