Kent Community Health
NHS Foundation Trust

Learning from Deaths Annual Report October 2018 – September 2019

1. Introduction

1.1 In line with national guidance on learning from deaths, KCHFT collects and publishes mortality data quarterly via a paper to Quality Committee and Public Board, which 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 those deaths reviewed, the Trust must report how many deaths were judged more likely than not to have been due to problems in care. Each year an annual report is submitted in November.

2. September Dashboard

2.1 The dashboard below has been based on national suggested format. Deaths in scope include all community hospital inpatient deaths, any deaths where a complaint or potential SI has been raised, and a small sample of deaths in the community.

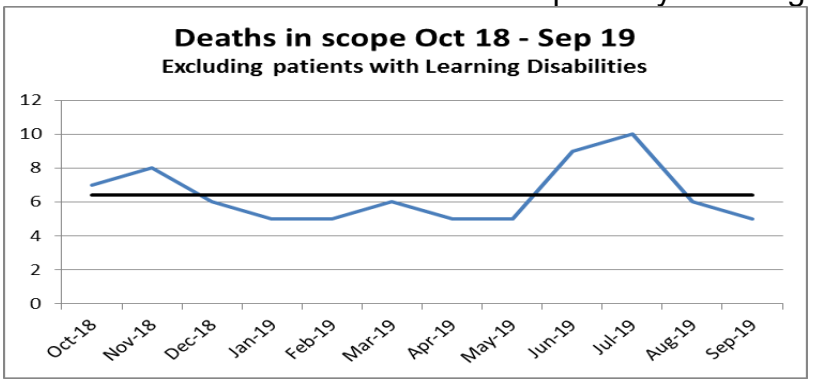
Total Number of Deaths in Scope			Total Deaths Reviewed			Number of deaths judged to be more likely than not due to problems in healthcare	
This Month		Last Month	This Month		Last Month	This Month	Last Month
1		3	3*		7	0	0
This Quarter (QTD)		Last Quarter	This Quarter (QTD)		Last Quarter	This Quarter (QTD)	Last Quarter
13		19	17		13	0	0
This Year (YTD)		Last Year	This Year (YTD)		Last Year	This Year (YTD)	Last Year
47		77	41		69	0	0

**Deaths reviewed in a calendar month may exceed the number of deaths reported that month, as the figure includes deaths taking place in the previous month, but falling into the next month for review; this also applies to those occurring in one year e.g. December, but reviewed in January of the next.*

2.2 Four deaths in the last year have been reviewed or are being reviewed, as part of an SI:

- 1 in March 2019 re a pressure ulcer while under the care of Thanet community teams
- 1 in July 2019 at Whit & Tank re sub-optimal care of a deteriorating patient *(ongoing)*
- 1 in July 2019 re delay in receiving EOL medication while under care of Faversham Long Term Services team *(ongoing)*
- 1 in July 2019 re delayed visit to check faulty syringe driver while under care of Canterbury Long Term Services team *(ongoing)*

2.3 The graph below shows the number of deaths in scope this year along with the average.



3. Learning from Mortality Reviews

3.1 The table below outlines key areas of good practice identified in reviews completed this quarter. These reflect positive findings similar to those emerging from reviews throughout the rest of the year, with recurring examples of excellent holistic care, communication with families, thorough documentation and consideration of spiritual needs.

3.2 All areas of good practice and areas for learning are reported at monthly matrons' meetings in the East and West and wider dissemination to all ward staff is encouraged. A summary report is also reviewed at the bi-monthly End of Life Steering Group, and themes are discussed at the bi-monthly Mortality Surveillance Group (MSG).

