Dorset HealthCare University NHS Foundation Trust

**Ref No: IN-543**

# POLICY FOR REPORTING AND INVESTIGATING DEATHS

| | | |
|---|---|---|
| **AREA:** | Trust Wide | |
| **NAME OF RESPONSIBLE COMMITTEE / INDIVIDUAL** | Medical Director | |
| **NAME OF ORIGINATOR / AUTHOR** | Senior Clinical Risk Manager | |
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| **Added to intranet by:** | Amanda Ponchaud | **Date added:** 13/06/2018 |
| **Directorate:** | Corporate | |

## Contents

## EXECUTIVE SUMMARY

The National Guidance on Learning from Deaths was published by the National Quality Board in March 2017 to initiate a standardised approach, ensuring that learning from a review of the care provided to patients who die, should be integral to a provider's clinical governance and quality improvement work. To fulfil the standards and new reporting, set out in this guidance, this policy identifies and highlights:

- The Trust's governance arrangements.
- The Trust's processes on reporting, reviewing and investigation of deaths, including those deaths that are determined more likely than not to have resulted from problems in care.
- The Trust's processes, to share and act upon any learning derived from these processes.

The standards expect providers to have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. This policy seeks to provide guidance on how it will undertake processes which ensure working closely with bereaved families and carers as a priority. In addition, to ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

## 1.0 INTRODUCTION

1.1 A CQC review in December 2016, 'Learning, candour and accountability, a review of the way trusts review and investigate the deaths of patients in England, found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care.

1.2 The National Quality Board (NQB) introduced 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). The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning, leading to higher quality of care.

1.3 This policy covers how Dorset HealthCare (DHC) responds to patient deaths in care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing NHS Improvement's 2015 'Serious Incident Framework'.

1.4 This policy supports the DHC Policy for Managing Incidents & Serious Incidents and should be read in conjunction with this. It outlines the specific requirements for reporting, reviewing and investigating deaths.

1.5 For ease of reference, the term 'patient' is used throughout this document. This is intended to refer to all people who make use of any of the health care services provided by the Trust.

## 2.0 PURPOSE AND SCOPE

2.1 This procedure provides staff with information in relation to which deaths should be reported internally on the Trust's online incident and risk management system (Ulysses), subsequent review and the level of investigation that is required.

2.2 This procedure is applicable 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 behalf of the Trust.

2.3 This policy focuses on two key areas - robust, high quality governance around patient deaths and involvement of families and carers with the Trust and to offer support and guidance to them.

## 3.0 DEFINITIONS

| Term and abbreviation | Definition of term |
|---|---|
| After Death Analysis (ADA) | After Death Analysis (ADA) is a web-based, End of Life Care audit tool, developed as part of the Gold Standards Framework (GSF) programmes in primary care, care homes and hospitals. |
| Avoidable mortality | The basic concept of avoidable mortality is that deaths caused by certain conditions, for which effective public health and medical interventions are available, should be rare and ideally, should not occur. |
| Being open | Service users, relatives, carers, staff and partner agencies need to know when something has gone wrong and what the Trust is going to do to minimise harm and prevent recurrence. Service users, carers, relatives and staff can expect to be provided with appropriate information and support by the Trust following any patient safety incident. See the Trust's Being Open Policy for further guidance. |
| Care Quality Commission (CQC) | The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisation. |
| Case record review | The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians. |
| CDOP | Child Death Overview Panel. |
| CHIS | Child Health Information Service. |
| Clinical Commissioning Group (CCG) | Clinically lead organisation that commissions most NHS funded healthcare on behalf of its relevant population. |
| Death due to a problem in care | A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable. |
| Duty of Candour | Regulated requirement to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. |
| Incident | An event or circumstance which could have resulted, or did result, in unnecessary damage, loss or harm to patients, staff, visitors or members of the public. |
| Learning Disabilities Mortality Review Programme (LeDeR) | The LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The |

| Term and abbreviation | Definition of term |
|---|---|
| | LeDeR programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements. |
| NHS Improvement | NHS Improvement has taken on the role that was previously provided by NHS England and is responsible for operating the National Reporting and Learning System (NRLS), and responsibility for using information from the NRLS and elsewhere, to develop advice and guidance for the NHS on reducing risks to patients. |
| PAS System | Patient Administration Systems (often abbreviated to PAS) developed out of the automation of administrative paperwork in healthcare organisations, particularly hospitals and are one of the core components of a hospital's IT infrastructure. |
| Root Cause Analysis (RCA) | A systematic process whereby the factors that contribute to an incident are identified. As an investigation methodology, it looks beyond the individuals concerned and seeks to understand the underlying causes and environmental content in which an incident happens. |
| Serious Incident (SI) | Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.<br><br>Further definition of when a SI must be declared can be found within the NHS England Serious Incident Framework. |
| Online incident reporting system | The risk management database used by the Trust to record all risk management activity, including incidents, customer care, claims and coroners inquests. Ulysses allows the Trust to record and search data e.g. by severity and category. Patient safety incidents are uploaded to NHS improvement via the NRLS on a regular basis. |
| Serious Case Review | A Serious Case Review (SCR) may be undertaken by the Local Safeguarding Children Board (LSCB) when a child dies or suffers serious harm and abuse, or neglect of a child is known or suspected and there is cause for concern as to the way in which agencies have worked together to safeguard the child. Cases may also be reviewed by the LSCB as a Case Audit, when cases do not meet the threshold for an SCR. The decision as to whether an SCR or Case Audit is undertaken will be made by the LSCB, following a referral from a partner agency. The SCR process runs alongside and complements the Child Death Overview Panel (CDOP) process. |

| Term and abbreviation | Definition of term |
|---|---|
| STEIS | The Strategic Executive Information System (STEIS) captures all Serious Incidents. Serious Incidents (as defined in the Serious Incident Framework). |
| Structured Judgement Tool (SJT) | Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. |
| Natural and unnatural deaths | A natural death conclusion by HM Coroner is where a death was primarily attributed to an illness or an internal malfunction of the body not directly influenced by external forces. An unnatural death conclusion would be where the coroner considers that the death may have been caused by violence, neglect or abortion, or occurred in suspicious circumstances. |

## 4.0 DUTIES

4.1 **The Medical Director**
Has ultimate responsibility for corporate governance including patient safety and for the learning from deaths agenda.

4.2 **Committee with overarching responsibility for this policy**
The Mortality Governance Group (chaired by the Medical Director) reporting to the Quality Governance Committee will have overall responsibility for the monitoring and review of this policy.

