



Royal College
of Physicians

National Mortality Case
Record Review Programme

Using the structured judgement review method

A guide for reviewers (England)

Supported by:



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Structured judgement review

1 Background to the method and its strengths

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.¹ The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to answer these questions, there is a need to look at: the whole range of care

provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.

Structured judgement case note review can be used for a wide range of hospital-based safety and quality reviews across services and specialties, and not only for those cases where people die in hospital. For example, it has been used to assess the care provided for people who have had a cardiac arrest in hospital, to review safety and quality of care prior to and during non-elective admission to intensive care settings and to review the care provided for people admitted at different times of the week.

An important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has been judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

2 How the structured judgement review method works

2.1 Who does what and when?

There are two stages to the review process. The first stage is mainly the domain of what might be called 'front line' reviewers, who are trained in the method and who undertake reviews within their own services or directorates, sometimes as mortality and morbidity (M&M) reviews, sometimes as part of a team looking at the care of groups of cases. This is where the bulk of the reviewing is done and most of the reviews are completed at this point.

A second-stage review is recommended where care problems have been identified by a first-

stage reviewer and an overall care score of 1 or 2 has been used to rate care as very poor or poor. This second-stage review is usually undertaken within the hospital governance process and normally uses the same review method. At this stage the hospitals may also choose to assess the potential avoidability of a death where harms due to care have been identified (see Section 4 below and *A clinical governance guide* (RCP 2016) associated with the review guide).

2.2 Phases of care – the ‘structure’ part of the method

The phase of care structure provides a generalised framework for the review and also allows for comparisons among groups of cases at different stages of care. The principal phase descriptors are shown in Box 1. However the use of the phase structure depends on the type of care and service being reviewed – not all phase of care headings will be used for any particular

case. Thus the procedure-based review section may only be required in a few medical cases (eg a lumbar puncture, a chest drain or non-invasive ventilation) but are likely to be used in many surgical cases. It is up to the reviewer to judge which phase of care forms are appropriate in a particular case.

Box 1 Phase of care headings

- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/ procedure care
- End-of-life care (or discharge care)*
- Assessment of care overall

*Note that discharge care is included because this method is just as applicable for the review of care for people who do not die during an admission.

2.3 Explicit judgement comments – the core of the method

The purpose of the review is to provide information from which teams or the organisation can learn. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary that other health professionals can readily understand if they subsequently look at the completed review.

When asked to write comments on the quality and safety of care, clinical staff often tend to write a resume of the notes or make an *implicit* critique of care. This is not helpful when others try to understand the reviewer’s real meaning. So the central part of the review process comprises short, written, *explicit* judgement statements about the perceived safety and

quality of care that is provided in each care phase.

This review guide does not include a glossary of explicit terms that reviewers might choose from, because this approach would inevitably be constraining or would fail to cover all eventualities in the complexities of clinical practice. Instead, reviewers are asked to use their own words in a way that explicitly states their assessment of an aspect of care and gives a short justification for why they have made the assessment.

Explicit statements use judgement words and phrases such as ‘good’, ‘unsatisfactory’, ‘failure’ or ‘best practice’. See Box 2 and Box 3 for examples.

Box 2 Examples of phase of care structured judgement comments

- Continued omission to provide oxygen and respiratory support – poor care.
- Team still failed to discuss potential diagnosis with patient – unsatisfactory.
- Referral to intensive treatment unit (ITU) was too late.
- There was some evidence of good management by the overnight team, with prompt review and intervention.
- Although patient discussed with a consultant once and a specialist registrar (SpR) once, for 4 days they were only seen by junior doctors – this is completely unsatisfactory.
- Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment.

Additionally, these judgement words are accompanied by short statements that provide an explicit reason why a judgement is made – eg ‘unsatisfactory because, etc’ and ‘for example, resuscitation and ceiling of treatment decisions made far too late in course of admission – poor care’. The purpose here is not to write long sentences but to encapsulate the clinical process in a few explicit statements.

Judgement comments should be made on anything the reviewer thinks is important for a particular case. Among other things, this will include the appropriateness of management plans and subsequent implementation together with the extent to which, and how, care meets good practice. In some cases, there may be care in a phase that has both good and poor aspects. Both should be commented on.

Commentary on holistic care is just as important as commentary on technical care, particularly where complex ceiling of treatment and end-of-life care discussions might be held. Judgements should be made on how the teams have managed end-of-life decision making and to what extent patients and their relatives have been involved. Thus, for example, a judgement comment might be couched as ‘end-of-life care met recommended practice, good ceiling of

treatment discussion with patient and family’. Similar approaches and levels of detail are required when care is thought not to have gone well, or where aspects of care are judged to be only just acceptable. Then words such as ‘unsatisfactory’, ‘poor’ or ‘doesn’t meet good practice standards’ might be necessary.

