Surrey & Sussex Healthcare NHS Trust

Learning from Deaths (Mortality Review) Policy

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Contents **Page**

Appendices:

Equality statement

This document demonstrates commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners**.** The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief**,** and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals and communities. This document is available in different languages and formats upon request to the Trust Procedural Documents Coordinator and the Equality and Diversity Lead.

1. Introduction

Reducing preventable deaths is an important safety goal for any Trust. Research suggests that only 10% of errors are ever reported through voluntary incident reporting systems and of these, 90 to 95% cause no harm to patients. Other, complimentary means of detecting and understanding error are therefore needed to quantify the degree and severity of harm, and to act as a basis for selecting and testing changes. A robust mortality review programme provides a structured approach to data capture, investigation and analysis to accurately identify opportunities for improvement.

2. Purpose

This document sets out the Trust approach to mortality review and establishes minimum standards to which all Departments must adhere to ensure that the Trust is effectively learning from any and all deaths where appropriate. It describes a consistent approach to the review and classification of all deaths and aims to reduce avoidable mortality by ensuring that all deaths are systematically reviewed, and the recommendations arising are considered regularly for implementation.

3. Definitions

Mortality Review is a routine, structured approach for the open examination and review of cases which have led to death of a patient in order to collectively learn from events and to improve patient management and quality of care.

4. Duties

Trust Board

The Trust Board has responsibility for the oversight of mortality monitoring and learning from deaths and must take appropriate steps to gain assurance that the Trust has robust systems and processes in place to review and learn from deaths.

Safety and Quality Committee

On behalf of the Trust Board the Safety and Quality Committee (SQC) have responsibility to ensure that the Trust systems and processes for monitoring mortality as well as learning from deaths are systematic and effective. The SQC provides information and assurance to the Trust Board

Executive Committee - Quality and Risk

The Executive Committee Quality and Risk (ECQR) have responsibility for ensuring that mortality and learning from deaths is reported, to ensure that the relevant teams have sufficient support and resources to deliver requirements and to provide assurance and appropriate challenge.

Effectiveness Committee

The Effectiveness Committee have responsibility to ensure there is appropriate discussion and where necessary challenge with regards to learning from deaths, mortality governance and monitoring. Effectiveness Committee has responsibility for the Learning from Deaths

(Mortality Review) Policy and associated documentation. The Trust Effectiveness Committee receives reports from the Trust Mortality Group.

Mortality Group

The Trust Mortality Group defines standards for mortality review and monitors the implementation of these standards on a Trust wide basis. It receives reports from all Divisional Mortality meetings to enable aggregate analysis of the information arising. The Mortality Group advises on quality improvement priorities.

The Mortality Group receives regular information on clinical outcomes and mortality rates (provided by Dr. Foster Intelligence) and commissions clinical reviews as required to ensure a timely and robust response to alerts, and to provide a basis for wider improvement efforts.

Divisional Management Board

Divisional Management Boards are responsible for ensuring that arrangements are in place within their area of responsibility to facilitate multi-professional mortality review in line with the requirements of this policy.

The recommendations arising from mortality review will be performance managed through the relevant Divisional Management Board monthly governance meeting.

Nominated Non- Executive Director

The nominated Non-Executive Director is responsible for ensuring oversight of progress in relation to learning from deaths.

Chief Executive

The Trust Chief Executive has overall responsibility to ensure that the Trust has effective systems and processes for learning from deaths in place to provide assurance to the Trust Board.

Medical Director (Chair of Mortality Group)

The Medical Director is responsible for ensuring that this policy is implemented consistently across the Clinical Divisions and Specialties. He/ she provides professional leadership on a Trust wide basis to ensure that all deaths are systematically reviewed and that any lessons learned are reliably translated into practice. He/ she is supported in this by the Chiefs of Division.

Chiefs of Division and Divisional Mortality Reps are responsible for ensuring that all Departments within their area of responsibility comply with this policy.

Clinical Governance Compliance Manager is responsible for ensuring that this policy is reviewed on an annual basis and that appropriate audit is in place to review compliance with the policy. The post holder is also responsible for the notification of external partners for any learning disability deaths.

