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**MORTALITY SCREENING**

Prompts to consider when reflecting on the patient’s clinical care prior to death

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| As far as you are aware were there any concerns related to the following: | Examples |
| Before the patient was admitted to hospital | * Patient had a hypoglycaemic episode as a result of unopposed insulin. * Warfarin not prescribed/monitored. * AF not treated and patient died from stroke |
| Communication with the patient/family | * Were the relatives informed that the patient had a high risk of dying before the patient died? * Poor communication with the family regarding end of life care/plans for care |
| Admission & initial management (first 24hrs including ED) | * Was the patient seen by a consultant within 14 hours of admission? * Timely investigations/reporting * Clear management plan documented and discussed with patient and relative * Drugs/treatment given on time (i.e. sepsis) |
| Out of hours care and ongoing care | * Were there any issues about handover of care from one team to another? * Plan for care not followed by handover team * Plan for care not communicated to handover team * Necessary investigations/treatment not completed within expected timeframe due to time of day/day of the week |
| Seniority of decision making, are there issues? | * Was the patient seen appropriately by a senior decision maker (ST3 and above) at appropriate intervals during the patient’s stay in hospital? |
| Diagnosis (failure or misdiagnosis) | * Were there any elements of care which you feel led to a delay in diagnosis |
| Medication/fluid errors/nutrition | * Were there any errors in medication prescription/administration? * Were there any errors in fluid prescription/administration? * Was the patient fed safely? |
| Errors in clinical reasoning/issues around managing sepsis/ VTE | * Were the elements of the Sepsis 6 bundle completed appropriately? * Was the patient risk assessed for VTE and appropriate prophylaxis prescribed if appropriate? |
| Investigations (problems with interpretation/delay) | * Were planned investigations undertaken? * Were there any delays in planned investigations? * Were results feedback/interpreted promptly? |
| Delays in treatment (interventions/fluids/drugs) | * Were planned treatments undertaken? * Were there any delays in planned treatments? (delays in going to theatre?) |
| Deterioration recognised in a timely manner/escalation of care | * Did the patient trigger EWSS and was this escalated appropriately? * Was the Trust escalation protocol followed? |
| Appropriateness of resuscitation /TEP decisions? | * Did the team recognise that the patient was dying early enough for end of life care plans to be made/discussed with the patient/family? * Was a DNACPR in place and completed appropriately? * Were treatment escalation plans documented * Were treatment escalation plans discussed with the patient/family as appropriate |
| End of life care – clarification of patient treatment preferences | * Did the patient die where they had wanted to die? * Were the patient’s treatment preferences taken into consideration? * Was the Personalised Care Framework used? |