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NHS

STRUCTURED JUDGEMENT REVIEW WITH SJR*PLUS* IN LEARNING FROM DEATHS

DR JEAN MACLEOD, CLINICAL LEAD
TRACEY SPARKES, PROGRAMME LEAD

SJR TRAINING SESSION

Covering

Learning from deaths context and background

Learning from deaths - fire alarms and smoke detectors

Guidance and governance

Structured judgment reviews principles and practice

Being a reviewer

Using SJR*Plus* effectively

Who's in the room?

Pop your cameras on and say hello to everyone!

L&D Community of practice

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SLIDO RESULTS

What is your role?

Wordcloud Poll | 39 responses | 35 participants

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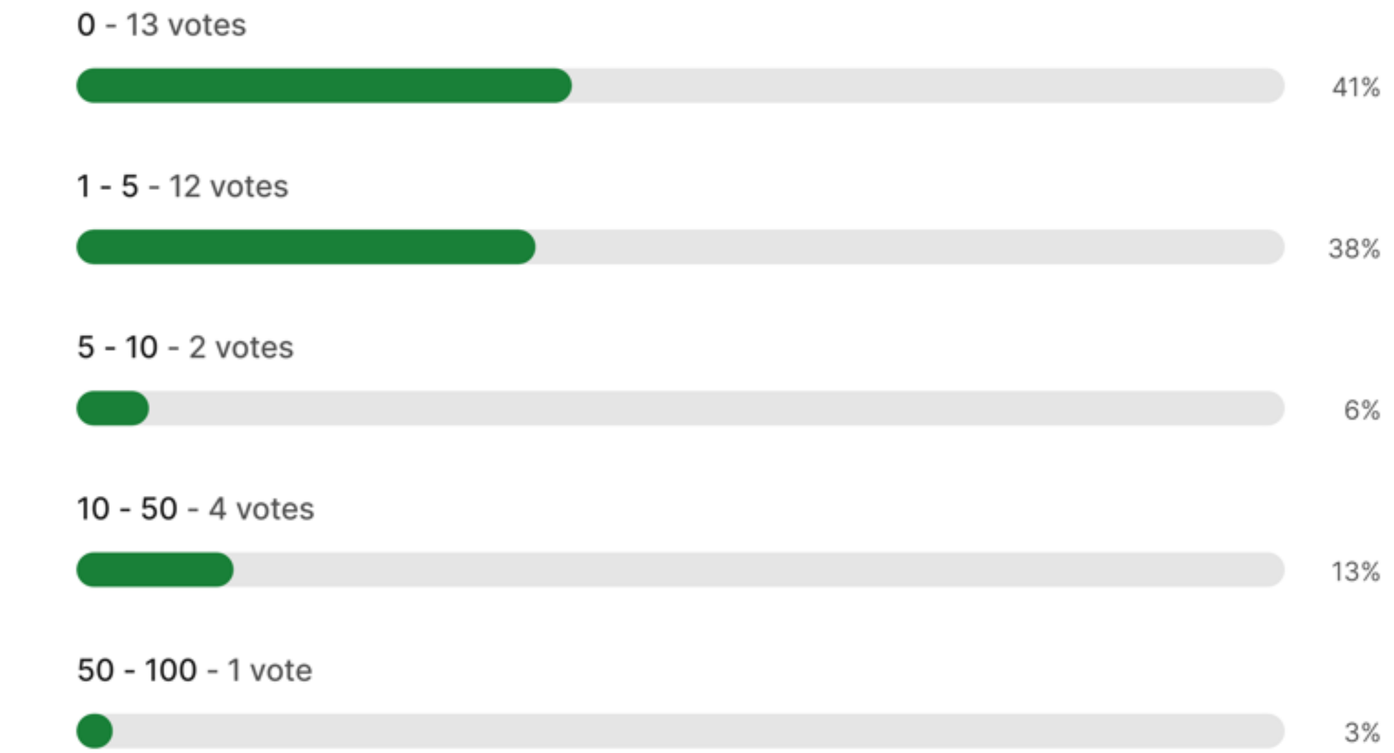
SLIDO RESULTS

How mnay SJRs have you done so far:

Multiple Choice Poll | 32 votes | 32 participants



slido

LFD - WHY BOTHER?

Reviewing care provided to people who have died can help improve care for *all* patients

- by describing excellent care as an achievable ambition
- by identifying problems associated with poor outcomes
- working to understand how and why these occur so that meaningful action can be taken
- sharing the information to develop resilient organisations with a memory

- provide balancing perspective of care

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GUIDANCE AND GOVERNANCE

…failures often have a familiar ring, displaying strong similarities to incidents which have occurred before, and in some cases, almost exactly replicating them. Many could be avoided if only the lessons of experience were properly learned.

