CURRENT STATE – Mortality Patient Safety Incident Reporting (OVERVIEW)

Mortality_PSIRF-MEO process v1.1 FINAL

Point A

No, SII/CR not recommended at PSS (check process here)

NO (below Moderate)

DATIX/Risk

Enquiries by MEO/ Trust Mortality Lead (TML)/Audit Facilitator with Risk Team

Does DATIX need to be raised?

YES

DATIX raised by MEO/TML/Audit Facilitator

NO

Is an SJR to be raised

YES

MEO email the request for an SJR the Audit Facilitat

SJR R

NO

YES (Risk Identified)

Is Moderate or above?

YES

DATIX reviewed at PSS

Patient Safety Summit

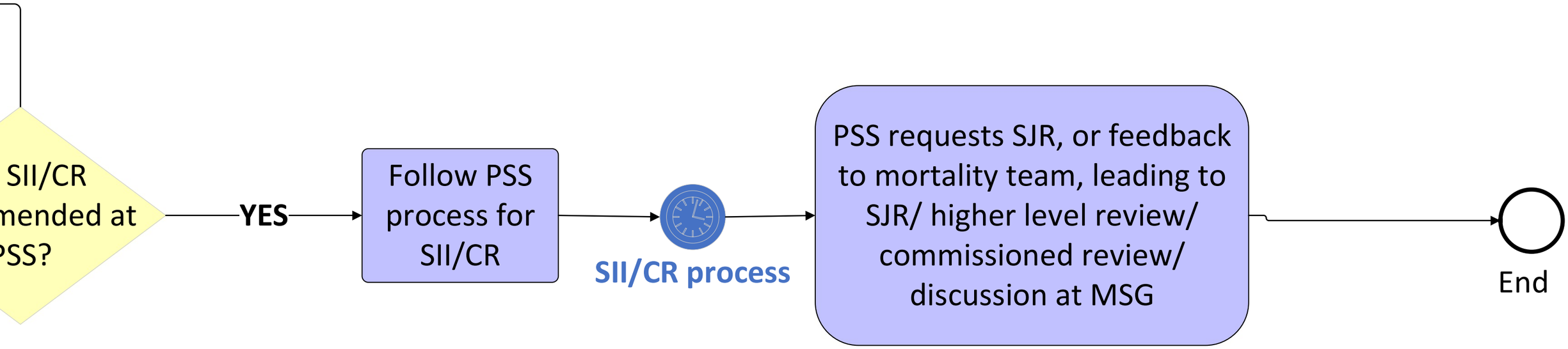
Is a SII/ recommen PSS?

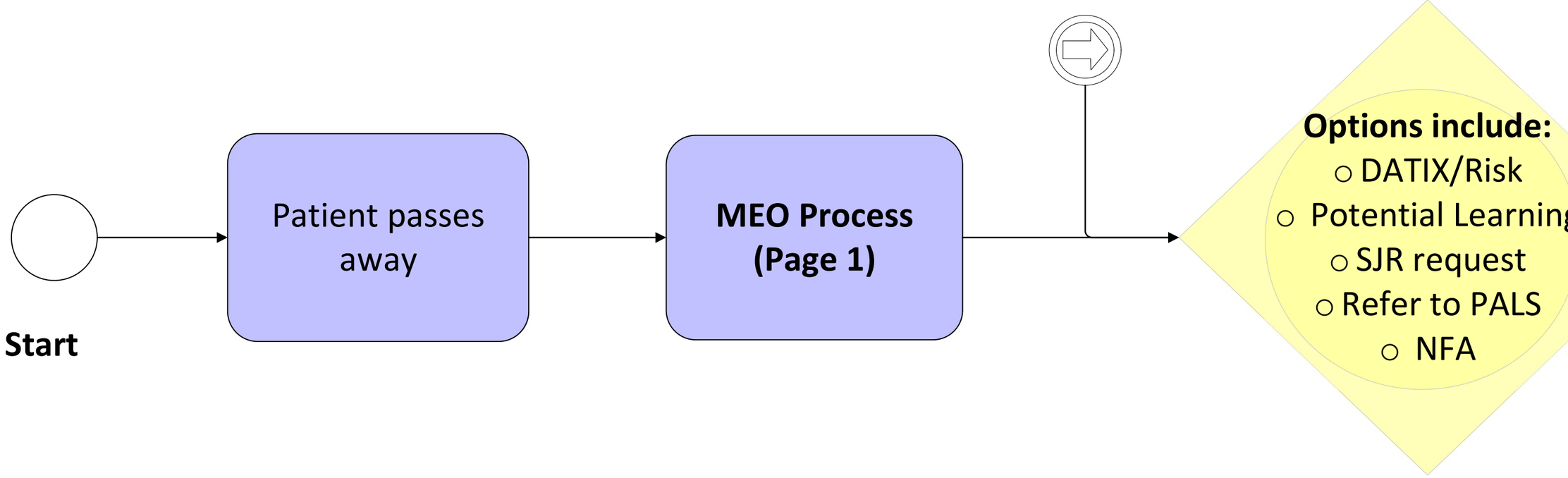
JR Request template

the SJR to itator

Go to Page 2 (SJR Allocation Process)

End


SII/CR
mended at
PSS?
YES
Follow PSS process for SII/CR
SII/CR process
PSS requests SJR, or feedback to mortality team, leading to SJR/ higher level review/ commissioned review/ discussion at MSG
End



Key to Symbols:

de:
k
rning
t
LS

Potential Learning

Potential learning/M&M: MEO to highlight via email to Audit Facilitator & TML

Further distribution/ decision on how/who to complete review

Based on fee
outcome – dep
will determin
(may require
discussions w

YES (SJR)

SJR process

SJR requested via email to Audit Facilitator

SJR Allocation Process (Page 2)

Point B

Upda
to SJ

n feedback/
departments
mine action
quire SJR) –
ns with TML

Is an SJR recommended?

