Morbidity and Mortality Review UHL Policy

<table>
<thead>
<tr>
<th>Approved By:</th>
<th>Mortality Review Committee Policies &amp; Guidelines Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Original Approval:</td>
<td>December 2017</td>
</tr>
<tr>
<td>Trust Reference:</td>
<td>B48/2017</td>
</tr>
<tr>
<td>Version:</td>
<td>V2</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>v1 - June 2019 (review date extension)</td>
</tr>
<tr>
<td>Trust Lead:</td>
<td>Head of Outcomes &amp; Effectiveness</td>
</tr>
<tr>
<td>Board Director Lead:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date of Latest Approval</td>
<td>17 January 2020 - Policy and Guideline Committee</td>
</tr>
<tr>
<td>Next Review Date:</td>
<td>July 2020 (extended by PGC 17 Jan 2020)</td>
</tr>
</tbody>
</table>
## REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

This policy replaces the previous Mortality & Morbidity Policy in response to the national Implementing the Learning from Deaths framework: requirements, July 2017

## KEY WORDS

Medical Examiner, Death Certification, MCCD, M&M, Mortality Screening, Structured Judgement Review, SJR, Death Classification, Learning from Deaths, Bereavement, M&M; Mortality; Morbidity; Mortality Review; HSMR; SHMI, Clinical Review
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. 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) subsequently provided a framework for NHS Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.

1.4 UHL’s processes for reviewing mortality have been revised in line with this latest guidance and our overarching ‘Learning from Deaths’ framework is described in the ‘Learning from the Deaths of Patients in our Care Policy’ B31/2017.

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 document provides details of the processes involved in undertaking the different types of mortality reviews, morbidity reviews and death classification.

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

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) Corporate Mortality and Morbidity Administrative Team
   c) Mortality & Morbidity Leads
   d) Mortality reviewers
   e) Consultants, Matrons and Ward Sisters
   f) Patient Safety Team
   g) Bereavement Support Nurses
2.4 The policy should be read in conjunction with:
   a) Incident and Accident Reporting Policy (A10/2002)
   b) Learning from the Deaths of Patients in our Care Policy (B31/2017)
   c) Medical Examiners’ Process Policy (B49/2017)
   d) Bereavement Support Guidelines (B4/2016)

3 DEFINITIONS AND ABBREVIATIONS

For the purpose of this policy the following definitions apply:

3.1 Morbidity: any condition or event that has a negative impact on the patient’s wellbeing. Whilst morbidity can result from a misadventure, events outside of misadventure can lead to morbidity e.g. surgical site infection, venous thromboembolism.

3.2 Mortality: death where the patient was under the care of UHL – for the purpose of this policy specifically relates to death whilst an in-patient or within 30 days of surgical procedure/chemotherapy.

3.3 Out of Hospital Mortality: death of a patient who has been discharged from UHL and dies within 30 days of discharge.

3.4 Case Record Review – retrospective review of a patient’s clinical records, carried out by clinicians, to determine whether there were any problems in the care provided to the patient.

3.5 Structured Judgement Review (SJR). A detailed review of the clinical record, normally undertaken by a senior doctor in the same medical specialty as that responsible for the patient’s care at the time of death (or discharge/procedure if morbidity related). It is ‘structured’ because it follows an approach defined by the Royal College of Physicians.

Within UHL, SJRs can be undertaken for either mortality or morbidity reviews but for the purpose of this policy an SJR will refer to the case record review for deceased patients.

3.6 Clinical Review - for the purpose of this policy 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.

3.7 Medical Examiner (ME) - This role is not the same as the proposed national role. The MEs roles in UHL are 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.

3.8 Mortality Screening - within UHL refers to the reading through of deceased patients’ clinical records (electronic and paper) with a view to identifying if further review is required to confirm if there were potential problems in care or lessons to learn. Mortality Screening by UHL MEs will also include speaking to a bereaved relative/carer, usually the ‘next of kin’.
3.9 **Death Classification** – Locally agreed 5 point scale applied to cases subject to a Structured Judgment Review:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Problems in care thought more likely than not to have contributed to death</td>
</tr>
<tr>
<td>2</td>
<td>Problems in care but unlikely to have contributed to death</td>
</tr>
<tr>
<td>3</td>
<td>Problems in care but very unlikely to have contributed to death</td>
</tr>
<tr>
<td>4</td>
<td>No problems in care</td>
</tr>
<tr>
<td>5</td>
<td>Good or Excellent Care.</td>
</tr>
</tbody>
</table>

3.10 **Death due to a problem in care**: A death that has been clinically assessed using a recognised method of case record review (Structured Judgement 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.

3.11 **Morbidity Classification** – Locally agreed 5 point scale applied to cases subject to a Structured Judgment Review:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Morbidity more likely than not to have resulted from a problem in care</td>
</tr>
<tr>
<td>2</td>
<td>Problems in care which may have contributed to Morbidity but not very likely.</td>
</tr>
<tr>
<td>3</td>
<td>Problems in care but very unlikely that these contributed to Morbidity</td>
</tr>
<tr>
<td>4</td>
<td>No problems in care</td>
</tr>
<tr>
<td>5</td>
<td>Good or Excellent Care.</td>
</tr>
</tbody>
</table>

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.

4 **Roles and Responsibilities**

4.1 **Board Level Lead - Medical Director has**

a) Overall responsibility for mortality and morbidity review processes
b) Responsibility for ensuring reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the mortality review process.

c) Responsibility for Learning from Deaths reporting to the Trust Board and publication of the Trust's 'death due to a problem in care' data

The Deputy Medical Director will have delegated responsibility for the above

4.2 **Mortality Review Committee will**

a) Oversee the mortality and morbidity review process
b) Receive reports on learning and actions being taken as a result of SJR findings, specifically in respect of cases given a Death Classification of 1 to 3.
4.3 **Head of Outcomes & Effectiveness will oversee**
   a) Implementation of this policy with support from the MRC, the Corporate M&M team and Specialty M&M Leads
   b) Quality assurance of the mortality and morbidity review processes within UHL – to include peer review of SJRs
   c) Quality assurance of both internal and external reporting of SJR findings and death classification data
   d) Co-ordination of theming of SJR and clinical review findings for reporting to Speciality M&M Leads, the MRC and CMG Q&S Boards
   e) Provision of a Quarterly Mortality Report to the Trust Board and ‘Learning from Deaths’ Dashboard for publication on the trust’s website
   f) Annual reporting of UHL’s mortality data and details of learning and actions taken in the Trust’s annual Quality Accounts
   g) Review of this policy and supporting documents

4.4 **Corporate M&M Administrative Team will:**
   a) liaise with the ME Assistant to ensure case notes and prepopulated SJR templates are sent to the relevant Specialty M&M as per their agreed process
   b) liaise with the Learning Disability Acute Liaison team where cases referred for SJR
   c) liaise with Leicestershire Partnership Trust Mental Health team where deaths of patients with Severe Mental Illness referred for SJR
   d) liaise with the ME Assistant to ensure ME feedback, to include compliments and requests for clinical reviews, are forwarded to the relevant clinical team
   e) collate SJR findings and Death Classification details findings for inputting into the Mortality Review Database
   f) support M&M Leads with tracking SJR completion progress and following up of actions
   g) provide progress reports to M&M leads
   h) support the HOE with feeding back learning for other organisations as applicable

4.5 **Medical Examiners will:**
   a) Refer deaths to the Specialty M&M for mortality review or to the relevant Clinical Team for Clinical Review/Feedback in line with the Medical Examiner Process Policy standards.