Sometimes it is just not clear what has been happening during part of the process of care, where there appears to be a lack of decision making or guidance. Here, judgement words such as ‘delay’, ‘poor planning’ and ‘lack of leadership’ etc may be used. Or if this lack of clarity is due to the level of documentation, comments such as ‘inadequate record keeping’ may apply.

Overall, phase of care comments are intended to bring a focus to the review by asking for an explicit, clear judgement on what the reviewer thinks of the whole care episode, taking all aspects into consideration. It is not necessary to repeat all of what has been commented on before, although it is sometimes useful to repeat some key messages – that is a reviewer’s choice. Again, however, it is important to make clear and explicit what the overall judgement is and why. Examples are given in Box 3.

Box 3 Examples of overall care structured judgement comments

- Overall, a fundamental failure to recognise the severity of this patient's respiratory failure.
- Good multidisciplinary team involvement.
- On the whole, good documentation of clinical findings, investigation results, management plan and discussion with other teams.
- Poor practice not to be aware of the do not attempt resuscitation (DNAR) status of the patient, especially when it has been discussed with family, clearly documented when first put in place and reviewed later on.

Cause of death information should form part of the review framework. If, on review, the certified cause of death causes the reviewer some concern, this should be explicitly stated, because there may be a clinical governance question involved.

So, the overall message about review language is that it should be explicit and clear, in order that you, the reviewer, feel you have made the points clearly and that others who read the review will be able to understand what you have said and why.

2.4 Giving phase of care scores

Box 4 Phase of care scores

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Care scores are recorded after the judgement comments have been written, and the score is in itself the result of a judgement by the reviewer. Only one score is given per phase of care: it is not necessary to score each judgement statement.

Scores range from 'Excellent' (score 5) to 'Very poor' (score 1) – see Box 4 – and are given for each phase of care that is commented on and for care overall.

These scores have a number of uses. For the individual reviewer, scores help them to come to a rounded judgement on the phase of care,

particularly when there may be a mix of good and unsatisfactory care within a phase. The reviewer must judge what their overall decision is about the care provided for each phase and for care overall. Scoring makes this very explicit.

Overall care scores are particularly important in the review process. A score of 1 or 2 is given when the reviewer decides that care has been very poor or poor. Research evidence suggests that this might happen in upwards of 10% of cases in some circumstances, but less in others. A score at this level should trigger a second-stage review through the hospital clinical governance process (see Section 4).

2.5 Judging whether problems in care have caused harm

Problems in care take many forms and may have a range of impacts, some of which are potential rather than actual. Some of these events cause harms, but many do not.

The first-stage reviewer has an important role here in assisting the hospital to identify both actual and potential threats to patient safety. Using the assessment sheet at Appendix 1, reviewers are asked three questions in relation to problems identified in care. These are in the following format.

A) Were there one or more problems in care during this admission? Yes or no

B) If so, in which area(s) of the care process did this/these occur?

C) And for each of these problems, did any cause harm?

While the results of this assessment will be of importance in clarifying the issues in each review, it is the information aggregated across reviews that may pick up more fundamental care process issues that require attention.

2.6 Judging the quality of recording in the case notes

Case note review of course depends critically on the content and the legibility of the records. Safety of care also depends to some extent on good record keeping. Therefore, as part of the

overall care assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records, again using a score of 1–5.

3 The review in practice

Case note review takes up expensive clinical resource so that the time spent on establishing the purpose and desired outcome of the review is important.

In some hospitals, the majority of mortality reviews take place in an M&M context and so they are often already being considered to be potentially problematic cases. Structured judgement review has been found to be of value in providing a reproducible process for M&Ms.

However the challenge for hospitals has often been the gathering together of the material from the reviews so that it can be used to examine care processes. Data from M&M cases should be entered into the hospital reviews database. Aggregated information is more powerful in the longer term than the data from individual cases.

Screening deaths for possible problems is another means of indicating where focused reviews are necessary. Valuable information about specific issues can be gained in this way, although generalising messages from complex cases can produce ‘solutions’ that may themselves have unintended consequences.

Another approach is to evaluate care for all or some patients who come to a particular service, or to explore the care provided for the majority of people who die in hospital over a particular time period in particular services; for example, all elective surgery deaths or people who die from acute kidney injury might require review. This aspect is covered in some detail in the *governance guidance* which forms part of the overall guidance materials.

