

Reporting Learning from Deaths to Board

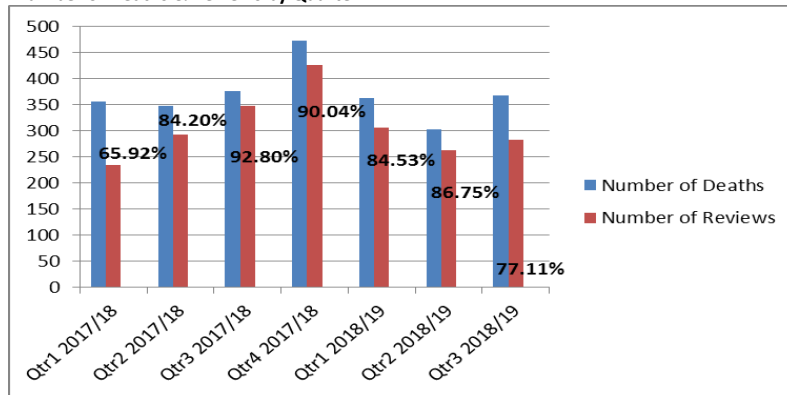
Learning from Deaths Dashboard Quarter 3 2018/19

Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Oct-18	110	92	83.64%	0
Nov-18	129	110	85.27%	0
Dec-18	128	81	63.28%	0
Qtr 1	362	306	84.53%	3
Qtr 2	302	262	86.75%	2
Qtr 3	367	283	77.11%	0
Qtr 4			#DIV/0!	
Year 18/19	1031	851	82.54%	5
<i>Year 17/18</i>	<i>1550</i>	<i>1300</i>	<i>83.87%</i>	<i>21</i>

Deaths in groups under special focus Qtr 3 2018/19

Group	Total
Learning Disability / Mental Health Patients	3
STEIS SI	2
Internal Investigations	3
Investigations opened by the Coroner	6
Investigations converted to Inquests	3
Inquests opened without prior investigation	1
Investigations closed without Inquest	8
Concluded Inquests	8

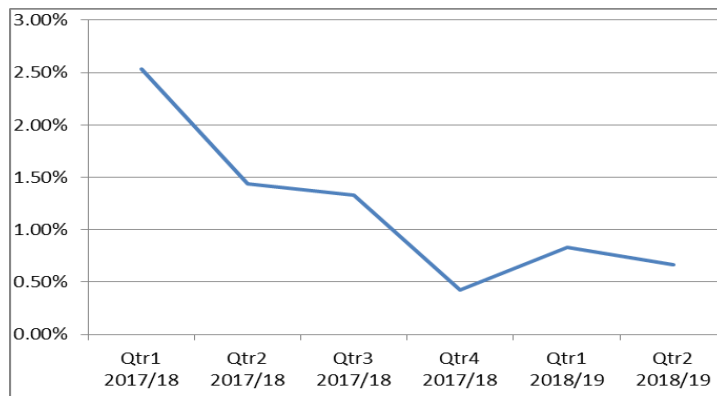
Number of Deaths & Reviews by Quarter



Key Learning/Themes identified from Inquests

- *The importance of obtaining accurate information re a patient's history quickly, specifically around previous history of falls to enable timely and appropriate falls assessments to be completed and safety measures put in place
- *The importance of making sure the "This Is Me" booklet is utilised for patients with Dementia to ensure that carers in different localities have an individualised care plan for each patient and information - like dietary requirements and aspects of advance care planning are handed over.
- *The importance of handing over relevant patient information between SFH and care teams in the community
- *The requirement to review the current drug chart to ensure safe documentation of medication thus assist staff who prescribe and administer anticoagulants. A revised prescription chart has been agreed and will be introduced from the next print run. Temporary amendments to the current drug chart have been implemented in the meantime.

% of deaths with Avoidable Factors



Summary Hospital Mortality Index (SHMI)