4.6 **Clinical Management Group Management Teams:** are responsible for
   a. ensuring that appropriate multi-disciplinary M&M Meetings take place in their CMG and that there are approved Terms of Reference for each Specialty M&M
   b. ensuring that there is appropriate administrative support identified for the M&M processes within their CMG
   c. ensuring M&M Leads are aware of any quality issues/data reported at the CMG Quality and Safety Board (QSB) relating to mortality or morbidity
   d. confirming reporting processes between M&M Meetings to the CMG QSB and for escalating issues and areas of concern to the Mortality Review Committee (MRC) as appropriate
   e. monitoring and surveillance of M&M Meeting outcomes/themes at a CMG level.
   f. having oversight of externally reported mortality and other clinical outcomes, relevant to their CMG
4.7 Specialty Clinical Leads/Heads of Service: are responsible for
   a. identifying an M&M Lead and reviewing their role as part of the annual job planning process
   b. contributing to the facilitation of appropriate multi-disciplinary M&M Meetings for Specialty/service staff
   c. being aware of M&M outcomes/themes at a specialty level and supporting M&M leads with effective dissemination of learning points and implementation of relevant actions.
   d. Supporting the M&M lead with ensuring processes are in place for the timely and accurate collection, validation and submission of relevant externally reported mortality data and other clinical outcomes,
   e. ensuring appropriate review, response and actions are taken in respect of relevant published mortality and other clinical outcomes, to include responses to mortality alerts, where applicable

4.8 Specialty M&M Leads will:
   a) Oversee the mortality and morbidity review process within their Specialty in order to meet the standards in Section 5.
   b) Co-ordinate the Specialty M&M meeting schedule and agenda in order that Mortality SJRs are completed and Death Classification confirmed within 4 months of the death (or 6 months if there have been delays in receipt of relevant information)
   c) Be a point of contact for the Corporate M&M team where delays are identified
   d) Review proposed Death Classifications and Morbidity Classifications and confirm whether the case needs full discussion at the Specialty M&M
   e) Ensure relevant Consultants and Ward Sisters/Matrons are aware of cases to be discussed where problems in care have been identified
   f) Ensure cases given a Death Classification of 1 are reported as a Patient Safety Incident with Major Harm on Datix and that all other Patient Safety Reporting requirements are met as part of either Mortality or Morbidity Reviews.
   g) Escalate cases given Death Classification of 1 to MRC via the Corporate M&M team
   h) Have oversight of Specialty process for responding to ME feedback, where SJR considered to have been inappropriately requested
   i) Oversee dissemination of learning from deaths or from morbidity reviews –both within their Specialty and other areas where relevant
   j) Ensure identified actions are Specific, Measurable, Achievable, Realistic and Timely (SMART) and escalate to relevant Head of Service, or other managerial leads as appropriate
   k) Ensure learning and actions are appropriately documented and completed reviews are securely archived on the UHL M&M Drive.
   l) Track actions against agreed timescales and escalate to Head of Service if not completed
   m) Ensure their M&M process is in line with the Specialty M&M Process Guidelines and Terms of Reference (Appendices 5 and 6)
   n) Being a point of contact for the Corporate M&M team in respect of any Mortality alerts and associated reviews

4.9 All Matrons and Consultants are responsible for:
   a) Carrying out clinical reviews and taking forward identified learning and actions
   b) Participating in the Specialty M&M process as per the Specialty M&M Process Guidelines and Terms of Reference (Appendices 5 and 6)
4.10 Mortality and Morbidity Reviewers are responsible for:
   a) Completing reviews within the timescales set out in Section 5.7.
   b) Informing the Specialty M&M Lead of cases where review has identified problems in care which requires discussion at the M&M meeting
   c) Being available to present the findings of their review at the next M&M meeting

4.11 Structured Judgement Review Reviewers (SJR Reviewers) will:
   a) Ensure they did not have either overall responsibility or substantial direct involvement during the final admission of a patient where the death or complication has been referred for SJR
   b) Undertake SJRs in line with the national requirements – see Appendix 1
   c) Complete all relevant sections of the SJR Template – See Appendices 2 & 3
   d) Propose a Death Classification or Morbidity Classification following SJR completion, taking into account identified problems in care and with reference to the Classification criteria
   e) Escalate to the Specialty M&M Lead any cases where the proposed Death Classification or Morbidity Classification is 1 or 2

4.12 Bereavement Support Nurses will:
   Support Specialty M&M Leads with feeding back the outcome of SJRs and M&M discussions to bereaved relatives, where this has been requested

4.13 Learning Disability Acute Liaison Lead Nurse Practitioner
   Ensuring that the deaths of patients with Learning Disability are registered with the Learning Disability Mortality Review Programme (LeDeR)
   Providing advice and support for the Corporate M&M team and Specialty M&M Leads in respect of reviewing the deaths of patients with a Learning Disability

4.14 All staff involved in the care of patients are responsible for:
   a) Referring cases for Structured Judgment Review as part of the Specialty M&M process where potential learning identified
   b) Ensuring they are aware of all relevant learning from their Specialty Mortality and Morbidity meetings and support implementation of actions as applicable
   c) Taking forward learning and actions identified through Morbidity Reviews, SJRs or Clinical Reviews

5. **POLICY STANDARDS**

5.1 Mortality Reviews

5.1a Deaths can be referred for a Structured Judgement Review (SJR) either by the
   - Medical Examiner following their 'mortality screening',
   - Certifying doctor – either via the ME or directly to the Specialty M&M Lead
   - Any other member of the clinical team
   - Bereavement Support Nurse, in response to discussions with the bereaved
   - Patient Safety Team, in response to a complaint or patient safety incident

5.1b Structured Judgment Reviews will be undertaken for all case where Mortality Review by the ME identifies potential problems in care relating to
   - Assessment, Investigation, Diagnosis
   - Medication, IV fluids / Electrolytes / Oxygen
   - Treatment and Management Plan
- Infection Control/Healthcare Acquired Infections
- Operation/Invasive Procedure
- Clinical Monitoring
- Resuscitation following cardiac or respiratory arrest

5.1c A Structured Judgement Review and Death Classification will be undertaken 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
- Deaths where primary diagnosis on admission is part of a CUSUM alert

5.1d All deaths of people with learning disabilities aged four years and older will be referred to the national Learning Disabilities Review Programme (LeDeR)

5.1e If the patient has a Learning Disability or Severe Mental Illness, the LD Acute Liaison team or Leicestershire Partnership Trust Mental Health team will be contacted by the Corporate M&M team to inform them and seek their input to the review process as applicable.

5.1f Structured Judgement Reviews (SJR) of the care provided to deceased patients will be undertaken using the Royal College of Physicians tool which has been adapted into a powerpoint template (Appendix 2)

5.1g The SJR template will be created by the Corporate M&M team and prepopulated with the patient’s demographic and admission details; cause of death (where known); cremation summary plus details of any patient safety incidents, prior to being sent to the relevant Specialty.

5.1h The doctor who undertakes a Structured Judgment Review for mortality must not have had either overall responsibility or substantial direct involvement in the deceased patient’s care during their last admission.

5.1i All deaths subject to SJR will have a Classification proposed by the SJR reviewer, using the criteria set out in 3.9 which will then be ‘signed off’ by the Specialty M&M Lead

5.1j SJRs of deceased patients should be completed and Death Classification agreed within 4 months of the death and must be completed within 6 months. Where deaths are subject to Inquest or the bereaved have requested a meeting to discuss their concerns, the SJR should be completed in time for these.

5.2 Morbidity Reviews

5.2a Morbidity reviews should be undertaken where patients have a complication of treatment, as defined by the Specialty M&M’s Terms of Reference (Appendix 6). These should also set out the process for referring cases for Morbidity review.

5.2b The Morbidity SJR template should be used for morbidity reviews (Appendix 3)
5.2c All cases subject to SJR will have a Classification proposed by the SJR reviewer, using the criteria set out in 3.11 which will then be ‘signed off’ by the Specialty M&M Lead

5.3 **M&M Discussion and Escalation**

5.3a All cases given a Death Classification or Morbidity Classification of 1, 2 or 3 must be discussed at the Specialty M&M meeting.