Clinical Leads/ matrons are responsible for ensuring that arrangements are in place within their area of responsibility to facilitate multi-professional mortality review. They are accountable to the Chief of Division for ensuring that all deaths are subject to preliminary review and those requiring more detailed clinical review are referred to the local mortality meeting for further analysis and discussion.

All clinical staff are responsible for maintaining and improving their performance through participation in regular and systematic audit and systems of quality assurance and quality improvement participation in mortality review is mandatory.

5. Guidelines for Mortality Review

5.1 Objectives of Mortality meetings

The primary goal of Mortality Review is quality improvement based on structured analysis of clinical practice and systems in selected cases.

Effective Mortality meetings should be **multi-professional** and should:

- Identify key events resulting in adverse patient outcomes
- Foster open and honest discussion of those events
- Identify and disseminate information and insights about patient care that are drawn from individual and collective experience
- Foster collaboration with community partners on end of life care (place of death)
- Reinforce system level, and individual accountability, for providing high quality care
- Create a forum which supports open and honest discussion through the provision of a just, patient centred culture
- Contribute to clinical governance processes by making recommendations for improving processes of care and overseeing the progress of related actions

The purpose of Mortality Review is **NOT** to assess an individual clinician's performance but to provide an opportunity for system level improvement. Mortality Reviews may provide information to support a greater understanding of clinical practice at the individual clinician or clinical team level. This can only be achieved however, when Mortality Reviews are conducted in a consistent, reproducible fashion within a 'just' culture which supports excellence through open discussion of key patient care issues.

Clinical performance issues related to an individual clinician will normally be identified through other mechanisms and are managed through relevant Trust policies.

5.2 Mortality Review

5.2.1 Stage 1 Assessment and Referral: Preliminary Review of All Deaths

- All In-patient deaths are reviewed using a standardised 2 stage process. Initial assessment should take place within 24 hours of death to support death certification and coding requirements. For deaths which occur at weekends, preliminary review will take place on the following Monday morning
- All deaths must be discussed with a senior team member before completion of the Medical Certificate of the Cause of Death (MCCD) to determine
    - If the patient's death should be referred to the Coroner

- What should be written on the MCCD
- The category of death see below

- When completing the death certification, if the junior doctor is not available this must be escalated to the senior responsible doctor

- Each death should be assigned to one of the following 4 categories:

1. Anticipated Death:
   - due to terminal illness (anticipated by clinicians and family)
   - following cardiac or respiratory arrest before arriving at the hospital
2. Not unexpected death which occurred despite appropriate medical management
3. Unexpected death which was not reasonably preventable with medical intervention
4. Unexpected death requiring detailed clinical review

- All Category 3 and 4 deaths should be referred to the relevant Speciality M&M for Detailed Clinical Review. Additionally, any death meeting the criteria for a Serious Incident should be reported in line with the Incident Reporting, Management and Investigation Policy. Deaths in categories 1 or 2 may be referred for Detailed Clinical Review at the discretion of the reviewer. This may be for educational purposes and/ or sharing of good practice. All deaths referred to the Coroner for whatever reason should be discussed

- All Category 3 and 4 deaths should be logged on the Datix system as an incident to ensure appropriate reporting and learning

- The responsibility for the assessment lies with Consultant who had primary responsibility for the care of the patient. A member of the team will complete the Preliminary Review Template after discussion with the relevant Consultant

- A summary of the results of Preliminary Review for all patients will be discussed at the next Mortality meeting along with all Category 4 deaths which will be presented for Detailed Clinical review

- All patients who die must have a categorisation. The completeness of categorisation will be monitored on a quarterly basis via the Mortality Group and an exception report on all un-categorised deaths must be presented by the relevant Division.