Areas of Good Practice aligned to the Five Priorities for Care of the Dying Person	
Recognise	**Involve**
- End of Life was acknowledged explicitly and discussed with the family – Faversham - Observations and medications stopped appropriately – Faversham - Excellent forward planning as it was noted that need for end of life meds should be established or if Fast Track should be considered, as the weekend was approaching – Faversham - End of Life assessment and individualised care plan in place, enabling clear documentation of priorities for the patient's care and the needs of the family - QVMH - An End of Life care plan was put in place on the day of admission, evidencing good, appropriate recognition – Deal - NEWS2 chart was clearly and appropriately marked and discontinued in view of end of life - Deal	- Personalised care evident in the provision of specific dietary requirements for the patient, to suit their preferences as a vegan – Whit & Tank - The patient's wishes were considered as it was noted that she did not want further hospitalisation in the event of deterioration – Faversham - The patient's husband was involved as much as possible, despite being elsewhere in the county undergoing his own health investigations – Faversham - A very holistic approach was evident, which involved the family and spiritual considerations, with a visit from a priest arranged as requested by the patient – Faversham - This is Me document was in place with very detailed information about the patient's likes and hobbies, showing an excellent holistic overview of the patient as an individual – Faversham

Support	
- The team contacted the family very promptly on recognising the patient's deterioration and the family were able to come to the ward to be present when she died - Tonbridge - The patient's friends were involved and visited regularly. She was nursed in a side room with soft lighting and it was noted that her friends were sitting around her bed and sharing stories. It was documented that the friends were given refreshments and made aware they could call the nurse at any time if they noticed any discomfort or concerns – QVMH - Daily delivery of care was well documented, providing a good review of the patient's evolving needs and symptoms and addressing the son's emotional needs - QVMH - It was well documented that the doctor asked the family to come in to discuss the patient's poor prognosis rather than deliver the news over the phone, which shows sensitivity and support for the family. Further discussions were documented after death as to whether they wanted to come in to see their relative, and their funeral wishes were noted – Faversham - Very sensitive approach from nurse who had a needle stick injury, as she was discreet in order not to cause further distress to the family, and followed the policy appropriately – Thanet Community Nursing	- A DNA CPR form was signed by the doctor 3 days after admission. This reflects excellent care as it was completed promptly, shows the patient's view, clearly documents capacity, and involved discussion with the patient's daughter - Hawkhurst - It was documented that it was the patient's wish to stay at Deal and that he was aware he was at end of life and wanted his family around him. This is good evidence of an understanding by the nursing staff of the patient's individual needs and wishes - Deal

Plan & Do	Communicate
- Good general nursing care provided and relevant assessments completed including input from dietician, and the patient's food preferences were noted – Tonbridge - All relevant assessments completed and physio review occurred promptly – QVMH - MCA requirements followed in completion of complex decision form when patient could not discuss DNA CPR – QVMH - Appropriate response to stool type 5 or above, with samples sent to IPC and contact barrier nursing documented – QVMH - Staff took the correct action to contact on-call pharmacist for advice when no drug chart came over with the patient from the acute – QVMH - NEWS scores were regularly recorded and observations were increased in frequency when it rose to 4, showing good ongoing monitoring with thorough documentation and appropriate actions – QVMH - Sticker present on the drug chart alerting staff to the importance of accurate timing of medication for Parkinson's disease - QVMH - Very good initial assessment and care after patient was admitted at midnight in a vulnerable state – Hawkhurst - This patient would normally trigger outreach care so the team did well to keep him in the community hospital; good work with other	- Ward staff escalated all concerns appropriately and many services were involved, with good communication throughout – Hawkhurst - Excellent documentation of discussions with the family around end of life, early in the admission. Good evidence of collaborative work with the family – Whit & Tank - Conversations with the family were well documented throughout – Faversham - Detailed documentation throughout and staff responded appropriately and sensitively to complaint from granddaughter re delay with death certificate and cremation form, which was out of the control of ward staff – Faversham - There were well documented discussions with the family about what would be best for the patient – Faversham - Conversations with the family well documented throughout. A family meeting also took place with the patient present – Hawkhurst - Every effort was made to communicate with the acute to chase gastroenterology appointment for the patient and dilatation procedure for oesophageal stricture, showing excellent cross-team communication. - The team involved the family and hospice, and discussions were well documented – Cranbrook Community Nursing