L Donaldson 2000

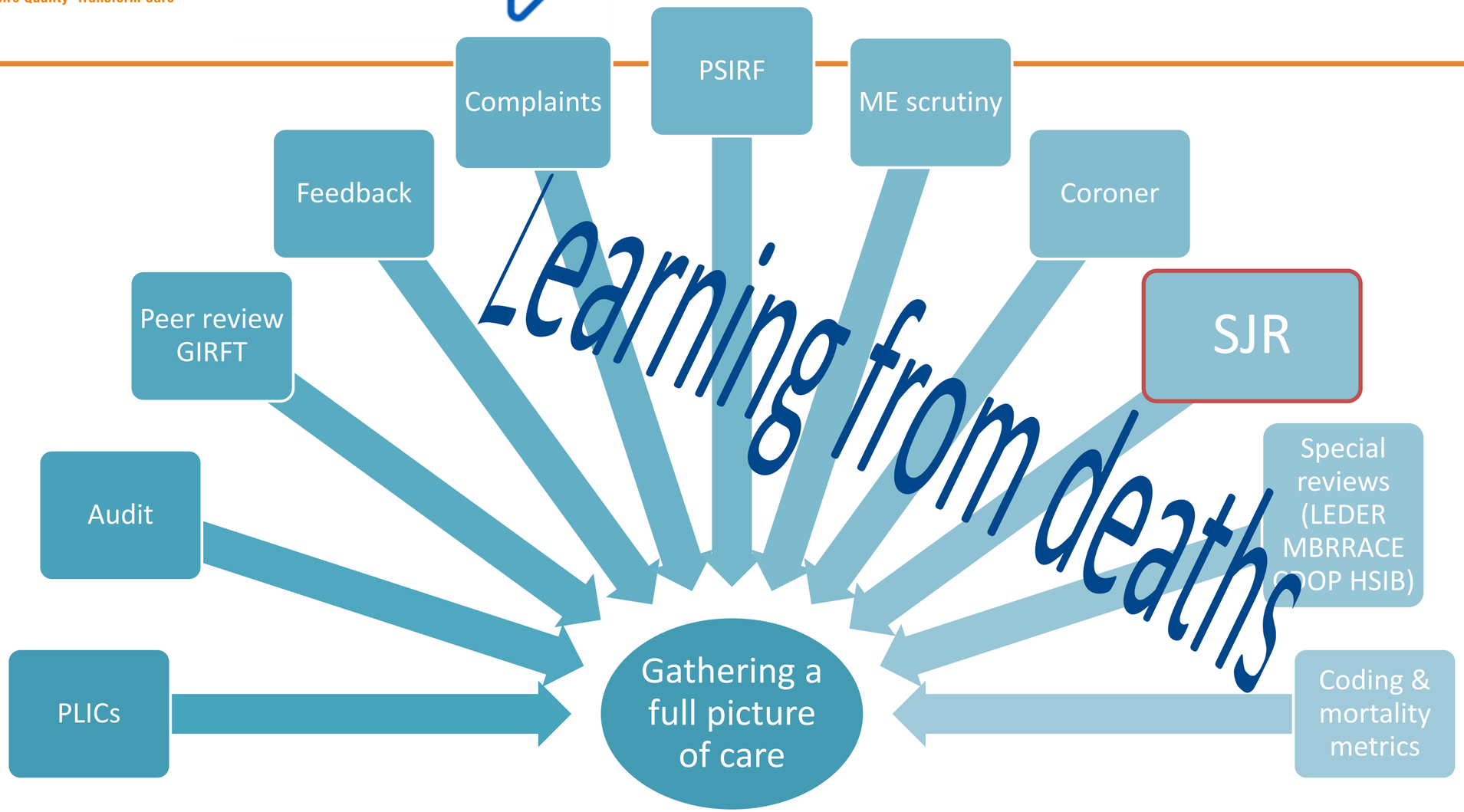
… demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

B Keogh 2013

Seek out the patient and carer voice as an essential asset

D Berwick 2013

SJR AMONG OTHER SOURCES



Thematic analysis

↓

Action, learning and improvement

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FILTERING CASES

Coroner Inquest

Collate factual statements for Coroner, document accurate chronology of events and investigate through internal process, capturing positive and negative lessons Use Duty of Candour if relevant. Ensure family &/or carers are aware of referral. Coroner will also liaise with family &/or carers for information gathering and let them know processes. Use feedback from Coroner Inquests to gather trends and inform improvement plans.

Coroner
Wants to know facts
Expects and values honesty
Appreciates improvement
Gives judgement

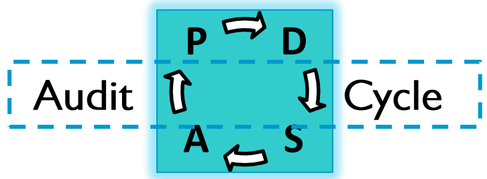
Patient Safety Incident, Complaint or Duty of Candour

Generate incident report to prompt information gathering. Collate factual information: chronology of events and circumstances; contributory factors; and any positive and negative lessons. Different learning approaches can be used depending on the information gathered.
Use Duty of Candour if it is needed. Liaise with family &/or carers to address their concerns, answering complaints directly with available information, involving clinical teams throughout investigation.

Patient Safety Incident Investigation, Multidisciplinary team (MDT) review or After Action Review
Refer to Patient Safety Incident Response Framework

Audit of care bundles or care processes

Review of care processes and care delivery against a standard operating policy or standard of practice, capturing positive and negative lessons. Use improvement methods to complete audit cycle and demonstrate progress. Involve family &/or carers in improvement planning based on audits.
Use an investigation of events and Duty of Candour if any failings influenced the outcome for an individual.



If none of above apply, then consider case for:

Structured Judgement Review

Judgement based holistic review of care with narrative, ratings and grading which captures positive and negative lessons. If SI, Near Miss or DoC identified in case review, then investigate as above.

Involve family &/or carers and system partners in discussion of trends and improvement planning.

Mixed quantitative and qualitative data

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Use Duty of Candour if it is needed. Liaise with family &/or carers to address their concerns, answering complaints directly with available information, involving clinical teams throughout investigation.

Patient Safety Incident Investigation
Multidisciplinary review of

Insight and learning comes from sharing all of these

Audit of care bundles or care processes

Review of care processes and care delivery against a standard operating policy or standard of practice, capturing positive and negative lessons. Use improvement methods to complete audit cycle and demonstrate progress. Involve family &/or carers in improvement planning based on audits.
Use an investigation of events and Duty of Candour if any failings influenced the outcome for an individual.

If none of above apply, then consider case for:

Structured Judgement Review

Include random cases and exemplars for balance.
"Capturing the everyday care"

Mixed quantitative and qualitative data

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USING THE DATA FROM STRUCTURED JUDGEMENT REVIEW (SJR)

OUTPUT FROM SJR

A rich set of information about each case

Qualitative	Quantitative
Judgments about quality of care	Demographic information, ethnicity
Free text comments	Length of stay
Good practice examples	Weekend deaths
Lessons for improvement	Ratings by phase of care
Feedback from staff and relatives	Overall rating of care
Feedback from reviewers	Clinical complexity, comorbidity
Completeness of documenting care	Cause of death
Quality of records management	Disease specific data

USING SJRPLUS DATA

Sharing the output

- Individual records shared with second reviewer or a mortality review team
- Collated records shared within a report
  - cohorts and pathways
  - common themes and findings
  - lessons for embedding good behaviours and supporting improvement plans
- Dashboard displaying information in context for wider audience
- Mapping changes over time to ensure organisational memory

The story of Mrs B....

