

MORTALITY REVIEW

For a Patient with a Learning Disability

Clinical area where death occurred	
Date of death	
Cause of death	<as on death certificate?>
Subject of Coroner's inquest?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incident report number (if applicable)	
Patient hospital number	
Reviewer	Liz Jennings, Learning Disabilities Liaison Nurse
Mortality Review date	
Mortality Review reference number	

Checklist

Was the patient admitted for elective surgery? Yes No

Was the patient admitted for emergency surgery? Yes No

Was the patient admitted as a medical emergency? Yes No

Was there a late diagnosis of illness Yes No

If yes, please describe

Was the learning disability flagged? Yes No

Specific Requirement Assessment Form completed? Yes No

Was the patient referred to LD Liaison Nurse? Yes No

If Yes, date of referral

Name/job title of referrer

Were the patient's family or paid carers involved? Yes No

Did the patient have the mental capacity to make decisions about serious medical treatment? Yes No

If No, what process was followed?

<Insert process followed here>

MORTALITY REVIEW

1.0 PART ONE – BACKGROUND AND CHRONOLOGY

1.1 Cause of death

<Details from death certificate>

1.2 Background and context

<A brief description of the events leading up to and surrounding the death in terms of care provided to the patient>

1.3 The review team

List of those involved in the Mortality Review:

Liz Jennings, LD Liaison Nurse Investigator, report writer

Alex Grice, Consultant Anaesthetist GTT Reviewer

Marie-Noelle Orzel, Director of Nursing

1.4. Involvement and support of patient's carers

<Describe any meetings with advocates/carers/relatives (ref: the Trust's Being Open Policy) and their involvement, if any, in the care of the patient>

1.5 Chronology of events

<If appropriate or possible, you could summarise what is on the Chronology... or else just state:> Please see Appendix 2 for a detailed chronology of events.

1.6 Notable practice

- <List any points in the incident or investigation process where care and/or practice had an important positive impact and may provide valuable learning opportunities, e.g. exemplar practice, involvement of the patient, staff openness, etc.>

1.7 Care and service delivery issues relating to care of a patient with learning disabilities

<A list of key problem points, variations from acceptable practice, something happened that shouldn't have – or should have and didn't>

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2.0 PART TWO – MORTALITY REVIEW WITH GLOBAL TRIGGER TOOL (GTT)

2.1 Results of GTT casenote review <to be completed by GTT review team>

Was this an expected or planned death? Yes No

<Triggers and adverse events?>

2.2 Analysis of results <to be completed by GTT review team>

<Narrative summary>

3.0 PART THREE – RECOMMENDATIONS, ACTION PLAN AND LEARNING

3.1 Recommendations

Should this case proceed to a full RCA investigation? Yes No

Recommended by:

- <List other recommendations>

3.2 Action Plan

Details may be found in the Action Plan at Appendix 2.

3.3 Arrangements for shared learning

<who will be informed of the outcome and how>

- The report will be presented to the <name of group or committee, e.g. Lead Nurses, Senior Matrons meeting, etc>
- The report will be presented to the Adverse Events Forum which will ensure dissemination of relevant learning Trust-wide via the adverse event newsletter, Intranet and other appropriate patient safety communication tools
- The report will be presented to the <name?> Divisional Governance Group which will monitor the Action Plan

APPENDIX 1

ACTION PLAN: MR00?-09

Item	CDP/SDP	Action Required	Lead Responsibility	Delivery Date	Update on action
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

APPENDIX 2

CHRONOLOGY: MR00?-09

Date	Time	Events/Interventions	Observations/comments