The role of the Mortality Governance Group is:

- To review the trends from all deaths that occur in patients who have been in Trust care, but discharged in the previous 6 months, where the Trust has been the lead provider of care and the care provided has been relevant to the cause of death.
- All patient deaths reported via the incident reporting system to be allocated to the appropriate review process by the Patient Safety & Risk Team. Confirmation of these process and identification to be reviewed by the group.
- Oversee communication with mortality review work elsewhere within Dorset, particularly that led by the Dorset CCG.
- Receive information from national initiatives such as LeDeR and National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).

4.3 **Non-Executive Director (who chairs the Quality Governance Committee)**
Shall have oversight of progress and act as a 'critical friend' in holding the organisation to account for its approach to learning from deaths, particularly those assessed as having been avoidable.

Seek assurance from the Executive Directors regarding mortality governance, that dissemination of learning and changes in practice as a result of this have occurred throughout the Trust.

## 5.0 DETERMINE WHICH PATIENTS ARE CONSIDERED TO BE UNDER THE CARE OF THE TRUST AND FOR INCLUSION OF CASE REVIEW

5.1 The Trust is responsible for all mental health services and many physical health services in Dorset, delivering both hospital and community-based care.

The Trust cares for patients in a number of sites and community teams across Dorset. Due to the complexity of the way in which health and social care is delivered to patients accessing our services, the Trust has developed a number of processes by which it identifies certain preventable deaths:

- All deaths of patients in community hospitals are automatically recorded on the electronic patient record systems and reported into the incident database.

- A weekly report of all deaths reported as an incident is reviewed to identify and confirm that the most appropriate review mechanisms are in place to investigate the death.

- Recording of whether this is an expected or unexpected death, with cause of death, date and time, must also be completed by ward staff/doctor responsible for the patient. Reporting of such incidents automatically enacts the DHC's After Death Analysis (ADA) process, using the Trust ADA tool. The Standard Operating Procedure for the Review of all Inpatient Physical and Mental Health Deaths can be found in Appendix A.

- There is an expectation that all unnatural deaths, as defined by the cause of death/coroner, of mental health patients who are on a current caseload, or discharged within the last six months, are reported as an incident and reviewed in real time for consideration of meeting the Serious Incident Reporting criteria.

- Reconciliation of individual coroners reports with the PAS system, to identify those patients who are known or have been known to our services.

5.2 In addition to existing requirements of reporting, review and investigation for specific deaths, such as those that are reportable as serious incidents, or deaths of patients detained under the Mental Health Act 1983, the Trust will undertake a case record review. At a minimum, the Trust will undertake a case record review for:

- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
- All deaths in a service specialty where the death has been alerted through means other than an incident form, such as mortality indicator, or commissioner, CQC or NHS Improvement report.
- All deaths in areas where people are not expected to die, such as elective procedures.

- Deaths where the learning will inform the Trust's existing or planned improvement work.
- Review of care offered in a sample of cases which ended in death in care.

## 6.0 REPORTING REQUIREMENTS

6.1 Serious incidents will be reported by the Nursing and Quality Directorate to the lead commissioning body (NHS Dorset Clinical Commissioning Group) via the Strategic Executive Information System (STEIS) and to the National Reporting & Learning System via the local incident reporting system, in line with the NHS England Serious Incidents framework.

6.2 The Trust will report all serious incidents to NHS Improvement that breach or represent a potential risk breaching the Trust's terms of authorisation.

6.3 The Trust will report to the Care Quality Commission via the National Reporting and Learning System (NRLS) any serious incident that risks breaching the terms of registration and compliance with Care Quality Commission Standards. Notification of deaths of detained mental health patients are reported to the CQC via the Mental Health Legislation Office.

6.4 The Medical Director will be responsible for identifying any such incident that requires reporting to external bodies such as commissioners, or which poses a risk of breach of registration requirements. Following discussion with the Chief Executive, the Director of Nursing, Therapies and Quality will undertake reporting to the CQC and the Director of Finance and Strategic Development will undertake reporting to NHS Improvement.

6.5 Procedures for reporting specific incidents shall follow the Trust's Policy for the Reporting and Management of Incidents including Serious Incidents. The procedures specific to this policy are identified below and specific flowcharts can be found in Appendix B.

**Deaths in Inpatient Mental Health –** an incident form is completed for all deaths in inpatient mental health units by front line staff.

**Unexpected Deaths of Community Mental Health Patients** - an incident form is completed for unexpected/unnatural deaths of community patients in current contact with the services or who have been discharged within the last 6 months.

**Unexpected Deaths of Community Hospital Inpatients** - are reported via the incident reporting system by front line staff.

**Expected Deaths of Community Hospital Inpatients** - are reported by the incident reporting team using the reports produced from the patient administration system and automatic notifications inform the Chief Executive, Director of Nursing, Therapies and Quality and the relevant service director.

**Notifications of a child/young person's death** come from a variety of sources and should be sent to the Safeguarding Children's team who will record the death

on Ulysses. Automatic notifications will be sent to the Trust's Incident team, CHIS, Chief Executive, Director of Nursing, Therapies and Quality, the relevant Service Director and the Safeguarding Children's Lead (and Deputy) at Dorset Clinical Commissioning Group

**For Homicide cases** - staff immediately report details via the on line incident reporting system which immediately notifies the line manager, Service Director, Chief Operating Officer (COO) and CEO. The Internal Management Review proforma is sent to the Clinical Commissioning Group by the Head of Patient Safety and Risk within 72 hours of becoming aware of a homicide.

An internal NHS Mental Health Trust investigation using Root Cause Analysis should be completed within 60 days.

A NHS England Local Area Team investigation is commissioned and conducted independently of the providers of care.

6.6 For unnatural or unexpected deaths of mental health patients who were on caseload at the time of their death, or had been discharged within the last 6 months, a letter from the Medical Director and Director of Nursing, Therapies and Quality is written to the GP advising of the investigation and offering opportunity to engage/share information.

6.7 Under the new framework, the Trust is required to comply with new data reporting requirements relating to patient deaths on a quarterly basis. DHC will publish the total number of deaths in the Trust's specified scope (as a minimum this will include all adult inpatient deaths), total number of deaths subject to a case record review and total number of deaths assessed to have a more than 50% chance of being preventable. DHC utilises the template dashboard that has been provided by the National Quality Board to assist with collating and publishing this information.

## 7.0 RESPONDING TO THE DEATH OF SPECIFIC PATIENT GROUPS

7.1 All deaths of patients in community hospitals are automatically recorded on the electronic patient record, SystmOne. There is local multi-professional review of deaths in these service settings and reporting arrangements are in place under the Gold Standard Framework (GSF) process. Unexpected deaths attract a greater level of scrutiny. A quarterly After Death Analysis review is carried out by the clinical team with support from the End of Life Care Facilitator. Findings from this process are reported quarterly to the Quality Governance Committee, where they are subject to further scrutiny.