5.3b All cases given a Death Classification or Morbidity Classification of 4 or 5 should be considered for discussion at the Specialty M&M meeting for any learning points or dissemination of good practice

5.3c All cases confirmed as a Death Classification of 1 must be escalated to the Mortality Review Committee

5.4 **Patient Safety Considerations**

5.4a All cases given a Death Classification of 1 must be reported as a Patient Safety Incident with Major Harm on Datix, if not already reported as such. Reporter to advise PSI identified through SJR Review or M&M discussion.

5.4b Where either a mortality or morbidity 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.

5.5 **Dissemination of Learning and Actions**

5.5a Where a need for learning or action is identified via feedback from bereaved relatives/carers, ME mortality screening or the SJR process or morbidity reviews, this must be taken forward by the relevant clinical team / Specialty M&M and progress monitored by the Specialty M&M

5.5b Details of learning and actions must be documented. Documentation should be in both the Structured Judgment Review template and Specialty M&M Minutes or Specialty M&M Action Tracker.

5.5c Clinical reviews, learning and actions will be taken forward by the relevant consultant/ward sister/matron.

5.5d Where clusters or trending of problems are identified, a thematic review will be undertaken by the Corporate M&M team and reported to the Specialty M&M

5.5e Where potential problems in care are identified for other organisations as part of the SJR process, this will be fed back to the relevant organisation for their learning via the Corporate M&M team

5.5f The outcomes of all, SJRs and M&M discussions will be recorded on the UHL Learning from Deaths Database for reporting internally and externally
5.5g Where requested, SJR or clinical review findings, to include details of learning and actions being taken, will be shared with bereaved relatives/carers via the Bereavement Support Nurses.

5.6 Mortality Alerts

5.6a Where case notes reviews are requested in response to a mortality or morbidity alert, these will be undertaken in line with the ‘Mortality Alert Template’ (Appendix 7) and reported to MRC.

5.6b Mortality Alert Reviews should include consideration of staffing, activity levels and patient safety data.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 The skills required to undertake SJRS are considered to be within the skills and competencies of a medical consultant and therefore a specific training programme is not considered to be required

6.2 The Royal College of Physicians have published the “Using the structured judgement review method - A guide for reviewers” (Appendix 3) which provides guidance on how to undertake a Structured Judgement Review

6.3 Training has been provided by the Academic Health Sciences Network to a number of M&M Leads who are available for advice or ‘cascade training’. Further information is available from the Corporate M&M team via the Mortality Mailbox Mortality@uhl-tr.nhs.uk

7 PROCESS FOR MONITORING COMPLIANCE

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>SJRs completion timescales (Mortality)</td>
<td>M&amp;M Leads / HOE</td>
<td>LFD Database</td>
<td>Quarterly</td>
<td>Mortality Review Committee</td>
</tr>
<tr>
<td>Death Classifications</td>
<td>HOE</td>
<td>LFD Database</td>
<td>Monthly</td>
<td>Mortality Review Committee</td>
</tr>
<tr>
<td>% Actions Implemented/ on Track</td>
<td>HOE</td>
<td>LFD Database</td>
<td>Quarterly</td>
<td>Mortality Review Committee</td>
</tr>
</tbody>
</table>

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


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.
(ii) Case Record Review: Some deaths should be subject to further review by the provider, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. At a minimum, providers should require reviews of:

i. all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;

ii. all in-patient, out-patient and community patient deaths of those with learning disabilities (the LeDeR review process outlined at Annex D should be adopted in those regions where the programme is available otherwise StructuredJudgement Review or another robust and evidence-based methodology should be used) and with severe mental illness;

iii. all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);

iv. all deaths in areas where people are not expected to die, for example in relevant elective procedures;

v. deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;

vi. a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983 (Annex E).
1. PATIENT PROFILE AND REASON FOR STRUCTURED JUDGEMENT REVIEW

**JUDGEMENT REVIEW** *Corp M & M team to complete*

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>$ Number:</th>
<th>Sex</th>
<th>Age</th>
<th>M&amp;M Ref:</th>
</tr>
</thead>
</table>

**Consultant at time of death:**

<table>
<thead>
<tr>
<th>Date/Time of Admission:</th>
<th>Admitted</th>
<th>From:</th>
<th>Adm Pathway:</th>
<th>Adm type:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date/Time of Death:</th>
<th>LOS</th>
<th>If Obit Death Date of Disch</th>
<th>Days from Disch to Death</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HME:</th>
<th>LDL/SMR</th>
<th>DNACPR / Cardiac Arrest?</th>
<th>Post Code:</th>
</tr>
</thead>
</table>

**Unit/Spec Admitted to:**

<table>
<thead>
<tr>
<th>Unit at Time of Death:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Diagnosis Coded on admission:</th>
<th>Primary Diagnosis Coded on final episode</th>
<th>Pall Care / SOL Codes</th>
</tr>
</thead>
</table>

**CAUSE OF DEATH**

1a

1b

1c

2

**Referred to Coroner?**

**Why referred**

<table>
<thead>
<tr>
<th>Case Screened by ME</th>
<th>ME referred for SIR?</th>
<th>ME</th>
<th>BSSN Involved?</th>
</tr>
</thead>
</table>

**Why SIR if case has not been referred by the ME:**

2. MEDICAL EXAMINER SCREENING

**Corp M & M team to complete**

**PRELIMINARY SCREENING: ✔ if applicable**

| Problem in Assessment, Investigation, Diagnosis in delays or omission (including assessment of pressure ulcer risk, VTE risk, history of falls) |
| Medication / IV Fluid / Electrolytes / Oxygen (other than anaesthetics) |
| Problem re treatment and management plan including procedures of res, tuberculosis, etc. |
| Problem with Infection Control |
| Problem related to operation / invasive procedure (other than infection control) |
| Problem in Clinical Monitoring (including failure to plan, to understand or to recognise and respond to changes or take appropriate action e.g. (CWS-3) |
| Problem in resuscitation following a cardiac arrest (including CPR) |
| Other problems not fitting categories above |

**Details of Issues/Problems or Potential Learning**

| Case Note Screening findings: |
| Part 2 Crem Form Summary / Details of Datix Incident (If applicable): |

**Relatives Feedback:**

<table>
<thead>
<tr>
<th>Relatives have requested copy of M&amp;M Review findings?</th>
<th>If yes, details/contact</th>
</tr>
</thead>
</table>

---

*Morbidity and Mortality Review UHL Policy*

V2 Approved by Policy and Guideline Committee on 17.1.20 Trust Ref: B48/2017

Next Review: July 2020 (extension agreed PGC 17.1.20)
### 3. STRUCTURED CASE NOTE REVIEW (SJMR):

**REVIEWER TO COMPLETE AND ADD NEW SLIDE IF NEEDED.**

<table>
<thead>
<tr>
<th>REVIEWER</th>
<th>DATE OF REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### TIME LINE OF KEY EVENTS:

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

---

**Please rate the quality of the patient record:**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Excellent</td>
</tr>
<tr>
<td>4</td>
<td>Good</td>
</tr>
<tr>
<td>3</td>
<td>Adequate</td>
</tr>
<tr>
<td>2</td>
<td>Poor</td>
</tr>
<tr>
<td>1</td>
<td>Very Poor</td>
</tr>
</tbody>
</table>

---

**For Each Phase of Care, Please rate the care received by the patient during this phase and record your explicit judgements about the quality of care the patient received and whether it was in accordance with good practice (for example your professional standards or your professional perspective). State N/A in Rating if Phase of Care not Relevant.**

<table>
<thead>
<tr>
<th>PHASE OF CARE</th>
<th>RATING</th>
<th>SUPPORTING STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMISSION &amp; INITIAL MANAGEMENT (admission within 2.8 hrs):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONGOING CARE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARE DURING A PROCEDURE (if applicable): (excludes HCA care):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERIOPERATIVE CARE (if applicable):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>END OF LIFE CARE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREVIOUS ADMISSION (if applicable):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OVERALL UHL CARE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTSIDE UHL (if applicable):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. ASSESSMENT OF PROBLEMS IN HEALTHCARE

Please comment on whether one or more specific types of problem(s) were identified and, if so, indicate whether any led to harm.

