Royal College of Physicians

National Mortality Case Record Review Programme

Patient Safety Conference Salford

April 2019

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NMCRR programme - aim

To establish and rollout a standardised methodology and process for retrospective case record review for adult acute deaths in England and Scotland to improve understanding and learning about problems in care that may have contributed to a patient's death.

Commissioned by: HQIP Healthcare Quality Improvement Partnership

NMCRR programme

- Initially a stand-alone programme
- March 2017 ‘Learning from Deaths’ a wider mortality structure implemented by DoH
- Mortality reviews mandated but not Structured Judgement Review

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The role of Structured Judgement Review (SJR)

- The review system can be used for individual cases (e.g. prioritised cases or morbidity and mortality reviews) and for selected groups of cases
- Results highlight **good care** as well as poor care (good care is much more frequent)
- The information provided allows units or organisations to ask ‘why?’ questions about things that happen, to enable understanding, improvement and action where required
- Like all mortality review programmes, a robust governance support process is required

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Phases of care

- Admission and initial care – first 24 hours approximately
- Perioperative and procedure care
- Ongoing care up to end of life (or discharge of the patient) – this may cover a prolonged period in hospital and may take some time to review
- End-of-life care (or discharge care)
- Overall care

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The phase of care score

1 Very poor care

2 Poor care

3 Adequate care

4 Good care

5 Excellent care

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NMCRR programme – training

- Approx 500 Tier One trainers
- Minimum 2000 hospital reviewers
- Continue to respond to need
- Scotland and England dates 2019

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RCP National Mortality Review tool – on-line platform

- Implementation continues
- Around 60 Trusts/Health Boards have implemented
- Further 32 Trusts implementing/expressed interest
- 888 registered users
- 2183 cases currently on the platform
- E-learning tool to provide training and on-going support released October 9 2018

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NMCRR programme

- First Annual Report published October 4 2018
- First Annual Conference Wednesday 10 October 2018
- Toolkit launched 7 June 2018
- Collaborations: Medical Examiners, Learning from Deaths NHSE/I, other mortality programmes

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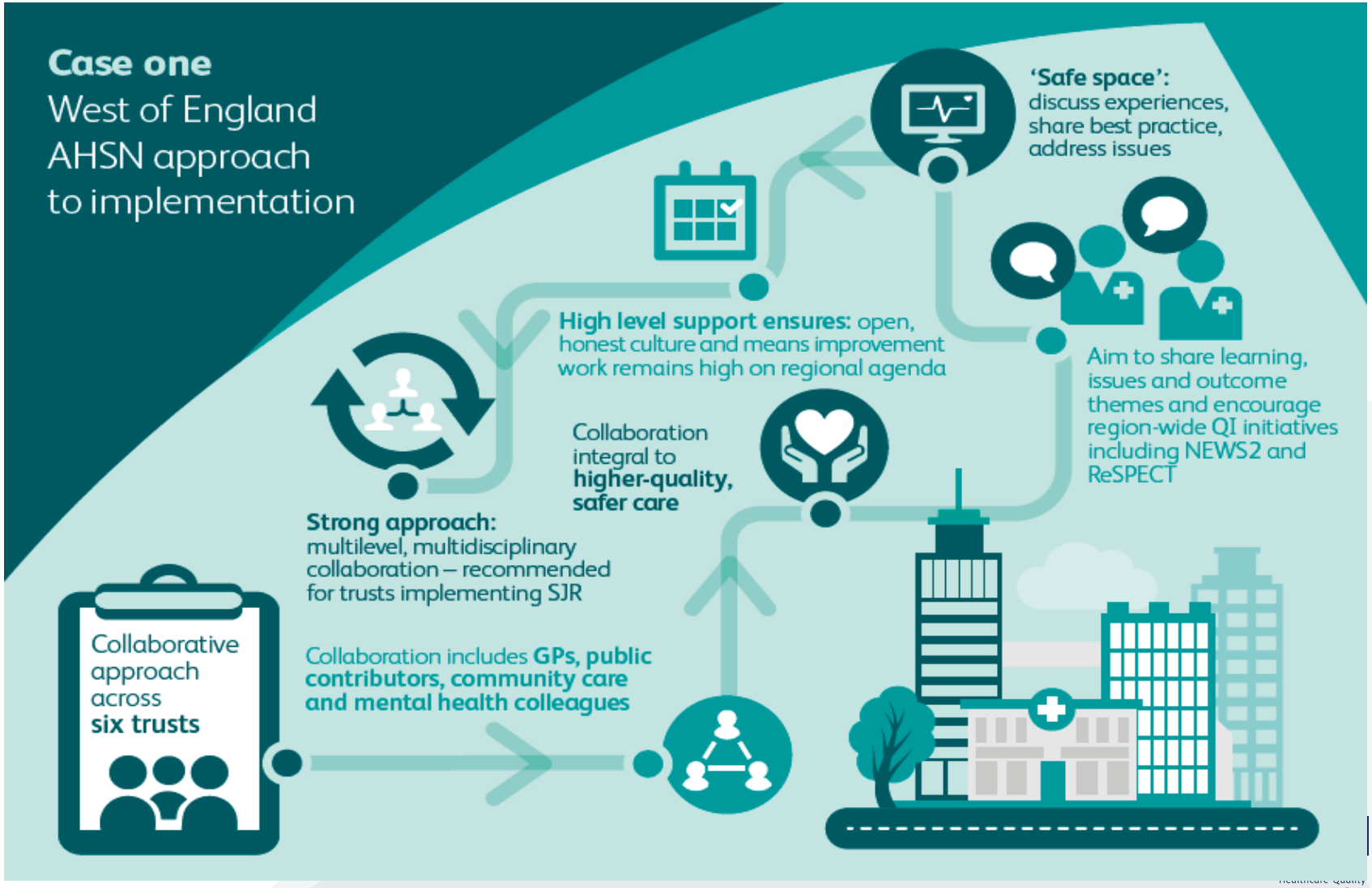

