



Policy:

MD002 Learning from Deaths: The right thing to do

Executive Director Lead	Medical Director
Policy Owner	Patient Safety Specialist
Policy Author	Patient Safety Specialist

Document Type	Policy
Document Version Number	V4
Date of Approval By PGG	28 March 2022
Date of Ratification	13 April 2022
Ratified By	QAC
Date of Issue	April 2022
Date for Review	28 March 2023

Summary of policy

The purpose of this policy is to set out the Trust's expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the Trust will learn from them.

Target audience	Staff, Families & Carers
------------------------	--------------------------

Keywords	Mortality, death, learning, deaths
-----------------	------------------------------------

Storage & Version Control

This is version 4 of the policy.
This policy is stored and accessible via the Trust's intranet and internet.

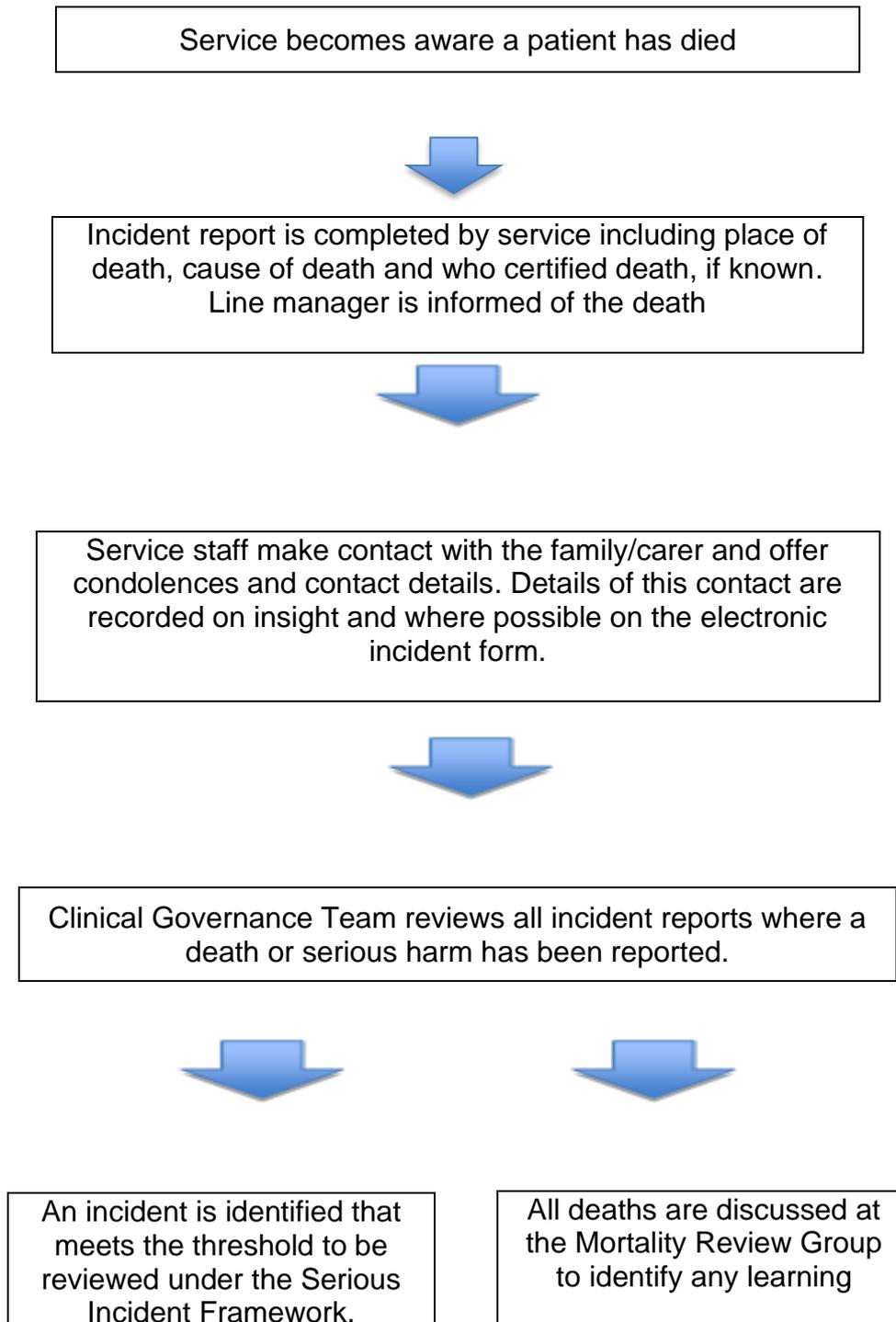
Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
1.0	Policy Development	July 2017	Northern Alliance Trusts developed policy
2.0	Policy Development	April 2018	Policy reviewed and developed
3.0	Review Ratification	March 2019	Policy ratified
4.0	Review on expiry of policy	March 2022	Review undertaken to update Committee and Trust structure.