service providers – Hawkhurst - Very comprehensive medical review on admission and Personalised Care Plan in place – Hawkhurst - Clerking was completed at the earliest available opportunity. CIS checklist was in place on admission, enabling a clear check of assessments completed. All items on checklist completed within first 24 hours, evidencing good care – Hawkhurst - Good care shown by the presence of a handwritten care plan on the day of admission, written by an agency nurse despite known issues of lack of access to CIS for agency staff - Hawkhurst - Comfort round charts were commenced on the day of admission and recorded 2 hourly checks throughout the day and night with no gaps or omissions – Hawkhurst - Good follow-up and actions from medical findings, e.g. the presence of atrial fibrillation following ECG at the acute was reviewed and Apixaban commenced – Hawkhurst - The patient's falls were well documented and responded to appropriately - Hawkhurst - Good respiratory assessment carried out – Whit & Tank - Good response to discomfort caused by catheter, as it was promptly changed for a smaller size – Whit & Tank - Good assessment of syringe driver use and response to this, with appropriate pain	- A positive action arose from a 72 hour report re a medication delay, to devise a sticky label for the patient's home notes with all numbers and instructions on so in future, patients' families are clear on contact numbers and cover for out of hours – Thanet Community Nursing - There was thorough documentation on CIS of long conversations with the patient's daughter - Deal

management throughout – Whit & Tank - All assessments completed promptly on admission and Personalised Care Plan in place - Faversham - Good care given considering a challenging situation where the patient consistently refused input – Faversham - Nurse noticed moisture lesion on admission and promptly Datixed appropriately – Faversham - All assessments completed on first visit and MCA consent documented appropriately – Cranbrook Community Nursing - Very thorough notes on CIS throughout – Cranbrook Community Nursing - All assessments completed promptly and well documented – Thanet Community Nursing - Good care given in a challenging situation where the patient's disease was unpredictable and distressing – Thanet Community Nursing - All appropriate assessments completed and well documented on CIS, and all policies and guidelines followed. The patient's capacity was well documented when he declined to attend hospital against advice – West Kent Home Treatment Service - All care was offered and good care provided considering the patient had a history of being non-concordant with treatment and advice and had been verbally aggressive – West Kent Home Treatment Service	

3.3 Recurring themes around areas for learning and improvement identified throughout the past year are medication, end of life recognition and the need for standardised documentation. These are summarised below along with ongoing or planned actions.

Themes for Learning	Comments/Actions
Medication - Possible inappropriate prescribing, e.g. use of midazolam for coughing and struggling when other meds could have been considered first - Glycopyrronium prescribed as a dose of 400mcg, when a first dose of 200mcg for a frail, elderly patient should have been considered - Non-essential drugs being stopped at end of life are not always clearly crossed through, dated and signed on drug chart - Consideration not always given to stopping antibiotics at end of life - Sub-therapeutic dose of midazolam prescribed on "0-30mg" scale with insufficient guidance - Transfer of Care issue re meds; in one case, patient died within 24 hours of discharge from the acute back to community hospital, but no preparations were made for End of Life. Crisis drugs should have been prescribed either upon discharge or re-admission to KCHFT care.	All feedback from mortality reviews around medication issues are notified to Ruth Brown, Chief Pharmacist, and Clare Fuller, Lead Practitioner for Palliative and End of Life Care. Feedback is also sent to ward matrons for sharing with the team, and is presented at monthly matrons' meetings and bi-monthly End of Life Steering Group. Ruth Brown is planning an accelerated education programme for staff around syringe driver dosing. Staff have been made aware of upcoming MedSavvy events to improve knowledge and confidence. Where appropriate, ward staff are encouraged to Datix any Transfer of Care issues which are then taken forward with the acute via the Transfer of Care Working Group.
Documentation - Delirium is not always explicitly recognised or noted. Conversations with family	Dr Shelagh O'Riordan, Clinical Director for Adult Services, has proposed a

