Gloucestershire Safety & Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Learning from deaths:

Using the structured judgement review methodology.

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Thanks to Leta Beard;Datix Administrator, Hospital Mortality Group, Bereavement Team and Mortality leads.

1.Background

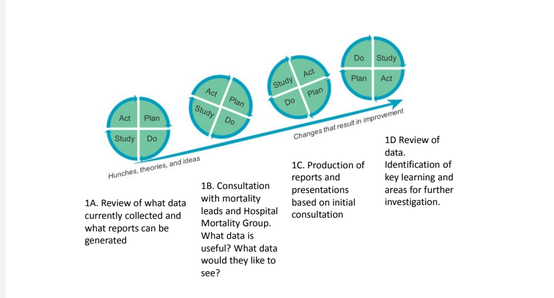
The Royal College of Physicians commenced a programme in 2016 to introduce a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland. The primary goal was to improve healthcare quality through qualitative analysis of mortality data using a standardised, validated approach linked to quality improvement activity. GHNHSFT introduced a policy for reviewing deaths in 2017 based on the structured judgement review (SJR) tool . The policy identified a number of triggers for which deaths were to be reviewed. To support this implementation the Datix incident reporting system was modified to report in hospital deaths and reporting commenced by the bereavement team in January 2018. The new tool required a culture change in how mortality was reviewed in the organisation and raised concerns regarding responsibilities, workload and resource which needed to be overcome.

2. Aims (6 month project)

1. To increase the numbers of SJR undertaken Trust wide by 50%
2. To Introduce and improve the numbers of key learning messages identified Trust wide by 50%
3. To design and complete reports for key divisions, specialties and expert groups

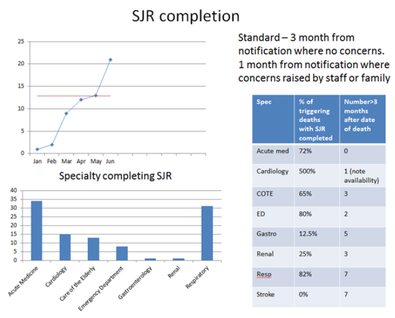
3. How it was achieved

Primary Drivers	Secondary Drivers	Change ideas
To develop the datix system to collect information on all in hospital deaths and to identify those deaths triggering for review	Need for accurate and complete information on in-hospital deaths	Daily review of death reports Feedback to bereavement team
	Need for a clear workable trigger list for death reviews	Monitoring of triggers and related learning Feedback to Hospital Mortality Group
To develop a process for notifying clinicians of deaths and requesting SJRs to be undertaken	Need to inform clinicians of deaths of patients under their care and causes of death and provide opportunity for raising concerns with care	Standard operating procedure Promotion of awareness at divisional boards, specialty governance groups/mortality leads
	Need for clear roles and responsibilities	Identification of mortality leads in each specialty
To engage clinicians in undertaking mortality reviews using SJR methodology	Need for culture change in the way mortality reviews are undertaken	Feedback to clinicians by providing reports on death statistics and learning that are useful
	Need for education and support of clinicians in the use of the SJR tool and the datix system	Circulation of PowerPoint training package on SJR Datix mortality training and training guide
	Need for performance monitoring and an escalation process	Performance figures in risk managers report to divisional board, specialty governance reports and Hospital mortality group monthly reports.
To develop the datix system to enable production of reports on death statistics and learning messages	Need for redesign of datix fields to facilitate reporting requirements	Consultation with clinicians re data required in reports Introduction of key learning message box on datix
	Need for education and feedback to clinicians on documenting concise learning messages that will enable themes to be identified	
To develop a reporting structure at corporate, divisional and specialty level that will enable analysis of data and identification of learning	Need for data to be accessible to clinicians and expert groups	Mapping data with expert group requirements Creation of template reports Training guides for producing reports Pre-set searches on datix Presentation of data to meetings at all levels amending datix fields as required Trend analysis of key learning messages
	Need for education and support of clinicians in generating reports on mortality from datix	