Contents

Section		Page
	Version Control and Amendment Log	
	Flow Chart	1
1	Introduction	2
2	Scope	3
3	Purpose	3
4	Definitions	3
5	Objectives	5
6	Duties	5
7	Procedure	6
8	Development, Consultation and Approval	13
9	Audit, Monitoring and Review	22
10	Implementation Plan	22
11	Dissemination, Storage and Archiving (Control)	24
12	Training and Other Resource Implications	24
13	Links to Other Policies, Standards, References, Legislation and National Guidance	24
14	Contact details	25
	APPENDICES	
	Appendix 1- DYING AND DEATH PROTOCOL	
	Appendix 2 – Equality Impact Assessment Process and Record for Written Policies	
	Appendix 3 – New/Reviewed Policy Checklist	

Flowchart



1 Introduction

After the events of Mid Staffordshire the then Prime Minister asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review 14 hospital trusts national mortality records. The investigation looked broadly at the quality of care and treatment provided within these organisations and noted that the focus on combined mortality rates was distracting Boards from the practical steps that could be taken to reduce avoidable deaths in NHS hospitals.

These findings were reinforced in 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 2016*. It showed that in some organisations learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed.

The National Quality Board (NQB) guidance on *Learning from Deaths (2017)* is the starting point to initiate a standardised approach across the NHS to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning. These reviews will provide the Trust with valuable information in deciding how avoidable the death may have been and how Executive Teams and Boards can use these findings.

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people therefore it is important that organisations widen the scope of deaths which are reviewed in order to maximise learning.

We will make it a priority to work more closely with families and carers of patients who have died and ensure meaningful support and engagement with them at all stages, from the notification of the death of their loved one right through to actions taken following from an investigation or Structured Judgment review (if deemed appropriate).

The Trust fully supports the approach developed with other mental health trusts in the north of England as part of our collaborative approach to learning from deaths. The trusts participating are:

- Bradford District Care NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust
- Humber NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Sheffield Health & Social Care NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust

Working collaboratively will enable shared learning and good practice, valid comparisons across organisations and shared capacity.

During 2021 and 2022 the Trust is working closely with the Better Tomorrow national initiative to improve the mortality processes in individual Trusts. This policy and future policy developments will be shaped by this important piece of work. This policy should be read in conjunction with our Incident Management Policy and our Duty of Candour and Being Open Policy. The Dying and Death protocol is appended to this policy.

2 Scope

2.1 This policy applies to all Trust staff with a responsibility for patient care as set out below:



The National Quality Board Guidance on Learning from Patients Deaths applies to all acute, mental health/learning disability and community NHS Foundation Trusts.

Working with families/carers of patients who have died offers an invaluable source of insight to improve services. Therefore there is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the NQB guidance on Learning from Deaths, every trust must have a policy in place that sets out how it identifies reports, investigates and learns from a patient's death. This should include the care leading up to the patient's death and considering if this could have been improved.

This policy informs the organisation of staffs' roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.



Learning from a review about the care provided to patients who die in our care is integral to the Trust's governance and quality improvement work.

3 Purpose

The purpose of this policy is to set out the Trust's expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the Trust will learn from them.

This policy sets out how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are easy opportunities to discuss or ask questions about the care received by their loved one to their preferred timescale.

4 Definitions

Term	Definition
record review/SJR	Reviewing case records/notes to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. The Better Tomorrow Structured Judgement Review methodology provides an agreed template for this.

Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.
---------------------------------------	--

Investigation	The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies and procedures, guidance, good practice and observation – in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred.
LeDer	The Learning Disabilities Mortality Review (LeDeR) programme has been commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to: <ul style="list-style-type: none"> • identify common themes and learning points and: • provide support to local areas in their development of action plans to take forward the lessons learned.

5 Objectives

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.
- To help to identify what can be improved to ultimately reduce the inequality in the life expectancy of people with a serious mental illness/learning disability.
- To standardise approaches to reviewing deaths across the northern cohort of mental health trusts in order to share information and key learning.
- To enhance learning at a personal, team and organisational level.
- To ensure the Trust engages with other stakeholders (Acute Trusts, Primary care, public health, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximize learning from deaths
- To support the evaluation of the Trust’s approach to learning from deaths in line with the northern cohort of mental health trusts agreed principles.

6 Duties

Mortality governance is a priority for all Trust boards and the Learning from Deaths Framework places a greater emphasis on the importance of board leadership to ensure that learning from patient deaths becomes embedded in the organisation.