NO

Is a Risk identified?

NO

End

Point C

Point D

Updates relating to to SJR Completion (Page 3)

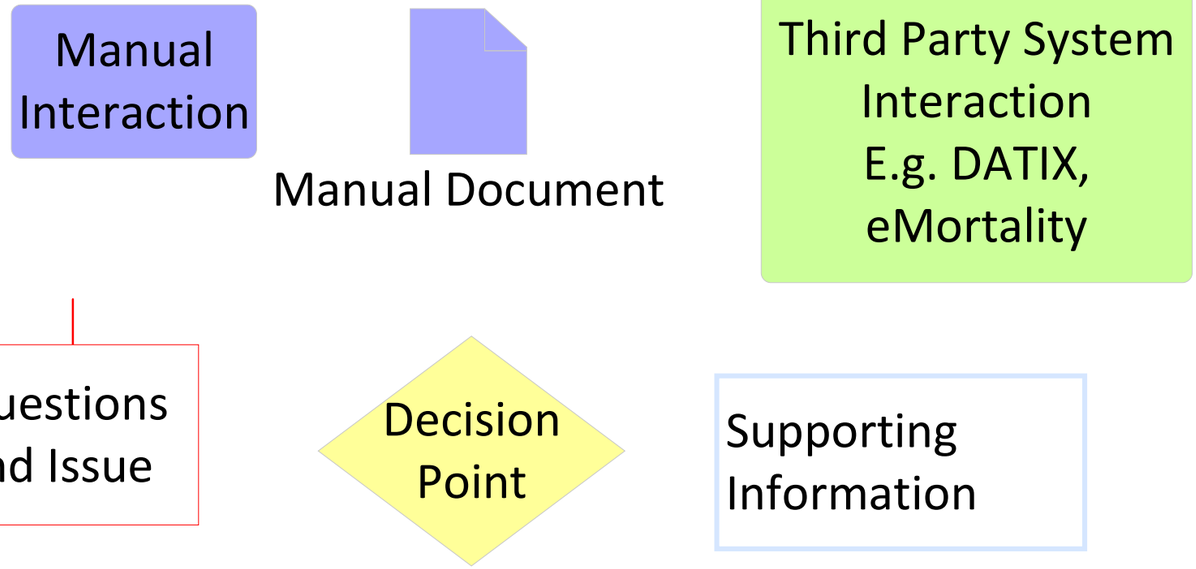
SJR Outcomes (Page 4)

Outcome depends on SJR – high level review

End

d

Key to Symbols:



SJR Request template

PALS

Refer to PALS

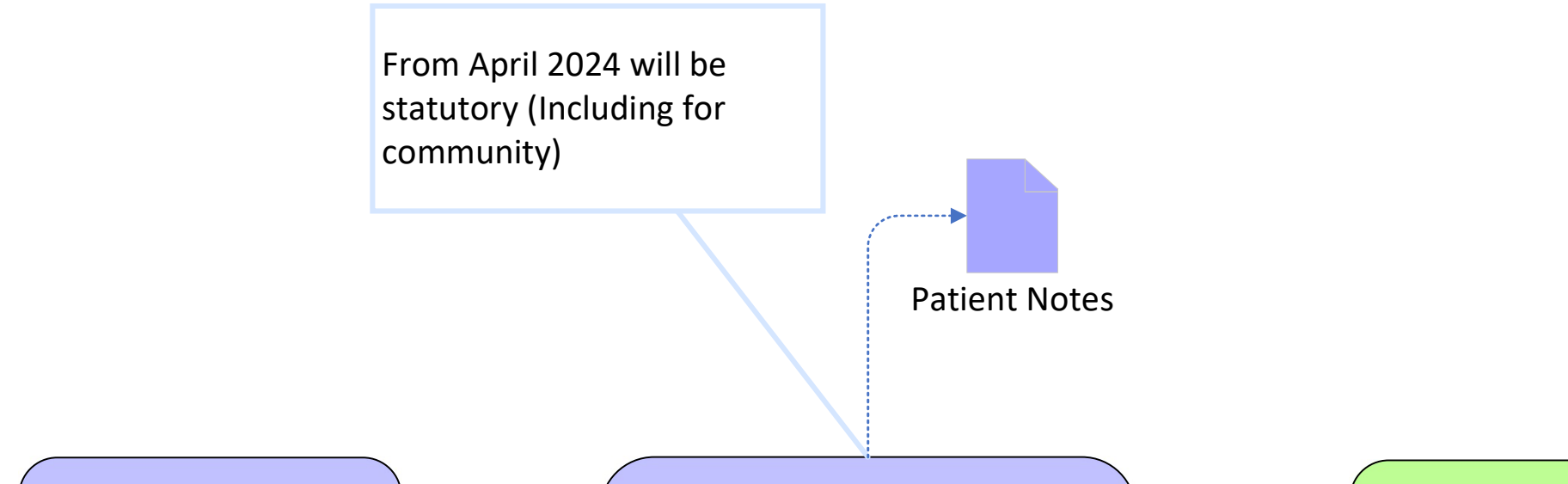
Go to PALS process map

No Further Action (NFA)