7.2 Unexpected Deaths of persons due to suicide who have been in current contact with the services or who have been discharged within the last 6 months will have an initial review, in line with the Trust's 72 hour management review process. A Root Cause Analysis (RCA) may then be requested to establish learning and actions arising from the death.

7.3 If the death of a community mental health or addictions services patient was related to the misuse of drugs, it is initially reviewed by the Addiction Services

Manager or Serious Incident Investigator and any learning is shared with the Drug Action Team, an external group where there is also representation from the CCG. A multiagency Root Cause Analysis (RCA) may be requested in some cases where there is evidence of multiagency learning and actions.

7.4 Deaths where there may have been safeguarding issues related to neglect or domestic homicides will be seen by the Dorset and the Bournemouth and Poole Local Safeguarding Adults or Children's Boards. The Trust Serious Incident Panel reviews the findings prior to the reports being shared as part of the safeguarding process.

7.5 For patients who died in the community where the death is not due to suicide, illicit drugs or directly related to the care provided by our services, the death may or may not be reported on the Trust incident system. Under these circumstances, it will be recorded that the death was due to natural causes. Where a death is unexpected and there are concerns about care offered, consideration is given to whether the case meets the SI threshold.

7.6 All deaths of people with learning disabilities are notified to the Learning Disabilities Mortality Review (LeDeR) programme, commissioned by the Healthcare Quality Improvement Partnership for NHS England. The programme receives notification of all deaths of people with learning disabilities and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 and above.

7.7 For the death of a child/young person, the LSCB (Local Safeguarding Children's Board) may decide that a serious case review (SCR) needs to be carried out as well. A Serious Case Review may be undertaken by the LSCB when a child dies or suffers serious harm and abuse or neglect of a child is known or suspected and there is cause for concern as to the way in which agencies have worked together to safeguard the child. Cases may also be reviewed by the LSCB as a Case Audit, when cases do not meet the threshold for an SCR. The decision as to whether an SCR or Case Audit is undertaken will be made by the LSCB, following a referral from a partner agency. The SCR process runs alongside and complements the Child Death Overview Panel (CDOP) process.

## 8.0 REVIEW OF PROVISION OF CARE

### 8.1 Learning Disabilities

8.1.1 The Trust appreciates that the lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. Furthermore the Trust appreciates that looking wider than NHS related circumstances leading to a person's death are essential in order to identify the wider range of potentially avoidable contributory factors to their death.

8.1.2 To review deaths of people with learning disabilities that were in receipt of our care the Trust has joined the Learning Disability (LeDeR) pilot programme in conjunction with Bristol University which is a cross county peer review process.

8.1.3 The purpose of the LeDeR is to review deaths meeting the inclusion criteria for mortality review to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination will guide necessary changes in health and social care services in order to reduce premature death s of people with learning disabilities who are aged 4 years and over.

8.1.4 The standardised review process involves discussing the circumstances leading up to the person's death with someone who knew them well (including family members wherever possible). The cross agency approach to the review develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death.

## 8.2 Mental Health

8.2.1 The Trust understands that physical health and mental health are closely linked, as people with severe and prolonged mental illness are at risk of dying on average 15-20 years earlier than other people. It is also understood that people with long term physical illnesses suffer more complications if they also develop mental health problems.

8.2.2 In circumstances where there is reason to believe the death (subject to reporting requirements identified in this policy) may have been due or in part due to problems in care the Trust will report and review the incident in line with the Serious Incident Framework.

## 8.3 Children and Young People

8.3.1 Since 1st April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children and to prevent future deaths.

8.3.2 Following identification of a death of a child or young person who was in receipt of care from the Trust, the Trust will work with the Dorset Safeguarding Children's Board to review the death in line with the Child Death Overview Process (CDOP).

8.3.3 The procedure to be followed, following notification of a child death, can be found at Appendix F. Advice and support about these processes, how to respond to requests for information and completion of the forms is available from the safeguarding children's service on 01305 361465.

## 8.4 Drug Related Deaths

8.4.1 Deaths identified as being related to illicit substances are reviewed by the local Dorset Drug Action Team.

8.4.2 In addition to local review by the Dorset Drug Action Team all drug related deaths in Dorset are reviewed by the Pan Dorset Confidential Inquiry Panel to identify where there are lessons to be learnt that could prevent future drug related deaths

in the future, to identify potential risks to drug using populations and to highlight the learning and risks to commissioners and service providers so that lessons can be applied to service responses as well as policies and procedures.

### 8.5 Cross System Reviews and Investigations

8.5.1 Where there is a death of a patient who was under the care of more than one organisation and the death falls within the Serious Incident Reporting Framework, the Trust will co-operate with a joint case record review or investigation, which is co-ordinated by the appropriate CCG.

### 8.6 Structured Judgement Review

8.6.1 As part of the RCA and After Death Analysis Review process that follows reporting and investigation of a death, the Trust will adopt a SJR template to be completed by the reviewers.

## 9.0 ENGAGEMENT WITH FAMILIES AND DUTY OF CANDOUR

9.1 The Trusts recognises that it must make it a priority to work more closely with the families and carers of patients who have died to ensure meaningful support and engagement at all stages, from notification of the death right through to actions taken following an investigation.

9.2 This policy sets out the key principles it will follow, including the need to treat bereaved families and carers as equal partners and recognising that paying close attention to what families/carers say can offer an invaluable source of insight to improve clinical practice.

9.3 Following the Francis Enquiry into Mid Staffordshire NHS Foundation Trust, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 included in regulation 20 the Duty of Candour which came into force on 27th November 2014.

9.4 The aim of the regulation was to ensure that providers are open and honest with patients when things go wrong with their care and treatment.

9.5 The Duty of Candour applies “as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred” a health service body must notify the “relevant person” that the incident has occurred.

9.6 Where it is clear at the time of reporting an incident that Duty of Candour requirements are met, the Locality Manager (or nominated deputy) will contact the patient and family and in line with the duty will:

- Provide an account, which to the best of the Trust’s knowledge is true, of all the facts the Trust knows about the incident as at the date of the notification.

- Advise the patient and/or family what further enquiries into the incident the Trust believes are appropriate - including an apology.

- Record all actions and outcomes in a written record which is kept securely by the Trust.

9.5 The Trust will also ensure that reasonable support is provided to the patient / family in relation to the incident from the time of notification and ongoing as required.