4. What the project achieved?

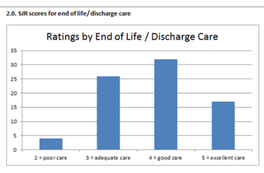
Divisional/Specialty reports



Standard – 3 month from notification where no concerns. 1 month from notification where concerns raised by staff or family

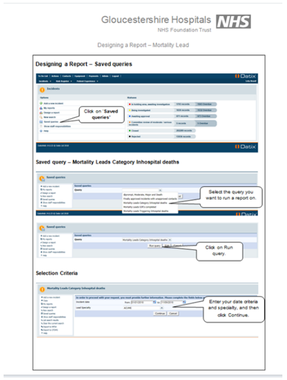
Spec	% of triggering deaths with SJR completed	Number>3 months after date of death
Acute med	72%	0
Cardiology	500%	1 (note availability)
COTE	65%	3
ED	80%	2
Gastro	12.5%	5
Renal	25%	3
Resp	82%	7
Stroke	0%	7

Expert Group Report



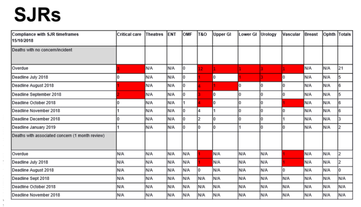
	2 = poor care	3 = adequate care	4 = good care	5 = excellent care
1a Trauma	0	0	2	1
4a Acute Medicine /Endocrine	0	1	0	0
4b COTE	0	3	0	0
5th Floor	0	0	0	1
7a Gastro	0	1	0	0
7b Renal	0	1	0	0
8b Respiratory	0	2	1	1
9a Gynae	0	1	0	0
9b COTE	0	1	0	0
ACUA / AMU	0	1	3	1
Awening Respiratory	0	2	4	1
Cardiac Cardiology, CGH	0	8	0	0
Cardiology Ward, GRH	0	0	1	1
Chest Pain Assessment Unit Cardiology	0	0	1	0
Critical Care CGH	0	0	4	4