REVIEWER TO COMPLETE AND M&M MEETING TO CONFIRM

<table>
<thead>
<tr>
<th>Problem Type</th>
<th>Problem / Harm</th>
<th>Phase of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes/No</td>
<td>On Aim</td>
</tr>
<tr>
<td>1. Problem in assessment, investigation or diagnosis (including assessment of PIs, VTE risks, history of falls)</td>
<td>No</td>
<td>Probably</td>
</tr>
<tr>
<td>2. Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic)</td>
<td>No</td>
<td>Probably</td>
</tr>
<tr>
<td>3. Problem related to treatment and management plan (including prevention of PIs, VTE, falls)</td>
<td>No</td>
<td>Probably</td>
</tr>
<tr>
<td>4. Problem with infection control (e.g., wound infection)</td>
<td>No</td>
<td>Probably</td>
</tr>
<tr>
<td>5. Problem related to operation / invasive procedure (other than infection control related problems)</td>
<td>No</td>
<td>Probably</td>
</tr>
<tr>
<td>6. Problem in clinical monitoring (including failure to plan, to undertake, or to recognize and respond to changes)</td>
<td>No</td>
<td>Probably</td>
</tr>
<tr>
<td>7. Problem in resuscitation following cardiac or respiratory arrest (inclusion CPR)</td>
<td>No</td>
<td>Probably</td>
</tr>
<tr>
<td>8. Problem of any type not fitting the categories above (including those outside UHL)</td>
<td>No</td>
<td>Probably</td>
</tr>
</tbody>
</table>

** If Yes, Reviewer to complete below and confirm at M&M meeting

---

5. DEATH CLASSIFICATION:

Death Classification to be proposed by SIR Reviewer. Please put ✓ in relevant category:

- Category 1-3 MUST be discussed at Specialty M&M.
- Category 4-5 Death Classification can be signed off by M&M Lead

<table>
<thead>
<tr>
<th>Category</th>
<th>Rationale</th>
<th>SIR Lead</th>
<th>M&amp;M Lead</th>
<th>MDT M&amp;M</th>
<th>MRC</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Problems in care thought more likely than not to have contributed to death</td>
<td>Upon initial classification of DC-3 L.I. (i.e., by Reviewer; M&amp;M Leader at MDT M&amp;M). Confirm Category as applicable. Check if reported as Patient Safety Incident (PSI). If not already on Data as Moderate, Major or Death graded incident, M&amp;M Lead to arrange update as PSI with Major Harm on Data. Reporter to advise PSI identified via SIR Review/M&amp;M. MDT M&amp;M to Escalate to MRC for further review via Mortality Mailbox and confirm learning and actions.</td>
<td>SIR Lead</td>
<td>M&amp;M Lead</td>
<td>MDT M&amp;M</td>
<td>MRC</td>
</tr>
<tr>
<td>2</td>
<td>Problems in care but unlikely to have contributed to death</td>
<td>Upon initial classification of DC-2 (i.e., by Reviewer; M&amp;M Leader at MDT M&amp;M). Confirm Category as applicable. Check if reported as PSI. If not considered relevant, send to MRC via Mortality Mailbox. Update SIR form: Confirm learning and actions.</td>
<td>SIR Lead</td>
<td>M&amp;M Lead</td>
<td>MDT M&amp;M</td>
<td>MRC</td>
</tr>
<tr>
<td>3</td>
<td>Problems in care but very unlikely to have contributed to death</td>
<td>Discuss at M&amp;M meeting. Confirm learning and actions and Patient Safety Implications. Update SIR form with M&amp;M discussion and send to Mortality Mailbox.</td>
<td>SIR Lead</td>
<td>M&amp;M Lead</td>
<td>MDT M&amp;M</td>
<td>MRC</td>
</tr>
<tr>
<td>4</td>
<td>No problems in care</td>
<td>Confirm if any learning and disseminate accordingly. Update SIR form if discussed at M&amp;M meeting and send to Mortality Mailbox.</td>
<td>SIR Lead</td>
<td>M&amp;M Lead</td>
<td>MDT M&amp;M</td>
<td>MRC</td>
</tr>
<tr>
<td>5</td>
<td>Good or Excellent Care.</td>
<td>Confirm if any learning /sharing of best practice and disseminate accordingly. Update SIR form if discussed at M&amp;M meeting and send to Mortality Mailbox.</td>
<td>SIR Lead</td>
<td>M&amp;M Lead</td>
<td>MDT M&amp;M</td>
<td>MRC</td>
</tr>
</tbody>
</table>

REASON FOR JUDGEMENT ON CHOSEN DEATH CLASSIFICATION

---

6. SPECIALTY M&M MEETING REVIEW

DATE OF M&M MEETING

M&M Discussion Summary: To make reference to problem type identified and level of harm – use next slide if applicable.
### M&M Discussion Summary cont:

To make reference to problems identified and quality of care provided.

---

### 7. LEARNING POINTS / QUALITY IMPROVEMENT ACTIONS

**M&M Lead/Chair to complete**

<table>
<thead>
<tr>
<th>Are there lessons to be learned from this review?</th>
<th>Yes/No</th>
<th>Should actions be taken to improve care?</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning point / issue (add more rows if applicable)</td>
<td>Action to be taken</td>
<td>Action Lead</td>
<td>Due date</td>
</tr>
</tbody>
</table>

**Dissemination of Learning Plan**

Include details of target audience, methodology & lead

---

### 8. FURTHER REVIEW/INVESTIGATION REQUIRED

| a. Does this case need to be reviewed as part of another specialty’s M&M process? | Yes/No |
| b. Does this case need to be reviewed as part of another organisation’s M&M process (e.g. HP, GP) | |
| c. Does this case need Exception Reporting to the UHL Mortality Review Committee/CMG QoS? | |
| d. Do the case notes need to be reviewed by the Coding Team (clinical coding queries) or Data Quality Team, Rogers Ward, URI | |

**Patient Safety Incident (PSI) Reporting considerations—Tick ✓ below (if PSI also ensure Duty of Candour requirements met)**

<table>
<thead>
<tr>
<th>No PSI</th>
<th>Already reported as PSI</th>
<th>Date Ref</th>
<th>Patient Safety Incident (PSI) Reporting considerations—Tick ✓ below (if PSI also ensure Duty of Candour requirements met)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be reported as PSI</td>
<td>Date Reported</td>
<td>Reported by</td>
<td>DatRef</td>
</tr>
</tbody>
</table>

**FULL REVIEW COMPLETED – TO BE EMAILED TO THE ‘MORTALITY MAILBOX’**
1. PATIENT PROFILE AND SUMMARY OF KEY EVENTS – MORBIDITY REVIEW TEMPLATE

<table>
<thead>
<tr>
<th>Consultant at time of care (Inpatient/Outpatient):</th>
<th>CMG/Speciality at time of Discharge (Inpatient/Out-Pt):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit/Spec Admitted/First presented to:</td>
<td>Unit at Time of Discharge Inpatient/Outpatient:</td>
</tr>
<tr>
<td>Consultant at Time of Procedure (if applicable):</td>
<td>CMG/Speciality/Unit at time of Procedure (if applicable)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Admission:</th>
<th>Adm type:</th>
<th>Date / Time of Procedure</th>
<th>El / Em Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Discharge:</td>
<td></td>
<td>Date of Complication:</td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis Details
Procedure Details

Complication Details / Reason for Review

REVIEWER: ___________________________ DATE OF REVIEW: ___________________________

2. STRUCTURED CASE NOTE REVIEW (SJR):

For Each Phase of Care Please rate the care received by the patient during this phase and record your explicit judgements about the quality of care the patient received and whether it was in accordance with good practice (for example your professional standards or your professional perspective). State N/A in Rating if Phase of Care not Relevant