Role	Responsibility
-------------	-----------------------

<p>Chief Executive, Executive Board Directors and Non-Executive Directors</p>	<p>Trust boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remain key by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. They can do this by demonstrating their commitment to the work e.g. spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of service users and by ensuring that sufficient priority and resource is available for the work.</p> <p>The Medical Director has been identified as the Board level 'Mortality Lead' with responsibility for learning from deaths. Additionally, a named Non-Executive Director has taken lead responsibility for oversight of progress to act as a critical friend holding the organisation to account for its approach in learning from deaths.</p> <p>The Board will ensure:</p> <ul style="list-style-type: none"> • That robust systems are in place for reporting, reviewing and investigating deaths • That bereaved families are engaged and supported • That there is evident learning from deaths both internally and with our external partners and quality improvement is championed • That processes focus on learning, can withstand external scrutiny, by providing challenge and support and assurance of published information
<p>Clinical Directors, Medical Staff, Heads of Service, Nursing Leaders, Senior Practitioners, Ward and Team Managers and all Registered Nurses and Allied Healthcare Professionals</p>	<p>Staff should familiarise themselves with this policy and understand the process for learning from deaths. Identify the key changes required to implement this policy and ensure all appropriate action is taken;</p> <p>In conjunction with the Clinical Governance Team, to support staff to report, review and investigate deaths ensuring they have the time to carry this process out in skilled way to a high standard, and as part of that to:</p> <ul style="list-style-type: none"> • Ensure staff have the right level of skill through training and experience; • To promote learning from deaths; • That sufficient time is assigned in local governance forums to outline and plan for any lessons learned; • To ensure that learning is acted on
<p>The Clinical Governance Team, (incorporating Risk Management and</p>	<p>These corporate Trust departments have a responsibility to ensure:</p> <ul style="list-style-type: none"> • New data is collected and published to monitor trends in deaths (April 2017 onwards) with Board level oversight of this process

Quality Improvement Teams)	<ul style="list-style-type: none"> • Ensuring the Ulysses incident reporting system is used to its full potential to record deaths (expected and unexpected) in accordance with Trust policy. • Processing information consistently and precisely and in a meaningful way to fulfil governance processes required to ensure high standards in mortality governance are maintained.
-----------------------------------	--

 The Trust requires all staff to be conscientious open, honest and transparent about reporting deaths and for engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved.

7 Procedure

7.1 Encouraging a learning from deaths culture

We will continue to educate staff and encourage a more open culture of listening to the views and opinions of families and carers, following a death of a person in our care. Staff will become more confident in identifying what can be done differently and improve systems where necessary.

7.2 Family engagement

Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don't always want to make a complaint.

If you are reading this as a family member of someone who has recently died, and has received care from our Trust and you have anything you would like to discuss, you can contact us on 0114 2716739 or via email risk.risk@shsc.nhs.uk

Where clinicians have had close contact with a service user and their family/carer, they will often be the first to offer condolences and support and to give appropriate information to those involved regarding the opportunity to be involved in the review of the care. There are however some circumstances where the Trust may find out about the death of a service user after some delay. In these circumstances a discussion should take place between the Clinical Governance Team and the clinical team involved to determine the best approach. We have begun a dialogue with families about how they would wish to be involved in reviews of a family member's death or in an investigation. This work will inform the Trust's practice in the future as will anticipated national guidance*.

It is understood that dealing with the death of a loved one is a sensitive matter for families, carers and staff and that all situations are different. Staff may need to offer the opportunity for on-going involvement in-keeping with the family's needs and wishes.

The Trust's approach should be to treat the family/carer as an equal in the review process from the beginning taking their views and opinions into account at each stage.

Families can choose how they wish to be involved, this may include:

- agreeing the level of the review / investigation (see 6.5);
- contributing to the terms of reference for serious incident investigations;
- providing evidence / contributions to the review or investigation e.g. providing a pen portrait of the person, time-line of events
- Commenting on a draft report.

Families/carers should also be given the option of seeing a final report to ensure they are comfortable with any findings. Ideally this should be undertaken in a face to face meeting with a senior staff member talking the family member/carer through the report.

To support families, we will provide a range of information for relatives that explain these processes and what they can expect.

If the family member/carer decides they do not want to be involved in the review process staff should make it clear they can contact us at any time should their decision change and that any relevant information can still be shared. If the family does not want contact at all about the process or findings, this should be honoured and staff should record their wishes.

Staff should be prepared for the types of questions that families may have such as:

- Why is there an investigation?
- Can I access the records for my relative?
- Can I speak to the staff that were caring for my relative?
- Who was the last person to see my relative?
- What do I do next?

One way to ensure that answers are provided to the questions that families/carers have is to ask them, at an early stage, what they want to know and to involve them in writing the terms of reference of any review or investigation. Further information and support can be accessed by the Clinical Governance Team.

7.3 Identifying and reporting deaths

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (Insight) and where appropriate on its risk management system (Ulysses). This is to help ensure that the Trust board has a comprehensive picture of the deaths of all its services users and the opportunities to learn from them.

Trust staff must report deaths that they are made aware of on Ulysses within 24 hours of being informed and provide the cause of death and how the death was certified, where known. Once the Ulysses incident report is completed staff must immediately attempt to engage with the family and or carers unless otherwise instructed. In the first instance this would take the form of a condolence telephone call/letter with contact numbers for contacting the service and this should be recorded on the patient record (Insight).

This applies to deaths of patients open to SHSC services and those that have had an open episode within the last 6 months, except for patients within the Trust's Memory Service, where staff should only report deaths that have occurred within 6 months of contact with the service.



