Learning from Deaths via the Structured Judgement Case-note Review

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It is widely recognised that the focus on aggregate hospital mortality rates has caused a distraction from the practical steps that can be taken to reduce avoidable death within hospitals.

The Care Quality Commission (CQC) report "Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England", highlighted the fact that some organisations were not giving sufficient priority to learning from patient deaths. As a consequence, valuable opportunities for improvement are missed and lessons are not learned and shared.

Hull and East Yorkshire Hospitals NHS Trust has begun to take large steps in ensuring it learns all it can from patient deaths, whilst appropriately engaging families and carers in the review of care delivered to their loved one.

Introduction

In 2014, the Improvement Academy began working with acute, community and mental health Trusts in Yorkshire & the Humber on a new, evidence based mortality review programme, known as the Structured Judgement Review (SJR) .

The Structured Judgement Review is a systematic case-note review which relies on explicit judgement comments to be made, along with an accompanying score, for different phases of care delivered to the patient during their hospital stay.

'When asked to write comments on the quality and safety of care, clinical staff either 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.'[1]

The information provided allows units or organisations to ask 'why' questions about things that happen, to enable understanding, improvement and action where required and examines both holistic and interventional care.

One of the key intentions of the SJR methodology is that, in addition to highlighting sub-optimal care, it also allows great care to be highlighted and shared with staff, service users and peers. It is of vital importance that good practice is shared throughout the Trust to allow collective learning and further drive the quality of care delivered to patients.

'Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care'.[2]

In March 2017, the National Quality Board released the "National Guidance on Learning from Deaths" publication (first edition). The document provides a framework for NHS Trusts/Foundation Trusts on identifying, reporting, investigating and learning from deaths in care. The Structured Judgement Review forms part of this framework.

From April 2017, Trusts are required to collect and publish information on deaths. A substantial volume of this information will be gathered from a SJR.

Process of SJR

The review is undertaken by medical professionals who have received training in the SJR methodology. Training is currently provided to Hull and East Yorkshire Hospital NHS staff, delivered by the Clinical Outcomes Manager and Clinical Leads in mortality.

The reviewer is prompted to make explicit judgement commentaries on 4 phases of care delivered to the patient during their hospital stay.

These phases of care are:

- Admission and Initial Care (approximately the first 24 hours)
- Ongoing care
- Care during a procedure (including intraoperative, postoperative and preoperative)
- End of life care

Additional judgement commentary is also given to summarise the overall care delivered to the patient.

Explicit judgement commentary for the "admission and initial care" phase of care may look like this:

"Patient arrived in A&E and was triaged within 1 hour. Pain relief was given in a timely and appropriate manner, with a senior clinician review delivered within 2 hours of arrival. A well-

documented management plan was in place, with the theatre staff alerted and ready to operate on the patient. Good communication with the patient's family is evident and advice sought from a multi-disciplinary team."

The language used in explicit judgement commentary should be clear for others to understand, including those who are not medically educated. It is important that others who read the review will be able to clearly understand what has been written and why.

In addition to explicit judgement commentaries, each phase of care also require the reviewer to allocate a score (another judgement of the reviewer), to reflect the quality of care delivered to the patient. These scores are allocated after each phase of care commentary has been written.

The care score uses a 1 to 5 grading system:

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

The care score helps the reviewer deliver a well-rounded judgement of care, particularly when the judgement commentary shows a mixture of good and unsatisfactory care within a phase.

The care score also plays a vital role in the escalation process. When a care score of 1 or 2 is given, this suggests that the care delivered to the patient was potentially unsatisfactory. These cases will require a second review to be undertaken to verify or challenge the decision to identify care as unsatisfactory.

A second stage review (Tier 2 review) will be undertaken by a group of dedicated, multidisciplinary Tier 2 reviewers. The Tier 2 reviews are undertaken at monthly group meetings with the Clinical Outcomes Manager present. All outcomes will be recorded and escalated where necessary to the Mortality Committee.

Who can undertake a Structured Judgement Case-note Review?

Hull and East Yorkshire Hospitals NHS Trust is currently providing reviewer training to the following staff:

- Consultants
- Specialist Registrars
- Specialist Trainee grade 6/7
- Doctors
- Matrons & Specialist Nurses
- Other senior staff with a clinical background

Training is provided by the Trust's mortality leads and the Clinical Outcomes Manager.

Choosing a case to review

In an ideal world, all hospitals would have the capacity to allow a Structured Case-note Review to be undertaken on every single patient death. However, in the real world this simply isn't feasible. As a result, the National Quality Board publication "Learning from Deaths"[3] has released guidance on what hospitals should, as a minimal, aim to deliver.

Part of this publication states that each Trust will be required to undertake a Structured Case-note Review on:

- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision – This includes complaints relating to care made via the Trust Patient Advice Liaison Service (PALS);
- All in-patient, out-patient and community patient deaths of those with learning disabilities and patients with severe mental illness. – Hull and East Yorkshire Hospitals NHS Trust has adopted the "LeDeR" review method to ensure deaths of patients with learning disabilities are reviewed. The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England;
- All deaths in a service speciality, 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);
- All deaths in areas where people are not expected to die, for example in relevant elective procedures;
- A sample of 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;
- 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. For example, a sample of 10 deaths from the Medical Elderly ward that occurred over the weekend.

Recording the Review

Hull and East Yorkshire Hospitals NHS Trust has adopted an electronic patient record system known as Lorenzo, which is the chosen platform for recording all Structured Judgement mortality

reviews. Implementing an electronic approach to recording reviews has numerous advantages over the older paper based systems, including better security of highly sensitive information, a higher level of data accuracy and of the course, the ability to utilise electronic reporting software to collate and present data in a useful and effective way.