<table>
<thead>
<tr>
<th>CARE RATINGS</th>
<th>5 = Excellent Care</th>
<th>4 = Good Care</th>
<th>3 = Adequate Care</th>
<th>2 = Poor Care</th>
<th>1 = Very Poor Care</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PHASE OF CARE</th>
<th>RATING</th>
<th>SUPPORTING STATEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSESSMENT / INITIAL ADMISSION (if applicable):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONGOING CARE (Inpatient / Outpatient):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARE DURING A PROCEDURE (if applicable): [Excludes IV/consultation]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERIOPERATIVE CARE (if applicable):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREVIOUS ADMISSION OR ATTENDANCE (if applicable):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OVERALL UHL CARE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTSIDE UHL (if applicable):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. **ASSESSMENT OF PROBLEMS IN HEALTHCARE**  
*please comment on whether one or more specific types of problem(s) were identified and, if so, indicate whether any led to harm*

**REVIEWER TO COMPLETE AND M&M MEETING TO CONFIRM**

<table>
<thead>
<tr>
<th>Problem Type</th>
<th>Problem / Harm</th>
<th>Phase of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Problem in assessment, investigation or diagnosis (including assessment of PI, VTE risks, history of falls)</td>
<td>No (Yes?)</td>
<td>On Adm</td>
</tr>
<tr>
<td>2. Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic)</td>
<td>No (Yes?)</td>
<td>On Adm</td>
</tr>
<tr>
<td>3. Problem related to treatment and management plan (including prevention of PI, VTE, falls)</td>
<td>No (Yes?)</td>
<td>On Adm</td>
</tr>
<tr>
<td>4. Problem with infection control (e.g., wound infection)</td>
<td>No (Yes?)</td>
<td>On Adm</td>
</tr>
<tr>
<td>5. Problem related to operation / invasive procedure (other than infection control related problems)</td>
<td>No (Yes?)</td>
<td>On Adm</td>
</tr>
<tr>
<td>6. Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)</td>
<td>No (Yes?)</td>
<td>On Adm</td>
</tr>
<tr>
<td>7. Problem in resuscitation following cardiac or respiratory arrest (Inc. CPR)</td>
<td>No (Yes?)</td>
<td>On Adm</td>
</tr>
<tr>
<td>8. Problem of any type not fitting the categories above (including those outside UHL)</td>
<td>No (Yes?)</td>
<td>On Adm</td>
</tr>
</tbody>
</table>

**Classification to be proposed by SIR Reviewer. Please put ✓ in relevant category**

- **Category 1-3 MUST be discussed at Specialty M&M.**
- **Category 4-5 Classification can be signed off by M&M Lead**

<table>
<thead>
<tr>
<th>Category</th>
<th>Rationale</th>
<th>SIR Lead</th>
<th>M&amp;M Lead</th>
<th>M&amp;M Lead</th>
<th>M&amp;M Lead</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Morbidity more likely than not to have resulted from a problem in care</td>
<td>Confirm Category as applicable (i.e. with M&amp;M Lead or at MDT M&amp;M). Check if reported as PSI if not already on Data as Moderate or Major graded incident. M&amp;M Lead to ensure reported as PSI on Data. Reporter to advise PSI identified thru SIR Review/M&amp;M MDT. Confirm learning / actions. Update SIR Template. Send to Mortality Mailbox.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Problems in care which may have contributed to morbidity but not very likely.</td>
<td>Check if reported as PSI. If not discuss with M&amp;M Lead, confirm Category and consider if requires reporting as PSI. Confirm learning / actions. Update SIR proforma and send to Mortality Mailbox.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Problems in care but very unlikely that these contributed to morbidity</td>
<td>Discuss at M&amp;M meeting. Confirm learning / actions and Patient Safety Implications. Update SIR proforma with M&amp;M discussion and send to Mortality Mailbox.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>No problems in care</td>
<td>Confirm if any learning and disseminate accordingly. Update SIR proforma if discussed at M&amp;M meeting and send to Mortality Mailbox.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Good or Excellent Care.</td>
<td>Confirm if any learning and dissemination of best practice and disseminate accordingly. Update SIR proforma if discussed at M&amp;M meeting and send to Mortality Mailbox.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REASON FOR JUDGEMENT ON CHOSEN CLASSIFICATION**

**5. SPECIALTY M&M MEETING REVIEW**

**DATE OF M&M MEETING**

**M&M Discussion Summary:** To make reference to problem type identified and level of harm – use next slide if applicable.
### 6. LEARNING POINTS / QUALITY IMPROVEMENT ACTIONS

<table>
<thead>
<tr>
<th>Learning point / issue (add more rows if applicable)</th>
<th>Action to be taken</th>
<th>Action Lead</th>
<th>Due date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**M&M Lead/Chair to complete**

**Are there lessons to be learned from this review?** Yes/No

**Should actions be taken to improve care?** Yes*/No

**DISsemination of LEarning Plan**
Include details of target audience, methodology & lead

### 7. FURTHER REVIEW/INVESTIGATION REQUIRED

- a. Does this case need to be reviewed as part of another speciality’s M&M process?
- b. Does this case need to be reviewed as part of another organisation's M&M process (eg LTP, GP)?
- c. Does this case need Exception Reporting to the CMG Q&As?
- d. Do the case notes need to be reviewed by the Coding Team (clinical coding queries) or Data Quality Team, Rogers Ward, LRI?

**Patient Safety Incident (PSI) Reporting considerations – Tick ✓ below (if PSI also ensure Duty of Candour requirements met)**

- No PSI
- Already reported as PSI
- PSI to be by MRC
- To be reported as PSI

**FULL REVIEW COMPLETED – TO BE EMAILED TO THE ‘MORTALITY MAILBOX’**
Using the Structured Judgement Review method
A guide for reviewers
2017
Dr Allen Hutchinson

Emeritus professor in public health
University of Sheffield
Structured Judgement Review

1 Background to the method and its strengths

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

Structured Judgement Review (SJR) 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.

The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The object of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to ask these questions, there is a need to look at:

- the whole range of care provided to an individual;
- holistic care approaches;
- the nuances of case management;
- and the outcomes of interventions.

Structured judgement case note review can be used for a wide range of hospital-based safety and quality reviews across services and specialties, and not only for those cases where people die in hospital. For example, it has been used to assess care provided for people who have had a cardiac arrest in hospital, to review safety and quality of care prior to and during non-elective admission to intensive care settings and to review care for people who are admitted at different times of the week.

An important feature of the SJR method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has been judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learnt from the evaluation of high-quality care.

2 How the Structured Judgement Review method works

2.1 Who does what and when?

There are two stages to the review process. The first stage is mainly the domain of what might be called ‘front-line’ reviewers, who are trained in the SJR method and who undertake reviews as part of the hospital mortality review programme. There is evidence of a wide range of approaches being taken to case and reviewer choice, including cases being selected through the governance process or within a reviewer’s own services or directorates; and reviews sometimes taking the form of mortality and morbidity (M&M) reviews, and sometimes taking the form of a team looking at the care of groups of cases. This is where the bulk of the reviewing is done and most of the reviews are completed at this point.

A second-stage review is recommended where care problems have been identified by a first-stage reviewer and an overall care score of 1 or 2 has been used to rate care as ‘very poor’ or ‘poor’ or where harms have been identified. This second-stage review is usually undertaken within the hospital governance process, using a variety of approaches, which could include a repeat ‘validation’ SJR by a second reviewer.
2.2 Phases of care – the ‘structure’ part of the method

The phase of care structure provides a generalised framework for the review and also allows for comparisons among groups of cases at different stages of care. The principal phase descriptors are shown in Box 1. However the use of the phase structure depends a lot on the type of care and service being reviewed – not all phase of care headings will be used for any particular case. Thus the procedure-based review sections may only be required in a limited number of medical cases (eg a lumbar puncture, a chest drain or non-invasive ventilation) but are likely to be used in most surgical cases. It is up to the reviewer to judge which phase of care forms are appropriate in a particular case.

Box 1 Phase of care headings

- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative / procedure care
- End-of-life care (or discharge care*)
- Assessment of care overall

*Note that discharge care is included because this method is just as applicable for the review of care for people who do not die during an admission.

