

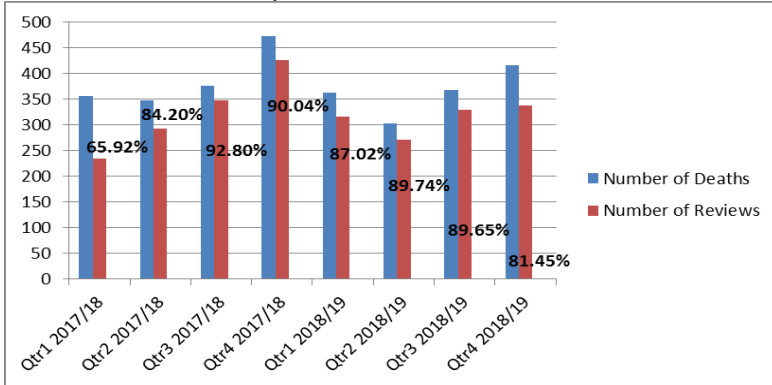
Learning from Deaths Dashboard Annual Summary 2018/19

Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Jan-19	151	135	89.40%	2
Feb-19	131	94	71.76%	1
Mar-19	133	109	81.95%	0
Qtr 1	362	315	87.02%	3
Qtr 2	302	271	89.74%	2
Qtr 3	367	329	89.65%	3
Qtr 4	415	338	81.45%	3
<b>Year 18/19</b>	<b>1446</b>	<b>1253</b>	<b>86.65%</b>	<b>11</b>
<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 4 2018/19

Group	Total
Learning Disability / Mental Health Patients	12
STEIS SI	12
Internal Investigations	24
Investigations opened by the Coroner	19
Investigations converted to Inquests	15
Inquests opened without prior investigation	9
Investigations closed without Inquest	15
Concluded Inquests	16

Number of Deaths & Reviews by Quarter

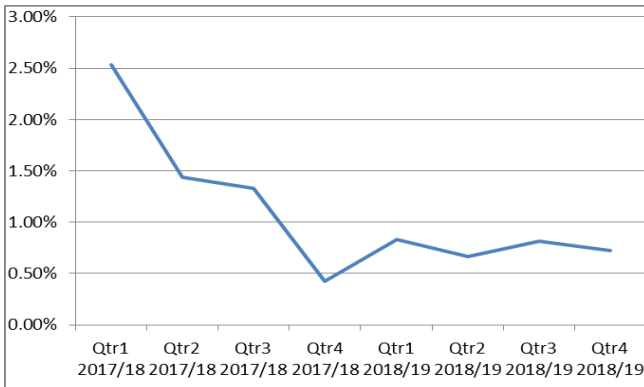


Key Learning/Themes identified

1. Ceilings of Care - the implementation of the ReSPEC Tool will support clinical staff in having early, meaningful conversations with patients, their families and carers. 2. The importance of obtaining accurate information re a patient's history quickly to support effective decision-making. 3. The importance of ensuring the 'This is Me' booklet is utilised for patients with Dementia to ensure carers in different localities have the appropriate information to support the individualised care plan - i.e dietary requirements. 4. 'The importance of handing over relevant patient information between SFHFT and care teams in the community. 5. The requirement to review the current drug chart to ensure safe documentation of medication thus assist staff who prescribe and administer anticoagulants. 6. The need to improve the awareness and prescribing of warfarin.

Summary Hospital Mortality Index (SHMI)

% of deaths with Avoidable Factors



SHMI (with adjustments) and HSMR for Oct 2017 to Sep 2018