All deaths fitting the above criteria, that staff are made aware of, must be reported through the Ulysses system to start the process of learning from patient deaths.

All Ulysses incident reports for deaths are reviewed by the Daily Incident Safety Huddle on a daily basis and any unnatural unexpected deaths are taken forward through the Serious Incident processes. All reported deaths are taken to the Mortality Review Group (which is a multi-disciplinary forum) where each death is reviewed to establish what level of further review, if any, is required.

7.4 The decision to investigate or review

The Trust collects data on all known deaths and has a process in place to determine the scope of deaths which require further review or investigation. The information below sets out these processes in addition to the existing Serious Incident Framework which remain.

For people with a Learning Disability the Trust supports the approach of the LeDer program.

The NQB National Guidance on Learning from Deaths provides the context to the review or investigation of deaths and establishes a number of “must dos” in terms of investigations. These include:

- all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- all in-patient, out-patient and community patient deaths of those with learning disabilities
- all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means
- all deaths in areas where people are not expected to die, for example in relevant elective procedures
- 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 may be reviewed thematically
- 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 NQB guidance requires that all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review.

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

Further national guidance is expected to clarify expectations about mortality review in mental health and community services in the future however in the meantime, Trusts have been asked to use the above description of SMI.

In order to support consistency in determining the scope of deaths for further review, the cohort of Northern Mental Health trusts have agreed the following approach:

Where the trust provides a wide range of clinical services across inpatient, community and other provider organisations this can lead to both a degree of confusion as to who is responsible for the reporting and investigating of a patient's death and the risk of double reporting and investigation.

To support staff in their decision making they should refer to the following guidelines. However if there is any doubt staff should contact their line manager for advice.

A We are the main provider if at the time of death the patient was subject to:

- An episode of inpatient care within our service.
- An episode of community treatment under CPA.
- An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
- A Community Treatment order.
- A conditional discharge.
- An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
- Guardianship

B Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.

In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also exercise the responsibilities under Duty of Candour. However there will be a discussion to agree on if it is to be a joint or single agency investigation (this will be determined by the cause of death) and in the case of joint investigations who the lead organisation will be.

C Services provided by the Trust where we are not classed as the main provider.

For the following services the Trust is only providing a small component of an overarching package of care and the lead provider is the patients GP.

- The drug and alcohol shared care services
- Care home liaison
- Acute hospital liaison

D Exception.

In addition to the above, if any act or omission on the part of a member of trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the trust.

Where problems are identified relating to other NHS Trusts or organisations the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. A culture of compassionate curiosity should be adopted and the following questions should be asked:

- Which deaths can we review together?
- What could we have done better between us?

- Did we look at the care from a family and carers perspective?
- How can we demonstrate that we have learnt and improved care, systems and processes?

In addition the Northern Mental Health Trusts have identified a number of potential triggers for a Review / Investigation. These include deaths:

- where a family / clinical staff / risk management staff flag or raise a concern
- where medication with known risks, such as Clozapine, was a significant part of the treatment regime, or prescribing above BNF doses of antipsychotics
- from causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);
- Where they had been subjected to a care intervention where death wouldn't have been an expected outcome e.g. ECT, rapid tranquilisation
- where the service user had no active family or friends and so were particularly isolated e.g. with no one independent to raise concerns
- where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services
- associated with known risk factors / correlations

Also:

- particular causes of death e.g. epilepsy
- deaths in distress which might include: drug and alcohol deaths, or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support and from whose experience there may be learning from a thematic review;
- where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn't responded to in a timely manner
- random sampling

7.5 The types of review

Practice varies across Trusts with regard to how deaths are reported and categorised. Each Trust has core processes around:

- an initial screen of each death e.g. at a weekly Mortality Review Group (MRG) which will always necessitate the collection of core data around the service user and his or her death and sometimes the use of a structured tool;
- a way of making a judgement about which deaths are subject to further review which might be explicit and transparent against a set of criteria or sometimes more reliant on individual and clinical judgement
- a way of deciding the level of further review however this is described e.g. a Structured Judgement Review (SJR)

7.5.1 Local review

All deaths that are reported through the Ulysses system are reviewed by the Mortality Review Group. This review sets out to establish

- Cause of death

- What service/s were involved with the individual at the time of death
- Whether the death was expected or unexpected
- Where the individual died
- Who verified the death
- Was contact made with family or significant other

Dependent upon whether all questions can be answered at this stage, further enquiries may be made prior to the death being ultimately signed off as warranting no further review.

Where the MRG is concerned about a death, i.e. they have not been able to satisfy themselves about the care provided, a 48hr report will be requested from the service. This will either then be agreed as warranting no further investigation at the MRG meeting, or the Trust's Incident Management procedures will be instigated.

Where an unexpected/unnatural death occurs, the Trust's Incident Management Policy will be evoked. The progress of which will be monitored through the MRG.