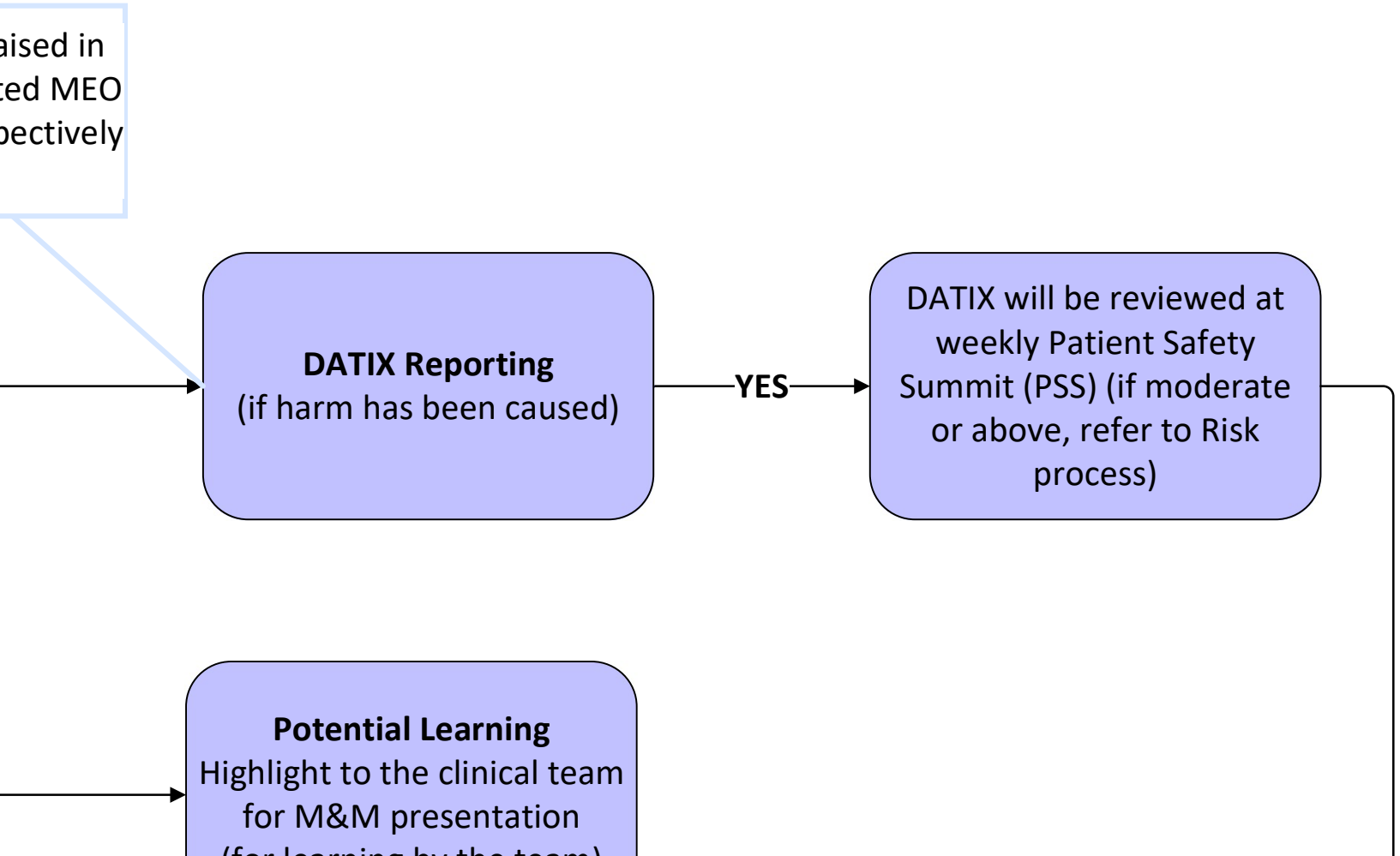
End

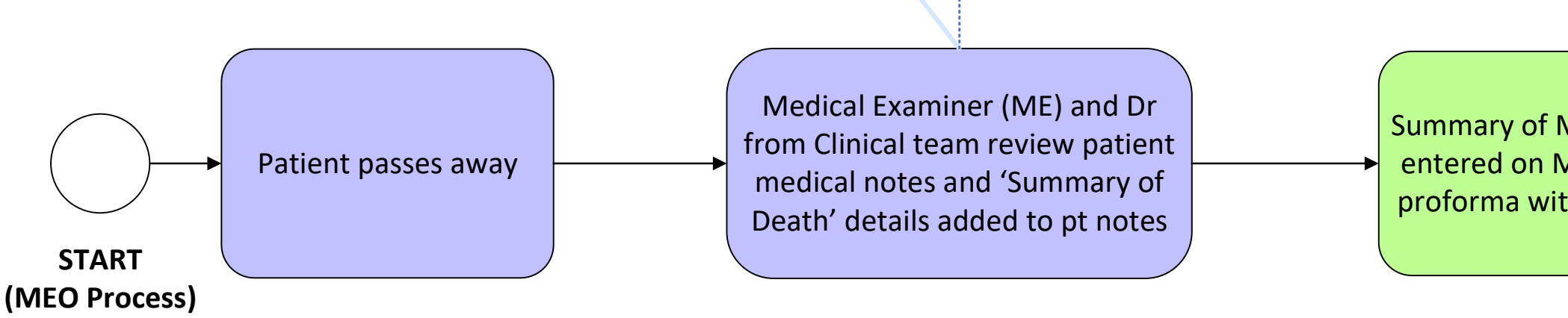
Mortality_PSIRF-MEO process v1.1 FINAL

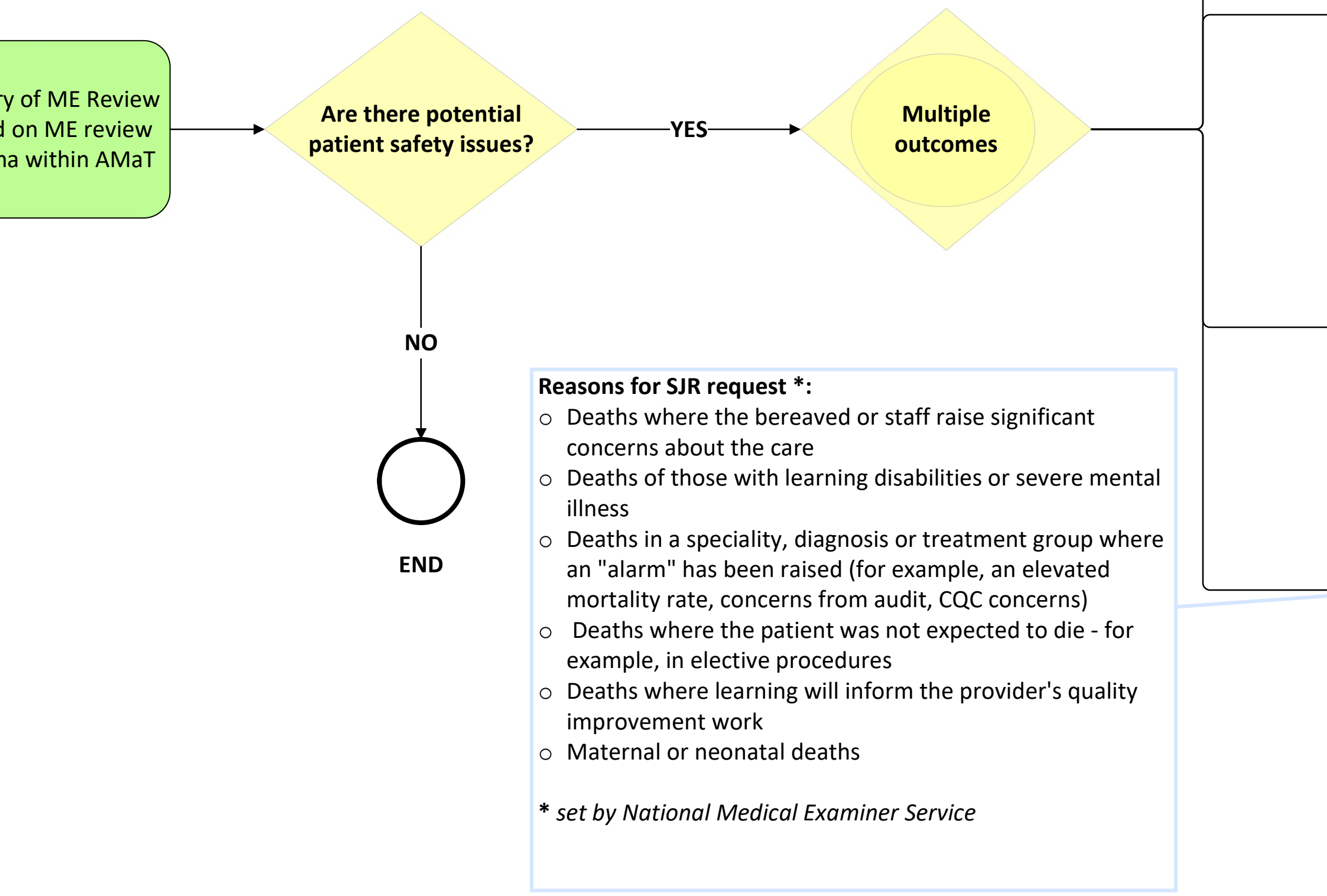
Page 1 MEO Process




MEO checks if DATIX raised i
notes, if not documented M
will raise DATIX retrospectiv
(added as Moderate)


aised in
ted MEO
pectively
DATIX Reporting
(if harm has been caused)
YES
DATIX will be reviewed at weekly Patient Safety Summit (PSS) (if moderate or above, refer to Risk process)
Potential Learning
Highlight to the clinical team for M&M presentation