5.2.2 Stage 2 Analysis: Detailed Clinical Review

- Clinical teams have discretion to analyse any death which falls within the Departments duty of care

- All deaths referred as Category 3 or 4 deaths must be analysed consistent with the Detailed Clinical Review template at Appendix 2

- Deaths of Patients who die after an elective or scheduled admission

- Deaths of people identified as having a Learning Disability

- Deaths within 30 days of Chemotherapy

- Progress against actions agreed following Detailed Clinical Review must be tracked at subsequent M&M meetings to ensure implementation and improvement

- Detailed Clinical Reviews should take place within 3 months of death where possible

5.3 Mortality Meeting Case selection

Case selection may be based on a number of approaches including, but not limited, to:

- All deaths assigned to category 3 or 4 at Preliminary Review stage as above (mandatory) including any death associated with significant In-hospital morbidity
- Other selected deaths assigned to categories 1 or 2 at the discretion of the Reviewer and/ or Clinical team
- Cases referred by other M&M meetings or the Risk Management/ Patient Safety team (complaints/ claims/ incidents)
- Identification of a diagnostic, disease, patient, or procedure group for further analysis based on team experience or other sources of data e.g. Dr. Foster Intelligence
- Patient who has been identified as having a learning disability must be subject to a review and discussed at the relevant Mortality meeting.
- Patients who have died during an elective care episode
- Deaths which have been referred to the Coroner
- Deaths where concerns have been identified through safeguarding, complaints or serious incident reporting

Case selection should be tailored to suit the relevant Department and should reflect a considered approach to learning from unit level morbidity and mortality. The Trust recognises that approaches to case selection may vary and encourages local ownership of the agenda. All deaths assigned to Category 4 at the Preliminary Review stage however, must be subject to Detailed Clinical Review as above.

All meetings should be multidisciplinary and should include all clinicians, (and others where relevant) who are involved in the care of that group of patients. All levels of staff involved in the care of these patients – both junior and senior – should be involved. Staff from other Departments / specialities should be invited where relevant to the particular case

- M&Ms should be chaired by a senior doctor who takes responsibility for the process and in doing so, has an ability to engage with clinical colleagues and to facilitate change at the patient care level. This may be the Clinical Lead or delegate.
- M&Ms to be regularly scheduled to maximise participation
- M&Ms to take account of guidance on Key Elements of Effective M&M Meetings set out in 5.4
- M&Ms to take place no less than quarterly in all Departments

The Trust Mortality Group to oversee the conduct of these meeting

5.4 Guidelines for the Conduct of Mortality meetings

Key Elements of Effective M&M
Opening: reminder of systems based approach and confidentiality
Review of progress from prior conferences
Case presentation
Brief literature review as relevant to the case
Identification of key issues associated with any undesired outcome
Identification of recommendations / actions to address the key issues
Evaluation of M&M

Appendix 3 contains the post Mortality meeting reporting template, required to be completed by each speciality and which will form the basis of reporting to Divisional Board and the Trust Mortality Group.

6. Learning Disability

The term Learning Disability (LD) is used to describe a person who has developmental delay or intellectual disabilities which are usually evident from birth or early childhood.

There are three core criteria, which must be used for the term learning disability to apply:

- Significant impairment of intellectual function
- Significant impairment of adaptive and or social function (ability to cope on a day to day basis with the demands of his/her environment and the expectations of age and culture)
- Age of onset before adulthood

Learning disability does not include:

- The development of intellectual, social or adaptive impairments after the age of 18
- Brain injury acquired after the age of 18
- Complex medical conditions that affect intellectual and social/adaptive functioning: eg dementias, Huntington's chorea
- Specific learning difficulties, e.g. dyslexia, literacy or numeracy problems, or delayed speech and language development

People with learning disabilities may present as having:

- Difficulties communicating and expressing choices and needs including pain management
- Difficulty understanding their diagnosis, treatment options or services available to them

- Difficulty understanding the consequences their decisions can have on their health status
- Difficulties in adapting to a hospital environment and the expectations of hospital staff

6.1 Identifying patients with Learning Disability

The Trust is supported by Learning Disability Liaison Nurses who have identified people from within the Surrey and Sussex catchment areas who have a learning disability as per the above definition.

The Trust electronic patient record has an identifier which is present on the patient 'powerchart' and as such is easily identifiable. (Example in Appendix 4)

Not all patients with a learning disability may have the identification flag on their electronic record it is therefore important to also examine the patient notes and talk with family and/ or carers. These methods may also support the identification of person with a learning disability. Any patient who has died and has been identified as having a learning disability but does not have a flag on the Trust system must be notified to the Learning Disability Nurses and reported to the Clinical Governance Compliance Manager.