On a monthly basis, the MRG will receive data related to the deaths of service users recorded solely on Insight and a random sample of these will be reviewed in order to identify learning for the Trust.

7.5.2 Structured Judgement Reviews:

A SJR blends a traditional clinical judgement based review with a standard format that enables reviewers to make safety and quality judgements over phases of care and which provides explicit written comments and a score for each phase. A SJR provides a relatively short but rich set of information about each case in a format that can be aggregated to provide knowledge about clinical services and systems of care. The SJR is linked to the Ulysses system and will be completed electronically.

7.6.3 LeDer Review Process

The Learning from Learning Disabilities Deaths process is managed via the Clinical Commissioning Group (CCG). Internally all death of patients with a learning disability are reported on the incident management system and reviewed in the mortality review group.

Completed LeDer reviews are sent to the mortality review group for a review of any identified learning and action points before they are sent to the learning disability lead for action planning and dissemination. The learning disability lead will notify the CCG and the mortality review group of completion of actions as appropriate.

7.6 Governance Process / Ensuring Learning

The prime objective of a Learning from Death Policy is that we can improve services and the experience of those services of the people that use them.

We are working with eight other mental health trusts to develop a consistent framework around learning. This will focus on whether the activity we do under the guidance of this policy (i.e. talking to the families of those who died, the investigations, thematic reviews, the analysis of data, the review of case notes including SJR) makes a difference.

How we measure the impact of the work will develop over time as the information we access improves, as we evaluate the policy overall including feedback from families and as the national guidance emerges.

We will all assess learning against a common framework that:

- identifies potential improvements
- develops a shared understanding of what these improvements might be across the trust
- leads to a series of actions locally, that should be able to be measured
- provides knowledge of the difference made by those actions

We will take the opportunity to share learning with our partner Trusts and other, local stakeholders. For example, there may be common issues we could commission thematic reviews of.

The actual practice in each Trust will differ for a variety of reasons: different cultures, priorities and ways of doing things. This co-existence of cohesion and diversity will be a strength as we will have the opportunity (through our continued regional work) to share and learn from each other's approaches and see which ones work best.

The Trust will ensure that lessons learnt result in change in organisational culture and practice by; identifying themes and trends in formal meetings and in the Quality Account; commissioning thematic reviews on a regular basis by the MRG and ensuring that associated action plans are implemented.

We will ensure learning is cascaded to frontline clinical staff and ' on a regular basis by use of incident governance reports, quality newsletters, briefings at the and updates from patient safety champions.

The SJR's, identifying any lessons to be learned, will be presented to the Mortality Review Group as a standard agenda item to be reviewed and approved. Any actions required will be agreed and monitored in the first instance through the Mortality Review Group and cascaded through the operational management structure as appropriate. This could take the form of a formal request for a review of a particular theme or topic or more general learning in the Quality Newsletter.

We will ensure transparency in decision making and accountability.

7.7 Data reporting

From October 2017, we have been publishing information on deaths, reviews and investigations via a quarterly agenda item and paper to our public board meetings.

8 Development, Consultation and Approval

The policy has been reviewed in consultation with the Better Tomorrow Project, the Mortality Review Group and the Clinical Quality and Safety Group. This has been an interim consultation in anticipation of more detailed changes within the next 12 months.

Appendix A – Dying and Death Protocol

Protocol: DYING AND DEATH PROTOCOL

Executive Director lead	Dr Mike Hunter Executive Medical Director
Protocol author/ lead	Vin Lewin Patient Safety Specialist
Feedback on implementation to	Vin Lewin

Document type	Protocol
---------------	----------

Target audience	Medical and Nursing staff, Managers
-----------------	-------------------------------------

Protocol Version and advice on document history, availability and storage

Version 1 issued November 2006

Version 2 issued May 2008

Version 3 issued April 2018-(this version) available as an appendix on the intranet

This version replaces all previous versions. All paper copies of the previous version should be destroyed.

Contents

Section		Page
1	Introduction	1
2	Scope	1
3	Definitions	1
4	Purpose	1
5	Duties	2
6	Process – i.e. Specific details of processes to be followed	2
	6.1	2
	6.2	2
	6.3	3
	6.4	3
	6.5	4
	6.6	4
	6.7	5
7	Audit, monitoring and review	6
8	Implementation plan	7

9	Links to other policies, standards and legislation (associated documents)	7
10	Contact details	7
11	References	7

1. Introduction

This protocol has been developed to provide all Trust staff with information about the approach they must take when a patient's life is reaching an end and/or their death occurs whilst in the care of the Trust. It is written to reflect the requirements of CQC Care Standards and the Mental Capacity Act 2005 and supports the learning from deaths culture of the Trust.

2. Scope

This protocol applies equally to all the Adult and Older Adult services, inpatient staff members and any other staff working in or with the community teams or bed based services (including agency staff, flexible staffing, etc.). The protocol applies where death is expected or unexpected.

