Frimley Health
NHS Foundation Trust

Trust Policy

Policy on Learning from Deaths

Key Points

- Mortality review is an important part of our Safety and Quality Improvement Process.
- All patients who die in our trust have a review of their care.
- There is a clear structure for identification of cases that require detailed review.
- There is trust wide dissemination of learning from mortality review.
- There are clear lines of responsibility within the mortality review process.
- The mortality review process and patient safety processes are aligned.
- There is board oversite of the process.
- There is a non-executive lead for the mortality review process.
- There is regular reporting of the outcome of mortality review to the medical director and the board.
- All avoidable deaths will be investigated under the Serious Incident Framework.
- Patients' families will be informed of all such investigations and invited to feed into this process.

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Version Control Sheet

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0.2	26/06/2017	Clare Stapleton, Clinical Lead for Mortality	Draft	
1.0	June 2017	Policy Officer	Final	Ratified at HEB
1.1	September 2018	Clare Stapleton, Clinical Lead for Mortality	Interim	Policy reviewed to incorporate the role of Medical Examiner.
1.2	March 2020	Alexandra Higton, Associate Medical Director for Patient Safety Joao Peixoto Mortality & Morbidity Lead Nurse	Interim	Policy reviewed to incorporate the role of RL reporting system and ME service. Adjustments to M&M review criteria. To be ratified by SLC post Covid

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Related Documents

Document Type	Document Name
National Guidance	Learning from Deaths (National Quality Board) 2017
Royal College of Physicians	Using the Structured Judgement Review Method (2017). Data collection form.
Policy	Management of Incidents including Serious Incidents

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1. INTRODUCTION

1.1. Learning from the death of patients who have been treated in our trust is a vital component of improving the quality and safety of care we provide.

1.2. This Policy sets out the framework adopted by Frimley Health NHS Foundation Trust (the Trust) for retrospective case record review (RCRR) to assess the clinical care we deliver in our hospitals. It allows us to find out where any problems in care lie so that they can be remedied and help us to prevent future harm. It also allows the identification of excellent care.

1.3. Mortality review, presentation and discussion has long been part of clinical governance. Traditionally it has taken the form of specialty run morbidity and mortality (M&M) meetings in hospitals. More recently has there been a drive to standardise this process and design systems which allow widespread learning from case note review across specialties within a trust and across organisations.

1.4. National mortality review guidance was published in March 2017 by NHS Improvement and the Care Quality Commission with the aim of standardising mortality review processes in all trusts. This guidance has followed inspections, reports and academic studies prompted by well publicised problems in care and safety in the NHS over the last 5 years.

1.5. The vision of this national project is that learning and action resulting from mortality review will be more effective and visible. That there will be greater board oversight of this aspect of safety and quality improvement within trusts and that there will be greater involvement of families and carers in investigations of deaths. Also, that there will be better communication and cooperation of different organisations within the health economy so that information after a patient's death is shared appropriately and learning is spread as widely as possible

1.6. Frimley Health NHS Foundation Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

2. SCOPE OF THE POLICY

2.1. This Policy applies to all members of staff employed by the trust and, in particular, those staff involved in delivering direct care to patients.

3. DEFINITIONS

3.1. **Structured Judgement Review:** Form used to review the deaths referred to deeper review.

3.2. **Morbidity and mortality (M&M) meetings**: Meetings held regularly, usually monthly, in each specialty to discuss deaths, complications and patient safety incidents

3.3. **Mortality Review Group (MRG):** The trust has two mortality review groups, one for Frimley Park Hospital and one for Heatherwood and Wexham Park Hospitals. Each group has a chair. The groups:

- Receive reports from specialty M&M meetings.
- Provide a forum where learning from M&M can be shared across specialties.

- Direct and support specialty mortality leads and to highlight where help may be needed.
- Direct, support and refine the screening process as necessary.

