Reporting Learning from Deaths to Board

Sherwood Forest Hospitals NHS Foundation Trust

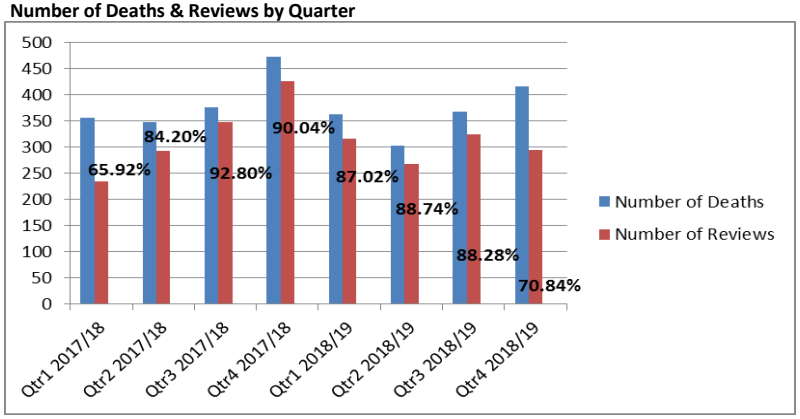
Learning from Deaths Dashboard Quarter 4 2018/19

Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Jan-19	151	130	86.09%	2
Feb-19	131	87	66.41%	1
Mar-19	133	77	57.89%	0
Qtr 1	362	315	87.02%	3
Qtr 2	302	268	88.74%	2
Qtr 3	367	324	88.28%	3
Qtr 4	415	294	70.84%	3
Year 18/19	**1446**	**1201**	**83.06%**	**11**
Year 17/18	*1550*	*1300*	*83.87%*	*21*

Deaths in groups under special focus Qtr 4 2018/19

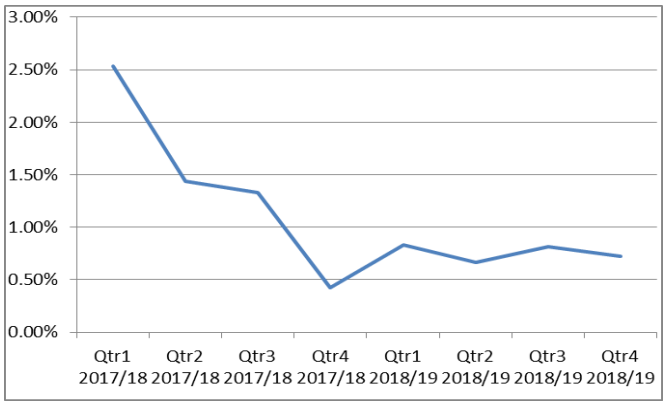
Group	Total
Learning Disability / Mental Health Patients	5
STEIS SI	5
Internal Investigations	6
Investigations opened by the Coroner	10
Investigations converted to Inquests	1
Inquests opened without prior investigation	7
Investigations closed without Inquest	3
Concluded Inquests	6

Number of Deaths & Reviews by Quarter



Key Learning/Themes identified	
The need to improve the awareness and prescribing of warfarin has been a key learning theme through Q4	a) The anticoagulation chart should be with the main prescription chart at all times with the anticoagulant medication prescribed on both b) The Trust Anticoagulation Policy must reflect the minimum interval for warfarin monitoring so when potential interactions are missed a safety net is in place c) NICE guidance suggest all patients on an anticoagulant and antibiotics should have a repeat INR every 3-5 days due to side effects and increased risk of bleeding

% of deaths with Avoidable Factors



Summary Hospital Mortality Index (SHMI)