3. Definitions

Term	Meaning
CQC	Care Quality Commission.
Older Adult service	Collective term for inpatient services for older people including Nursing Home care.
Resident	A term describing a person living in a nursing home.
Patient	A term describing a person admitted to hospital.
Patient	A term describing a person who has been assessed as needing care and support.
On-call manager	The person responsible for taking action and making decisions on behalf of SHSC and for providing advice to all staff on duty outside of normal working hours.
Manager	A term used to describe a person who has responsibility for running a service.
Expected Death	A term used to describe a person being cared for in the last few days of their life.
Unexpected Death	A term used to describe a person who dies suddenly whilst receiving care and treatment in bed based services.

4. Purpose

This protocol has been developed to ensure a consistent approach is used when a patient's life is reaching an end and/or their death occurs whilst they are receiving services from the Trust. It is intended that the process of dying and death itself is never regarded as routine by managers and staff. The quality of the care which patients receive in their last days is as important as the quality of life which they experience prior to this. This means that their physical and emotional needs must be met, their comfort and well-being attended to and their wishes respected.

The impact of the death of a patient on team members, the community of a ward or Nursing Home may be significant and it is important that opportunities are available for patients to come to terms with it in ways which individuals find comforting and acceptable. Thus opportunities for meditation and reflection and for contact with local and religious and spiritual leaders should be provided. Patients should be encouraged to express their wishes about what they want to happen when death approaches and to provide instructions about the formalities to be observed after they have died. Cultural and religious preferences must be observed.

For further information on the care of dying adults follow the link to NICE guidance:
<https://www.nice.org.uk/guidance/ng31>

5. Duties

All deaths of patients with an open episode of care or an open episode of care within the last 6 months (with the exception of the memory service) must be reported fully via the Ulysses electronic incident reporting system as soon as possible after the information is received.

All staff should be aware of their responsibility for recording a death on Ulysses at the time of closing and/or archiving a service user's records.

All staff members working in or in the Trust have a responsibility to be aware of this protocol and to work in accordance with it.

Managers are responsible for ensuring that all members of their team have access to this protocol both electronically and in a paper version (in the event of information technology difficulties).

6. Process

6.1 All deaths that occur whilst the patient is in receipt of community care **must** be reported as soon as they are known about via Ulysses electronic incident reporting system. Although it is acknowledged that it is not always possible staff should try to ascertain the likely cause of death and how the death was certified and this should be added to the electronic incident form. Trust staff responsible for the care of the client should contact the next of kin at the earliest opportunity to pass on their condolences and ask if they have any questions in regard to the care provided by the Trust and this should be recorded on the patients care record (Insight) and where possible the electronic incident form.

6.2 For each admission to a Nursing Home staff should refer to any patient held records if the client brings this with them. Check with them or a relative that the information is up to date. If no patient held record or pertinent information is available then ensure the Patients' Needs Assessment and collaborative care plan is completed with the following information (under the Dying and Death section), which should be asked of the Patient as sensitively as possible or, if otherwise not obtainable, their relatives/representative(s).

- Next of kin,
- Whether the patient has registered a lasting power of attorney (LPA) and with whom; this may be either a "Property and Affairs LPA" or a "Personal Welfare LPA",
- Who will be responsible for making funeral arrangements?
- Although a particularly sensitive subject, Care Standards require that each Patient (or their representative) be asked whether a burial or cremation would be preferred, and if known, who their preferred funeral director would be. (Note: The intention of these questions is to try and make the process, should it occur, of handling a patient's death whilst in residence as respectful as possible. It must be recognised that wishes can and do change over time such that different requirements may be expressed by relatives at the time of a resident's death. These up-to-date and reasonable wishes must be respected and every effort made to fulfil them.)
- Contact details and whether the family wish to be contacted during the night, if so, record the preferred contact details,
- Any religious or cultural preferences to be followed,
- How the Patient would wish the personal effects (jewellery and clothing) they are wearing at the time of death to be treated,
- Whether there is an "advance statement", "advance decision" or "advance directive" (or a living will) in place in accordance with the Mental Capacity Act 2005, and/or a "Do not attempt cardiopulmonary resuscitation" order completed in accordance with the Trust's resuscitation protocol.

6.3 In the event of an unexpected serious illness on a ward, residential accommodation or Nursing Home - If a Patient is taken seriously ill or their physical condition deteriorates to an extent that causes concerns, the following procedures should be followed:

- Ring for an emergency ambulance (dial 999 or 2222), if the illness is not considered immediately life threatening request a review from a medic, on-call medic or GP visit.
- Inform relatives; review/discuss any “advance statement”, “advance decision” or “advance directive” (or a living will) in place in accordance with the Mental Capacity Act 2005 and/or any Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order completed in accordance with the Trust’s resuscitation protocol, with Patient, or relatives, and the GP and record this on the patient’s records,
- If the Patient has expressed wishes for arrangements following their death, ensure that all relevant persons know these.