3.4. **Mortality Surveillance Group (MSG):** The trust wide Mortality Surveillance Group is chaired by the medical director (or his/her deputy) and meets bi-monthly. The aim of the group is to examine all the available information gained from data and mortality and morbidity review and recommend the necessary quality improvement. The group is also responsible for strategy relating to mortality review based on national directives and any new challenges for the trust.

3.5. **Summary Hospital level Mortality Indicator (SHMI):** The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

3.6. **Copeland Risk Adjusted Barometer (CRAB)**: A system which uses coded data from the Secondary Users Service (SUS) to measure the occurrence of medical triggers in inpatients as an indicator of morbidity. It also calculates risk adjusted operative mortality and morbidity at trust, site, specialty and consultant level.

3.7 **Associate Medical Director for Patient Safety (AMD**) – Senior Consultant overseeing Mortality and Morbidity Service among other responsibilities.

4. PURPOSE OF THE POLICY

4.1. The aim of this policy is to set out the framework for mortality review; how learning from these reviews is shared and how statutory reporting will take place. It also sets out how the mortality review process interacts with the Serious Incident Review Process.

4.2. The publication, *National Guidance Learning from Deaths* (National Quality Board, 2017) requires that the Trust have a policy.

4.3. There is specific guidance for action following the death of patients with learning difficulties and mental health problems in acute trusts.

4.4. This policy applies to all adult deaths in the trust, separate guidance on review of neonatal deaths, stillbirths and child deaths and will be updated before September 2017.

5. THE POLICY

5.1. The trust will review deaths if they meet the trust criteria which include those described as mandatory by NHS Improvement and the CQC. Identified cases are fast tracked through the coding process and then made available for the mortality lead for the specialty who oversees the review. In some cases this will need to be undertaken in partnership with other healthcare organisations. These include deaths within 30 days of discharge as an inpatient from the trust.

5.2. All adult deaths are scrutinized by the Medical Examiner. The Medical Examiner will support the Medical team with the completion of the Medical Certificate of

Cause of Death (MCCD), communicate with the family, explaining the cause of death and escalate any concerns. The Medical examiner will then scrutinize the case and, using the screening checklist, refer the case to deeper review if necessary.

5.3. All deaths of patients with learning difficulties or a serious mental health problem will be subject to review.

5.4. The specialty review will be conducted by one of the consultants within the specialty that was caring for the patient at the time of death. This consultant will ideally not have been directly involved in the patients care. It is recognised in smaller and team based specialties that this may not be possible. In this case at least 2 consultants should review the case. The format of case note review will be a subjective judgemental review based on that designed by the Royal College of Physicians.

5.5. The case reviewer will present the case at the specialty M&M meeting where the judgement of the chance of the death being avoidable will be made as a group consensus. There will also be a judgement of overall quality of care made at the M&M meeting and agreements about any Learning from the case review.

5.6. Throughout the process those involved must consider whether the case should be the subject of a patient safety investigation. If it is considered that it might require investigation a recommendation must be made immediately. The patient safety team will manage contacting the family of the patient. All cases judged to be “avoidable” are then subject to this process.

5.7. The output of specialty M&M meetings is presented at the site Mortality Review Group (MRG).

5.8. A summary of the MRG meetings will be prepared as a PowerPoint presentation and sent to each mortality lead. This presentation will be part of the regular presentation at each specialty M&M.

5.9. The Mortality Surveillance Group receives a report prepared from both MRGs and includes themes of learning from SJR and a summary of current data. That is Summary Hospital level Mortality Indicator (SHMI), diagnostic group SHMI and Copeland Risk Adjusted Barometer (CRAB).

5.10. The Quality Committee will receive a quarterly update from the trust mortality lead or his/her deputy highlighting key themes.

5.11. The Board will receive a quarterly report. These quarterly reports will be summarised into an annual contribution to the quality accounts.

5.12. The Associate Medical Director for Patient Safety will maintain relationships and communication with other organisations within the local health economy in order to disseminate learning.