6.2 Review of deaths for people identified as having a Learning Disability.

All people who die whilst an inpatient or whilst in the Emergency Department and who have the LD flag must be fully reviewed internally.

Once this review has been completed there will be an external multi agency review undertaken as part of the LeDeR requirements.

6.3 Notification of death of a person with Learning Disability.

All deaths of a person with a learning disability must be notified to the Clinical Governance Compliance Manager who will have responsibility for notifying the central LeDeR programme team.

Children under the Age of 4

All people 4 years and younger will be subject to review under the Statutory Child Death Review Process.

The LeDeR programme will continue to use the Child Death Review Process terminology of 'potentially avoidable contributory causes of death' and the Office for National Statistics definition of avoidable deaths using ICD-10 coding of the underlying cause of death

7. Duty of Candour

Mortality meetings must comply with the requirements of the Trust Being Open Policy. This policy should be referred to where a patient safety incident is identified which has resulted in moderate or severe harm, or, death.

8. Information Governance

Patient information which is the subject of Mortality Review must be managed in accordance with Trust and NHS policy. The duty of confidentiality persists after death and all usual safeguards should be applied:

- All communications (email) should be marked NHS CONFIDENTIAL – PATIENT INFORMATION
- Patient names must not be included in subject headers
- All emails must be sent securely and records saved to network drives
- All electronic data/ files must be retained securely
- Hard copy documents containing person identifiable information must be destroyed confidentially after use
- Minutes of Mortality reviews must not contain patients' names
- The external review of patients with LD deaths will be covered by an information sharing agreement

Freedom of Information Act 2000 (FOIA)

It is likely that the Trust will receive requests for information relating to the Trust's Mortality Review process. Each request will require scrutiny to ensure that any disclosures are consistent with the legislation's intent to promote a culture of openness and transparency, whilst not:

- Compromising the common law duty of confidence owed to the deceased patient;
- The Data Protection Act principles for living individuals;
- Individuals' rights to a private life under the Human Rights Act 1998.

In general it is likely to be appropriate to release aggregated, anonymised data/lessons learnt but caution must be exercised to avoid providing information from which it may be possible to derive the identify an individual.

Advice should be sought on a case by case basis from the Trust's Freedom of Information lead or Information Governance.

9. Reporting

The Trust reports Mortality data as an integral aspect of performance and quality reporting. The following will be reported via the Governance arrangements detailed in Section 4.

All elective patient deaths

Learning Disability deaths

Inquest where there are concerns and learning

Divisional Minutes should contain evidence of discussions Mortality – Monthly

Divisional Boards should receive updates every month from Speciality/Dept Mortality Meetings where meetings do not take place monthly (a report should be received within 1 month of the meeting taking place)

Detailed quarterly report will be provided to ECQR, SQC and Trust Board

The Quality account will contain a Mortality report and is published annually

Sources of internal and external data which are reviewed and reported regularly within the Trust are:

HSMR
SHMI
Crude Morality

Reports are provided for Clinical Commissioning Groups as part of the overall Quality Performance Monitoring.

10. Consultation and Communication with Stakeholders

This policy has been developed following consultation with the following groups:

- Trust Mortality group
- Clinical Leads
- Chiefs
- Matrons
- Divisional Management Teams
- Consultant body
- Information Governance Lead

11. Approval and Ratification

This subject expert group for this policy is the Mortality Group
The Ratifying Committee for this policy is the Effectiveness Committee

12. Review and Revision

This policy will be reviewed in line with the Trust Policy on Management and Development of Procedural Documents; the standard length of time for review is one year.
However, changes within the organisation affecting this process, together with any changes in legislation or the requirements of external regulators /accreditation organisations may prompt the need for revision before the 3 year natural expiry date. The Trust Mortality group and participating staff should monitor the content and working arrangements for the policy in order to assist in its revision.

13. Dissemination and Implementation

The Trust process for dissemination of policies will be followed as described in the Organisation Wide Policy for the Management and Development of Procedural Documents.

This includes:

- posting on the dedicated Policies and Procedures page of the Intranet
- notification to all staff of the new policy on the next available E-Bulletin

14. Archiving

The policy will be held in the Trust database, known as the library and archived in line with the arrangements in the Organisation wide Policy for the Management and Development of Procedural Documents.