6.4 When death is imminent, (following illness/it is expected; i.e. under the advice of a GP):

- Inform the relatives and/or representatives and record this on the patient’s records,
- Inform the Nursing home Manager, if on duty, or the Duty Manager,
- Inform the Trust’s On-Call Manager,
- Offer hospitality to relatives/visitors; offer them the chance to stay with the Patient,
- Ensure the Patient is cared for as agreed and recorded in their plan of care, including pain control, privacy, dignity and use of professional services (e.g. MacMillan Nurses),
- Whilst the Patient is receiving personal care, ask visitors to wait outside unless they wish to assist,
- For Patients who have no relative/visitor present, try to arrange for staff members to spend time with the dying person,
- Ensure all staff members are aware and are provided with appropriate support,
- Ensure staff members respect the dying person; remind staff that hearing is the last faculty to diminish. Ask staff to listen to, offer respect and support relatives and or visitors,
- Ensure the Patient’s cultural/religious wishes are followed.

6.5 When **expected death** occurs:

- Contact GP – remember a locum may only verify death but not certify.
- Contact relatives and inform them that you have reason to believe that their mother/father, etc., has died, that you have contacted the GP and are waiting for them to visit. Inform them that they are welcome to come to the Nursing Home, if they wish, or that you will contact them again after the GP has visited,
- Inform the Nursing Home Manager, if on duty, or the Duty Manager,

NO FURTHER ACTION TO BE TAKEN UNTIL GP HAS VISITED

- Inform CQC within 24-hours of the death and include the cause of death,
- Inform the preferred undertaker and ensure the Patient’s jewellery is dealt with according to their recorded wishes and include any wishes for last offices,
- Nursing Home staff should attend to the Patient following the wishes recorded in their care plan, including religious/cultural wishes,
- The Duty Manager must record the incident in the appropriate files, complete an electronic incident report form and provide support to staff,
- DO NOT give the Patient’s valuables or money to relatives – valuables (e.g. jewellery and cash) are to be collected and checked against the inventory of belongings and immediately kept in secure storage. The returning of money and valuables is the responsibility of the Nursing Home manager or their designated officer. Relatives should be required to collect items, provide proper identification and sign to record receipt of the goods.
- The room should be made tidy, bedding taken to the laundry, the bed cleaned and covered,
- No personal belongings (other than jewellery and cash, etc.) are to be removed without the permission of relatives/ representatives. A list of any items removed by relatives should be made by staff and checked against the Patient’s property inventory sheets. Appropriate action should to be taken to safeguard personal belongings until relatives/ representatives have visited,
- All medication to be removed from the drugs trolley, clearly identified and placed in lockable storage before disposal.

6.6 When **unexpected or sudden death** occurs:

- Call for an ambulance (dial 999 or 2222),
- Start resuscitation, (Note: This must not be in contravention of any written 'Advance decision refusing life- sustaining treatment i.e. DNACPR'.)

CONTINUE RESUSITATION UNTIL THE EMERGENCY SERVICES ARRIVE

- If resuscitation is not possible / directed restrict access to the area in which death has occurred and await the arrival of the police. Do not clean the area or remove any items from the area,
- The Ambulance Staff or Police will advise on actions to be taken, including whether any items can be removed,
- Inform the Nursing Home Manager or Ward Manager, if on duty, or the Duty/Shift Manager,
- Inform the Trust's On-Call Manager, if the incident occurs out of normal hours,
- Contact relatives and inform them as advised by the Ambulance Staff/Police,
- If the family/friend does not have a telephone, the police may visit to inform them of the death,
- Inform CQC if the unexpected death is in a Nursing Home,
- Record the incident on an electronic Incident Form,
- Nursing Home Manager/Duty/Shift Manager to provide support to staff,
- **DO NOT** give the Patient's valuables or money to relatives – money and valuables have to be collected and checked against the inventory of belongings and kept in secure storage. The returning of money and valuables is the responsibility of the Nursing Home manager, Ward Manager or their designated officer. Relatives should be required to collect items, provide proper identification and sign to record receipt of the goods.
- The room should only be made tidy, bedding taken to the laundry, the bed cleaned and covered when the police advise it is acceptable to do so,
- In Nursing Homes no personal belongings are to be removed without the permission of relatives/ representatives. A list of any items removed by relatives should be made by staff and checked against the Patient's property inventory sheets. Appropriate action should be taken to safeguard personal belongings until relatives/ representatives have visited,
- All medication to be removed from the drugs trolley, clearly identified and placed in lockable storage before disposal advice is taken from either the police or responsible manager.

6.7 Family engagement

Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don't always want to make a complaint.

If you are reading this as a family member of someone who has recently died, and has received care from our Trust and you have anything you would like to discuss, you can contact us on 0114 2716739 or via email risk.risk@shsc.nhs.uk

7. Dissemination, storage and archiving (Control)

This protocol is available on the SHSC intranet and is available in hard copy to all staff. A hard copy should be stored in the team office at each service area.

It is the responsibility of the Manager to ensure that the copy of this protocol held in the service area is the most up to date version and to ensure that any previous versions have been destroyed.

