Royal College of Physicians

Mortality Case Record Review
End of Life Lessons Learnt

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The case for case note review?

- Mandated – Learning From Deaths
- The whole story?
- Evidence of quality and safety of care provided
- Opportunity for improvement
- Useful in all clinical environments?

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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
- Supporting improved understanding and learning about problems in care

Mortality review context

- The National Mortality Case Record Review Programme is in place to assist acute care hospitals in England and Scotland to review the safety and quality of care of adults who die in hospital
- The national programme supports hospitals in the use of an evidence-based review method called Structured Judgement Review (SJR)
- SJR provides both quantitative and qualitative information on care that goes well, or not so well
- The methodology can be applied to all clinical settings

NMCRR information use

- This work is not designed to generate data for comparison of Trust performance or to contribute to a national measure of the number of deaths due to problems in care.
- The data generated from this programme is primarily for use by Trusts/Organisations to support their own learning and improvement.

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The role of Structured Judgement Review

- 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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What is special about the SJR method?

- It is a quality and safety of care review method
- It examines **both** interventions and holistic care – which means that the whole record must be reviewed, including nursing notes
- Reviewers are trained to give written, short, **explicit clinical judgements** on safety and quality of phases of care (the structure)
- Reviewers give phase of care scores and an overall care score to accompany the judgements
- SJR is usually based on one reviewer's judgement, with a referral to the hospital governance programme where there is cause for concern [a low overall score] at first review

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

Implicit versus Explicit Phrases

- Implied or understood though not plainly or directly expressed - Prior knowledge or understanding is required
  - "I am a bit dry"
  - "Its raining so make sure you dress appropriately"
  - "Your hands are a little dirty"
- Explicit - Expressed or stated clearly leaving no room for doubt
  - "Please make me a cup of tea"
  - "Wear your raincoat "
  - "Please wash your hands"

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What should a judgement comment look like?

- Reviewers have a tendency not to be explicit but rather to imply a view, thus:
  - Well looked after on the whole (meaning?)
  - No ABGs (arterial blood gases) and patient was tachypnoeic and hypoxic (this doesn't answer the 'So what' question – there is no 'because')
- A subsequent reader, such as a member of the mortality review group, has to impute what the reviewer was trying to say – this is not helpful

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Assessment of problems in healthcare

- In this section, reviewers comment on whether specific types of problems were identified and, if so, whether harm was caused, e.g. no, or if yes, please identify problem type(s) from selected list and indicate whether any led to harm. There is also a text box for comment.

- There are eight problem categories, e.g:
  Problem related to end of life care.
  Did the problem lead to harm?
  No [ ] Uncertain [ ] Yes [ ]

Hindsight plagues mortality review

- 112 anaesthetists judged appropriateness of care for 21 live cases with temporary or permanent adverse events. Then researchers produced plausible alternative outcomes set
- 6 months later, in 15 cases, appropriate care ratings decreased by 31% when alternative outcome changed from temporary to permanent and increased by 28% when outcome changed from permanent to temporary

Caplan R et al JAMA 1991, 265;15:1957-1960

Case selection – match with review purpose

- In most cases, less done better is more (so far as information and learning is concerned)
- Conform to hospital policies
- For a service review, 40–50 cases will cause a significant workload, but is usually manageable and will produce breadth and depth of information
- Review cases early when possible, in view of possibility of duty of candour needs

From review results to information

- Care scores – use these to identify patterns in phases or aspects of care for further exploration
- Judgement commentaries – draw out the themes, e.g. ‘Early senior planning in complex cases means care usually goes well’
- Contrast good and poor assessments within the themes – asking the question ‘why does practice variation happen?’

Word association analysis

End-of-life phase

Reviewer Comments

- “Missed opportunity to avoid potentially futile resuscitation at end of life.”
- “Patients wishes accounted for fully and documented – good care.”
- “The overall standard of EOL care is difficult to assess due to scanty documentation.”
- “DNACPR discussion undertaken promptly and presence of NOK – excellent care.”
- “The patient had an advanced directive that they did not want CPR or admission to CPR. Good documentation.”

Themes

- Resuscitation status
- Communication with patient and relatives
- Unnecessary procedures
- Failure to identify dying patient
- Management of pain and distress
- Poor documentation
- Planning
- Leadership

No Surprises?

- Nuances in same organisation
- Role of clinical leadership – nursing and medical
- Complaints around EOL care prevalent
- EOL processes often not robust
- Role of the MDT
- Specialist involvement/advice sporadically sought
- Who delivers end of life care?
- Access to the best end of life care

What are the themes within your organisation?

What processes do you have in place to resolve the issues?

What can you take back to your organisation?