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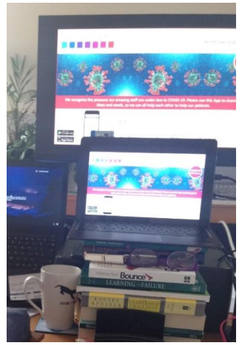
USING A STRUCTURED JUDGEMENT REVIEW (SJR) APPROACH TO REVIEWING MORTALITY

PRINCIPLES OF SJR

- Combines traditional, clinical-judgement based, review methods with a standardised format
- Usable across services, multiprofessional teams and specialties
- Relies upon trained reviewers looking at the patient record in a critical and holistic manner and commenting on specific phases of clinical care
- Requires safety and quality judgements and a score for phases of care
- Uses free text and categorical variables to capture the quality of care delivered

Everyone looks at everything



PHASES OF CARE, PLACES OF CARE

An SJR requires reviewers to make judgements on and give scores to different phases of care:

- First 24-hours
- Ongoing care
- Care during a procedure
- End-of-life care

Also consider:

- Preadmission information
- Readmissions + opportunities
- Quality of documentation
- Evidence gaps

Appreciating different care phases to improve understanding of differences in access, pathways, behaviours and experience

MAKING JUDGEMENTS

- All review methods are based on opinion - on individual clinical judgement.
- There is about a 70% agreement between clinicians from the same specialty.
- It is not unusual for some aspects of scoring on the same case to differ between two reviewers.
- Standards of care can vary in different phases of admission

Can consistency be optimised?

OPTIMISING CONSISTENCY

Ways of promoting consistency include:

Using standardised terms for the assessment of care
Using drop down menus where possible
Using locally agreed terminology – site names?

Using a co-located multidisciplinary team of reviewers so that they can discuss cases together

Reviewing output as opportunity to learn together

REVIEWER RESPONSIBILITIES

Professional standards apply

Critical friends not critics

Existing policies and procedures reviewers must be familiar with

- *Scrutiny by the Medical Examiner*
- *Complaints and PSIRF*
- *Duty of candour*
- *Safeguarding and LeDeR*
- *Local screening reflecting "smoke signals" or alerts*

Follow agreed local procedures for escalating any cases if significant harm identified

REVIEWER BENEFITS

Benefits of and for an inclusive panel

Benefit for quality of reviews

- Wealth of expertise and valuable perspectives
- Medical usually consultants and specialist registrars
- Nursing usually specialists or autonomous in role
- Allied health professionals broad range relevant to care provision
- Non-training grade doctors often long relationship with trust and patient facing
- Clinicians in training less inclined to normalise or accept

Benefits for reviewers

- Influence on personal practice: act of reviewing changes the reviewer
- Transferrable skills and potential career path: skilled reviewer, trainer, LfD lead, QI, Patient Safety and Human Factors, Patient Safety Specialist, MEO, ME……..

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DATA ENTRY ON SJRPLUS

What does a "good" SJR include?

What should I write?

I'm not sure how to grade this...

Mortality Review (Arden & GEM CSU)

Demographics

1. Unique Patient Identifier *

Do not use the NHS Number

4. Casenote Number

LFD000395

2. Gender *

3. Age at death (years) *

5. Ethnicity

6. PostCode

Only enter the first part of the postcode

Hospital Stay

7. Hospital site *

15. Main Specialty at death *

Admission Details

8. Admission Date (DD/MM/YYYY)

9. Time

○ 8AM - 8PM ○ 8PM - 8AM

10. Was this a readmission

○ Yes ○ No ○ Don't know

11. Source of Admission

12. Type of Admission

○ Elective admission ○ Non-elective admission

13. Existing Conditions On This Admission - Elixhauser Comorbidity (select all that apply). For further details about Elixhauser, see https://future.nhs.uk/BetterTomorrow/view?objectId=143330917

14. Reason for this admission (provisional diagnosis)

Discharge Details

16. Date of Death (DD/MM/YYYY)

17. Calculated Length of Stay (days)

18. Has the cause of death been recorded

○ Yes ○ No

Mortality Review (Arden & GEM CSU)

Patient | Phases of Care | Problems in Healthcare | Overall Assessment | Lessons Learnt | Second Review | Submit

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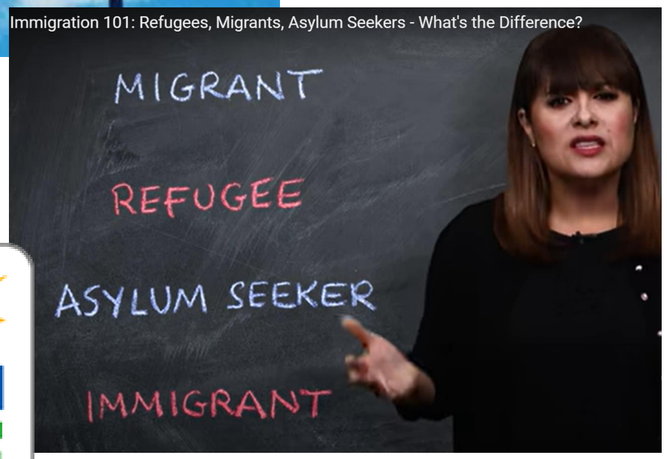
Addressing inequalities?