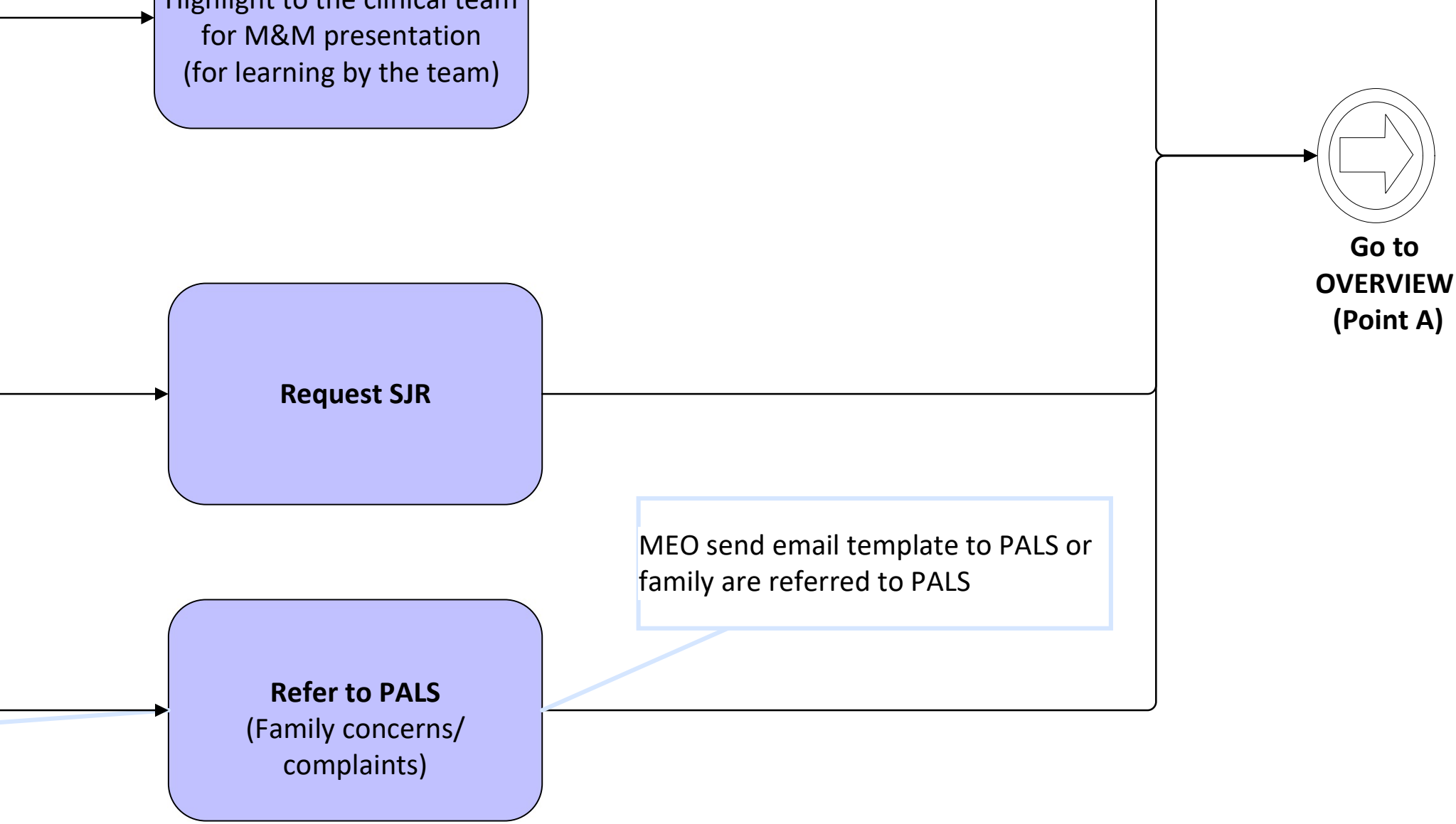

START
(MEO Process)
Patient passes away
Medical Examiner (ME) and Dr from Clinical team review patient medical notes and 'Summary of Death' details added to pt notes
Summary of M
entered on M
proforma wit