It is the responsibility of the Service Manager to ensure that all previous versions of this protocol are held in an electronic archive and stored centrally to enable access when and if required (this can be arranged with the Communications team).

8. Training and other resource implications

Awareness of policies is a central part of the induction and training of new staff and managers, including training in advance directives/decisions, resuscitation and DNACPR procedure.

9. Links to other policies, standards and legislation (associated documents)

- i) This protocol refers to and works in tandem with the Trust's Resuscitation protocol in respect of "do not attempt cardiopulmonary resuscitation" orders (DNACPR's).
- ii) This protocol reflects the requirements of The Mental Capacity Act 2005 particularly in respect of;
 - a) "Advance statements", "advance decisions" or "advance directives" (or a living will), and,
 - b) "Lasting powers of attorney".
- iii) This protocol reflects the requirements of CQC care standards and NICE guidance for care of dying adults in the last days of life.

10. Contact details

<i>Title</i>	<i>Name</i>	<i>Phone</i>	<i>Email</i>
Patient Safety Specialist	Vin Lewin	27 16379	Vin.lewin@shsc.nhs.uk

11. References

- 1) <https://www.nice.org.uk/guidance/ng31>
- 2) <http://www.legislation.gov.uk/ukpga/2000/14/contents>
- 3) <http://www.legislation.gov.uk/ukpga/2005/9/contents>

9 Audit, Monitoring and Review

This section should describe how the implementation and impact of the policy will be monitored and audited. It should include timescales and frequency of audits.

If the policy is required to meet a particular standard, it must say how and when compliance with the standard will be audited.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/committee for action plan development	Responsible Individual/group/committee for action plan monitoring and implementation
A) Compliance with National standards	Review	Mortality Review Group	Annual	Quality Assurance Committee	Mortality Review Group	Mortality Review Group

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. March 2023

10 Implementation Plan

All policies should include an outline implementation plan (this will summarise sections 7, 8 and 9 above). It should include consideration of:

- *Dissemination, storage and archiving*
- *Training and development requirements and who will provide the training*
- *Any new job roles and responsibilities and how these will be implemented*
- *Resources needed*
- *Timescales*
- *Lead role and responsibilities for implementation*
- *Audit or monitoring of implementation planned*

The implementation plan should be presented as an action plan and include clear actions, lead roles, resources needed and timescales. The Director of Corporate Governance team can provide advice on formats for action plans however; an example layout for the plan is shown below:

Action / Task	Responsible Person	Deadline	Progress update
<i>Upload new policy onto intranet and remove old version</i>	Comms	<i>April 2022</i>	

11 Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
4.0	April 2022	April 2022	April 2022	

12 Training and Other Resource Implications

The policy must include a consideration of any training and development requirements for its effective implementation. Where training needs are identified, these must be discussed with the Education, Training and Development Team and reflected in the Trust's Training Needs Analysis.

Other resource implications to consider include the cost of dissemination and any new job roles or functions which are not in current job descriptions or work plans. Any anticipated savings and efficiencies as a result of implementing the policy should also be considered.

13 Links to Other Policies, Standards (Associated Documents)

Any policies, procedures, guidelines which link to this policy should be indicated here. The document should include key references for the evidence base, and relevant legislation or government policy.

14 Contact Details

The document should give names, job titles and contact details for any staff who may need to be contacted in the course of using the policy (sample table layout below). This should also be a list of staff who could advice regarding policy implementation.

Title	Name	Phone	Email
Patient Safety Specialist	Vin Lewin	16379	Vin.lewin@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – Relevance - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement.
I confirm that this policy does not impact on staff, patients or the public.

I confirm that this policy does not impact on staff, patients or the public.

Name/Date: Vin Lewin 21.03.2022

YES, Go to Stage 2

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – Policy Revision - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age			
Disability			
Gender Reassignment			
Pregnancy and Maternity			

Race			
Religion or Belief			
Sex			
Sexual Orientation			
Marriage or Civil Partnership			

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by: Name /Date

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
Engagement		
1.	Is the Executive Lead sighted on the development/review of the policy?	
2.	Is the local Policy Champion member sighted on the development/review of the policy?	
Development and Consultation		
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	
5.	Has the policy been discussed and agreed by the local governance groups?	
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	
Template Compliance		
7.	Has the version control/storage section been updated?	
8.	Is the policy title clear and unambiguous?	
9.	Is the policy in Arial font 12?	
10.	Have page numbers been inserted?	
11.	Has the policy been quality checked for spelling errors, links, accuracy?	
Policy Content		
12.	Is the purpose of the policy clear?	
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	
15.	Where appropriate, does the policy contain a list of definitions of terms used?	
16.	Does the policy include any references to other associated policies and key documents?	
17.	Has the EIA Form been completed (Appendix 1)?	
Dissemination, Implementation, Review and Audit Compliance		
18.	Does the dissemination plan identify how the policy will be implemented?	
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	
20.	Is there a plan to <ol style="list-style-type: none"> i. review ii. audit compliance with the document? 	
21.	Is the review date identified, and is it appropriate and justifiable?	