NWAS Learning From Deaths Dashboard Quarter 3 2021-2022 (October - December)

Overall Dashboard Description: This is a systematic dashboard that is a combination of those outlined in the guidance as 'must review' and those in the specified sample. These are described in more detail in the data-splits below.

	Total Number of Deaths in scope (sample cohort and Datix incidents)*	Total Number of Deaths Reviewed	%Deaths Reviewed	Total Number of Deaths where problems in care have contributed
October	58	26	44.8%	12
November	39	18	46.2%	8
December	65	27	41.5%	7
This Quarter	162	71	43.8%	27
This Financial Year	331	170	51.4%	67

* Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality of care provided where the patient died under the care of the ambulance service (from call to handover); after handover or within 24 hours of initial contact where the decision was to not convey the patient. The sample must contain incidents across the categories outlined in the document.

Table 1.

Learning from Deaths: Data over time

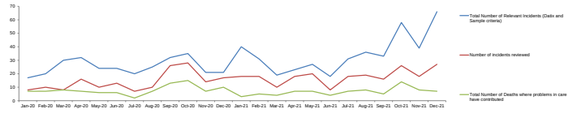

Figure 1.

Those in scope must have died under the care of the ambulance service (from call handling to before handover concludes), after handover (if notified by other trusts of these) or within 24 hours of contacting the service and the decision was not to be conveyed to hospital. This report draws on learning from the previous quarter and remains an iterative process.

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 24/02/2022.

Datix Cohort Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occurred in our care where there has been concern has been raised about the quality of care provided'. Patient experience module, records are included where Risk score is 4/5 and death has occurred; the review is considered complete when the record is closed. Incidents module data, it is considered as a death in cohort where 'Degree of harm' is 'Death- Caused by the incident'. Patient Experience module data, is included in the cohort where the incident is closed and 'Reason for SI: Unexpected /Potentially avoidable death'.

Incidents Module

Total Datix Death incidents in scope		Risk grading		
		1 or 2	3	4 or 5
October	26	0	7	18
November	18	2	1	15
December	23	4	5	12
Total	67	6	13	45

Table 2.

Month	Number of Deaths Closed on Datix	Of those closed, Number of Deaths considered as caused by the incident	Lessons Learned complete for those closed and considered caused by the incident
October	13	9	0
November	9	5	0
December	11	5	0
Total	33	19	0

Table 3.

Datix Degree of Harm (all in scope including those not yet closed)

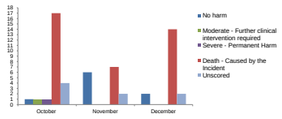

Figure 2.

Datix Category Type (of those reviewed and death determined by the incident)

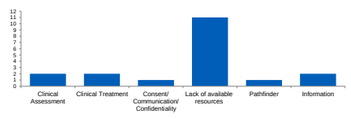

Figure 3.

Data source: Datix incidents query 'Inc.: LID (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (deathhead/deceased/died) Incident Date @lastquarter. Last extracted 09/02/2022. Last accessed 09/02/2022

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
October	9	0	0
November	8	1	0
December	10	0	0
Total	27	1	0

Table 4.

Learning theme

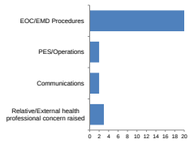

Figure 4

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	4	Reflection and/or feedback; refresher training to be undertaken; still under review
	Significant delay in responding to a patient with chest pain	7	Demand outstripped resources; reflection and/or feedback; EMD guidance re: EOC0001 & EOC0015 to be circulated; still under review
	Significant delay in responding to a patient with DIB	9	Demand outstripped resources; reflection and/or feedback; measures put in place for all EMDs to see which incidents have waited the longest.
PES/Operations	Lack of safety-netting, incorrect MTS application in a chest pain patient	1	Reflection and/or feedback; refresher training to be undertaken; still under review
	Lack of safety-netting, incorrect MTS application in an anticoagulant patient with a haemorrhage	1	Reflection and/or feedback; refresher training to be undertaken; still under review
Communication	111 did not convey sufficient information to EOC/EMD	2	Reflection and/or feedback; refresher training to be undertaken; still under review
Relative/external health professional concern raised	Relative concerned patient was not prioritised by call handlers	3	Demand outstripped resources; still under review

Table 5

(Note- This is the month the incident occurred, not when the notification of raised concern for care was received)

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 09/02/2022. Last accessed 09/02/2022.

Incidents on both Patient Experience Module and Incidents Module

Month	Relevant incidents on both modules	Incidents Closed on both modules	Number closed and death considered caused by the incident
October	3	0	0
November	2	0	0
December	2	0	0
Total	7	0	0

Table 6.