6. DUTIES / ORGANISATIONAL STRUCTURE

6.1 **Trust Board**

Ensure that there is a board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress.

Ensure that the trust has a policy on responding to deaths and appropriate processes in place for reviews.

Receive regular reports in relation to this work

Ensure that this work is reported in annual Quality Accounts.

6.2 **Medical Director**

Nominated board-level leader acting as patient safety director.

Chair of the Mortality Surveillance Group.

6.3 **Associate Medical Director for Patient Safety**

Communicating all available and relevant information gained from SJR and data.

Inform the Trust board via the medical director the activity of the mortality team, what has been learnt from its work and what improvement drives have been initiated and their effects.

Prepare the board report on mortality review every quarter.

Direct communication with other organisations within the local health economy to facilitate joint review of patients treated jointly and to disseminate learning.

Be aware of current national directives and recommendations concerning mortality review to ensure the trust continues to demonstrate excellence in this area of its work.

Consider ideas and design systems which will maximise the benefit of mortality review.

Reports directly to the medical director or his/her deputy and director of nursing, via the MSG (or directly for urgent matters).

6.4 **Mortality Group Chairs:** two (one on each acute site)

Chair the MRG and guide discussion at the meeting.

Preparation of summary reports to be distributed to specialty leads and for Quality Committee and MSG.

To attend MSG and help it fulfil the functions described above.

To direct and support specialty mortality leads and to highlight where help may be needed.

To direct, support and refine the screening process as necessary.

6.5 **Chiefs of Service**

Overall responsibility for the effectiveness of the mortality review process at specialty level.

6.6 **Specialty Mortality Lead**

Coordinate mortality reviews within their specialty.

To act as the line of communication between the MRG and their specialty

To report, via the formal process described above, the result of the M&M activity in their own specialty

To seek support from the mortality team or their own chief of service if the process develops challenges.

6.7 **Patient Safety Team**

Coordinate process of patient safety incidents.

Provide administration support.

6.8 **Consultant undertaking review**

Undertake the review objectively using the tool provided in a timely manner.

Present report to M&M meeting.

6.9 **Medical Examiners**

Appointed from the Consultant body on each acute site.

Available for advice and support 5 days per week.

Responsible for supporting junior doctors to complete MCCD.

Ensure that all MCCDs are appropriately completed and that the causes of death documented are appropriate based on the clinical history and are compatible with national guidance on the completion of the MCCD.

Identify cases and support referrals to the Coroner's office.

Contacting families and/or carers of bereaved patients to inform them of MCCD details and understand their view on the quality of care provided to the patient.

Screen all case notes to identify which cases should undergo deeper review.

Document evidence of screening using RL.

Identifying cases that may require a serious incident review and liaise with the Patient Safety Team.

Completing part 2 of the cremation forms.

Compile and maintain 18 point data set database.

6.10 **Lead Medical Examiner (Trust wide role)**

To provide clinical leadership for ME service

Will oversee the appointment, training and updating of the Medical Examiners.

Available to support and advise the Medical Examiners in their day to day roles.

To provide independent scrutiny of individual cases when required.