Working copies will be available on request from the Policy Co-coordinator by contacting the dedicated mailbox trustpolicies@sash.nhs.uk

15. Monitoring Compliance

The implementation of this policy in all relevant specialties/ departments is monitored by the respective Divisional Management Board and the Trust Mortality Group.

Divisional Management Boards will monitor the implementation of recommendations arising from Mortality at least quarterly at their governance meetings.

The Mortality Group will receive a report on the proceedings of local Mortality meetings monthly for the purposes of identifying emerging and/ or common themes. They will produce an aggregate analysis of all deaths quarterly and will report to the Effectiveness Committee on any themes arising and action taken.

Peer audit of the categorisation of death at preliminary review stage will be conducted at least annually under the direction of the Mortality Group to validate the reliability of death categorisation. Results will be shared with all specialties / departments for the purposes of shared learning and improvement.

The policy will be kept under constant review in light of emerging national and local requirements and will be officially reviewed within 1 year of approval and ratification.

16. References

- Morbidity and Mortality reviews; A comprehensive review of the literature, University of NSW 2009
- Learning from Death: A Guide to In- Hospital Mortality Review and Patient Safety, Alfred Health July 2010
- Partnering for Performance Toolkit: Understanding Clinical Practice Toolkit 2010
- Western Australia Review of Mortality policy and Guidelines for Reviewing Inpatient Deaths 2008
- Transforming the Morbidity and Mortality Conference into an Instrument for System-wide Improvement, Deis JN, Keegan M D, Smith M, Warren MD, Throop PG, Hickson GB, Joers BJ, Deshpande JK 2009
- The Clinicians toolkit for Improving Patient Care, NSW Health 2001
- Good Medical Practice: GMC 2006
- LeDeR guidance 2017

Associated documents

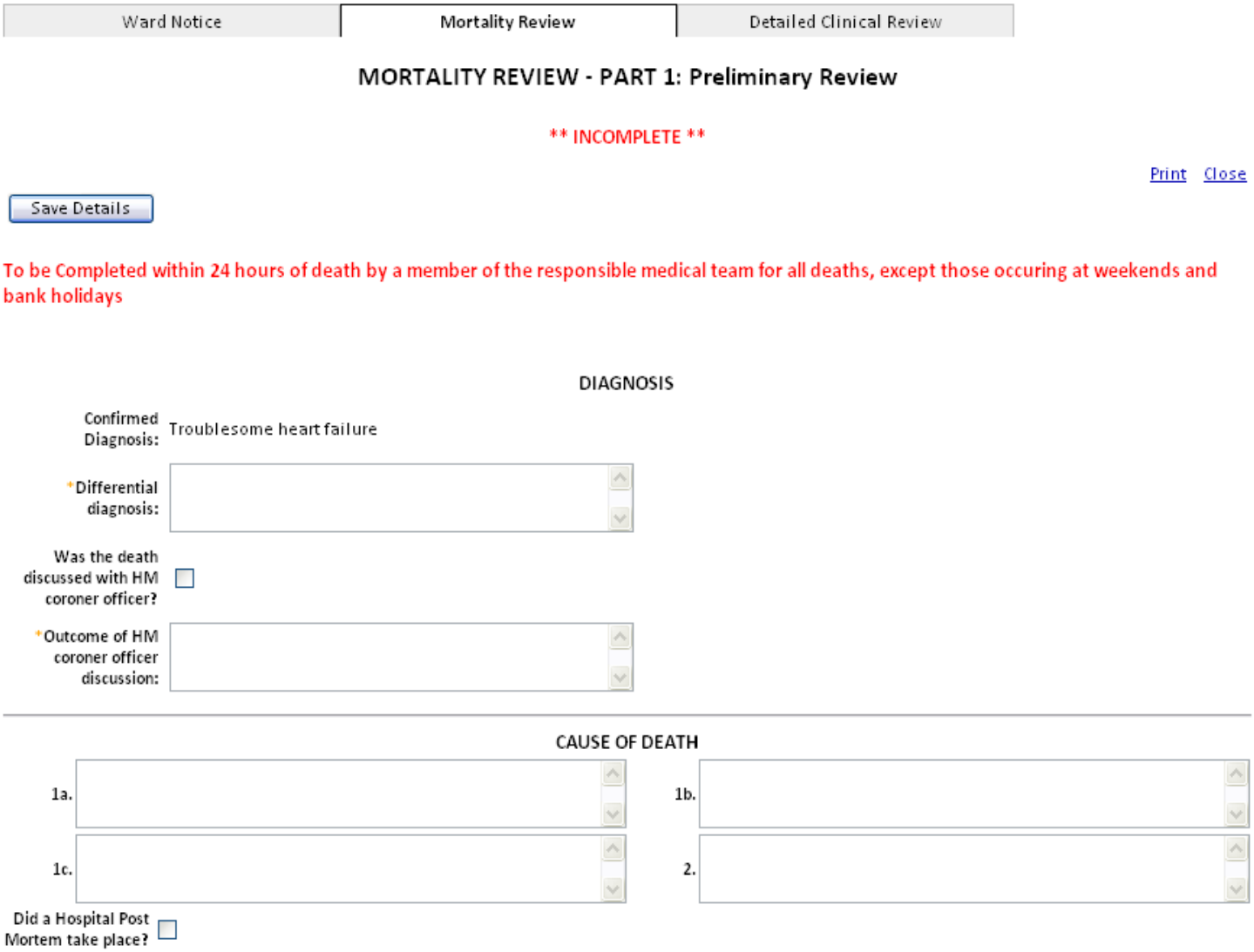
Incident Reporting, Management and Investigation Policy
Learning Disability Policy
Adult and Children Safeguarding