The Lorenzo system feeds data into the Trust Business Information Analyser, which is a powerful system that allows a whole plethora of data reporting and analysis.

Thematic Analysis

Thematic analysis is a key component of the structured mortality case-note review. It allows trends in both good care and sub-optimal care to be identified.

Thematic analysis requires the reviewer to select one or more aspect of patient care that they feel requires highlighting, whether it is positively or negatively.

Currently, reviewers will be prompted to comment on any one, or more, of the following aspects of patient care, including:

- End of life care
- Communication with patient/family
- Documentation

In addition to the above, a reviewer may also comment on any other aspect of care that is not listed, via free text on the mortality review proforma, based within the Lorenzo system.

Hull and East Yorkshire Hospitals NHS Trust has adapted the thematic analysis technique to allow reviewers to attribute a care score to these individual aspects of care, again, using the 1 to 5 grade as described earlier. In addition to an overall score, additional commentary can be applied to justify the reasoning behind the score given.

More than one aspect of care can be, and should be, commented on wherever possible.

The thematic analysis technique not only helps us identify where care is potentially sub-optimal, but also allows positive trends and themes to be identified and good practices celebrated and shared throughout the Trust.

For example, a reviewer may feel that the provision of care was excellent in regards to communication provided to the family/carer, therefore choosing to award this aspect a score of 5 (excellent) with subsequent commentary:

"It is evident within the case-notes that the patient's family were constantly updated on the situation and offered support from the chaplain. This was delivered in an appropriate environment and there is also good communication between the end of life team and other multidisciplinary teams."

Hindsight

The following excerpts are taken from training material developed by the Improvement Academy and the Royal College of Physicians.

Case note review is retrospective and is prone to unconscious reviewer bias, especially when an outcome is known or suspected to be poor. Mortality review falls into the category of high potential reviewer bias which may lead reviewers into judging that a case has lower quality care than is actually the case. Even the best reviewers will retain an element of outcome bias. The evidence is that this cannot be fully eradicated, but it can be ameliorated by the knowledge that reviewers understand that hindsight bias exists and have some knowledge of its effect.

Caplan's study on hindsight bias is possibly the best empirical study in the medical literature, even though it is more than 25 years old. The researchers accessed 21 anaesthetics cases from a claims file in which some claimants had permanent damage due to an anaesthetic accident and some had a transient injury. The study doctors were asked to give care ratings to the cases. Sometime later the study doctors were asked to review the cases again, this time with the patient outcomes switched from permanent to transient and vice versa.

In 15 cases, appropriate care ratings decreased 31% when outcomes were changed from temporary to permanent and increased 28% when outcomes were changed from permanent to temporary.

Engaging Families and Carers

It is of vital importance that the Trust involves patients and/or carers, where necessary, in the response to the death of a service user. Hull and East Yorkshire Hospitals NHS Trust adheres to the Duty of Candour. The Trust will ensure that:

Bereaved families and carers will be given an opportunity to raise questions or share concerns in relation to the quality of care received by their loved one.

Bereaved families and carers will be involved in the investigation of any death that is concluded to be avoidable as part of the Serious Incident investigation process. They will receive an investigation report including any actions taken to ensure lessons are learned.

Families and carers will also be made aware of the Trusts approach to structured mortality review via the printed bereavement booklet that is handed to the families and carers by the Bereavement Team.

Quality Improvement Work & Learning

The Trust has adopted the Measuring and Monitoring Safety Framework and is applying it to various quality improvement projects, including learning from deaths. The principles of the framework are detailed in the diagram below.

The framework consists of five 'dimensions' and associated questions that the Trust can use to help understand the safety of its services. Used over time, this will help to give a rounded, accurate and 'real time' view of safety and will support efforts to identify those areas which present the greatest opportunity for safety improvement. The delivery will be monitored through the Trusts Quality Improvement Plan.

Quality improvement must remain the key purpose of undertaking mortality reviews, by encouraging and supporting learning, leading to meaningful and effective actions that improve patient safety and experience whilst supporting cultural change. Where good practice is identified, it should be celebrated and shared to enable others to follow.

Conclusion

The Trust has taken very positive steps to ensure it begins to maximise learning opportunities taken as a result of patient death. The Structured Judgement Review is not designed to replace good learning practice that exists throughout the Trust, but rather to aid and support. The SJR process has received very positive feedback from clinical staff and although still in its infancy, the methodology is already proving itself a valuable ally in helping the Trust capitalise on learning and improving the service that it delivers to its many patients on a daily basis.

Quality improvement must always remain one of the key products of mortality review, as should the sharing of good practices, of which there are many. It is important that we identify and act upon substandard care in an efficient and proactive manner to further improve the great service we deliver to our patients.

For general queries or training opportunities, the Trust Clinical Outcomes Manager, Chris Johnson, can be reached via email (chris.johnson@hey.nhs.uk).

References

1, 2. Professor Allen Hutchinson; National Mortality Case Record Review Programme: A guide for reviewers (adapted with permission - Hutchinson A, McCooe M, Ryland E. *A guide to safety, quality and mortality review using the structured judgement case note review method*.)

3. National Quality Board: Learning from Deaths (March 2017) https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Supporting Information & Further Reading

CQC: How Trusts Investigate and Learn from Deaths
https://www.cqc.org.uk/news/stories/whats-happened-our-review-how-nhs-trusts-investigate-learn-deaths

National Guidance on Learning from Deaths
https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/

A Guide to Safety, Quality and Mortality Case Note Review
http://www.yhahsn.org.uk/wp-content/uploads/2015/09/Case-Note-Review-Guide-FULL.pdf

A Framework for Measuring and Monitoring Safety
http://www.health.org.uk/sites/health/files/