Finding cases and describing cases – checking understanding of the population



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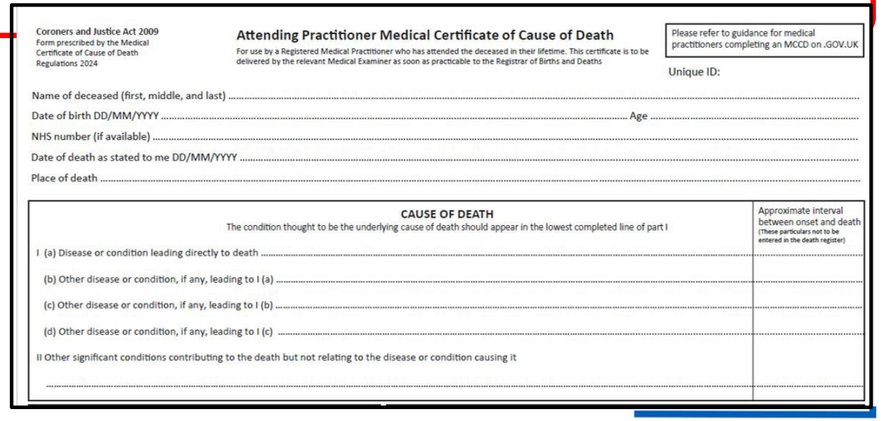

Coroners and Justice Act 2009
Form prescribed by the Medical Certificate of Cause of Death Regulations 2024

Attending Practitioner Medical Certificate of Cause of Death

For use by a Registered Medical Practitioner who has attended the deceased in their lifetime. This certificate is to be delivered by the relevant Medical Examiner as soon as practicable to the Registrar of Births and Deaths

Please refer to guidance for medical practitioners completing an MCCD on .GOV.UK

Unique ID:

Name of deceased (first, middle, and last) .....

Date of birth DD/MM/YYYY ..... Age .....

NHS number (if available) .....

Date of death as stated to me DD/MM/YYYY .....

Place of death .....

CAUSE OF DEATH

The condition thought to be the underlying cause of death should appear in the lowest completed line of part I

Approximate interval between onset and death (These particulars not to be entered in the death register)

I (a) Disease or condition leading directly to death .....

(b) Other disease or condition, if any, leading to I (a) .....

(c) Other disease or condition, if any, leading to I (b) .....

(d) Other disease or condition, if any, leading to I (c) .....

II Other significant conditions contributing to the death but not relating to the disease or condition causing it

.....

Mortality Review (Arden & GEM CSU)

Patient | Phases of Care | Problems in Healthcare | Overall Assessment | Lessons Learnt | Second Review | Submit

Demographics

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Working wth Elixhauser

https://future.nhs.uk/BetterTomorrow/view?objectId=143330917

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Elixhauser Comorbidity: calculating and using the scores

Elixhauser Comorbidity Index Summary

For those using SJR*Plus* with the standard report
the cumulative scores are calculated automatically

Congestive heart failure	7	Lymphoma	9
Cardiac arrhythmias	5	Metastatic cancer	12
Valvular disease	-1	Solid tumour without metastasis	4
Pulmonary circulation disorders	4	Rheumatoid arthritis / collagen vascular diseases	0
Peripheral vascular disorders	2	Coagulopathy	3
Hypertension	0	Obesity	-4
Paralysis	7	Weight loss	6
Neurodegenerative disorders *Note this does not include stroke*	6	Fluid and electrolyte disorders	5
Chronic pulmonary disease	3	Blood loss anaemia	-2
Diabetes	0	Deficiency anaemia	-2
Hypothyroidism	0	Alcohol abuse	0
Renal Failure	5	Drug abuse	-7
Liver disease	11	Psychosis	0
Peptic ulcer disease, no bleeding	0	Depression	-3
AIDS/HIV	0	Each individual has a cumulative score ranging from -19 to 89	

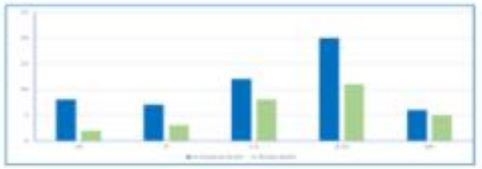
https://orthotoolkit.com/elixhauser-comorbidity-index will calculate for you

Reflecting on the scores

Remember:
This is not intended as a full list of co-existing conditions. The scores generate further questions to consider or can be used to compare different cohorts.

Within a cohort some will score negatively or have no conditions recorded: they could be low risk groups to consider

Individual scores within 0-20 group or potential groups to consider?



Comparing cohorts: comorbidity scores for in-hospital or community deaths

Better Tomorrow Using Elixhauser_082022_JMac

NHS England and NHS Improvement

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Ongoing Care

29. Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on, then please do so.

How much to write?
What to say?
How do I justify my rating?

Please do not enter any personal information

487 words remaining.

30. Ongoing Care Rating

Very Poor Care | Poor Care | Adequate Care | Good Care | Excellent Care | N/A

- *This should not have happened*
- *I'm dismayed to read this*
- *Perfunctory? The basics were done*
- *Yes that's what I'd want my team to do*
- *Wow this is impressive*

Care during a procedure (if applicable)

31. Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on, then please do so.

What is a procedure?
How do I rate this if I'm not a surgeon?

Please do not enter any personal information

486 words remaining.

32. Care during a procedure rating

Very Poor Care | Poor Care | Adequate Care | Good Care | Excellent Care | N/A

USING SJRPLUS NARRATIVE DATA

Case studies

Case 2 – excellent first 24-hour care

35-year-old male in 24-hour care Mobilises in wheelchair and non-verbal.

Evidence of lower limb contractures on admission.

Emergency care was prompt and thorough; presentation was with severe acute hypoxic respiratory failure, this was recognised by ED and immediately escalated to ICU. Intervention was swift with well documented and reasoned decisions to provide invasive mechanical ventilation. The process of initiation of mechanical ventilation was well managed as was the cardiovascular and ventilatory strategy selected.

Communication with family was done appropriately as was the recognition of potential legal / safeguarding issues.

The investigative strategy was comprehensive recognising the atypical presentation of covid pneumonitis (raised neutrophil count) and appropriately covered and investigated for community acquired pneumonia.