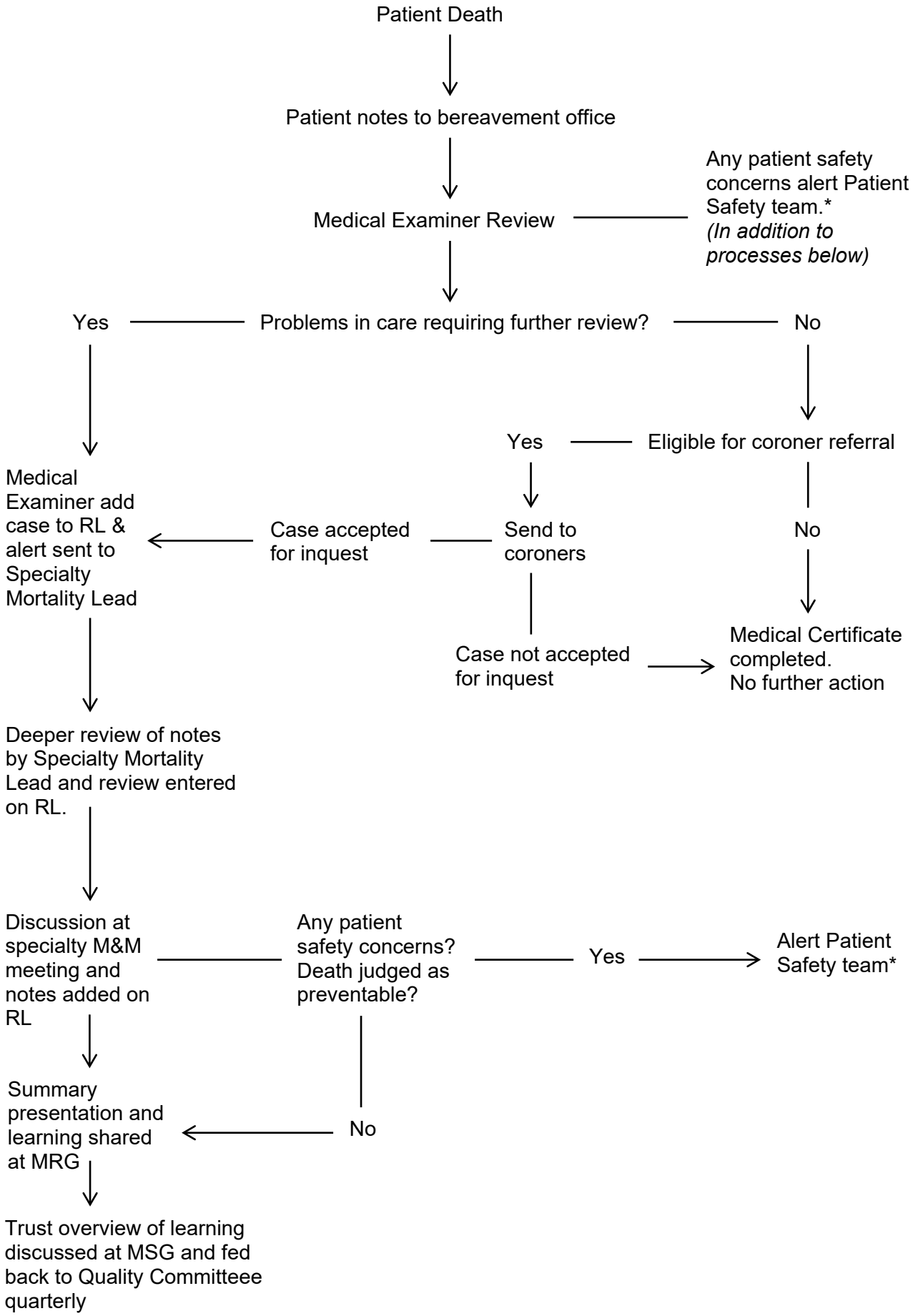
To monitor the process as a whole and ensure improvements where necessary.

To lead the appraisal process of ME's.

6.11 **All trust staff**

Cooperate actively and honestly with mortality reviews in which they are involved.

7. PROCESS OF REVIEWING CASES



*** Policy for the Management of Incidents including Serious Incidents (V 2.1)**

The process is divided into the following steps

1 Screening of case notes by Medical Examiner at time of death certification.
2 Coding of case notes
3 Scanning on EVOLVE
4 Specialty mortality review
5 Presentation at specialty M&M meeting
6 Presentation of areas of concern, themes of learning etc. at site mortality review group. (MRG)
7 Collation of broad areas of concern, number of cases reviewed and number judged to be preventable.
8 Presentation of summary from each MRG to trust wide Mortality Surveillance Group (MSG) and Quality Committee

7.1 **Screening of case notes**

7.1.1 The purpose of screening is firstly the Identification of cases for deeper review. This selection adheres to national guidance; additional cases will be selected based on experience of those cases where there is greatest learning. The additional triggers for deeper review may change with time as we identify different challenges in patient care. The trust will always adhere to national standards for mandatory review of cases.

