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What can you learn as a foundation doctor from analysing deaths in hospital?

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ABSTRACT

Deaths in hospital represent a vital learning opportunity for both individual clinicians and the wider healthcare system. Many deaths are reviewed and discussed in morbidity and mortality meetings, with the Royal College of Physicians promoting Structured Judgement Review (SJR) methodology to support this discussion. An analysis of 1 year of SJRs in one hospital was undertaken, generating a toolkit to support junior doctors in evaluating in-hospital deaths. Here, the opportunities and limitations of this analysis are discussed, with consideration of ways to improve the uptake of SJR across the hospital team. These reviews exemplify one way of maximising learning from in-hospital deaths.

KEYWORDS: quality improvement, structured judgement reviews, mortality, foundation

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Introduction

Verifying death is a core part of most foundation doctors' daily workload. It can be forgotten that each in-hospital death is reviewed carefully, with discussion in departmental morbidity and mortality meetings. Traditionally, deaths in hospital have been used as an opportunity to identify avoidable harms and ensure appropriate care has been provided, usually by senior medical staff.[1] They can also be used to identify areas for improvement within a department or service.

Deaths in hospital also represent a useful learning opportunity for the foundation doctors involved in caring for these patients, but these opportunities are frequently missed as a result of clinical pressures, or a sense that clinical governance is an issue 'for senior clinicians only'. In some departments, junior staff will prepare case-notes reviews for presentation and, in doing, so will review care provided in the context of a patient death, but there is evidence that they are less likely to participate in discussion.[2] There are numerous methods to review an admission, with NHS Improvement advocating the use of Structured Judgement Reviews (SJRs).[3]

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What is Structured Judgement Review?

SJR is a method of retrospective analysis of the care provided to a patient, such as during a hospital stay. SJR methodology was developed by the Royal College of Physicians alongside other bodies to attempt to standardise the analysis of case notes following a death in hospital.[3,4] The methodology aims to review care in a structured way, to facilitate learning and share best practice in patient care. It also aims to identify system factors during a hospital stay that might be associated with mortality.[4]

Every review divides a hospital stay into six phases. Each phase is then reviewed separately with two aims: (1) a narrative description (including value judgements) of the care provided; and (2) scoring: from 'excellent' to 'very poor' to assess the quality of care. Each phase receives its own score.

The aim is to summarise a patient's stay in hospital up to their death, to identify any harms that have occurred, and to identify and share best practice. Four of the phases are detailed in Table 1, with the exception of perioperative and procedural care, which did not form part of this analysis.

Why is this useful?

Many departments in the selected trust (University Hospitals Sussex) complete SJRs for morbidity and mortality (M&M) meetings and sometimes when concerns have been raised about a patient's care (eg by the medical examiner team). They are predominantly completed by senior clinicians (usually, but not exclusively, consultants) to review quality of care, and to identify examples of excellent practice and opportunities for learning.

It was identified that, although junior doctors would frequently prepare and present case-notes reviews for M&M meetings, they rarely used the SJR structure. Despite this, SJR has several benefits for junior doctors as an educational activity. It can encourage an individual doctor to review their own clinical practice, to assess an entire inpatient admission holistically and to identify areas where changes could be made. The aim of this project was to generate a toolkit to support junior doctors in completing SJRs for presentation.

Making a toolkit: reviewing deaths

The palliative care team obtained 84 reviews written over 1 year, following a patient death. Most were written by consultants. With scoring removed, 'blinded' thematic analysis of these was undertaken to identify common themes. In total, 36 themes were identified, outlined in Table 1.

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Table 1. Themes of care identified for different phases of a hospital stay

Admission	Ongoing care	End-of-life care	Overall care
Diagnosis	Ongoing senior input	Dying recognised and documented	Timely, safe, high-quality care
Assessment and severity	Complications recognised and managed Monitored appropriately and acted upon	End-of-life prescribing	Appropriate place of care
Background	Plan followed/adjusted as needed	DNACPR and treatment escalation plan	Views of patient and/or family considered
Assessment of frailty	Deterioration recognised	Individualised care plan for dying patient	Involvement of parent teams, specialists, high-acuity teams (eg intensive care)
Investigations	Plan with appropriate escalation	Monitoring	Clear and senior-led decision-making processes
Escalation planning	Patient and next-of-kin involvement	Evidence of consideration of patient wishes	Out-of-hours care
Referrals, specialist input	Specialty involvement	Communication with patient and/or family	Appropriate handovers
Patient and family/next-of-kin input	Transfers of care	Involvement of palliative care team for those with complex needs	
Management plan	System issues identified		
Senior review	Medical Emergency Team call/ cardiac arrest call?		
Handover			

DNACPR = do not attempt cardiopulmonary resuscitation.

Reviews were subsequently grouped by their overall ratings, to identify best practice or elements where harm was seen to have occurred. Common themes were integrated with reviewers' ratings to illustrate perceived 'excellent' or 'very poor' care. This formed a toolkit, which could facilitate SJR completion and support scoring. Excerpts from this toolkit are outlined in Tables 2 and 3.