Ongoing Care

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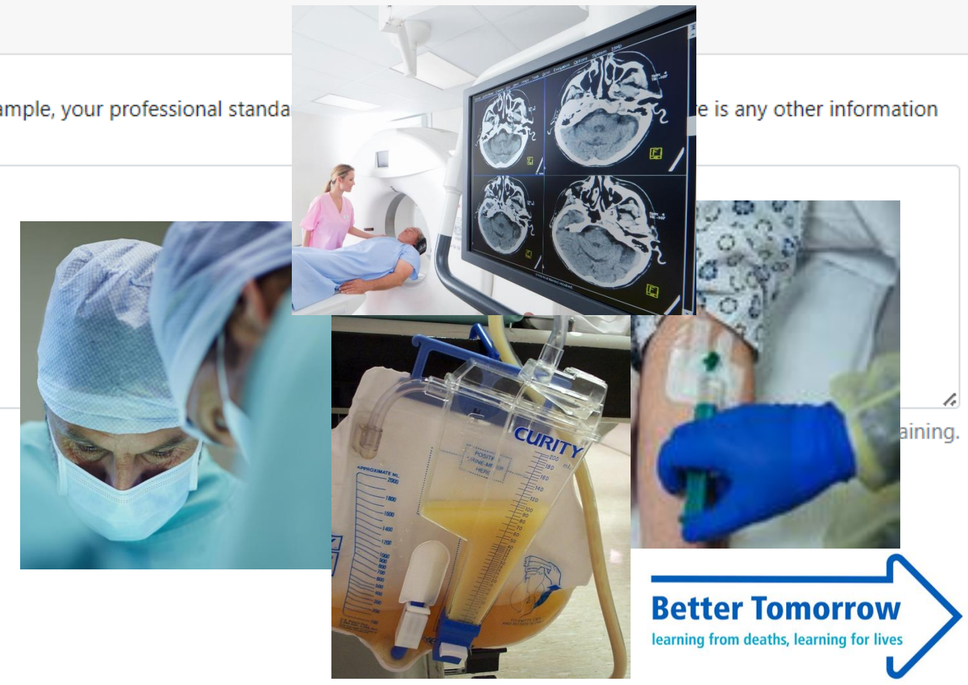
What is a procedure?
How do I rate this if I'm not a surgeon?

Please do not enter any personal information

…aining.

- ✓ *Consent*
- ✓ *Appropriate – can do, should do*
- ✓ *Correctly done, timely*
- ✓ *After care*
- ✓ *Documentation*



32. Care during a procedure rating

Very Poor Care | Poor Care | Adequate Care | Good Care | Excellent Care | N/A

Types of Problems

36. Problems leading to admission or readmission *(including transfer decision, admission avoidance, escalation planning and/or potential for admission avoidance)*

◉ Yes ○ No

37. Did this lead to harm?

○ Yes ○ No ○ Maybe

38. Problems in initial assessment, investigation or diagnosis *(including assessment of pressure ulcer risk, VTE risk, history of falls)*

○ Yes ○ No

40. Problem related to initial or ongoing treatment and management plan including preventative strategies? *(including pressure damage, falls, VTE)*

○ Yes ○ No

42. Problem in clinical monitoring? *(including failure to plan, to undertake, or to recognise and respond to change)*

○ Yes ○ No

44. Problem related to any invasive procedure, including surgical operation in theatre setting or intervention requiring anaesthetic? *(other than infection control)*

○ Yes ○ No

46. Problem in resuscitation following a cardiac arrest or respiratory arrest, including Do Not Resuscitate decisions?

○ Yes ○ No

48. Problem with medication?

○ Yes ○ No

50. Problems with IV fluids/Electrolytes/oxygen?

○ Yes ○ No

52. Problem with nutrition?

○ Yes ○ No

54. Problem with infection control? *(Including nosocomial infection)*

○ Yes ○ No

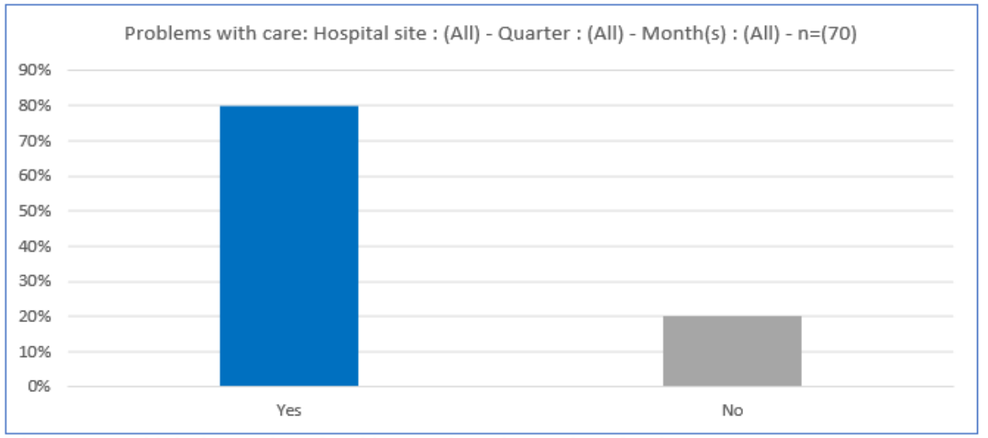
USING SJRPLUS DATA

Problems in care – thematic analysis

Problems with care: Hospital site : (All) - Quarter : (All) - Month(s) : (All) - n=(70)

	n.	%
Yes	56	80.0%
No	14	20.0%
Grand Total	**70**	**20.0%**

**number of incomplete records 0*



Please note – this is the number of problems and not the number of patients.
Some cases had problems in more than one phase of care