Given the constraints on reviewer availability and the need to produce usable information from the reviews, the principle of ‘less is more’ applies.

A simple time-based longitudinal sample of around 40–50 cases will produce a rich source of quantitative and qualitative information on what goes right and what is not working properly. Timely review, rather than review after a delay, provides better information.

Time spent on the analysis and information presentation outweighs the benefit of adding a few more cases to the sample. The textual information allows for themes to be developed that then allows a focus for the next improvement steps. Such an approach also has the benefit of enabling individuals to learn from, and celebrate, the cases where care has gone well.

4 Second-stage review

In the context of the National Mortality Case Record Review Programme, second-stage review takes place within the hospital governance framework when the first-stage ‘front line’ reviewer judges care overall to be very poor (score 1) or poor (score 2), or when harms have been identified, or if concerns have been raised about a case.

Second-stage review is also undertaken using the structured judgement method and is effectively a process of validation of the first reviewer’s concerns. If the second-stage reviewer broadly agrees with the initial case review (with poor or very poor overall scores and/or where actual harm(s) is judged to have occurred), the hospital governance group may decide on an additional assessment concerning the potential avoidability of the patient’s death.

Judging the level of the avoidability of a death is a complex assessment that can be challenging to

undertake. This is because the assessment goes beyond judging safety and quality of care by also taking account of such issues as comorbidities and estimated life expectancy. Recent evidence suggests the levels of agreement can be very low when assessing potential avoidability of death.

The judgement is framed by a six-point scale (6 – no evidence of avoidability, to 1 – definitely avoidable). This scale has been used in a number of recent national mortality review studies in Canada, the Netherlands and England.² Additionally, the national review process, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made.

The avoidability scale is shown in Box 5, together with an example of an ‘avoidability of death’ judgement comment. A score of 1, 2 or 3 on the avoidability scale would indicate a governance ‘cause for concern’.

Box 5 'Avoidability of death' scale

- Score 1** Definitely avoidable
- Score 2** Strong evidence of avoidability
- Score 3** Probably avoidable (more than 50:50)
- Score 4** Possibly avoidable, but not very likely (less than 50:50)
- Score 5** Slight evidence of avoidability
- Score 6** Definitely not avoidable

Example structured judgement commentary

Non-invasive ventilation management was sub-optimal, but ultimately it was the patient's wish not to continue treatment. There may have been an alternative cause of breathlessness that was not fully explored or treated, which is why there may have been some avoidability.

Score 5 – slight evidence of avoidability

Appendix 1 – Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No (please stop here) Yes (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls): Yes
Did the problem lead to harm? No Probably Yes
2. **Problem with medication / IV fluids / electrolytes / oxygen** (other than anaesthetic): Yes
Did the problem lead to harm? No Probably Yes
3. **Problem related to treatment and management plan** (including prevention of pressure ulcers, falls, VTE): Yes
Did the problem lead to harm? No Probably Yes
4. **Problem with infection control:** Yes
Did the problem lead to harm? No Probably Yes
5. **Problem related to operation/invasive procedure** (other than infection control): Yes
Did the problem lead to harm? No Probably Yes
6. **Problem in clinical monitoring** (including failure to plan, to undertake, or to recognise and respond to changes): Yes
Did the problem lead to harm? No Probably Yes
7. **Problem in resuscitation following a cardiac or respiratory arrest** (including cardiopulmonary resuscitation (CPR)): Yes
Did the problem lead to harm? No Probably Yes
8. **Problem of any other type not fitting the categories above:** Yes
Did the problem lead to harm? No Probably Yes

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

Editorial note

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The case note review methods discussed in this guide were primarily developed in a research study published as: Hutchinson A, Coster JE, Cooper KL, McIntosh A, Walters SJ, Bath PA *et al*. Comparison of case note review methods for evaluating quality and safety in health care. *Health Technol Assess* 2010;14(10):1–165.

All clinical examples and structured judgement comments in this document are taken from hypothetical scenarios.

Please note that this guide is subject to change following conclusion of the pilot phase of the programme.

References

1. Hutchinson A, Coster JE, Cooper KL, Pearson M, McIntosh A, Bath PA. A structured judgement method to enhance mortality case note review: development and evaluation. *BMJ Quality and Safety* 2013;22:1032–1040. DOI: 10.1136/bmjqs-2013-001839.
2. Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239.
3. Royal College of Physicians. *Using the structured judgement review method – a clinical governance guide to mortality case record reviews*. London: RCP, 2016.