Learning from deaths

NHS
The Princess Alexandra Hospital
NHS Trust

Project aims

- Implementation of policy to ensure that the trust is learning from deaths
- To implement the National Mortality Case Record Review Programme which includes structured judgement reviews (SJR)
- To relaunch speciality mortality and morbidity (M&M) meetings
- Implement the SMART (Structured Mortality Analysis & Review Tool) system for medical examiners, patient safety and quality teams, plus other key stakeholders enabling us to learn more effectively from deaths in hospital.

Timeline for delivery

From: November 2019 **To:** Currently ongoing

Measures

- Mortality dashboard provided within 7 working days of the end of the month
- Compliance with M&Ms for all specialities
- Death certificates issued within 72 hours
- Improvements with all elements of SJR scores
- 100% scrutiny of internal and community deaths

Tests for change

- Fewer complaints and incidents in relation to mortality
- Improvement in SJR themes
- Improvement in HSMR data and mortality outliers
- Fewer legal cases in relation to mortality

Nicola Tikasingh

Project team

Nicola Tikasingh (Lead Nurse for Mortality)
Rudi Swart (Lead Medical Examiner)
Quality First Team

Results

- PAHT have appointed a lead medical examiner, who will be leading a team of independent consultant colleagues whose role is to enhance the governance and regulatory systems by scrutinising the deaths of patients not under review or inquest by the coroner
- SMART system has been purchased and implemented
- Implementation of SJRs across all specialities
- Learning from deaths process – policy
- Review of avoidability of deaths
- Implementing M&M meetings across all specialties
- Audits and deep dives from outlier alert groups
- Networking with other organisations

Learning and next steps

- Continue to collate SJR Themes to review care and treatment which will feed into the mortality improvement program
- COVID learning, including vaccination and deaths
- Review of Dr Foster data monthly which will continue to feed into coding auditing and mortality outliers
- Continue to embed a sound governance process around learning from deaths