2.3 Explicit judgement comments – the core of the method

The purpose of the reviews is to provide information from which teams or the organisation can ask ‘why’ questions, and to support quality improvement. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary in a way that other health professionals can readily understand if they subsequently look at the completed review.

When asked to write comments on the quality and safety of care, clinical staff often tend to write a resume of the notes or make an implicit critique of care. This is not helpful when others try to understand the reviewer’s real meaning. So the central part of the review process comprises short, written, explicit judgement statements about the perceived safety and quality of care that is provided in each care phase.

This review guide does not include a glossary of explicit terms that reviewers might choose from, because this approach would inevitably be constraining or would fail to cover all eventualities in the complexities of clinical practice. Instead, reviewers are asked to use their own words in a way that explicitly states their assessment of an aspect of care and gives a short justification for why they have made the assessment.

Explicit statements use judgement words and phrases such as ‘good’ or ‘unsatisfactory’ or ‘failure’ or ‘best practice’.
Box 2 Examples of phase of care structured judgement comments

- Continued omission to provide oxygen and respiratory support – poor care.
- Team still failed to discuss potential diagnosis with patient – unsatisfactory.
- Referral to the intensive treatment unit (ITU) was too late.
- There was some evidence of good management by overnight team, with prompt review and intervention.
- Although the patient was discussed with a consultant once and an SpR once, for 4 days they were only seen by junior doctors. This is completely unsatisfactory.
- Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment.

These judgement words are included in short statements that provide an explicit reason why a judgement is made – eg ‘unsatisfactory because, etc’ and ‘for example, resuscitation and ceiling of treatment decisions made far too late in course of admission – poor care’. The purpose here is not to write long sentences but to encapsulate the clinical process in a few explicit statements.

Box 2 contains some examples.

Judgement comments should be made on anything the reviewer thinks is important for a particular case. Among other things, this will include the appropriateness of management plans and subsequent implementation together with the extent to which, and how, care meets good practice. In some cases, there may be care in a phase that has both good and poor aspects. Both should be commented on.

Commentary on holistic care is just as important as that on technical care, particularly where complex ceiling of treatment and end-of-life care discussions might be held. Judgements should be made on how the teams have managed end-of-life decision making and to what extent patients and their relatives have been involved. Thus, for example, a judgement comment might be couched as ‘end-of-life care met recommended practice, good ceiling of treatment discussion with patient and family’. Similar approaches and levels of detail are required when care is thought not to have gone well, or where aspects of care are judged only just acceptable. Then words such as ‘unsatisfactory’, ‘poor’ or ‘doesn’t meet good practice standards’ might be necessary.

Sometimes it is not possible to get a clear view from the records about why clinical decisions have been made, or there appears to be a lack of decision making or guidance. Here, judgement words such as ‘delay’, ‘poor planning’, ‘lack of leadership’ etc may be used. Where this lack of clarity is due to the level of documentation, comments such as ‘inadequate record keeping’ may apply.

Overall phase of care comments are intended to bring a focus to the review by asking for an explicit, clear judgement on what the reviewer thinks of the whole care episode, taking all aspects into consideration. It is not necessary to repeat all of what has been commented on before, although it is sometimes useful to repeat some key messages – that is a reviewer’s choice. Again, however, it is important to make clear and explicit what the overall judgement is and why. Examples are given in Box 3.
Box 3 Examples of overall care structured judgement comments

- Overall, a fundamental failure to recognise the severity of this patient’s respiratory failure.
- Good multidisciplinary team involvement.
- On the whole, good documentation of clinical findings, investigation results, management plan and discussion with other teams.
- Poor practice not to be aware of the do not attempt resuscitation (DNAR) status of patient, especially when it has been discussed with the family, clearly documented when first put in place and reviewed later on.

Cause of death information should form part of the review framework. If, on review, the certified cause of death causes the reviewer some concern, this should be explicitly stated, since there may be a clinical governance question involved.

So, the overall message about review language is that it should be explicit and clear, in order that you, the reviewer, feel you have made the points clearly and that others who read the review will be able to understand what you have said and why.

2.4 Giving phase of care scores

Box 4 Phase of care scores

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Care scores are recorded after the judgement comments have been written, and the score is in itself the result of a judgement by the reviewer. Only one score is given per phase of care: it is not necessary to score each judgement statement.

Scores range from ‘Excellent’ (Score 5) to ‘Very poor’ (Score 1) – see Box 4 – and are given for each phase of care commented on and for care overall.

These scores have a number of uses. For the individual reviewer, scores help them to come to a rounded judgement on the phase of care, particularly when there may be a mix of good and unsatisfactory care within a phase. The reviewer must judge what their overall decision is about the care provided for each phase and for care overall. Scoring makes this very explicit.

Overall care scores are particularly important in the review process. A score of 1 or 2 is given when the reviewer decides that care has been ‘very poor’ or ‘poor’. Research evidence suggests that this might happen in upwards of 10% of cases in some circumstances, but less in others. A score at this level should trigger a second-stage review through the hospital clinical governance process (see Section 2.1).

The full data collection tool is available from the Royal College of Physicians (RCP) website: www.rcplondon.ac.uk/mortality
2.5 Judging whether problems in care have caused harm

Problems in care take many forms and may have a range of impacts, some of which are potential rather than actual. Some of these events cause harms, but many do not.

The first-stage reviewer has an important role here in assisting the hospital to identify both actual and potential threats to patient safety.

The assessment of problems makes two important contributions. First, it is of importance in clarifying the issues within individual reviews. Second, the information that is aggregated within the hospital across reviews may pick up more fundamental care process issues that require attention.

Reviewers are asked three questions in relation to problems identified in care. These are in the following format.

A) Were there one or more problems in care during this admission? Yes or no
B) If so, in which area(s) of the care process and care phases did this/these occur?
C) For each of these problems, did any cause harm?

The data collection format is outlined further in Appendix 1.

2.6 Judging the quality of recording in the case notes

Case note review of course depends critically on the content and the legibility of the records. Safety of care also depends to some extent on good record keeping. Therefore, as part of the overall care assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records, again using a score of 1–5.

3 The review in practice

Case note review takes up expensive clinical resource so that time spent on establishing the purpose and desired outcome of the review is important. Case selection is increasingly being seen as a hospital policy issue and many organisations are formalising review management.

In some hospitals, the majority of mortality reviews take place in an M&M context and so they are often already being considered to be potentially problematic cases. SJR has been found to be of value in providing a reproducible process for M&Ms.

However the challenge for hospitals has often been the gathering together of the material from these reviews so that it can be used to examine care processes beyond the individual case. Data from M&M cases should be entered into the hospital reviews database. Aggregated information is more powerful in the longer term than the data from individual cases.

Another approach to case selection is to evaluate care for all or some patients who come to a particular service, or to explore the care provided for the majority of people who die in hospital over a particular time period in particular services; for example, all elective...
surgery deaths or people who die from acute kidney injury might require review.

For many situations, given the constraints on reviewer availability and the need to produce usable information from the reviews, the principle of ‘less done better is more’ applies.

In some situations a simple time-based longitudinal sample of around 40–50 cases will produce a rich source of quantitative and qualitative information about what goes right and what is not working properly. Timely review, rather than review after a delay, provides better information.

Time spent on the analysis and information presentation outweighs the benefit of adding a few more cases to the sample. The textual information allows for themes to be developed and that then allows a focus for the next improvement steps. Such an approach also has the benefit of being able to learn from, and celebrate, the cases where care has gone well.