9.6 For those incidents that require further investigation a Root Cause Analysis review is carried out. It is current practice of the Trust for families and carers to be invited to be part of the incident review. If it becomes apparent that the incident was as a result of failings in care then the Duty of Candour process is commenced by the Locality Manager (or nominated deputy) as identified via the review. Within this process families and carers will have proper opportunity to raise questions or share concerns about the quality of the patient's care.

9.7 Under the minimum requirements in the framework, a significant concern raised by families/carers should always trigger a case record review.

## 10.0 SIGNPOSTING AND PROVISION OF GUIDANCE ON OBTAINING LEGAL OR THIRD PARTY ADVICE AND SUPPORT FOR FAMILIES, CARERS OR STAFF

10.1 Support is available to individuals involved in an incident. This will be via identified leads from the Trust, or if more appropriate, via an independent organisation equipped to provide practical and emotional support as required. The Trust will follow the principles set out the in Being Open policy at all times.

Staff should ensure that carers and relatives are aware of how to make contact with the following:

- Citizens Advise Bureau.
- Patient Advise Liaison Service.
- Local law Centre.
- Advocacy Services.
- Named individual within the Trust for further information and support on an ongoing basis.

10.2 Families, carers and relatives and staff members should be informed face to face or verbally of the news of the service user's death as soon as possible in line with the Trust's Duty of Candour Policy.

10.3 Staff members should be offered support in line with the Trust's policy for supporting staff, service users, carers, relatives and / or visitors involved in incidents, complaints and claims.

## 11.0 DISSEMINATION AND IMPLEMENTATION

11.1 This policy will be available on the Trust intranet.

11.2 It is the responsibility of managers to ensure this policy is implemented; the Nursing and Quality directorate retain corporate oversight of incident, complaint and claims data and the database Ulysses which can record incident data.

## 12.0 MONITORING COMPLIANCE

12.1 All deaths reported are reviewed on a weekly basis by the Medical Director and the Director of Nursing and Quality to identify and confirm the most appropriate review mechanism.

12.2 A monthly and quarterly report is produced to the Executive Quality and Clinical Risk Group and to the Quality Governance Committee which includes details of how deaths have been reviewed and identifies any learning on Trends.

12.3 Should any shortfalls or any lack of implementation be identified, this will be escalated for action to the Mortality Group, who will then monitor any associated improvement plan.

12.4 Quarterly data reporting to the Trust Board

## 13.0 REFERENCES


- https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf
- http://www.supportaftersuicide.org.uk/help-is-at-hand
- *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.
- Valuing People: A New Strategy for Learning Disability for the 21st Century, Department of Health, 2001. LeDeR briefing paper.
- *The Five Year Forward View For Mental Health* (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf
- Learning Disabilities Mortality Review (LeDeR) programme. Background is available at http://www.bristol.ac.uk/sps/leder
- http://www.ncpc.org.uk/sites/default/files/user/documents/What_to_Expect_FINAL_WEB.pdf
- Trust Bereavement leaflets with contact details for the east and the west of the county support services: https://doris.dhc.nhs.uk/download_file/view/3829/978. https://doris.dhc.nhs.uk/download_file/view/3830/978
- Gold Standard Framework (GSF) audit tools (Including accreditation guidance and tools including GSFADA) https://doris.dhc.nhs.uk/download_file/view/3809/978
- The Child Death Review, a guide for parents and carers (The Lullaby Trust) https://www.lullabytrust.org.uk/bereavement-support/

## 14.0 ASSOCIATED DOCUMENTS

14.1 This Policy should be read in conjunction with;

- Policy for the Reporting and Management of Incidents including Serious Incidents
- Customer Care Policy (Complaints and Compliments)
- Risk Management Policy
- Risk Registers contained within Ulysses
- Management of Claims Handling and Litigation Policy
- Policy for the Investigation of Incidents, Complaints and Claims
- Being Open policy
- Support for Staff following an Incident, Complaint or Claim policy

## APPENDICES

| | |
|---|---|
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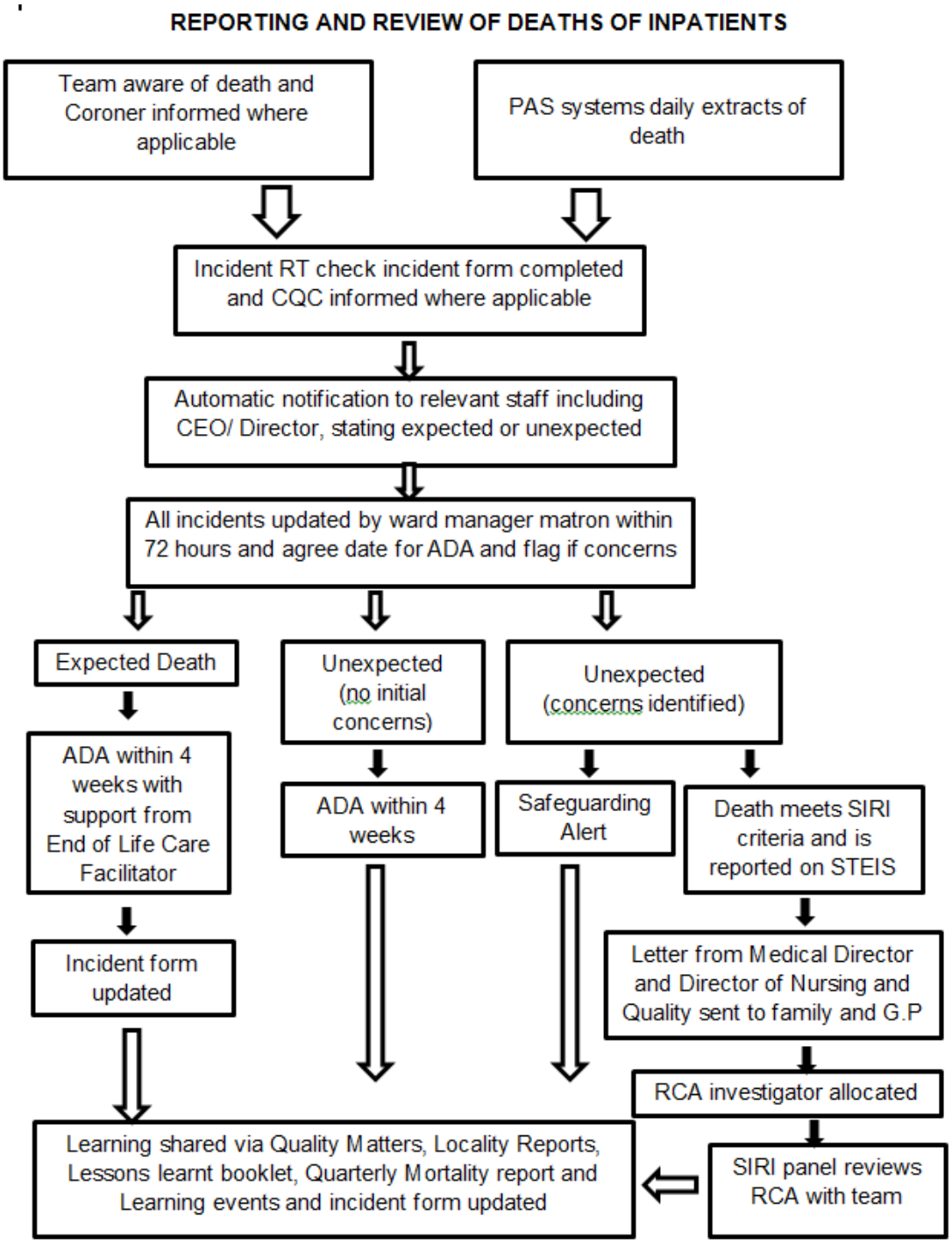
| Appendix B | Standard Operating Procedure for the ADA Process |
| Appendix C | ADA Audit Tool |
| Appendix D | Reporting and Review of Deaths of Community Patients Flowchart |
| Appendix E | Reporting and Review of Unexpected Deaths of Community Patients Flowchart |
| Appendix F | The procedure to be followed following notification of a child death |
| Appendix G | Equality Analysis. |