Learning theme

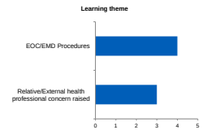

Figure 5

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	3	Reflection and/or feedback; refresher training to be undertaken; still under review
	Significant delay responding to a patient with DIB	1	Reflection and/or feedback; training guidance given to call handling staff re: ineffective breathing; still under review
Relative/external health professional concern raised	Relative concerned patient was not prioritised by call handlers	3	Demand outstripped resources; still under review

Table 7.

(Note- This is the month the incident occurred, not when the notification of raised concern for care was received)

This is an outline of the deaths recorded on the Incidents module and/or Patient Experience module that fit the cohort. The information is provided from the reviews and associated documents

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter; last extracted 04/01/2022. Information recorded on these incidents: last accessed 09/02/2022. Datix Incidents query 'Inc.: LID (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (deathhead/deceased/died) Incident Date @lastquarter - Listing Report' last extracted on 09/02/2022. Last accessed 09/02/2022

Sample Cohort Breakdown

Sample Data Description: A random sample of 40 incidents minimum using the specified criteria from the national guidance reviewed using the SJR process.
This includes deaths classified as requiring a Category 1 or Category 2 response, Category 3 and Category 4 incidents that resulted in deaths and deaths of patients that were not initially conveyed and the ambulance service was re-contacted within 24 hours.

Structured Judgement Review

Incidents used for the Sample criteria	Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
October	20	13	3
November	11	8	3
December	30	16	2
Total	61	36	8

Table 8.

Quarter 3 2021-2022 Sample Data Breakdown			
Month	C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
October	5	2	13
November	2	1	8
December	8	3	19
Total	15	6	40

Table 9.

SJR Stage 1 Overall Care Assessment

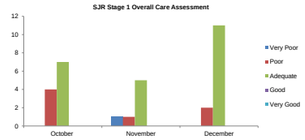

Figure 6.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	N/A	
Right Care	Patient Assessment Rating	5	24	2	26/31 patients	84%
	Management Plan/Procedure Rating	4	23	4	27/31 patients	87%
Right Place	Patient Disposition Rating	3	28		28/31 patients	90%

Table 10

† SJR Scoring Key:

Adequate: Care that is appropriate and meets expected standards;
Poor/Very Poor: Care that is lacking and/or does not meet expected standards;
Good/Very Good: Care that shows practice above and/or beyond expected standards

Definitions taken from the National Quality Board, "National Guidance for Ambulance Trusts on Learning from Deaths", July 2019

‡ EOC subject matter expert required to undertake the call handling/resource allocation element of the SJR.

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 31 patients)

Evidence of Poor/Very Poor Practice

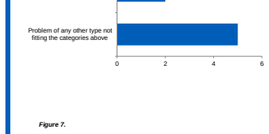

Figure 7.

Learning Theme	Learning Detail	Frequency (n= 31 patients)
Problem in assessment, investigation or diagnosis	Family informed crew there was a DNACPR in place and crew commenced resuscitation and ALS	1
	Lack of observations or investigations performed	3
	Poor assessment/ investigations anchoring bias	1
Problem with clinical monitoring	No ECG attached, digital blocker with GETAC	2
Problem relating to treatment and management plan	Poor experience for family	2
	MTS/Pathfinder incorrectly/not used	2
	No worsening advice documented	1
	NWAS COVID-19 guidance not followed	1
Problem related to an invasive procedure	Intraosseous inserted whilst waiting for DNACPR documents	1
Problem with resuscitation	Intraosseous inserted whilst waiting for DNACPR documents	1
	TOR protocol not followed	1
Problem of any other type	Poor clinical documentation	1
	Missed understanding of DNACPR/Futile arrest	2
	Indication for a 12-lead ECG missed	1
	Lack of escalation for decision making	1
	EOC to check if clinical support is needed for prolonged on scene time to support decision making.	1

Table 11.

Evidence of Good/Very Good Practice

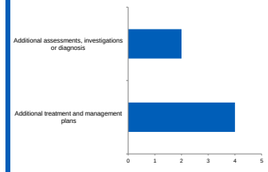

Figure 8.

Learning Theme	Learning Detail	Frequency (n=31 patients)
Additional assessments, investigations or diagnosis	Assessment of patient with additional investigations and assessments beyond expected practice.	2
Additional treatment and management plans	Collective decision making and safety netting between crew, SPTL, AP and GP whilst respecting the patient's wishes to remain at home.	1
	Crew demonstrated care and compassion by allowing a natural death and supporting the family/caregivers in the process.	2
	Detailed management plan to support the patient in the community who is at risk of dying and refusing conveyance.	1

Table 12.

The SJR Completion is an iterative process. All three months have been reviewed across three elements of the Stage 1 review process. Due to PRFs being unavailable and a lack of EOC subject experts for the SJR process, 36 reviews took place, 4 less than the minimum random sample size of 40 required. There are 5 reviews that need to go through panel moderation for Q3.

Data source: Informatics Learning from Deaths SSRS Feed last run on 04/01/2022, SJR data source: Learning from Deaths SJR Database, last accessed on 24/02/2022.