7.1.2 The following cases will all be reviewed:

a) When concerns of substandard care have been raised either by staff or the patient's family;
b) When a death is wholly unexpected for example following elective surgery or low risk emergency surgery;
c) When a patient dies, who has learning difficulties or a serious mental health problem;
d) When a flag has been raised of poor outcome in a specialty or diagnostic group by another means, for example CQC, SHMI, etc;
e) Diagnoses of particular concern to a trust in terms of quality improvement, for example sepsis.

7.1.3 The screening tool is constantly updated to reflect current trends or concerns raised by Patient Safety, CRAB/SHMI and NHS Alerts. However, there are standard triggers that would require a deeper review such as described above.

7.1.4 The screening must be done using a specifically designed tool and is undertaken by the Medical Examiner on both sites. The additional benefits are as follows:
Allows collection of other quality and safety data
All deaths in our trust get a review
Correct identification of all specialties involved in a patient's care to facilitate joint review when appropriate.
Early identification and reporting of serious incidents that may have not been recognised as such before death.

7.1.5 The information obtained at this stage of the process will be analysed every three months to monitor areas of concern.

7.1.6 The case notes of all adult patients who die in hospital must be taken to the bereavement office on the day of death or next working day.

7.1.7 The Medical Examiner will scrutinise the notes, complete a summary, liaise with the patient's family, liaise with the treating team regarding the medical cause of death certification. They will screen the case using standard triggers and identify which cases would benefit from an in-depth review.

7.1.8 The vast majority of cases requiring deeper review will be identified by this process; however some may be bought to the attention of the mortality team through other routes, for example, direct reporting from staff, family or through the patient safety team.

7.1.9 Screening and review of deaths within 30 days of discharge from hospital is more complex and will involve coordination with primary care and other organisations such as community care. These essential links are currently being established with CCGs and Community Trusts and are in development.

7.2 Coding of case notes

7.2.1 When cases are identified that require deeper review these notes will be sent to the coding department as a priority and then immediately to scanning. This way we guarantee that if a case needs be reviewed by different specialities there will be no delay due to unavailability of the case notes. The RL system will automatically alert the Speciality's Leads of the case.

7.3 Speciality Mortality Review

7.3.1 Each specialty must have a clinical lead for mortality for each part of the trust (FPH or HWPH). This must be a consultant in that specialty but may be supported by senior nursing staff and/or a doctor in training.

7.3.2 The clinical lead for mortality is not expected to undertake the reviews themselves but to ensure that they are done and that the workload is shared among the consultants. The review should ideally be done by a consultant not involved in that patient's care.

7.3.3 The format of case note review will be a subjective judgemental review based on that designed by the Royal College of Physicians (attached as appendix 2).

7.3.4 A record of this review will be held by the mortality team.

7.4 Presentation at Speciality M&M Meeting

7.4.1 The judgements of quality of each phase of care (admission, ongoing care, peri- operative care, end of life care) will be scored by the reviewer; however, the final judgement of the chance of the death being avoidable should be made as a group at the time of the M&M meeting. This collaborative approach will facilitate useful discussion. It will also reduce some of the individual bias that is inevitable in making this highly subjective judgement.

7.4.2 If, on review, a patient's death is viewed to be clearly avoidable or demonstrating overall poor care and has not previously been reported as a Serious Incident (SI) then the specialty mortality lead or clinical lead must discuss this as soon as possible with the Patient Safety Team.