## APPENDIX A


REPORTING AND REVIEW OF DEATHS OF INPATIENTS
Team aware of death and Coroner informed where applicable
PAS systems daily extracts of death
Incident RT check incident form completed and CQC informed where applicable
Automatic notification to relevant staff including CEO/ Director, stating expected or unexpected
All incidents updated by ward manager matron within 72 hours and agree date for ADA and flag if concerns
Expected Death
Unexpected (no initial concerns)
Unexpected (concerns identified)
ADA within 4 weeks with support from End of Life Care Facilitator
ADA within 4 weeks
Safeguarding Alert
Death meets SIRI criteria and is reported on STEIS
Incident form updated
Letter from Medical Director and Director of Nursing and Quality sent to family and G.P
RCA investigator allocated
Learning shared via Quality Matters, Locality Reports, Lessons learnt booklet, Quarterly Mortality report and Learning events and incident form updated
SIRI panel reviews RCA with team

Dorset HealthCare University NHS Foundation Trust

# APPENDIX B

# Standard Operating Procedure for the ADA Process

**Reporting process for undertaking an After Death Analysis and review of an inpatient death**

**Standard Operating Procedure**
**for Inpatient Physical and Mental Health Deaths**

| | |
|---|---|
| Objectives | To ensure a robust reporting system that will highlight trends or causes for concern with regard to clinical practice at end of life |
| **Scope** | **To include an in depth review of all deaths occurring within inpatient settings.** |
| **Responsibilities** | **Quality Directorate** |
| **Related Documents** | **Deteriorating Adult Patient Policy IN 168**<br>**End of Life Care Policy IN 237**<br>**Pan Dorset DNACPR Policy IN 337**<br>**Verification of Death policy no: IN 327**<br>**Gold Standards Framework (GSF) After Death Analysis( ADA)**<br>**Mortality reports**<br>**Coroners guidance and requirements** |

**The Stages of the Process**

1. All deaths of patients in community hospitals are automatically recorded on the electronic patient record systems. Recording of whether this is an expected or unexpected death, with cause of death, date and time, must also be completed by ward staff / Doctor responsible for the patient.

2. This information is then supplied to the Safeguard team, from SystmOne and directly by staff if a death is within Mental Health inpatients. This then raises a Ulysses incident form to ensure every death in the Trust is recorded on the same risk system.

3. The Ulysses incident form will then request, to the nominated responsible person, that an ADA is completed at an agreed review date, using the agreed Trust ADA tool.

4. Section A of the ADA, will then be completed by the ward lead for this patient who will also gain feedback from staff caring for the patient and collate any relative/ friends feedback. This will then be returned to the End of Life Care Facilitator (EOLCF) and Advanced Practitioner for Palliative Care, prior to the pre booked monthly review.

5. The review team should include, as a minimum, the Matron, Senior or Junior Ward Sister, medical representation of either the Non-Medical Prescriber/ Advanced Nurse Practitioner from the ward or a GP working in the ward.

6. A clinician with knowledge of palliative care prescribing and the Trust End of Life Care policy to include GSF will be part of the review team, to offer an impartial perspective to the review process. This may be the EOLC Facilitator, Advanced Practitioner for Palliative Care, Palliative Care Pharmacist, or Peer review from a Matron from another hospital.

7. Other members may be opted in as required.

8. Duty of Candour will be reviewed at this time

9. 9. Scoring using the Structured Judgement Review Method (2017) will be agreed at the MDT review.

10. Sign off of the Ulysses is then able to occur after this review, if no further investigation has been highlighted.

11. The excel spreadsheet should be e mailed after the MDT review to the EOLC facilitator and dhc.clinaudit@nhs.net when completed.

12. Completed copies will be sent back to the Matron and senior ward sister to act on any actions identified.

13. If the death is unexpected the completion of the Ulysses template should be completed as per Trust verification of death policy.

14. The report uses two definitions of death;

**Expected Death:** Where a service users has been admitted for end of life care or following admission is found to have a condition which they are unlikely to recover from and death is imminent or death occurs following on from a period of illness.

**Unexpected Death:**Those that occur when the patient has not been admitted specifically for end of life care, had not been identified as having a terminal illness during admission and death not anticipated at this time.

15. These reporting arrangements support the Hospital Standard Mortality Ratio (HSMR) process and provide information on the care through a Structured Judgement Review Method by providing a score on the phases of care, at the end of the review. 16.Findings from the mortality review process are then reported quarterly to the Executive Quality and Clinical Risk Group, and End of Life Care Operational Group where they may be subject to further scrutiny.