A guide to undertaking the analysis of the quantitative and qualitative data provided by SJR will be available through the Royal College of Physicians National Mortality Case Record Review Programme during late 2017.
Appendix 1 – Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here)  Yes ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)*: Yes ☐

   Did the problem lead to harm?  No ☐  Probably ☐  Yes ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*: Yes ☐

   Did the problem lead to harm?  No ☐  Probably ☐  Yes ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)*: Yes ☐

   Did the problem lead to harm?  No ☐  Probably ☐  Yes ☐

4. **Problem with infection control**: Yes ☐

   Did the problem lead to harm?  No ☐  Probably ☐  Yes ☐

5. **Problem related to operation/invasive procedure** *(other than infection control)*: Yes ☐

   Did the problem lead to harm?  No ☐  Probably ☐  Yes ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)*: Yes ☐

   Did the problem lead to harm?  No ☐  Probably ☐  Yes ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))*: Yes ☐

   Did the problem lead to harm?  No ☐  Probably ☐  Yes ☐

8. **Problem of any other type not fitting the categories above**: Yes ☐

   Did the problem lead to harm?  No ☐  Probably ☐  Yes ☐

Editorial note

This document has been adapted with permission from: Hutchinson A, McCooe M, Ryland E. A guide to safety, quality and mortality review using the structured judgement case note review method. Bradford: The Yorkshire and the Humber Improvement Academy, 2015. (Copyright The Yorkshire and the Humber Improvement Academy.)

The case note review methods discussed in this guide were primarily developed in a research study published as: Hutchinson A, Coster JE, Cooper KL, McIntosh A, Walters SJ, Bath PA et al. Comparison of case note review methods for evaluating quality and safety in health care. *Health Technol Assess* 2010;14(10):1–165.

All clinical examples and structured judgement comments in this document are taken from hypothetical scenarios.

References


1. Introduction and Who Guideline applies to

This guideline applies to

- all Specialties providing in-patient care and to the Emergency Department.
- Heads of Service and Matrons, Specialty M&M Leads and all medical, nursing and therapy staff involved in the care of patients in the above areas

2. Guideline Standards and Procedures

2.1 Multi-disciplinary M&M Meetings must be carried out in all Emergency Department and In-patient Specialties with formal Terms of Reference (see appendix 6)

2.2 An M&M Lead must be identified and the role agreed as part of the annual job planning process. The M&M Lead is responsible for ensuring effective chairing of the M&M Meetings.

2.3 Clinical Staff are expected to attend M&M meetings and participate in the M&M process as set out in Appendix 2

2.4 Clear reporting mechanisms must be identified by each Specialty M&M for escalating areas of serious concern identified by reviews so appropriate action can be taken

2.5 Specialty M&M meetings should include review of the following:

- Mortality cases, as set out in the UHL M&M Reviews & Death Classification Policy
- Morbidity cases, as defined by the Specialty’s Terms of Reference
- Clinical Outcomes as reported to national registers, clinical audits
- Risk Adjusted Mortality (HSMR and SHMI) for relevant Diagnostic and Procedural Groups
- Internally monitored clinical outcomes eg Hospital Acquired Thrombosis, Hospital Acquired Infections

2.6 M&M Reviews must be carried out in line with the M&M Reviews and Death Classification Policy.

2.7 The outputs of M&M reviews discussed at the speciality M&M meeting must clearly documented

2.8 An Assurance Report should be submitted from each Speciality M&M Lead to the relevant CMG Q&S Board on an annual basis, copied to the MRC (see Appendix 2).

   This should include details of actions taken where M&M reviews have identified problems in health care requiring actions to be taken to prevent reoccurrence.

2.9 Exception reports for individual M&M reviews, where serious concerns raised, must be submitted in real time to the Mortality Review Committee, copied to the CMG Q&SB.

3. Education and Training

Guidance on how to undertake M&M reviews (using the Structured Judgment Review approach) is given in the M&M Reviews & Death Classification policy.

4. Monitoring Compliance
<table>
<thead>
<tr>
<th>What will be measured to monitor compliance</th>
<th>How will compliance be monitored</th>
<th>Monitoring Lead</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at M&amp;M Meetings</td>
<td>Attendance Registers</td>
<td>M&amp;M Lead / HOE</td>
<td>Annually</td>
<td>MRC</td>
</tr>
<tr>
<td>Frequency of Meetings</td>
<td>Meeting Minutes against Terms of Reference</td>
<td>M&amp;M Lead / HOE</td>
<td>Annually</td>
<td>MRC</td>
</tr>
<tr>
<td>Output of Meeting Discussions</td>
<td>Meeting Minutes /Action Trackers</td>
<td>M&amp;M Lead / HOE</td>
<td>Annually</td>
<td>MRC</td>
</tr>
</tbody>
</table>

5. Supporting References


6. Key Words
M&M, Mortality Review, Morbidity Review

<table>
<thead>
<tr>
<th>CONTACT AND REVIEW DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline Lead</td>
</tr>
<tr>
<td>Rebecca Broughton, Head of Outcomes &amp; Effectiveness</td>
</tr>
</tbody>
</table>

Details of Changes made during review:
New Guideline
### Terms of Reference

<table>
<thead>
<tr>
<th>Speciality / CMG</th>
<th>xxxxxxxx / xxxxx CMG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author / Originator(s):</td>
<td>xxxxxxxxxx</td>
</tr>
<tr>
<td>Date of Latest Review:</td>
<td>xxxxx</td>
</tr>
<tr>
<td>Review Date:</td>
<td>xxxxxxxxxx</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Xxxxxxxxxxxx Q&amp;S Board</td>
</tr>
<tr>
<td>Date Approved:</td>
<td>Xx/xx/xxxx</td>
</tr>
</tbody>
</table>

#### 1. Membership

<table>
<thead>
<tr>
<th>Role</th>
<th>Name/Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair</td>
<td>xxxxxxxx</td>
</tr>
<tr>
<td>Deputy Chair (where applicable)</td>
<td>xxxxxxxxxxxxxx</td>
</tr>
</tbody>
</table>

**Core Members**

- *Indicate as applicable eg:*
  - All Consultants
  - Matrons

**Associated Members / Standing Invitees**

- *Indicate as applicable eg:*
  - Registrars and other junior medical staff members from the specialty,
  - Ward Sisters, Clinical Nurse Specialists/Advanced Nurse Practitioners
  - Other relevant clinical staff (eg perfusionists, surgical care practitioners, etc.) and other relevant medical/pharmaceutical staff.

**Invitees when appropriate**

- *Indicate as applicable eg:*
  - Radiologists,
  - AHPs i.e. Physiotherapists, Dieticians
  - Affiliated Speciality Clinicians as applicable

#### 2. Meetings

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Should be monthly – if less frequently, need to describe process for ensuring mortality reviews are in line with UHL policy</th>
</tr>
</thead>
</table>
| Expected attendance rate of Core Members | *NOTE:*
Consultant medical staff are required to attend the M&M Meetings as per the Terms of Reference for their speciality, with a recommended attendance as per the following standards:
- Monthly– 50% Attendance Rate (6 Meetings a yr)
- Bi-Monthly– 60% Attendance Rate (4 Meetings a Year)
- Quarterly– 75% Attendance Rate (3 Meetings a Year) |
3. Meeting Format

- **Approval of minutes** of previous meeting and update on discussions/queries, where applicable
- **Review of progress with actions** identified at previous meetings and confirmation of remedial actions being taken and revised timescales where behind schedule
- Quarterly to review outstanding actions
- **Review of Mortality Rates** for the Specialty and Diagnostic / Other relevant patient groups and discussion where applicable
- **Review of numbers of deaths** during reporting period and progress with screening, review and Death Classification of cases as per national requirements and UHL policy standards
- **Review individual Mortality cases** – where full Structured Judgement Review indicated – and to:
  o Consider learning and agree actions (to include leads and timescales as applicable)
  o Confirm whether there were problems in care and if these caused harm.
  o Agree Death Classification
- **Individual Morbidity Case reviews** and discussion
- **Any learning from Coroners cases or Patient Safety Incidents**
- **Final summing up by M&M Chairman** to include confirmation of actions

4. Selection and Timescales for Mortality Structured Judgement Review (SJR)

4.1 Selection

- Cases referred by the Medical Examiner for potential learning or confirmation of problems in care
- Deaths following an elective procedure
- Deaths where the patient had either a Learning Disability or Serious Mental Illness
- All deaths where an ‘alarm’ has been raised with the Trust through whatever means for either a Speciality, particular diagnosis or treatment group (eg HSMR CUSUM alert)

4.2 Timescales

Completed SJRs should be presented to the Speciality M&M and Death Classification agreed (or case referred to the Mortality Review Committee) within 4 months of death and all must be completed and presented within 6 months.