7.5 Presentation at Site MRG Meeting

7.5.1 The output of specialty M&M meetings is presented at the site Mortality Review Group (MRG). The information must be presented using a standardised format which includes the following:

Date of M&M meeting

Number, profession and grade of attendees

Number of deaths under that specialty in calendar month

Number identified for deeper review

Number reviewed and discussed at that meeting

Morbidity cases discussed

Themes of specialty learning from both

Action taken

Number identified as more than 50% likely to be due to an avoidable problem in care.

Specific cross specialty learning themes.

7.6 Collation of broad areas of concern, number of cases reviewed and number judged to be preventable

7.6.1 The data from the site MRG meetings will be compiled by the mortality team at both sites and reported to the mortality surveillance group (MSG).

7.7 Presentation of summary from each MRG to trust wide Mortality Surveillance Group (MSG)

7.7.1 The trust wide Mortality Surveillance Group is chaired by the medical director (or his/her deputy) and will meet bimonthly. The aim of the group is to examine all the available information gained from mortality and morbidity review and highlight the necessary quality improvement.

7.7.2 The MSG receives reports from both MRGs and includes themes of learning from RCRR and a summary of current data. That is Summary Hospital level Mortality Indicator (SHMI), diagnostic group SHMI and Copeland Risk Adjusted Barometer (CRAB). This information is aggregated to form top themes that require improvement.

7.8 Reporting to the Patient Safety Team and Family Involvement in Review

7.8.1 Cases which cause concern at screening stage which have not previously been reported will be sent to the patient safety team for consideration of a patient safety investigation.

7.8.2 Cases which the specialty identify that there was poor care overall or that the death was more likely than not to have been avoidable must be reported to the patient safety team. The case will then undergo review by the patient safety team. Should the case be graded as more than 50% likely to be related to problems in care at this point it will then be investigated under the SI process.

7.8.3 Should this be the case the patient's family will be informed as soon as possible by the patient safety team. They will be given the opportunity to express any views or concerns they have of their relative's care and will be kept informed of the review.

8. REPORTING

8.1 Quality Committee

8.1.1 The AMD for Patient Safety will report to the quality committee quarterly summarising the data and emerging themes and learning.

8.2 Report to Board

8.2.1 The AMD for Patient Safety will submit a quarterly report to the Trust Board. This report will include:
The number of deaths in the trust per month.
The number of cases undergoing review.
The number of cases deemed to be more than 50% likely to have been preventable.
The number of deaths of patients with learning difficulties.
The number of patients with severe mental health problems.

8.3 Annual Quality Accounts

8.3.1 The contents of the quarterly board reports will be summarised into the annual quality accounts.

9. DISSEMINATION OF LEARNING

9.1 A summary of the site MRG meetings are prepared as a PowerPoint presentation and sent to each mortality lead so that all the learning at both sites from all specialties is disseminated across the trust. This presentation should be part of the regular presentation at each specialty's M&M meeting. Learning from mortality cases that involve patient safety will also be shared vie processes into *Policy for the management of Incidents including the management of Serious Incidents.*

9.2 The AMD for Patient Safety maintains relationships with other organisations within the local health economy and shares learning with them.

10. RAISING AWARENESS/IMPLEMENTATION/TRAINING

10.1 The tool has been designed so that those who have some experience of case note review do not need specific training.

10.2 The Mortality and Morbidity Lead Nurse also assists with training of Consultants on SJR.

11. MONITORING COMPLIANCE OF POLICY & PROCEDURE

Compliance will be monitored by the mortality teams on both sites. The reviews will be expected to be returned to the team within 12 weeks of the patient's death.
The specialty attendance and presentation at MRG will also be recorded and monitored.
In some cases, such as complex case, case raised after a patient safety concern/complaint, the Speciality Lead may be requested to review at the next available M&M meeting

12. REFERENCES

National Quality Board. (2017). *National Guidance on Learning from Deaths 1st ed.*

Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. BMJ 2015;351:h3239. DOI: 10.1136/bmj.h3239

Appendix 1 – Medical Examiner Screening prompts triggering a deeper review.