APPENDIX 1: Mortality Review Templates

1. Ward Notice of Death Form (To be completed by Doctor issuing Medical Certificate of Cause of Death in the Bereavement office)

<table>
<tr><td colspan="2">Ward Notification of death
to be completed on WARD by nurse or ward clerk
WARD:
CONSULTANT:</td></tr>
<tr><td>PATIENTS SURNAME: (in block capitals)</td><td>WAS THE PATIENT ON THE LCP? YES/NO</td></tr>
<tr><td>FIRST NAMES:</td><td>DATE OF BIRTH:
/ /</td></tr>
<tr><td><u>FULL ADDRESS OF PATIENT:</u></td><td>NAME AND FULL ADDRESS OF GP
Dr</td></tr>
<tr><td>DATE OF ADMISSION
/ /</td><td>DATE OF DEATH / /
TIME OF DEATH: : HOURS</td></tr>
<tr><td>NAME OF DOCTOR WHO CERTIFIED DEATH:</td><td>NAME OF REGISTERED NURSE WHO NURSED PATIENT:</td></tr>
<tr><td colspan="2">Please confirm the following questions with the doctor verifying the patients death:
1) Is the verifying doctor able to complete the Medical Certificate of Cause of Death (MCCD)?
Yes □ if Yes, please insert bleep number (not on-call bleep) : Bleep …….
No □ if No, please give the name and bleep number of the appropriate doctor
Dr …….. Usual Bleep……
*NB
If the doctor who verified the death is the ONLY doctor who saw the patient during this admission and before death they will have legal responsibility to complete the MCCD/refer to the Coroner’s office as appropriate, please bleep them to inform them of the death (doctor informed □)</td></tr>
<tr><td colspan="2">ENTER NAME OF RELATIVE OR NEXT OF KIN INFORMED:
(Please also state their relationship to deceased eg Wife/Son)</td></tr>
<tr><td>Were there persons present at the moment of death ? Yes / No
If so, whom</td><td>Were they spoken to?
If so, by whom</td></tr>
<tr><td>Ward notification completed by: (Sign and print)</td><td>Bereavement countersignature (on receipt)</td></tr>
</table>

2. **Mortality Review Part 1: Preliminary Review Template** (To be completed by the team with primary responsibility for the patient under the direction of the responsible Consultant)



	CATEGORISATION OF DEATH	CATEGORY	REFER FOR DETAILED CLINICAL REVIEW
1.	Anticipated Death a.) due to terminal illness (anticipated by clinicans and family) b.) following cardiac or respiratory arrest before arrival at the hospital	☐	☐
2.	Not Unexpected Death which occured despite service taking preventive measures	☐	☐
3.	Unexpected Death which was not reasonably preventable with medical intervention	☐	☐
4.	Unexpected Death requiring detailed clinical review	☐	☐

*All Category 4 deaths should be referred to the relevant Specialty MMR for Detailed Clinical Review (See PART 2). Additionally, any death meeting the criteria for a Serious incident should be reported in line with the Incident Reporting Policy. Any death in categories 1 to 3 may be referred for Detailed Clinical Review, at the descretion of the reviewer. This may be for educational purposes and, or, to share good practice.