**Review**

This SOP will be reviewed every two years unless new guidance or legislation dictates a review any sooner. Date Reviewed:

26.4.17

| Written By | Signature | Date |
|---|---|---|
| Hilary Lawson | | 15.5.17 |

| Reviewed By | Signature | Date |
|---|---|---|
| Katrina Kennedy | | 15.5.17 |

| Authorised By | Signature | Date |
|---|---|---|
| Cara Southgate | | 15.5.17 |

Dorset HealthCare University NHS Foundation Trust

## APPENDIX C

# ADA Audit tool - After Death Analysis

**Section A - To be complete by the ward staff prior to the Multiprofessional Death Review**

**Details of inpatient Physical Health Death**

| | | | |
|---|---|---|---|
| Hospital | | RiO No. if Applicable: | |
| Ward | | | |
| Ulysses Number | | | |
| NHS No | | | |
| DOB | | Age: | #VALUE! |
| Date of Death | / / | Time of Death: | |
| Gender | | | |
| Date of Admission | | LOS | #VALUE! |
| Admitted from | | Other | |
| Cause of Death | | | |
| Expected / Unexpected Death | | | |
| Reason for Admission | 34 | | |
| GSF Code on Admission | | | |
| Duty of Candour | | | |
| Previously Reported Ulysses incidents numbers | | | |

**Co-morbidities, Impact of previous incidents? Also record reasons for any recent emergency admission, (acute hospital), if applicable.**

**Section A Continued.....**

| | | Questions - Please record details in summary of evidence/comments section | Select answer from Drop down list | Comments/ areas requiring further review |
|---|---|---|---|---|
| Recognise | 1 | What was the patient primarily was admitted for? | | |
| | 1.2 | If there is any other reasons for admission please specify here? | | |
| | 1.3 | Did the patients care status change to End of Life care after admission? | | |
| | 1.4 | Was it recognised that the patient was reaching end of life? | | How was this decision made if not admitted for EOLC? How was it recorded? |
| | 1.5 | Was the patient coded GSF Red at time of death? | | |
| | 1.6 | Was the patient coded GSF Yellow at time of death | | |
| | 1.7 | Was the GSF reviewed in the last 7 days? | | |
| | 1.8 | Has the patients resuscitation status been recorded on this admission? | | |
| | 1.9 | Is a valid DNAR present in the patients file. | | Review at MDT |
| | 1.10 | Was CPR performed on the patient? | | |
| C | 2 | Is there evidence of multi-professional team evaluation of the care of the patient? | | |
| | 2.1 | Was preferred place of death known? | | |
| | 2.2 | Where was the preferred place of death? | | |
| | 2.3 | Was the patient seen by a Dr within 48 hrs of death? | | |

| | | | | |
|---|---|---|---|---|
| | 2.4 | Was the patient seen by a Dr in the last 14 days? | | |
| | 2.5 | Was a baseline NEWS score recorded for the patient on admission? | | |
| | 2.6 | Was action required on this NEWS score? | | |
| | 2.7 | Was there a potential safeguarding adults concern e.g. significant gaps / omissions in care | | If yes ensure safeguarding team informed |
| | 2.8 | Was an Out hours message sent when recognised patient was dying? | | |
| | 3 | Had the patient made an advance care plan (ACP)? | | |
| e | 3.1 | Had the information in the ACP been incorporated in the patients care planning? | | |
| Involv | 3.2 | Were the patient and carer's / relatives involved in the AAND decision? | | |
| | 3.3 | Were the patients wishes reflected in their plan of care/ treatment plan? | | |
| | 3.4 | Were these wishes achieved? | | |
| Support | 4 | Was the patient subject to a DoLs? | | |
| | 4.1 | Was the patient under a MH section at time of death | | |
| | 4.2 | Had there been a 'Best interest' end of life care plan? | | |
| | 4.3 | Was a specialist nurse involved in the care (i.e. Palliative care, heart failure) | | |
| | 4.4 | Had the carers needs been documented? | | |
| | 4.5 | Had the Carer/s been supported during the dying phase? | | |
| | 4.6 | Had information been given on what to expect? | | |
| | 4.7 | Had bereavement information been given? | | |
| Plan and Do | 5 | Was the patient on the last days of life care plan? | | |
| | 5.1 | Did the patient have an existing infection prior to admission? | | |
| | 5.2 | Did the patient develop a hospital acquired infection during this admission? | | |
| | 5.3 | Did the hospital acquired infection contribute to cause of death? | | |
| | 5.4 | Was the infection related to an outbreak on the ward? | | |
| | 5.5 | Was NEWS score related to recognition of end of life / dying phase? | | |
| | 5.6 | Was a Treatment Escalation plan (TEP) in place? | | |
| | 5.7 | Was it clearly documented what to do in the event of a deterioration? | | review at MDT |
| | 5.8 | Were the appropriate EOL drugs used for the patients symptoms? | | review at MDT |
| | 5.9 | Were appropriate EOL drug doses and titrations used? | | review at MDT |
| | 5.10 | Was the prescriber the NP? | | |
| | 5.11 | Was the prescriber the ward Dr? | | |
| Reflection | | **Discuss next 5 questions with staff prior to MDT review** | | |
| | 6 | **Carers feedback from relatives (Patient Experience) received?** | | |
| | 6.1 | **What went well? (Was GSF followed? how did staff support patient and relatives? Was capacity assessed to involve patient at the time?)** | | |
| | 6.2 | **what could have gone better?** | | |
| | 6.3 | **What learning is there to be shared?** | | |
| | 6.4 | **Any actions already taken?** | | |

**Staff feedback after the death: how did they feel this had been managed and did they have support if needed?**

| | | |
|---|---|---|
| **Please record who completed Section A of this form** | **Name:** | |
| | **Designation:** | |

**Section B - Review notes**

**MultiProfessionalAfterDeathReview**

**Date of Review:**

**Attendance**

| | | **Other Attendees:** |
|---|---|---|
| **Doctor:** | | |
| **NMP:** | | |
| **Ward Matron:** | | |
| **Ward Sister:** | | |

**Reviewer notes**

**Section C - To be completed by the MP Reviewer**

**Summary of Multiprofessional Review findings**

| | | |
|---|---|---|
| Contributory Factors | 1 | 0 |
| | 2 | 0 |
| | 3 | 0 |
| Care and Service Delivery Problems | 1 | 0 |
| Learning identified | 1 | 0 |
| | 2 | 0 |
| | 3 | 0 |

**Key**

| | |
|---|---|
| 1 | Definitely avoidable |
| 2 | Strong evidence of avoidability |
| 3 | Possibly avoidable, but not very likely (less than 50:50) |
| 4 | Probably avoidable (more than 50:50) |
| 5 | Slight evidence of avoidability |
| 6 | Definitely not avoidable |
| **Outcome score** | |

**Please ensure that recommendations are SMART and include the action, person responsible and due date.**

| Recommendations | No. | Individual (Level 1) Team (Level 2) | Lead/ Responsible Person | date due | comments |
|---|---|---|---|---|---|
| | 1 | | | | |
| | 2 | | | | |
| | 3 | | | | |
| | 4 | | | | |
| | 5 | | | | |

| Recommendations | No. | Directorate (Level 3) and Trustwide (Level 4) | Lead/ Responsible Person | date due | comments |
|---|---|---|---|---|---|
| | 1 | | | | |
| | 2 | | | | |
| | 3 | | | | |
| | 4 | | | | |
| | 5 | | | | |