Datix User Guides



Key Learning Messages

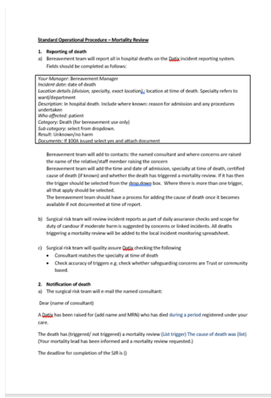
Performance Monitoring



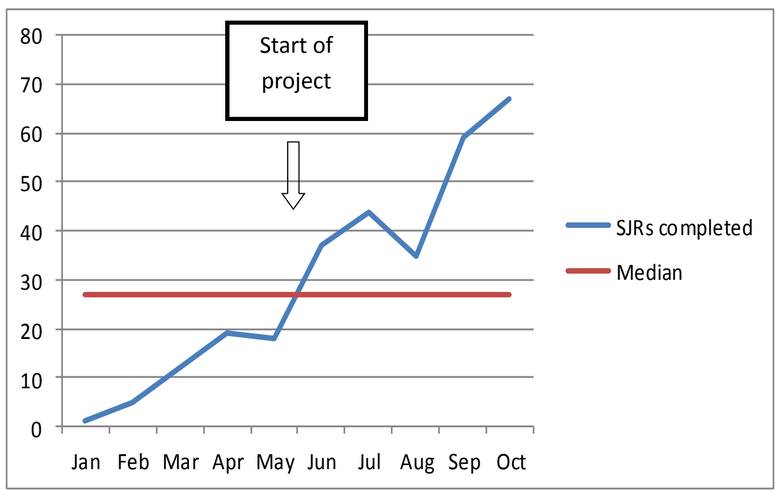
SJRs

Compliance with SJR timeframes 15/10/2018	Critical care	Theatres	ENT	GMF	T&O	Upper GI	Lower GI	Urology	Vascular	Breast	Ophth	Totals
Deaths with no concern/incident												
Overdue		N/A	N/A	0						N/A	N/A	21
Deadline July 2018	0	N/A	N/A	0					0	N/A	N/A	5
Deadline August 2018		N/A	N/A	0			0		0	N/A	N/A	9
Deadline September 2018		N/A	N/A	0		0	0	0	0	N/A	N/A	9
Deadline October 2018	0	N/A	N/A	1	1	0	0	0		N/A	N/A	8
Deadline November 2018	1	N/A	N/A	0	1	0	0	0	0	N/A	N/A	8
Deadline December 2018	0	N/A	N/A	0	2	0	0	1	0	N/A	N/A	3
Deadline January 2019	1	N/A	N/A	0	0	0	1	0	0	N/A	N/A	2
Deaths with associated concern (1 month review)												
Overdue	N/A	N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	2
Deadline July 2018	N/A	N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	2
Deadline August 2018	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	0
Deadline Sept 2018	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Deadline October 2018	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Deadline November 2018	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

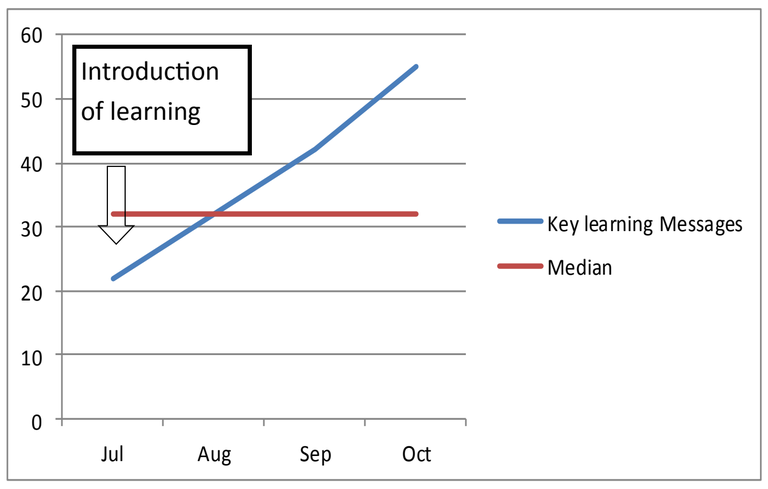
SOP



Number of SJRs completed : **81% improvement**



Number of key messages completed:**150% improvement**



Example of key learning Messages

Key Learning Messages

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Early, regular documented discussions with families	Seeking reviews from consultants or other specialties
Correct AMTS scoring	Checking patient allergies
Administration of antibiotics asap following identification of sepsis	Accurate management of fluid balance especially in elderly CCF patients
Review of patients receiving large doses of strong analgesia	Clear timings of reviews and transfers
consent should never be conducted by someone unfamiliar with a procedure	Documentation
Decision making re theatre after CT result	Standardisation of end of life pathway
No patients in ED should be NBM and offered refreshments and supplements as soon as possible. (#NOF)	Delays in surgical reviews overnight
If concern has been raised re vascularity of a stoma needs daily review.	

5. Conclusion

The project achieved its aims in increasing the numbers of SJRs undertaken by 81% and the number of key learning messages identified by 150%. The success was influenced by the work of the Hospital Mortality Group members raising the profile of SJRs and the Registrar review project from September 2018. 4 specialty reports, 2 divisional presentations and one expert group report were completed with positive feedback received.

6. Next Steps

1. Continue to improve engagement by extending reports to other specialties and expert groups
2. Improve timeliness of SJR completion and quality assure process
3. Circulation of key learning via newsletters, posters etc
4. Improve multidisciplinary involvement in SJRs.
5. Clarify links between SJRs and duty of candour/serious incidents
6. Further interrogate datix to investigate specific concerns