a) **Did the Bereaved family and/or carers, or staff raise a significant concern about the quality of care provision?**

b) **Did the patient have learning disability?;**

c) **Did the patient have a severe mental illness?;**

d) **Did the patient have elective surgery during the admission?;**

e) **Was anaesthesia/sedation administered in the 48 hours prior to death?;**

f) **Is there any suspicion of clinical management error including significant delays in treatments and investigations?**

g) **Did the patient suffer from the following condition or was submitted ro the following procedure … (can be changed depending on the alerts from patient safety, national audits, NHS, etc.)**

h) **Was an inquest opened?**

National Mortality Case Record Review Programme

Royal College of Physicians

Using the Structured Judgement Review method Data collection form

Improvement Academy
Part of the Yorkshire & Humber AHSN

Datix®
Software for patient safety

HQIP
Healthcare Quality Improvement Partnership

National Mortality Case Record Review Programme: structured case note review data collection

Please enter the following.

Age at death (years):

Gender: M/F

First 3/4 digits of the patient's postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:

Jan/Feb/Mar Apr/May/June Jul/Aug/Sept Oct/Nov/Dec

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death if known:

Guidance for reviewers

1 Did the patient have a learning disability?

☐ No indication of a learning disability.

Action: proceed with this review.

☐ Yes – clear or possible indications from the case records of a learning disability.

Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Learning Disability Mortality Review Programme.

2 Did the patient have a serious mental health issue?

☐ No indication of a severe mental health issue.

Action: proceed with this review.

☐ Yes – clear or possible indications from the case records of a severe mental health issue.

Action: after your review, please refer the case to the hospital's clinical governance group.

3 Is the patient under 18 years old?

☐ No, the patient is 18 years or older.

Action: proceed with this review.

☐ Yes – the patient is under 18 years old.

Action: after your review, please refer the case to the hospital's clinical governance group for linkage with the Child Death Review Programme.

Structured case note review data collection

Phase of care: **Admission and initial management (approximately the first 24 hours)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **Ongoing care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **Care during a procedure (excluding IV cannulation)**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **Perioperative care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **End-of-life care**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Phase of care: **Overall assessment**

Please record your explicit judgements about the quality of care the patient received overall and whether it was in accordance with current good practice (for example, your professional standards). If there is any other information that you think is important or relevant that you wish to comment on then please do so.

Please rate the care received by the patient during this overall phase.

1 = very poor care **2 = poor care** **3 = adequate care** **4 = good care** **5 = excellent care**

Please circle only one score.

Please rate the quality of the patient record.

1 = very poor **2 = poor** **3 = adequate** **4 = good** **5 = excellent**

Please circle only one score.

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. Please indicate whether it led to any harm and in which phase(s) of care the problem was identified. 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** ☐ **No** ☐

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

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐ Ongoing care ☐

   Care during procedure ☐ Perioperative care ☐

   End-of-life care ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)* **Yes** ☐ **No** ☐

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

   In which phase(s) did the problem occur?

   Admission and initial assessment ☐ Ongoing care ☐

   Care during procedure ☐ Perioperative care ☐

   End-of-life care ☐

3. Problem related to treatment and management plan *(including prevention of pressure ulcers, falls, VTE)* **Yes** ☐ **No** ☐

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

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

4. Problem with infection management Yes ☐ **No** ☐

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

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care

5. Problem related to operation / invasive procedure *(other than infection control)* **Yes** ☐ **No** ☐

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

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

6. Problem in clinical monitoring *(including failure to plan, to undertake, or to recognise and respond to changes)* **Yes** ☐ **No** ☐

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

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

7. Problem in resuscitation following a cardiac or respiratory arrest *(including cardiopulmonary resuscitation (CPR))* **Yes** ☐ **No** ☐

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

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐

8. Problem of any other type not fitting the categories above *(including communication and organisational issues)* **Yes** ☐ **No** ☐

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

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care ☐

Care during procedure ☐ Perioperative care ☐

End-of-life care ☐