Table 2. Excerpts from a toolkit to support SJR completion: 'end-of-life care' phase

End of life care: dying cannot be recognised in all patients, but in those for whom it is clinically appropriate, dying should be recognised and documented. If it is clinically appropriate, a programme of end-of-life care can be started at this time. Specialist palliative care teams can be involved in end-of-life care or advanced care planning. There are clear National Institute of Health and Care Excellence (NICE) quality standards for end-of-life care that inform this guidance.

Theme	Very poor	Poor	Adequate	Good	Excellent
Dying recognised and documented	Dying not recognised, with inappropriate intervention and/or escalation leading to potential or real harm to patient, family and staff	Dying not recognised when clinically appropriate, with inappropriate intervention or escalation given clinical status. This has the potential to harm patients, family and staff	Dying recognised and documented as appropriate	Dying is recognised and documented, with appropriate interaction with patient and loved ones	Recognition of dying process is clear and clearly documented, is rational and understood by whole team This recognition is broached with patient/ family/loved ones as appropriate ACP/EOLC planning is enacted appropriately and quickly

ACP = advanced care planning; EOLC = end of life care.

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Table 3. Excerpts from a toolkit to support SJR completion: 'overall care' phase

Theme	Very poor	Poor	Adequate	Good	Excellent
Timely, safe, high-quality care	Care is not provided in timely or safe manner Care might be actively inappropriate, and might have the potential to cause harm	Care is safe, but not timely Medical or nursing practice might not meet appropriate standards Care might not be appropriately 'joined up' to facilitate good practice	Care is safe and timely Appropriate documentation	Care is safe and timely, and in line with good practice Appropriate documentation Evidence of attempts to provide holistic, patient-centred and compassionate care	Care is holistic, patient centred, in line with good medical and nursing practice and delivered within a reasonable timeframe No evidence that delays to provision of care could have caused harm to patient Care is compassionate in all respects

Limitations and reflections of this analysis

The scoring of SJRs is fundamentally subjective, as is the identification of 'high-quality' care. Despite this, practical experience has been used here to interpret scoring, and it is felt that SJRs in general have face validity and are generally replicable between reviewers.

Reviewers are drawn from a small pool in hospital, usually of consultants, and this may bias the content of SJRs. In particular, close peer review of decision making and treatment may be less objective compared with external review. For this reason, the source material for this analysis should be interpreted cautiously.

Identifying themes solely from clinician-written case-note reviews emphasises the doctor's role in care, but marginalises patient and public voice. However, medical examiners frequently request SJR completion following discussion with bereaved families and loved ones, particularly when concerns have been raised. Improvements of the toolkit might be possible by integrating clinical perceptions of care quality with medical examiner-sourced patient and family feedback to provide a more holistic assessment. This could promote reflective medical practice and ensure a feedback loop to clinical teams, although it might be more time-consuming.

Future improvements could be sought by encouraging a multidisciplinary approach to SJR, with incorporation of nursing and allied health input, along with medical examiner oversight.

Although fundamentally a specialist review, it would be useful to explore perceptions of SJRs with patients and service users, particularly focusing on the role of SJR in identifying patient safety concerns. Greater service user and patient involvement could also counterbalance some of the fundamental subjectivity of SJR methodology.

There are significant challenges to improving uptake of the toolkit by Foundation doctors. In particular, SJR methodology was utilised variably across the Trust, limiting the utility of the toolkit. SJR methodology is more time-consuming compared with traditional M&M presentations, and mortality reviews remain only one aspect of the workload of a clinician. Further work is needed to establish SJR in M&M methodology, which could be achieved by emphasising the educational benefits of SJR completion for trainees. An abridged toolkit, to more quickly direct reviewers' efforts, might also be more effective.

Lessons for junior doctors

As a foundation doctor, there is a great deal to learn from reviewing case-notes after patient deaths. Reviewing an entire admission for any reason can provide a 'bird's eye view' of the patient's journey, enabling a more holistic appraisal of their treatment and clinical trajectory. In every case, there is specific clinical learning for the reviewer on aspects of diagnosis or management, and most cases provide a stimulus for further reading or research.

Analysing deaths specifically allows learning about end-of-life care in different contexts; the analysis above has informed further local projects on deaths in the emergency department following a 'crisis' admission.

Some cases might illustrate unexpected consequences of systemic or organisational practices: one unanticipated finding of this analysis was the serious impact on care of moving patients between wards during the Coronavirus 2019 (COVID-19) pandemic. 'Bigger picture' insights such as these can be elusive to foundation doctors.

Conclusion

The toolkit outlined above is designed to facilitate SJR completion by junior doctors, by helping them to appraise and score aspects of care. Key learning points for improvement can be identified in each case, usually alongside reassurance of the quality of care provided. It is then possible to disseminate these teaching points through M&M meetings and other governance pathways. It is hoped that the toolkit produced can involve junior doctors in the learning from deaths program in hospital from the beginning of their foundation training. ■

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