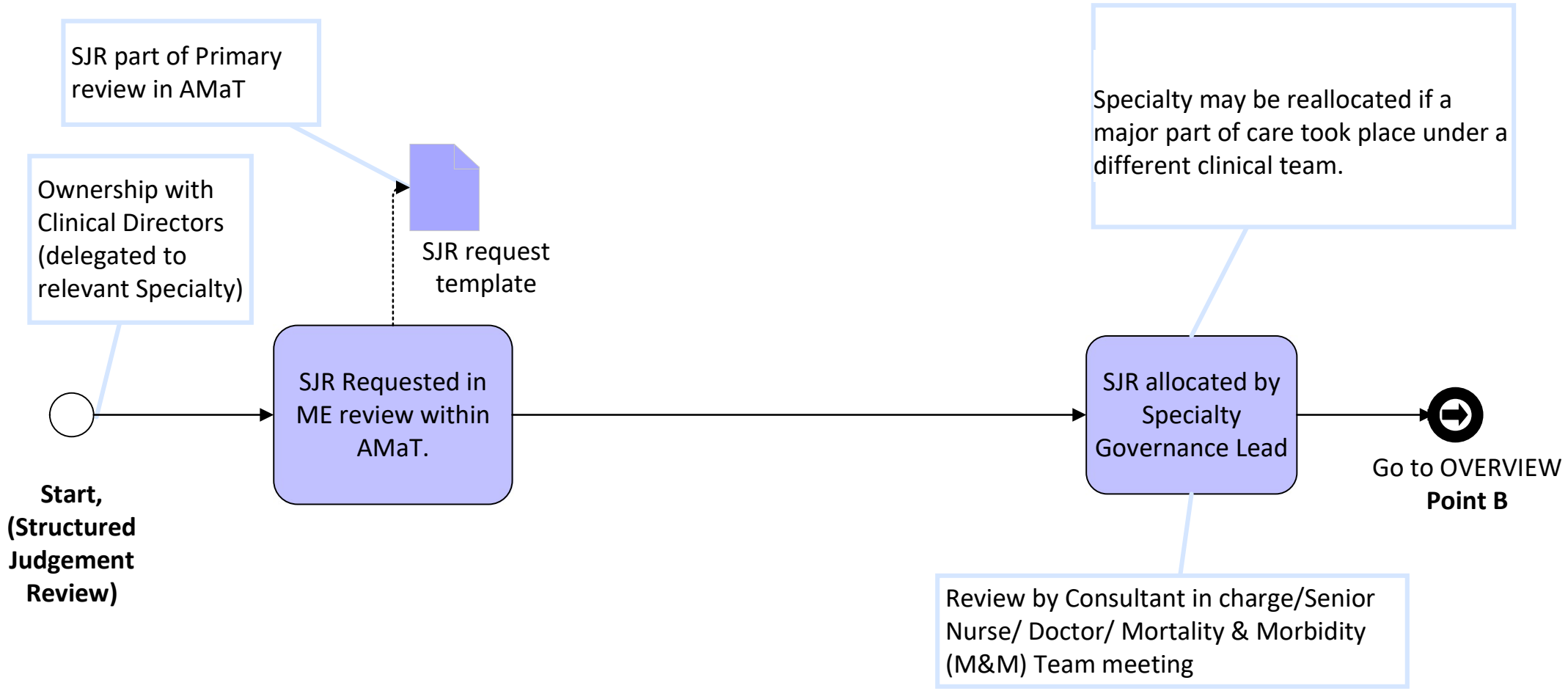
Reasons for SJR request *:

- Deaths where the bereaved or staff raise significant concerns about the care
- Deaths of those with learning disabilities or severe mental illness
- Deaths in a speciality, diagnosis or treatment group where an "alarm" has been raised (for example, an elevated mortality rate, concerns from audit, CQC concerns)
- Deaths where the patient was not expected to die - for example, in elective procedures
- Deaths where learning will inform the provider's quality improvement work
- Maternal or neonatal deaths