Ranked order

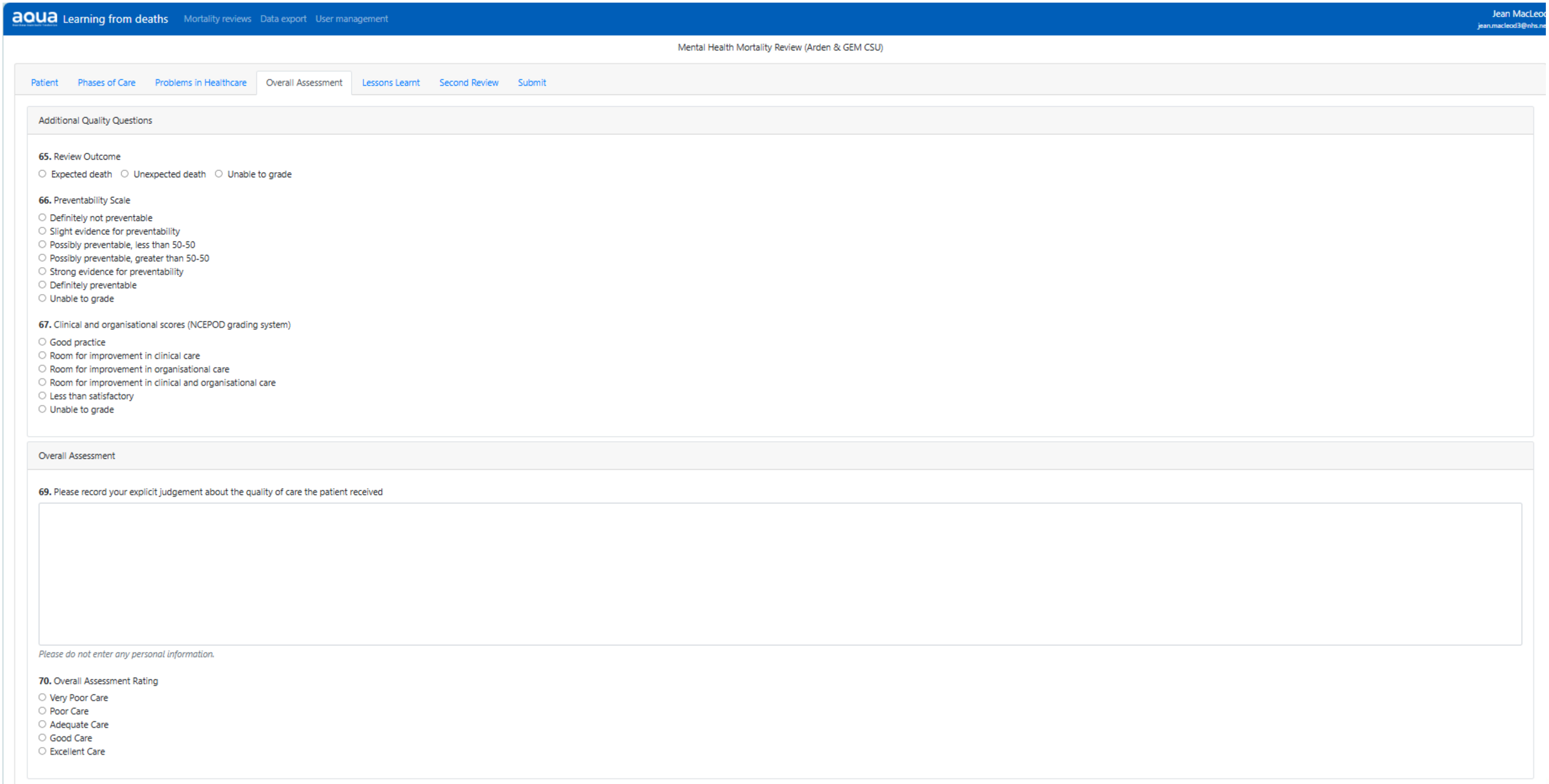
Problem area	Yes
Problem in Clinical Monitoring	56
Problems in Assessment	54
Problems in Communication	53
Problem related to Treatment	41
Problem with Medication	40
Problems leading to readmission	29
Problem of any other type	28
Problem with Infection Control	27
Problems leading to readmission harm	15
Problem with Nutrition	15
Problem related to Operation	1
Problem in Resuscitation	0

Click here to view detailed charts on problems with care

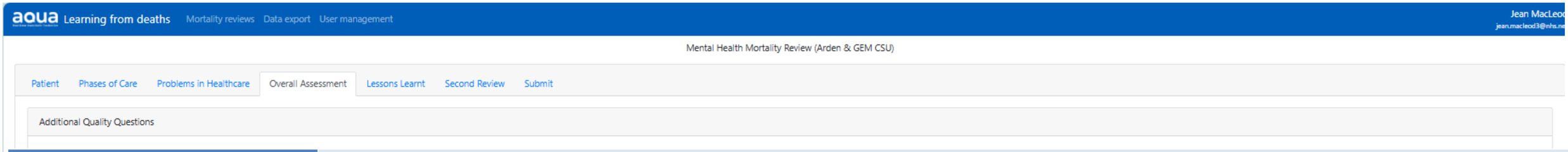
Ranked order

Problem area	Yes	Probably
Problem in Clinical Monitoring Harm?	40	15
Problems in Assessment Harm?	27	25
Problem with Infection Control Harm?	26	1
Problem related to Treatment Harm?	15	26
Problem with Medication Harm?	13	27
Problems in Communication Harm?	13	27
Problem of any other type Harm?	12	15
Problem in Resuscitation Harm?	0	0
Problem related to Operation Harm?	0	0
Problem with Nutrition Harm?	0	1

STANDARD OUTCOME DESCRIPTORS



STANDARD OUTCOME DESCRIPTORS



1. Review outcome (RCP inclusion)	**Expected death**: an expected death is the result of an acute or gradual deterioration in a patient's health status, usually due to advanced progressive incurable disease. The death is anticipated, expected and predicted. **A sudden or unexpected death**: an unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal. *Wilson, Laverty and Cooper (2016) definition for BMA*
2. Preventability scale definitions (Hogan)	2017 Learning from deaths guidance still in place Organisations must investigate and report those deemed **> 50:50** SJR escalates to investigation Individual reviewers may find it difficult to assess so a team approach helpful
3. NCEPOD definitions	**Good practice:** A standard that you would accept from yourself, your trainees and your institution. **Room for improvement:** Aspects of clinical care that could have been better. **Room for improvement:** Aspects of organisational care that could have been better. **Room for improvement:** Aspects of both clinical and organisational care that could have been better. **Less than satisfactory:** Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution. Insufficient data: Insufficient information in the case notes to assess the quality of care.

71. Are there any lessons to be learned from this review?

(•) Yes ( ) No ( ) Maybe

72. Are there any positive lessons to be learned from this case?

(•) Yes ( ) No

73. Please describe the positive lessons learned.

This happened which meant that
Exceeded standards
Addressed individual needs
Exemplary behaviours or practice
Wow why doesn't this happen every time

Please do not enter any personal information.

