Kent Community Health
NHS Foundation Trust

Summary of Learning from Mortality Reviews (July to September 2018)

1. Introduction

1.1 National guidance on learning from deaths requires KCHFT to collect and publish mortality data quarterly via a paper to the Quality Committee and Public Board. The quarterly report must include mortality data and learning points. Guidance states this data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

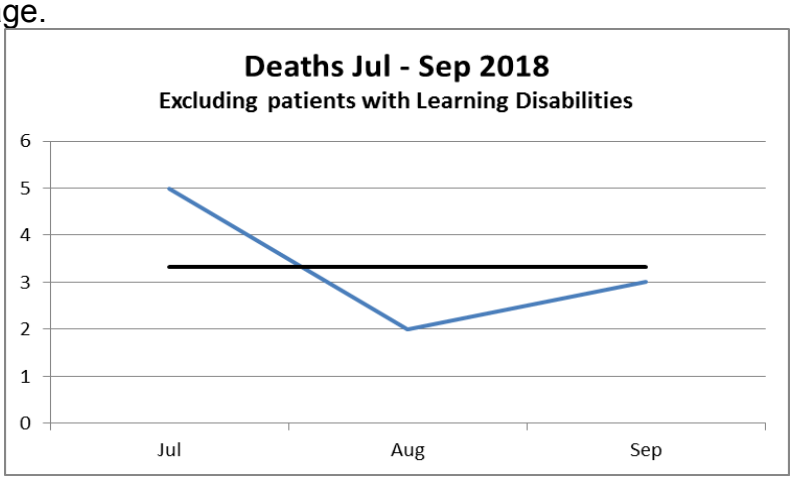
2. September Dashboard

2.1 The dashboard below has been based on national suggested format.

Total Number of Deaths in Scope			Total Deaths Reviewed			Number of deaths judged to be more likely than not due to problems in healthcare	
This Month		Last Month	This Month		Last Month	This Month	Last Month
3		2	4*		6	0	0
This Quarter (QTD)		Last Quarter	This Quarter (QTD)		Last Quarter	This Quarter (QTD)	Last Quarter
10		12	15		11	0	0
This Year (YTD)		Last Year	This Year (YTD)		Last Year	This Year (YTD)	Last Year
49		22	46		22	0	0

**Deaths reviewed in a given calendar month can exceed the number of deaths reported that month because the figure includes deaths which took place in the previous month, but have fallen into the next month for review.*

2.2 The graph below shows the number of deaths per month this quarter along with the average.



3. **Learning from Mortality Reviews**

3.1 The tables below outline key areas of good practice along with areas for learning identified in reviews completed this quarter, along with the actions taken. These are also reviewed in the monthly Mortality Surveillance Group (MSG).

3.2 All areas of good practice and areas for learning are reported at the monthly matrons' meetings in the East and West and wider dissemination to all ward staff is encouraged.

Areas of Good Practice	
Whitstable & Tankerton	**Faversham**
- Good, respectful interaction with family including offering refreshments and time alone with patient. - Family was integral to end of life experience. Staff involved family and were considerate of their needs, such as allowing them to stay in the side room throughout. Very person-centred care evident. - Clear notes on CIS re monitoring and comfort. Other teams such as safeguarding and dietetics were involved to ensure patient received high level of care. Although patient couldn't verbalise, they wrote a positive comment on the "This is Me" sheet about being happy with the care provided. - Anticipatory care medicines were in place at the right time, with good communication with family well documented on CIS. The patient's wife was an inpatient at Faversham at the time and was given the option to visit/transfer over to see her husband, demonstrating compassion that staff were willing to arrange this.	- Appropriate recognition and transition to End of Life care. - Good documentation around family's concerns; staff kept trying to communicate with them despite challenges. - Catheter passport in place. - All Best Interest, MCA, DoLs and Safeguarding forms completed. Good end of life medication management and good documentation on CIS. Overall very good management of a complex patient.

QVMH	Hawkhurst
- Care was considered holistically including pressure areas and catheter care. Good documentation on CIS and good communication with patient's son in final days.	- Good practice in contacting hospice re pacemaker as well as making funeral directors aware. Extremely positive feedback received from family via Meridian survey re excellent care, stating how all staff went "above and beyond." Clear notes and filing.

Areas for Learning	Comments/Actions
Documentation	
- Recommend increased use of electronic nursing assessment on CIS. Care plans should be fully on the PCP template.	- Recommendation fed back to ward matron and disseminated more widely at monthly matrons' meeting.
- There was a slight discrepancy with the death and discharge timings on CIS (noted as discharged from ward at 16:30 and died at 18:59; paper notes confirm death occurred at 15:00)	- Discrepancy fed back to ward matron and disseminated more widely at monthly matrons' meeting.
- Not specifically documented that bereavement leaflet was given.	- This is common across all community hospitals; staff typically give out documentation after death as a matter of course and have supportive conversations with family members, but it is not always evidenced in the notes. Work is ongoing with Nicola Le Prevost, Consultant Nurse for End of Life Care, to create a checklist for after death so that the giving of bereavement information can be more consistently evidenced.
Medicines	
- Oxygen used for EOL patient; possibly inappropriate - Glycopyrronium used without sedation or pain relief which are	- Nicola Le Prevost, Consultant Nurse for End of Life Care is working with Pharmacy to develop training for community hospital staff on end of life medications to

usually co-prescribed. - No anti-emetic prescribed along with morphine. - EOL medication use should have been reviewed but was not, and normal medications were not stopped.	ensure that best practice is followed. The mortality review session membership also now includes a pharmacist so that issues with medications can be more easily picked up and areas identified where staff may benefit from education.