Clinical Summary

Exhaustion

END OF LIFE CONSIDERATIONS: for Deaths in Categories 1 or 2 ONLY
(i.e. Anticipated / NOT Unexpected Deaths)

	END OF LIFE CONSIDERATIONS	YES / NO	COMMENT
1.	Were the patients priorities for end of life care known (e.g. place of care/death)?	☐	
1b.	If yes were they adhered to?	☐	
1c.	If no, were there opportunities for advance care planning?	☐	
2.	Was the patient's terminal care supported by the integrated care pathway for the dying patient (LCP)?	☐	
2b.	If not, should it have been?	☐	
3.	Was the patient seen by a member of the pallative care team?	☐	
3b.	Were all end of life questions addressed?	☐	

Save Details

3. **Mortality Review Part 2: Detailed Clinical Review Template** (To be completed at Specialty/ Department M&M meeting)

MORTALITY REVIEW - PART 2: Detailed Clinical Review

** INCOMPLETE **

Print Close

Save Details

To be Completed for category 4 deaths and other deaths referred by the reviewer in categories 1-3

I. Brief description of case

II. Identify any problem(s) in the pathway of care

Reference should be made to relevant national and local guidelines and standards to assist in the identification of any deviations from the desired standard of care.

	PROMPT	YES / NO	COMMENTS (yes answers must be supported by comments)
1.	Was there a delay in diagnosis/assessment (nursing and/or medical aspects of care)?	☐	
2.	Was there a delay in initiating treatment?	☐	
3.	Was there incorrect information provided or misinterpretation of information?	☐	
4.	Did the care management deviate from the policy or Clinical Practice Guideline?	☐	
5.	Was there a complication due to treatment/procedure/operation?	☐	
6.	Was there a medication error which may have contributed to the outcome?	☐	

7.	Was there a lack of availability or misuse of equipment?	☐	
8.	Was the deterioration in the patient recognised and responded to in a timely manner (nursing and/or medical escalation and response?	☐	
9.	Was the skill-mix available appropriate?	☐	
10.	Was assistance available when required?	☐	
11.	Other problem in process of care	☐	
12.	Was an adverse event* identified and, if so, was it documented in the notes?	☐	