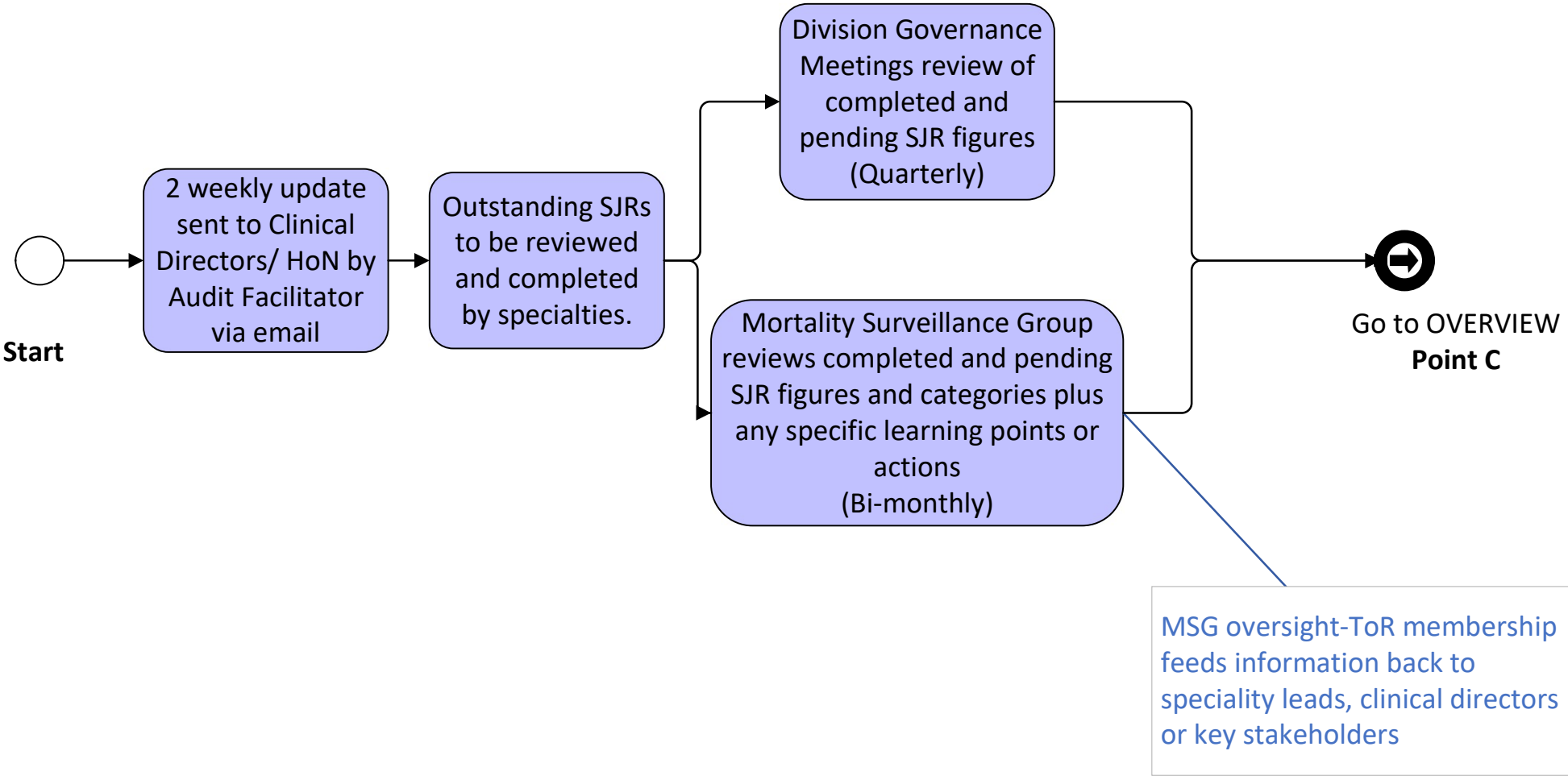
* *set by National Medical Examiner Service*


for M&M presentation
(for learning by the team)
Request SJR
MEO send email template to PALS or family are referred to PALS
Refer to PALS
(Family concerns/ complaints)
Go to OVERVIEW (Point A)