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Case ten
Buckinghamshire Healthcare NHS Trust implementation

Introduced medical examiners and structured judgement review (SJR) process

Objectives met: screen all deaths, meaningful engagement with bereaved relatives

Regional AHSN Mortality group created to share learning and standardise practice

Training in SJR facilitated by regional AHSN

Cases presented at M & M meetings for shared learning and multi-disciplinary review

60+ SJRs completed and entered onto the RCP National Mortality Review Tool (online platform)

80+ users have access to the online platform allowing transparency of reporting and data sharing across primary and secondary care

Results: during first six months

97% of deaths were screened

12% of all cases had SJR

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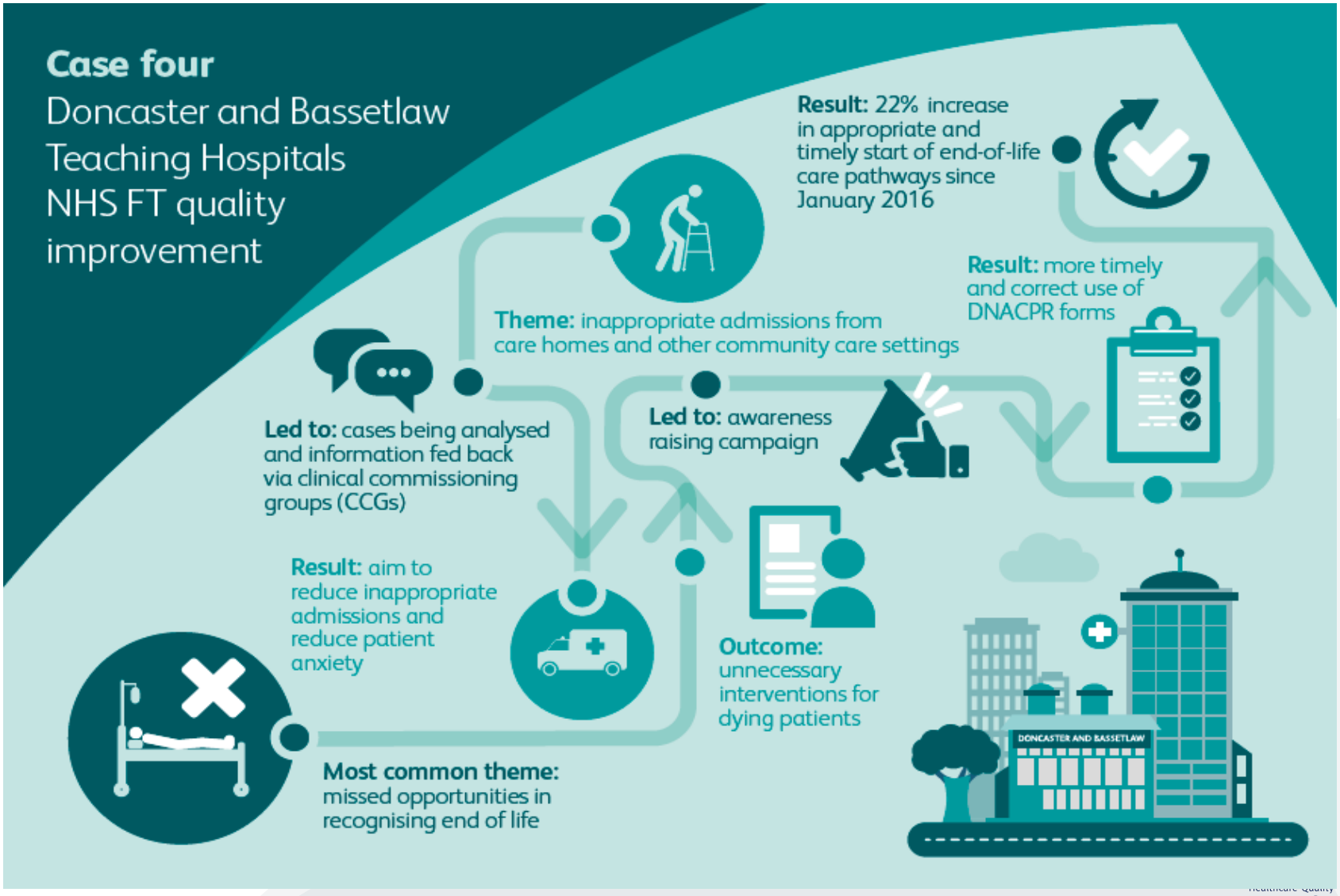

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Case nine

York Teaching Hospital NHS FT quality improvement

- Failure to identify and treat deteriorating patients
- The emergency department, the acute medical unit and out of hours identified as key risk areas
- Failure to consider and incorporate advance care planning (ACP)

Action:
Repeatedly fed back to medicine for older people meetings

Triangulation with CPR audit showed few survivors to discharge among in older, frailer patients with multimorbidity

Action:
Led to development of a new protocol for traumatic brain injury patients

Actions:
Complete review of the communication procedure for laboratory staff

Development of a situation, background, assessment, recommendation (SBAR)

Results:
Led to a marked increase in ACP decisions being documented

Concomitant fall in inappropriate cardiac arrest calls

A patient with traumatic subdural haematoma and anticoagulation for a long-term indication **suffered harm** when warfarin was restarted in error too soon

There was a case of **poor communication** of a severely low potassium result

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Over to you!

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