479 words remaining.

74. Are there any negative lessons to be learned from this case?

(•) Yes ( ) No

75. Please describe the negative lessons learned

This happened which meant that
This didn't happen which meant that
This behaviour has this potential impact
We should try to change this because...
if only we had done...

Please do not enter any personal information.

471 words remaining.

76. Where do you suggest this learning should be shared?

Person team organisation system

496 words remaining.

USING SJRPLUS NARRATIVE DATA

Positive lessons learned with qualitative illustrations

Category and number of times featured		Representative comment from notes or reviewer
Good involvement of specialist teams	18	*Regular reviews recorded including advice from specialist teams* *Evidence Trust has a hospital alcohol team who provide support and care to patients* *Evidence of lovely caring notes from physio team who saw people on ward 7. Taking time to explain what has happened to patient*
Clear and responsive treatment plans	18	*Involvement of ITU and move to level 3 age agnostic* *Recognition of O2 issue (high flow and hypercapnia in COPD)* *CT Scan reported quickly, and patient taken to surgery timely* *Good initial clinical assessment and treatment for sepsis in ED* *Responsive and flexible care as she rallied and exceeded her ceiling of care, treatment recommenced.*

SECOND REVIEWS

aqua Learning from deaths Mortality reviews Data export User management Jean MacLeod jean.macleod3@nhs.net

Mortality Review (Arden & GEM CSU)

Patient | Phases of Care | Problems in Healthcare | Overall Assessment | Lessons Learnt | Second Review | Submit

77. Does this review require a second review?

◉ Yes ○ No

78. What question(s) or issue(s) should the second reviewer or MDT consider?

Could a Respiratory physician review the indications and use of NIV please as I felt the documentation of decisions and progress implied room for improvement
Would the team review the potential preventability as I have concerns about the recognition of deterioration and delays in care
Would the LD representative review please as I felt this represented excellent care particularly involving family which could be exemplar

435 words remaining.

Second Review Findings

79. First 24-hour Care Rating

○ Very Poor Care ○ Poor Care ○ Adequate Care ○ Good Care ○ Excellent Care ○ N/A

80. Ongoing Care Rating

○ Very Poor Care ○ Poor Care ○ Adequate Care ○ Good Care ○ Excellent Care ○ N/A

81. Care during a procedure rating (if applicable)

○ Very Poor Care ○ Poor Care ○ Adequate Care ○ Good Care ○ Excellent Care ○ N/A

82. End of Life Care Rating

○ Very Poor Care ○ Poor Care ○ Adequate Care ○ Good Care ○ Excellent Care ○ N/A

83. Second reviewer comments

I have reviewed and my judgement is
We have given the ratings above due to
The MDT felt that
The rating of the second review differed from initial because
Further potential lesson recognised

Please do not enter any personal information.

467 words remaining.

Print this record

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Identifying a second reviewer

- Expert perspective
- Validation of perspective
- Collective opinion

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USING STRUCTURED JUDGEMENT REVIEW (SJR) DATA

USING SJRPLUS DATA

Cohort reporting with embedded interactive report

USING SJRPLUS DATA

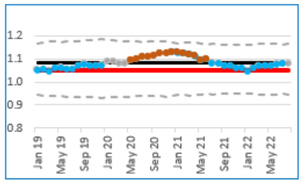
Acute trust dashboard: information sharing from bed to board

Trust A

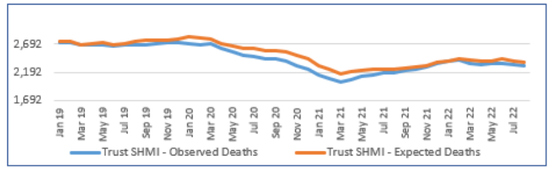
Context — Detail

SHMI

Latest month	Aug 22
SHMI	1.03
SHMI in expected range	
Observed deaths	2315
Expected deaths	2380

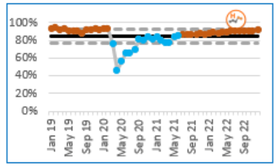


SHMI - Expected Vs. Observed



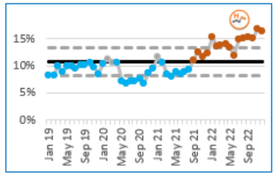
Hospital Occupancy

Latest month	Dec 22
%	91.9%
Significant deterioration	



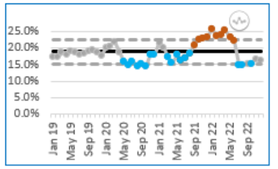
% Patients with LoS > 7 days

Latest month	Dec 22
%	16.3%
Significant deterioration	



% Patients with LoS > 21 days

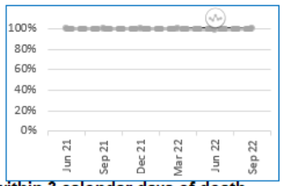
Latest month	Dec 22
%	16.3%
No significant change	



Scrutiny to SJR — Detail

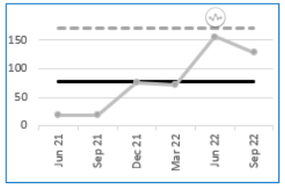
No. deaths scrutinised by ME - Q5h

Latest month	Sep 22
%	100.0%
Number	503
No significant change	



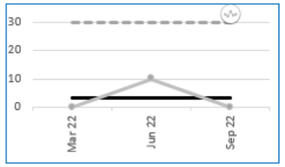
No. MCCDs not completed within 3 calendar days of death - Q16

Latest month	Sep 22
Number	129
No significant change	



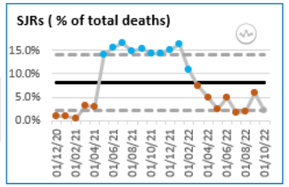
No. Patient Safety Incidents notified by medical examiner office as a result of scrutiny - Q23

Latest month	Sep 22
Number	0
No significant change	



SJRs (% of total deaths)