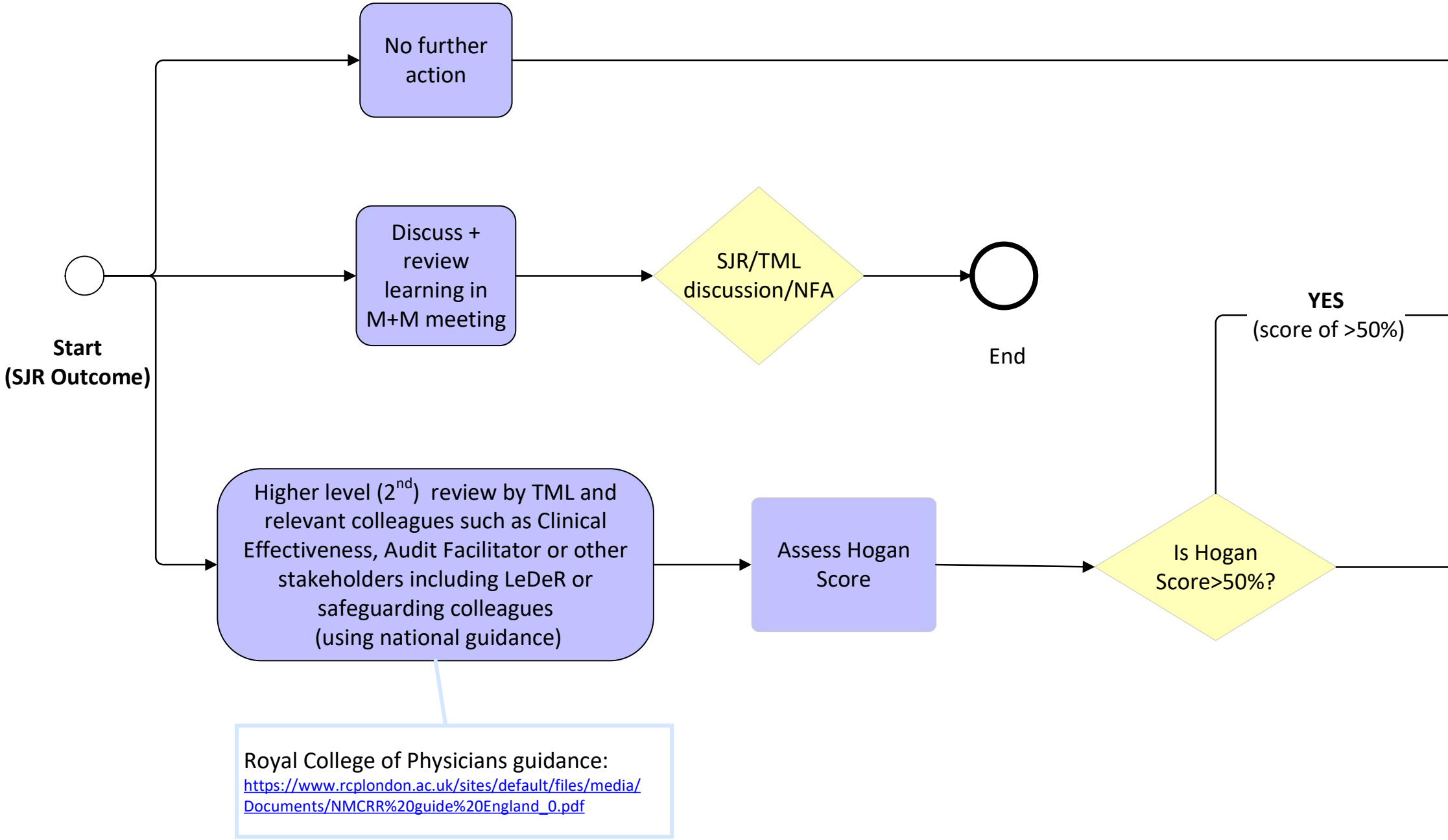
Page 2 SJR Allocation Process

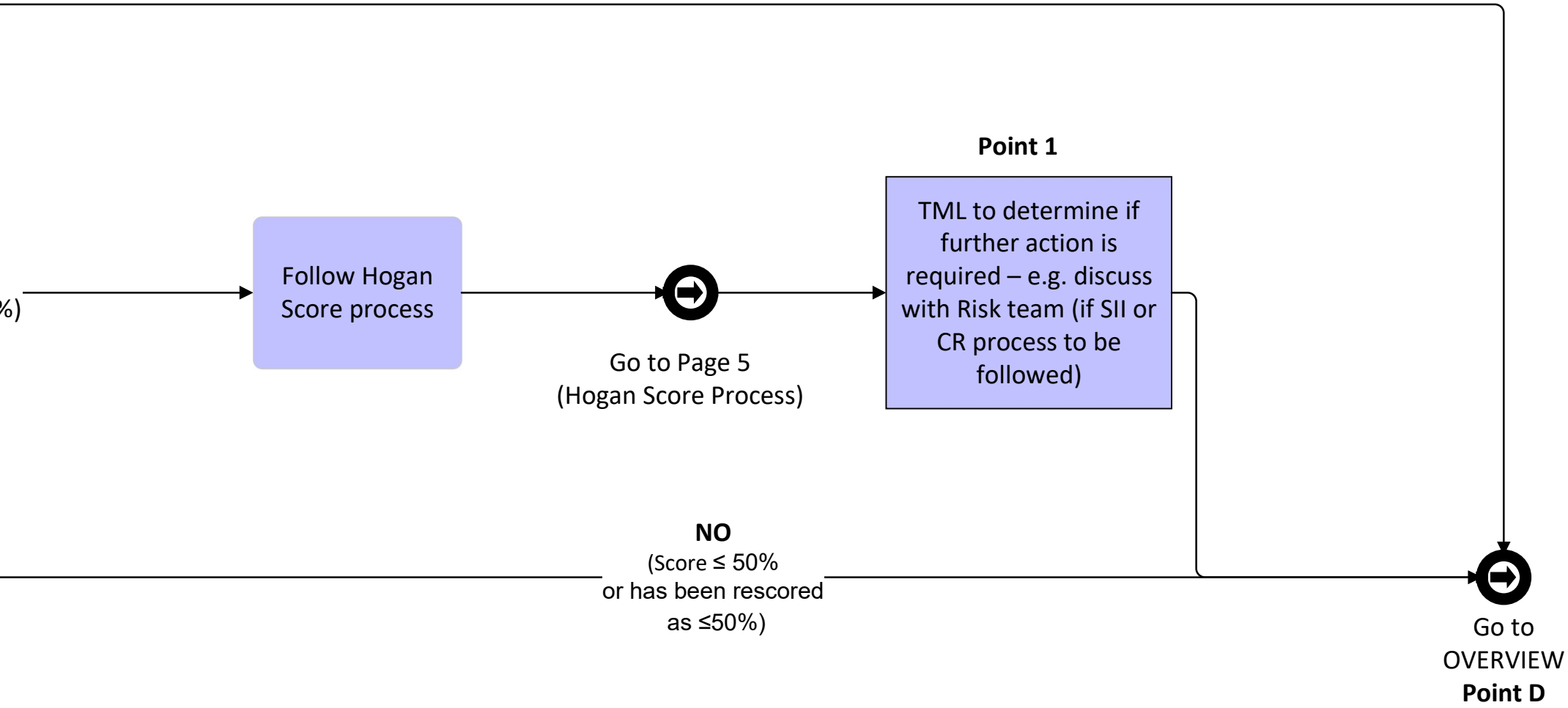


Page 3 Updates relating to SJR Completion



Page 4 SJR Outcomes




%)
Follow Hogan Score process
Go to Page 5 (Hogan Score Process)
Point 1
TML to determine if further action is required – e.g. discuss with Risk team (if SII or CR process to be followed)
NO
(Score ≤ 50% or has been rescored as ≤50%)
Go to OVERVIEW Point D

Page 5 Hogan Score Process