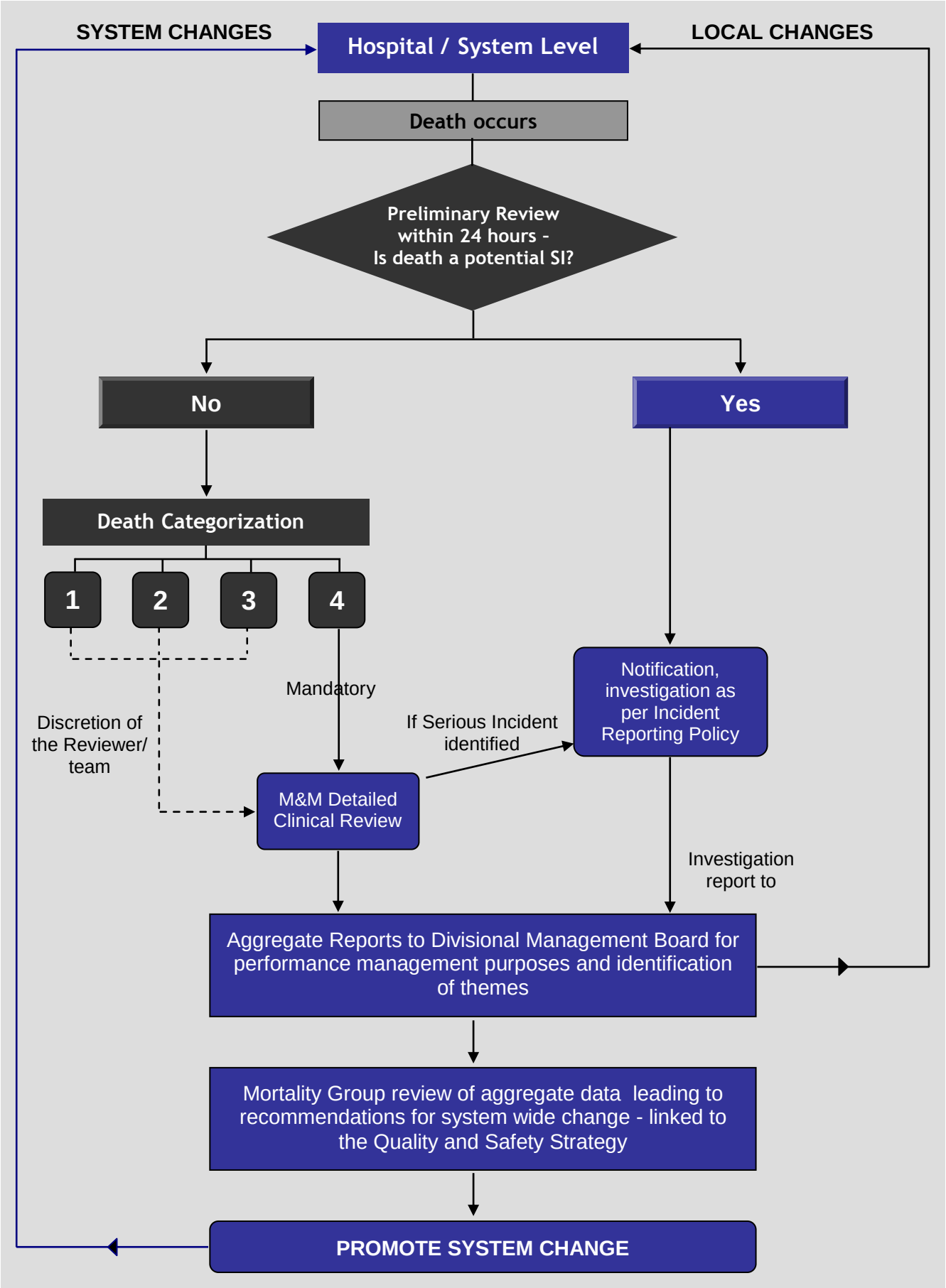
*An adverse event is defined as an incident in which harm resulted, or could have resulted, to a person receiving healthcare. This is caused by healthcare rather than the patient's disease/ condition.

III. Recommendations to address review findings

CLINICAL CARE ISSUE IDENTIFIED	RECOMMENDATION	PERSON(S) RESPONSIBLE

Save Details

Appendix 2: Mortality Review Algorithm



Appendix 3 – Mortality Meeting Reporting Template

Specialty Mortality Review Report

To be completed by specialty leads for Mortality after M+M meeting

Division	**Specialty**	
Month of meeting	**Review period**	**Month of next meeting**
Reviewer		
Staff present at meeting:		
Apologies:		

Number of deaths within specialty		
Deaths of people with Learning Disability	Number:	Category (1-4):
Category 1		
Category 2		
Category 3		
Category 4		
Number of detailed clinical reviews performed		

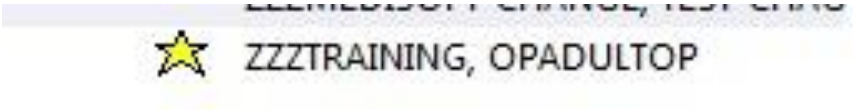
Cases reviewed in detail:

Initials	***Date of death***	***Category:***
Brief summary		
Initials	***Date of death***	***Category:***
Learning points		
Initials	***Date of death***	***Category:***

Brief summary		
Learning points		
Initials	***Date of death***	***Category:***
Brief summary		
Initials		***Category***
Brief summary		

Appendix 4: Identifying LD patients:

PowerChart patient List:



Patient Record in PowerChart- click on the Flag/Alert Hyperlink

Box open to show the problems