5. Selection and Timescales for Morbidity Reviews

5.1 Selection

- Morbidity reported as an Serious Incidents via Datix
- Serious or unexpected morbidity
- Cases of interest where learning can be made
5.2  Timescales
Morbidity Reviews should be presented and learning/actions agreed within 3 months of being the case being identified

6. Meeting Minutes
A summary will be offered at the end of each case discussed to include:
- Death classification, for each SJR completed/presented
- Whether there were any problems in care identified
- Learning and actions to be taken, where applicable

Minutes will be recorded and uploaded onto the UHL shared drive.

6. Mortality Rates Reporting
Annual Risk Adjusted Mortality, as reported by relevant national bodies, will be considered by the Specialty M&M and a summary report submitted to the CMG Q&S Board and Mortality Review Committee (MRC)

Quarterly HSMR and SHMI at a Procedure/Diagnosis Group level, as provided by the Corporate M&M Team, will be considered by the Speciality M&M and further sub analysis, case note review or other actions agreed, as applicable.

Mortality rates ‘greater than expected’ will require exception reporting to the CMG Q&S Board and MRC

7. Reporting Process
Minutes will be cascaded to Core Members via email or made accessible on the Speciality Shared Drive

Heads of Departments/Teams and Services will be sent copies of minutes for onward cascade accordingly

Where M&M findings identify learning for other Specialities, this will be reported to the relevant Head of Service or M&M Lead

Annual Assurance Report to the CMG Quality & Safety Board, copied to the Mortality Review Committee

8. Escalation Process
Where the Speciality M&M confirms Death Classification as 1-3 (and the case has not already been reported and actioned via the Trust’s Incident and Accident Policy process, these will be reported to the CMG Clinical Director and the next Mortality Review Committee (MRC).

The MRC will advise on action to be taken, to include consideration of new referral to the Coroner and Duty of Candour requirements.

Where there is evidence of professional misconduct, or concerns regarding trainees, these will be escalated, in line with trust policies, via the Head of Service.
M&M MEETING ATTENDANCE REQUIREMENTS:

1.1 Medical staff:
   a. _consultant medical staff_ are required to attend the M&M Meetings as per the Terms of Reference for their Specialty, with a recommended attendance as per the following standards (pro rata for staff working less than full time):

<table>
<thead>
<tr>
<th>Frequency of M&amp;M Meetings in specialty</th>
<th>Recommended attendance required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly (recommended frequency)</td>
<td>50% (6 per year)</td>
</tr>
<tr>
<td>Bi-Monthly (expected frequency)</td>
<td>60% (4 per year)</td>
</tr>
<tr>
<td>Quarterly (minimum frequency – where less than 5 deaths per year)</td>
<td>75% (3 per year)</td>
</tr>
</tbody>
</table>

   b. _all other medical staff_ are also expected to participate fully in all M&M Reviews relevant to their practice and should attend M&M Meetings where clinical duties allow

   d. all medical staff are expected to familiarise themselves with the outcomes of M&M discussions, (insofar as they affect their area of practice), and contribute to any resultant quality improvement initiatives, even if clinical duties do not permit attendance

   e. It is the responsibility of all registered medical practitioners to understand the outcomes of their clinical practice so this should form a core element of SPA time.

   f. medical students should be encouraged to attend M&M Meetings.

1.2 Matrons, Ward Sisters and Specialist Nurses
Matrons, Ward Sisters and Specialist Nurses should attend their specialty/CMG M&M Meetings (at the frequency outlined above).

1.3 Nurses, Allied Health Professionals and other clinical staff:
   a. All Registered Nurses (RNs) and Allied Healthcare Professionals (AHPs) are expected to participate in the M&M process as part of their clinical practice and, where clinical duties allow, to attend M&M Meetings

   b. Where clinical duties do not permit attendance, RNs and AHPs are expected to familiarise themselves with the outcomes of such reviews, (insofar as they affect their area of practice), and contribute to any resultant actions and quality improvements

   c. Nursing and AHP students should be encouraged to attend M&M Meetings

1.4 All Clinicians should consider every occurrence of patient morbidity or mortality to have the potential to be part of the review and learning process
### MORTALITY ‘ALERT’ REVIEW

<table>
<thead>
<tr>
<th>ALERT COHORT (Diagnosis/Patient Group)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SOURCE OF ALERT (DFI, HED, CQC, etc)</td>
<td></td>
</tr>
<tr>
<td>TIME FRAME OF ALERTING PERIOD</td>
<td></td>
</tr>
<tr>
<td>DATES OF PREVIOUS ALERT (if applicable)</td>
<td></td>
</tr>
<tr>
<td>NUMBER OF DEATHS DURING ALERT PERIOD</td>
<td></td>
</tr>
<tr>
<td>EXPECTED DEATHS DURING ALERT PERIOD</td>
<td></td>
</tr>
<tr>
<td>RELATIVE RISK FOR ALERT PERIOD</td>
<td></td>
</tr>
<tr>
<td>SPECIALITY(S)</td>
<td></td>
</tr>
<tr>
<td>CMG(S)</td>
<td></td>
</tr>
<tr>
<td>CLINICAL LEAD FOR REVIEW</td>
<td></td>
</tr>
<tr>
<td>MANAGERIAL LEAD FOR REVIEW</td>
<td></td>
</tr>
<tr>
<td>ANY KNOWN CONTRIBUTING FACTORS FOR THE ALERT (eg change of case mix)</td>
<td></td>
</tr>
<tr>
<td>AGREED REVIEW METHODOLOGY (Data validation via clinical databases, Retrospective Case Record Review (RCRR) of all / % of cases, etc)</td>
<td></td>
</tr>
<tr>
<td>TRIANGULATION DATA</td>
<td>Staffing levels, incidents, complaints and activity</td>
</tr>
</tbody>
</table>

#### REVIEW FINDINGS

<table>
<thead>
<tr>
<th>Theme</th>
<th>Summary</th>
<th>Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases Reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeline issues</td>
<td>ie delays or omissions in – diagnosis, investigations, delivery of care, treatment, etc.</td>
<td></td>
</tr>
<tr>
<td>Poor Communication</td>
<td>To include communication between clinicians, patients or family</td>
<td></td>
</tr>
<tr>
<td>Inadequate Monitoring</td>
<td>Failure to recognise or take appropriate action on ‘alerts’ e.g. NEWS &gt;3</td>
<td></td>
</tr>
<tr>
<td>End of Life issues</td>
<td>DNA CPR not considered when appropriate, invalid or not followed or inadequate end of life or palliative care</td>
<td></td>
</tr>
<tr>
<td>Triggers</td>
<td>i.e. New DVT, Pressure Ulcer, Allergic reaction, Hosp Acquired Infection, Wound infection, Hypoglycaemia High INR</td>
<td></td>
</tr>
</tbody>
</table>
### Death Classification – where Screening and RCRR process completed

<table>
<thead>
<tr>
<th>Criteria</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of deaths</td>
<td>Death is more likely than not to have resulted from a problem in care</td>
<td>Problems in care which may have contributed to death but not very likely</td>
<td>Problems in care but no evidence that these contributed to death</td>
<td>No problems in care</td>
<td>Good or Excellent Care.</td>
</tr>
</tbody>
</table>

### PRIORITIES FOR LEARNING / ACTION - add more rows as required

<table>
<thead>
<tr>
<th>Learning point / issue</th>
<th>Action to be taken*</th>
<th>Lead</th>
<th>Date due</th>
</tr>
</thead>
</table>

### CODING ISSUES?

<table>
<thead>
<tr>
<th>CODING ISSUES?</th>
<th>NO</th>
<th>YES - details below</th>
</tr>
</thead>
</table>