

Appendix 2

CCS Learning from Deaths Screening Tool

NAME:
DOB:
GENDER:
NHS NUMBER:
ADDRESS:

In March 2017 the Department of Health issued 'National Guidance on Learning from Deaths' which mandates that if certain criteria are present, NHS organisations must undertake a case record review of a patients care, with a view to develop an understanding of themes relating to mortality, in order to drive quality improvement.

The mandatory criteria indicating case review is necessary are present in the fields below.

Service:

CCS Lead Clinician:

Cause of death:

1 a	
b	
c	
2	

Criteria for Case Record Review	Yes	No/N/A
1. Do you believe the death unexpected? (See 4.1 in Learning from Deaths Policy) <small>There will be some patients with frailty and multiple comorbidities in whom death was not unsurprising to the clinical team - these do not require case record review unless other concerns are present.</small>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you concerned about the care this patient received by CCS? <small>A problem in healthcare is defined as 'any point where the patient's healthcare fell below an acceptable standard and led to harm'. E.g. Avoidable healthcare associated infection, avoidable acquired pressure ulcer, failure to respond in a timely manner to deterioration etc.</small>	<input type="checkbox"/>	<input type="checkbox"/>
3. Had concerns been raised previously about the care offered by CCS in this case, by staff or by the family/client?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you any concerns that this death was avoidable? <small>Even if you have slight concerns that this death was avoidable, you should refer for Case Record Review</small>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is this case subject to an investigation (internal or external)? <small>I.e. When an incident with moderate harm or above has been reported on Datix</small>	<input type="checkbox"/>	<input type="checkbox"/>
6. There has been a complaint by the deceased's family either internally through the CCS complaint process or externally <small>I.e. Cases in which the family/carers have made a complaint</small>	<input type="checkbox"/>	<input type="checkbox"/>
7. Deaths declared as an SI by CCS	<input type="checkbox"/>	<input type="checkbox"/>
8. Was this death reported to the coroner? (Including if the patient died whilst sectioned under the Mental Health Act). <small>Excluding when reporting industrial diseases</small>	<input type="checkbox"/>	<input type="checkbox"/>
9. Did this patient have a learning disability?	<input type="checkbox"/>	<input type="checkbox"/>
10. Was the death related to a concern about the quality of care delivered by CCS including adult safeguarding concerns Was a safeguarding concern raised?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
For Root Cause Analysis (RCA)? (If yes to any of the above then case note review is required)	<input type="checkbox"/>	<input type="checkbox"/>
If a RCA is not required are there any aspects of excellent care or compliments received you wish to highlight?		