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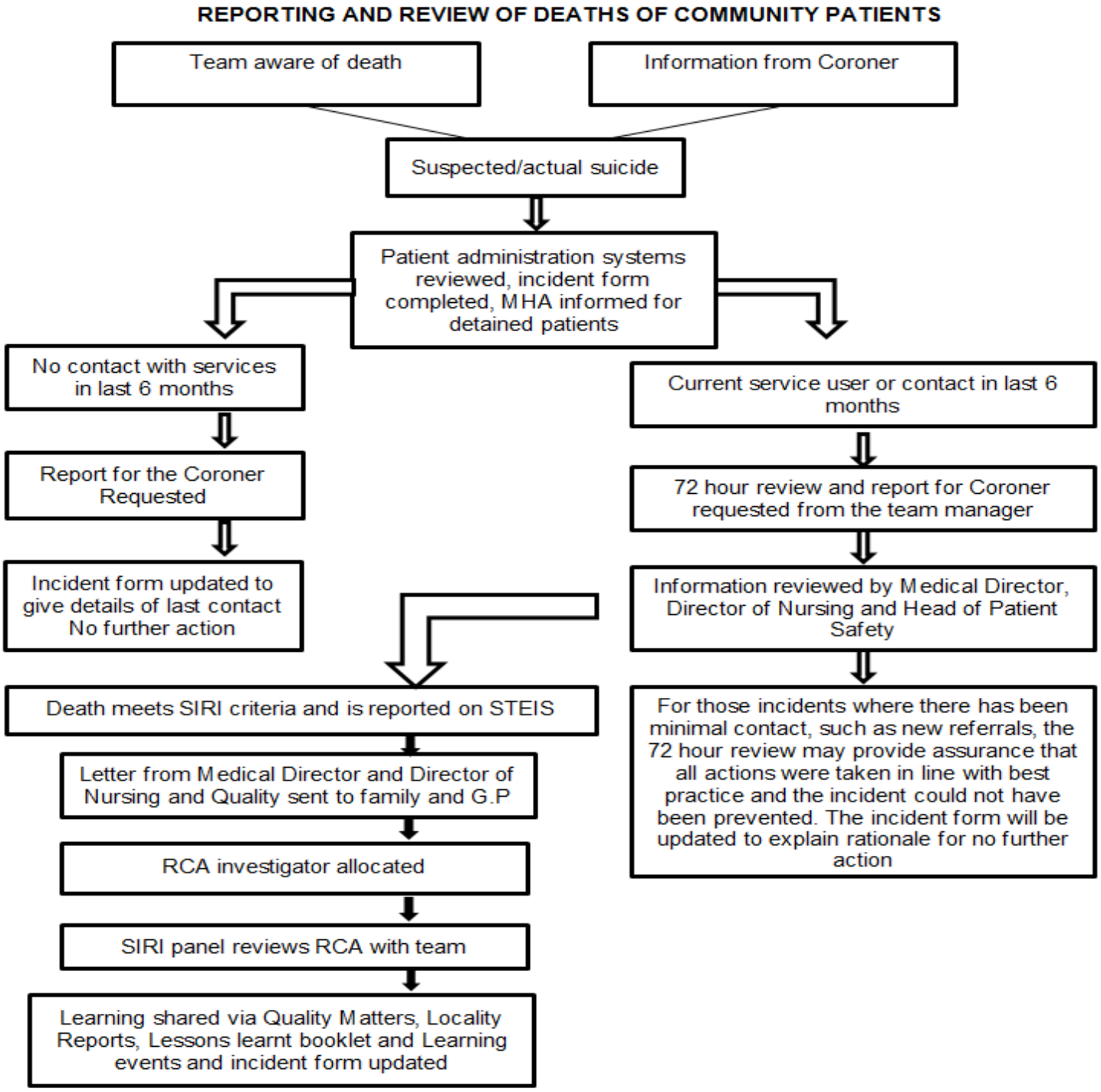
## APPENDIX D