around delirium are not always taking place or being documented.	delirium screening tool and action plan to be in place consistently across the Trust. Denise Hylton-McIntosh, Head of Patient Safety, is to take this forward with input from Dr Lisa Scobbie, Deputy Medical Director.
- Patient's wishes re ceiling of care/transfer to the acute on deterioration are not always explicitly recorded.	Advanced Care Plans should be clearer around patients' explicit wishes for each possible situation. Denise Hylton-McIntosh, Head of Patient Safety, is to take this forward to look at more consistent documentation to make recording patient wishes easier.
- In many cases, care plans are not written in the own words of the patient and could reflect more of the patient voice.	A Trust-wide QI project is ongoing around standardising Personalised Care Plans, with input from the Heads of Quality, Governance and Professional Standards.
- In response to one case, the Safeguarding team suggested that discussions should be documented as a written entry in the notes at the time, with the Safeguarding consultation document being uploaded to the patient record when available, to support others being aware of any concerns, advice and actions given.	All feedback is sent to ward matrons or team leaders for sharing with the team, and is presented at monthly matrons' meetings and bi-monthly End of Life Steering Group.
- DNA CPR forms are not always robust. In one case, the DNA CPR noted that the decision was "not discussed with IMCA as health related issue"; it is unclear why this wording was used. It was also unclear whether this had been discussed with the patient, and if not, the reason why. Attempts should have been made to contact the IMCA. In another case a post-it note was stuck to the form stating that the NHS number was incorrect which has then been amended on form, but it is unclear who made this amendment. The form should have been re-written.	Advice around robust record keeping sought from Trust Solicitor and fed back to teams re post-it notes and incomplete DNA CPRs. A DNA CPR audit recently took place; actions to be agreed when findings become available.

Recognition	
- In some cases, although patients had been originally for rehab and plans made for discharge home, there could still have been consideration to "what if…?" discussions and early exploration of patient wishes in the event of deterioration. - Good response to deterioration, but failure to holistically plan for End of Life. Missed opportunities for discussions; earlier response to signs needed. - In one case, family were still discussing possible homes for the patient so it was unclear whether situation was fully communicated or understood re End of Life.	All feedback is sent to ward matrons or team leaders for sharing with the team, and is presented at monthly matrons' meetings and bi-monthly End of Life Steering Group. Clare Fuller, Lead Practitioner for Palliative and End of Life Care is also copied into feedback and earlier recognition forms part of the future programme of work.

3.4 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 began in November 2018 which aims to sample one to two deaths per month from across East and West community teams to incorporate into the existing review process, subject to capacity of the review teams. Deaths are selected by team leaders who identify cases where there may be particularly rich learning, i.e. where problems occurred or care went well despite challenges.

3.5 For assurance, there are administrative processes in place for liaison 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. Deaths going through the SI process may not be re-reviewed to avoid duplication, if the RCA already identifies detailed learning. Cases deemed not to be SIs following a conference call and not subject to an RCA will undergo a mortality review to ensure no learning is missed.

3.6 Between October 2018 and September 2019, a total of 20 'other' deaths were reviewed that did not take place in community hospitals, but were either samples selected by community teams, deaths referred for mortality review by the Patient Safety team due to complaints or cases where concerns were raised but deemed not to be SIs. Areas of good practice from these cases were included in the table above, and areas for learning were consistent with issues identified across the Trust generally.

4. Learning Disability (LD) Mortality Review Process Update

4.1 At the July 2019 Quality Committee, a full report was submitted by Mark Anderson, Deputy Head of Service for Learning Disabilities, covering April 2017 – March 2019.

This report confirmed that the internal review process, developed in response to the lack of feedback from the national LeDeR programme, had led to a successful clearing of the backlog of deaths for review. MDT meetings are now arranged when needed; a snapshot provided to the Mortality Surveillance Group in September 2019 showed that 117 reviews had been completed and only four were currently pending.

4.2 Initial findings indicate that causes of death are similar to those reported nationally, i.e. respiratory, circulatory disorders and cancer. The majority of service users were on end of life care and there were no avoidable or preventable deaths from a KCHFT perspective, or Serious Incidents. Good practice has been highlighted around End of Life pathways, anticipatory care planning and joint working with other organisations such as GPs and hospices. Practitioners who attend the LD mortality review meetings have given very positive feedback and KCHFT staff have been found to be very proactive in supporting discharge from acute hospitals in order for people to die at home.

