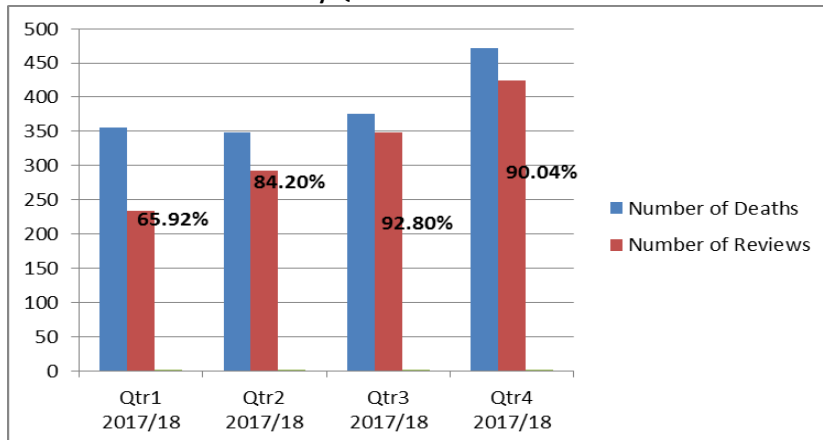


# Reporting Learning from Deaths to Board

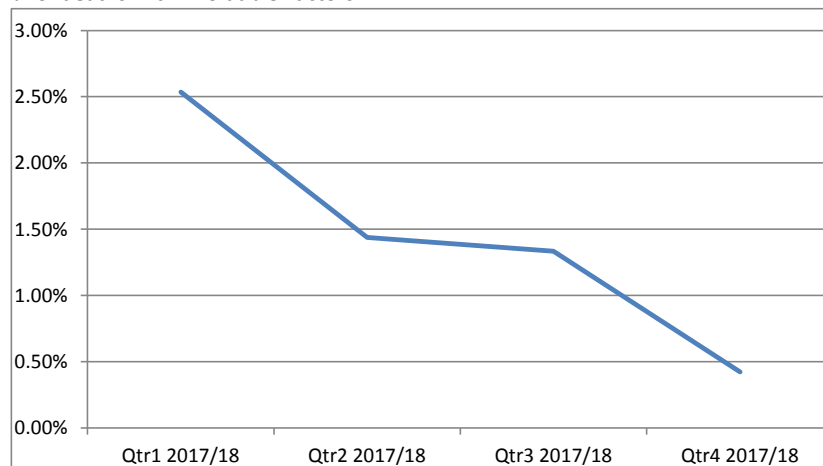
## Learning from Deaths Dashboard summary 2017/18

Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Qtr 1	355	234	65.92%	9
Qtr 2	348	293	84.20%	5
Qtr 3	375	348	92.80%	5
Jan-18	184	166	90.22%	0
Feb-18	135	127	94.07%	1
Mar-18	153	132	86.27%	1
Qtr 4	472	425	90.04%	2
Year 17/18	1550	1300	83.87%	21

## Number of Deaths & Reviews by Quarter



## % of deaths with Avoidable Factors



## Deaths in groups under special focus Qtr4

Group	Total
Learning Disability / Mental Health Patients	7
Deaths accepted by the coroner	220
Coroner's Inquest	25
STEIS SI	11
Internal Investigations	20

## Key Learning/Themes identified - now incorporated into the Quality Priority Plan 2018/21

Ceilings of Care	Ceilings of Care and early discussions with the patient and family about what to expect and how best to manage the last few weeks and/or days of life – this issue will be addressed through the implementation of the ResPECT Tool.
Responding to the Deteriorating Patient	There appears to be some disparity in understanding of appropriate escalation when a patient deteriorates. This has been compounded following the implementation of NerveCentre. A review of the Observation and Escalation Policy has been undertaken and additional training put in place. Monitored through the Deteerorating Patient Group

## Summary Hospital Mortality Index (SHMI)

