Kent Community Health
NHS Foundation Trust

Summary of Learning from Mortality Reviews (October to December 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.

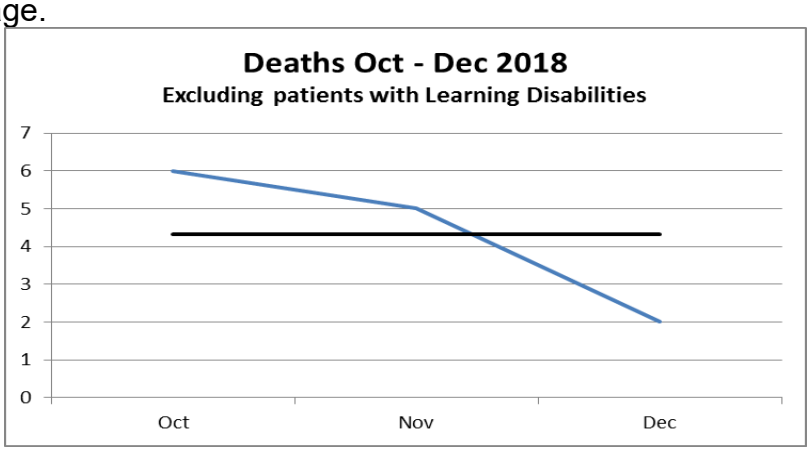
2. December Dashboard

2.1 The dashboard below has been based on national suggested format and refers to deaths in community hospitals.

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
1		4	2*		8	0	0
This Quarter (QTD)		Last Quarter	This Quarter (QTD)		Last Quarter	This Quarter (QTD)	Last Quarter
12		14	12		15	0	0
This Year (YTD)		Last Year	This Year (YTD)		Last Year	This Year (YTD)	Last Year
65		22	58		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.

<table>
<tr><th colspan="2">Areas of Good Practice aligned to the
Five Priorities for Care of the Dying Person</th></tr>
<tr><td>Recognise

- Anticipatory medications in place early (Deal)

- Clear, appropriate step-down of medication at end of life (Sevenoaks)

- The fact that patient was at End of life was well documented with good planning (Whitstable & Tankerton)</td><td>Involve

- Family were present when patient died and music was played, demonstrating personalised care (Deal)

- Good evidence of holistic care and getting to know patient well through “This Is Me” which includes likes, dislikes and what matters to the patient as a person (Westview)

- Good liaison with family and evidence of understanding patient's wishes (Westview)</td></tr>
<tr><td>Plan & Do

- All assessments completed thoroughly (Deal)

- Care responsive and appropriate according to clinical picture. and good consideration of patient's needs (Sevenoaks)

- Thorough assessment by admitting doctor and action plan for patient with clear documentation from the medical team (Whitstable & Tankerton)

- Excellent care considering that patient’s behaviour was challenging; observations were</td><td>Communicate

- Good evidence of communication with family and documentation that patient’s religious wishes were considered, demonstrating very person-centred, holistic care. (Whitstable & Tankerton)

- Evidence of good communication with family throughout (Deal)</td></tr>
</table>

taken every 15 minutes and every action taken to minimise risk as far as possible (Deal) - Good planning for patient's care throughout and responsiveness to needs such as pain management (Westview)	**Support** - Clear documentation that patient was made comfortable, family were well supported and were given condolence card and leaflets after death (Whitstable & Tankerton)

Themes for Learning	Comments/Actions
Transfers of Care - In several cases, there was a lack of handover or SBAR from the acute trust.	- Transfer of Care issues are being reported on Datix and will be taken forward with the acute. A Task and Finish Group is planned for January to discuss next steps.
Documentation - In several cases, it was identified that Personalised Care Plans (PCPs) could have been more detailed. - In one case, two separate drug charts were used which could have used confusion. The purple palliative care chart alone could have been used.	- Feedback sent to Ward Matrons for dissemination to the team. - This will be incorporated into training. Following the emergence in the previous quarter of themes around medications, the End of Life Nurse Consultant and Pharmacy have programmed updates at the December EOL Champions meetings and arranged two training sessions for community teams, with one to follow in January/February 2019. Further work is ongoing with pharmacists to highlight issues and training for next year.

3.3 Although the Trust is only required to review inpatient deaths in community hospitals and there is no national mandate to review deaths in the community, a process has begun for sampling one to two deaths per month from across East and West community teams to incorporate into the existing mortality review process. Deaths are selected by team leaders who identify cases for review where there may be particularly valuable learning, such as where there were problems or if something went well in spite of challenges. The tables

below outline areas of good practice and areas for improvement identified this quarter from the three sample community reviews completed since November.

Areas of Good Practice	Areas for Learning
Sevenoaks Community Nursing - Good documentation and consideration of the fact that patient could not communicate. Very detailed PCP in place and holistic assessments completed thoroughly with good documentation of consent throughout. Anticipatory medicines were written up early and DNA CPR was checked on first visit. Good end of life care and comfort given to family after death.	- No areas identified
Thanet Long Term Services - All end of life medication in place early with input from the hospice. Team very responsive to initial referral and provided an out of hours visit where pain was assessed and managed accordingly. The team was responsive to the patient's needs and all necessary equipment was in place. The family fed back that they were happy with the care received.	- Anticipatory care plan not documented and EOL assessment could have been completed earlier. It could have been considered whether patient required more scheduled visits rather than the team being reactive when calls were received. Team was unable to visit on the evening that patient died due to unprecedented workload. If patient had received daily scheduled visits this could potentially have been avoided. **Comment:** Feedback sent to team leader for wider dissemination. This case was taken to the Mortality Surveillance Group in December for oversight and a query will be taken forward around whether this was raised on Datix as a Transfer of Care issue as the patient should have been referred to KCHFT from the acute due to pressure ulcers. This was considered as a potential SI but the Assistant Director for Patient Safety and Patient Experience

	attended this review session and after a thorough multidisciplinary discussion it was decided that it did not meet the criteria.
West Kent Home Treatment Service - Good communication with family and care was personalised to the patient's needs. Good length and frequency of visits. Focus seamlessly and sensitively changed from active treatment to comfort in final days. Thorough notes give a good "story" of the patient's journey. Good partnership working with GP, hospice and between KCHFT teams.	- Although there were frequent sensitive conversations with the family throughout, it was not specifically documented that DNA CPR was discussed. **Comment:** Feedback sent to team leader for wider dissemination.

3.4 For assurance, there are processes in place to liaise with PALs, SI and Safeguarding teams so that all deaths where a complaint or concern has been raised will be reviewed, even if not normally in scope.