5. Mortality Review process developments, joint working and future plans

5.1 Over the past year, the Structured Judgement Review form and methodology has become further embedded, bringing KCHFT's mortality review process increasingly in line with acute trusts. This will facilitate greater ease of information sharing and quantitative analytics, should national requirements evolve for community trusts' learning from deaths reporting in the future. Quantitative data collection of themes and trends is also now aligned to the Royal College of Physicians problem categories; the up-to-date summary spreadsheet can be found in Appendix 1.

5.2 In November 2018, an additional question was added into the Structured Judgement Review form for assurance following the Gosport Inquiry, which asks the review group to answer 'yes' or 'no' to the question, 'Is there any evidence of unsafe practice by mismanagement or misuse of controlled drugs that contributed to death?'

5.3 At the September Mortality Surveillance Group, the Healthcare Insight Specialist from Dr Foster presented the latest insight report covering the latest available data up to May 2019. The long-term picture shown by the data in terms of mortality rates is stable, but it was noted that the volume of step-downs has been slowly increasing over the last three years. Step up volumes are decreasing overall although there were peaks over the winter period as expected.

5.4 Following the publication of the NHS England document 'Guidance for NHS trusts on working with bereaved families and carers', a gap in formal processes for involving families in mortality reviews was identified nationally. There is an ongoing QI project focusing on the bereavement questionnaire for relatives and carers, led by the Patient Experience Manager and building on examples of good practice from other trusts highlighted in the report. This work is overseen by the End of Life Steering Group and will be supported as appropriate by the Mortality Surveillance Group.

5.5 Within the past year, a mortality review identified an issue of awareness around what to do when a patient dies with no known next of kin. Written guidance has now been circulated to community hospitals for clarity, and the procedure has also been added to the Care after Death policy.

5.6 Work is ongoing to put a process in place for the Mortality Surveillance Group to receive regular reports from the Child Death Overview Panel for assurance, and to identify any themes and trends. This is to ensure any learning is received for child deaths where KCHFT teams may have had some input. Any Serious Case Reviews are included in an Action Tracker presented by the Safeguarding team at each Mortality Surveillance Group meeting so there is assurance that the Trust would already be aware of any cases of specific concern.

5.7 Contact has been made with acute trusts and the local mental health trust KMPT. While joint working with acute trusts is an aspiration for the future, it is hoped that imminent progress will be made with KMPT around sharing learning from mortality reviews of mutual patients, to ensure that care provided to patients with serious mental health needs who have died, is being reviewed from a KCHFT perspective where appropriate. A meeting is due to take place in the coming months between Dr Lisa Scobbie, Deputy Medical Director at KCHFT and Annie Oakley, Head of Patient Safety at KMPT, to take forward formal plans for collaboration.

5.8 Initial contact has been made with Patient Safety teams at West Kent CCG, and Ashford and Canterbury CCGs with a view to involving primary care in mortality reviews in the future. How this will be affected by potential CCG structure changes is currently unclear.

5.9 The Head of Nursing at Pilgrims Hospice has been identified as a contact point and is receptive to any shared learning for the hospice emerging from KCHFT mortality reviews.

5.10 Details of deaths where a mortality review has identified potential for cross-organisational learning are now brought to the next available bi-monthly Mortality Surveillance Group for discussion around how to take forward shared insights.

5.11 KCHFT took part in a focus group organised by the Patient Safety Fellow at the Kent Surrey and Sussex Patient Safety Collaborative in September 2019. Five clinical staff shared their views and experiences around deaths occurring at work, what they found helpful to support them as a team as well as the patient's family, and what other support they would find useful in future. The participants were from across East and West Kent, community hospitals and community teams. Findings will be shared with managers in due course, to inform further organisational improvements around supporting both staff and families leading up to, and following, a death.

5.12 The Learning from Deaths policy will be reviewed by the end of 2019 to ensure the document reflects the ongoing evolution of the process and the developments noted above.

Dr Lisa Scobbie - Deputy Medical Director

and

Melissa Ganendran - Mortality Review Project Lead

on behalf of **Dr Sarah Phillips - Medical Director**
October 2019