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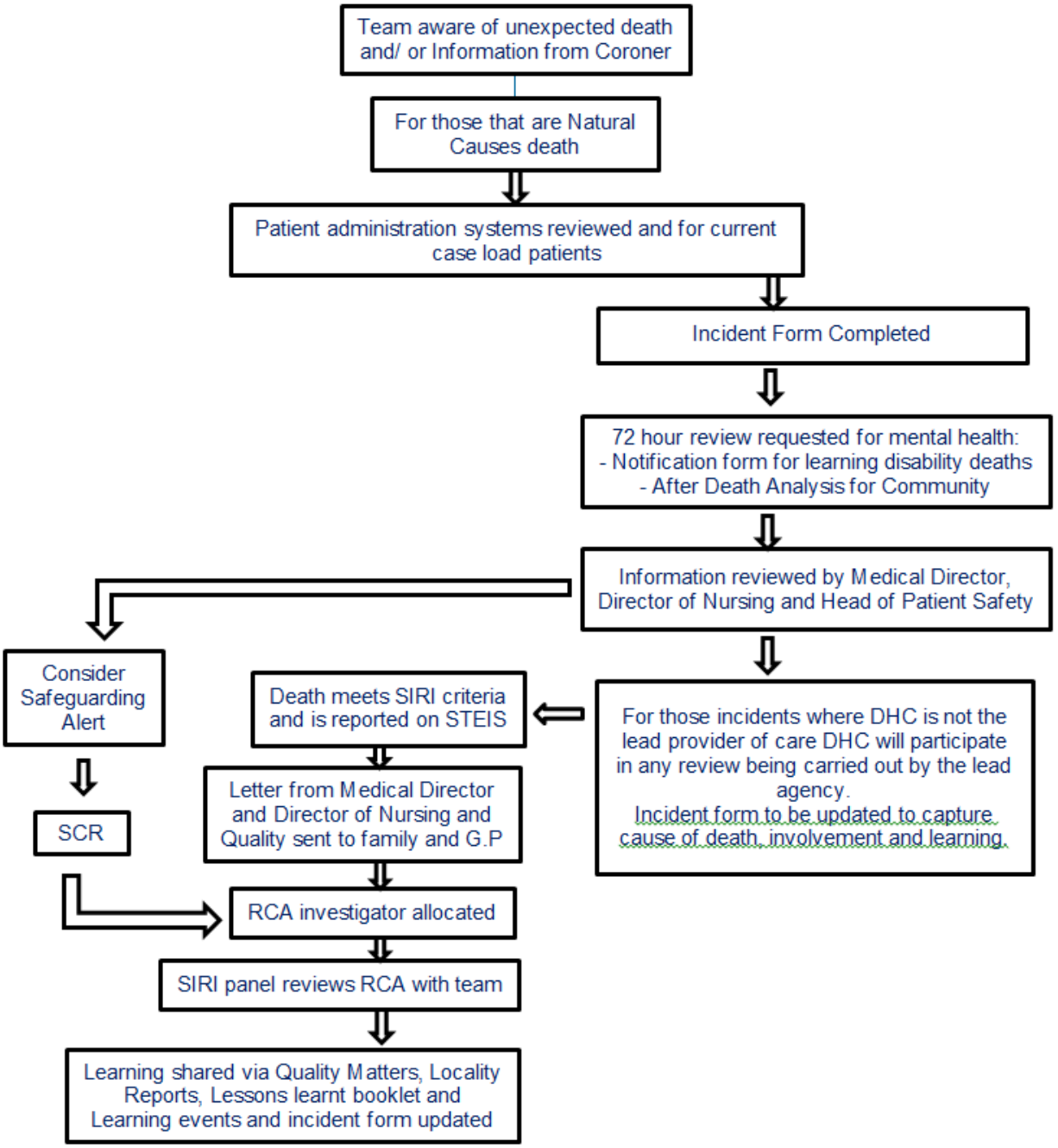
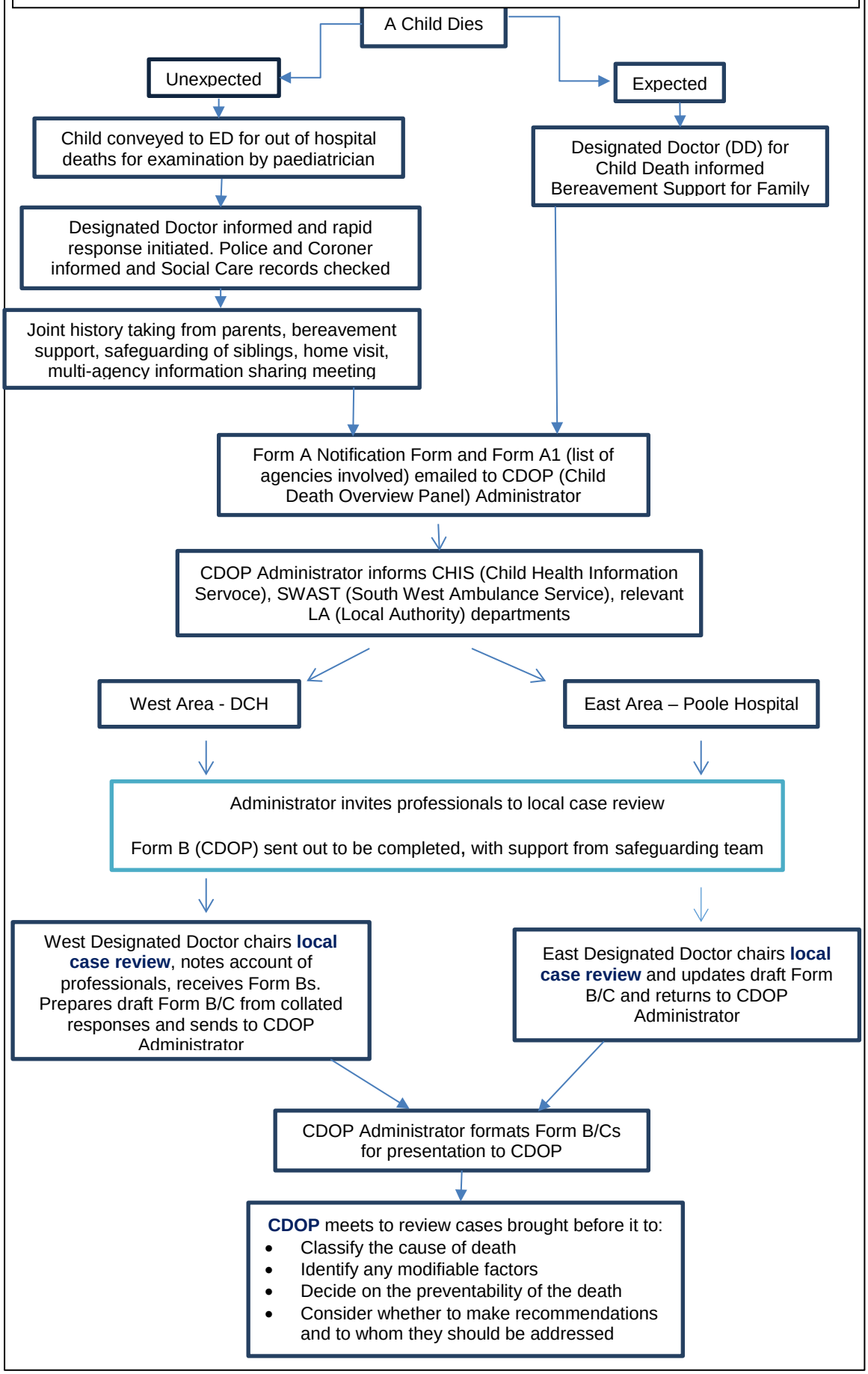
## APPENDIX E

**REPORTING AND REVIEW OF UNEXPECTED DEATHS COMMUNITY PATIENTS**



**APPENDIX F**

**PAN DORSET CDOP (Child Death Overview Panel) FLOWCHART OF PROCESS**



**APPENDIX G** **EQUALITY IMPACT ASSESSMENT RECORD**

| Version number and date/s | | | | | | | |
|---|---|---|---|---|---|---|---|
| Policy / Practice / Plan / Project Title and overview<br>Mortality Policy<br>This policy sets out the trusts approach to the reporting, responding and review of deaths which are identified by the Trust and engagement with families following a death | | | | | | | |
| Who will be affected? Staff/Patients/Both<br>Families, Carers, staff | | | | | | | |
| Protected Characteristic | Is it relevant to this policy? y/n | Equality Duty (Equality Act 2010) | | | Evidence for your decision including details of consultation | Resulting actions | Description of remaining Impact |
| | | Eliminate unlawful discrimination? y/n | Advance equality of opportunity? y/n | Foster good relations? y/n | | | |
| Age | Yes | | | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |
| Disability | Yes | | | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |
| Gender Reassignment | Yes | | | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |
| Race | Yes | | | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Religion or Belief | Yes | | | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |
| Sex | Yes | | | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |
| Sexual Orientation | Yes | | | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |
| Pregnancy and Maternity | Yes | | | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |
| Marriage and Civil Partnership | Yes | | [redacted] | | | Impact identified as positive and low – policy ensures procedures are in place for the identification, reporting and review of deaths. | |