Latest month	Oct 22
%	2.1%
No significant change	

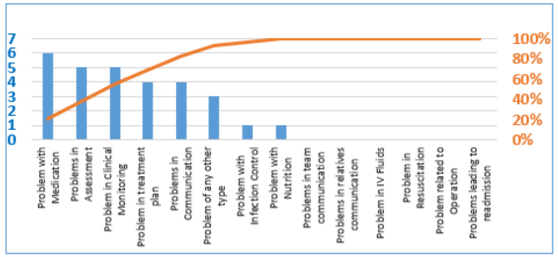


Care — Detail

Good care identified

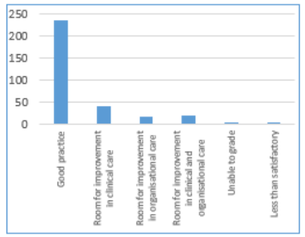
In 238 out of 327 cases (73%) good care was identified

Problems with care Apr-22 to Aug-22



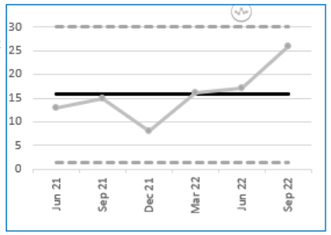
NCEPOD definitions Nov-19 to Oct-22

Good practice	238
Room for improvement in clinical care	41
Room for improvement in organisational care	18
Room for improvement in clinical and	22
Unable to grade	4
Less than satisfactory	4



Deaths where a significant concern about the quality of care provided is raised by bereaved families and carers - Q20a

Latest month	Sep 22
Number	26
No significant change	



Changing the structure and content of M+M meetings

Organisational data

Broad appreciation of organisation and system issues

Dashboard, SHMI, ME feedback, problems in care

National and regional alerts, organisation/system improvement projects

Divisional/Team data

SJR output including lessons and problems, cohort findings and trends, ME feedback, clinical audit, complaints, litigation, other smoke signals

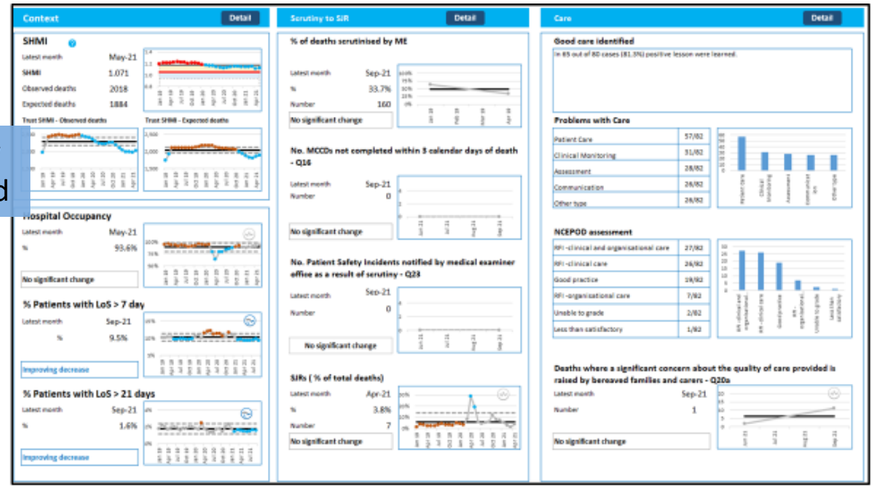
Improvement projects and planned QI

Case discussion of examplars

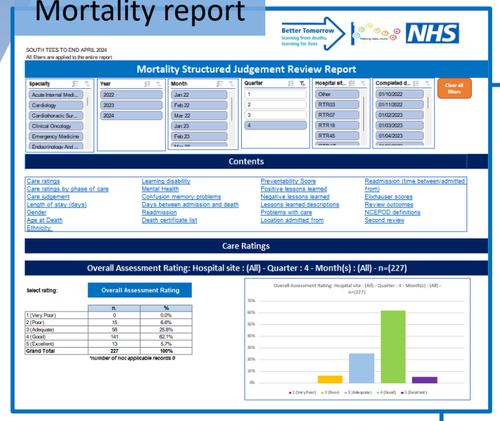
Sharing examples for improvement

Action and learning log

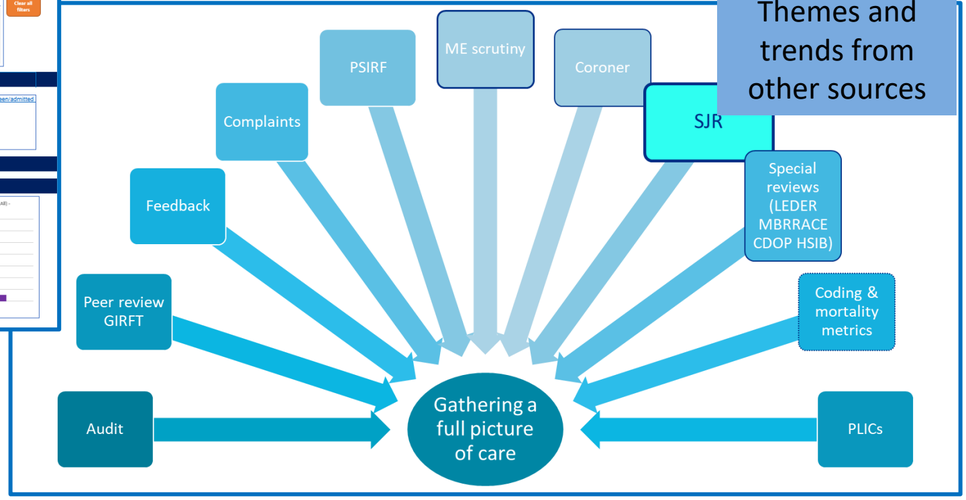
Mortality dashboard



Mortality report



Themes and trends from other sources



Case report

The story of Mrs B….

So what do we change?
How could we do it?
How will we know it worked?
Timescale?

FIND US ON FUTURENHS

Better Tomorrow resources and
Community of practice forum

FutureNHS

EVALUATION

QR code:

Here is the link to evaluation: https://www.surveyhero.com/s/15012025_LFD

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REACH US IN AQUA – HOW CAN WE HELP?

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