Learning from Deaths Annual Report September 2019 – August 2020

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.

2. Covid-19

2.1 The mortality review process was adapted in April 2020 in response to COVID-19 and these changes were approved at an Extraordinary Quality Committee shortly after the beginning of the pandemic. Reviews are now completed virtually, first by a doctor using physical notes, and then circulated to at least two other clinicians for independent review of CIS notes. This allows for further comment and a safe degree of peer review. A minimum of 3 clinicians including the lead medical reviewer are required.

2.2 The number of deaths in community hospitals increased dramatically as a result of COVID-19, with 41 deaths in KCHFT community hospitals in April. The volume of deaths in May and June decreased significantly but remained above average. July and August deaths have returned to expected levels.

2.3 Deaths are cross-checked against a list from the Performance Team each month, including their submission of COVID-19 deaths, to ensure records are accurate. The total number of COVID deaths since April is 49.

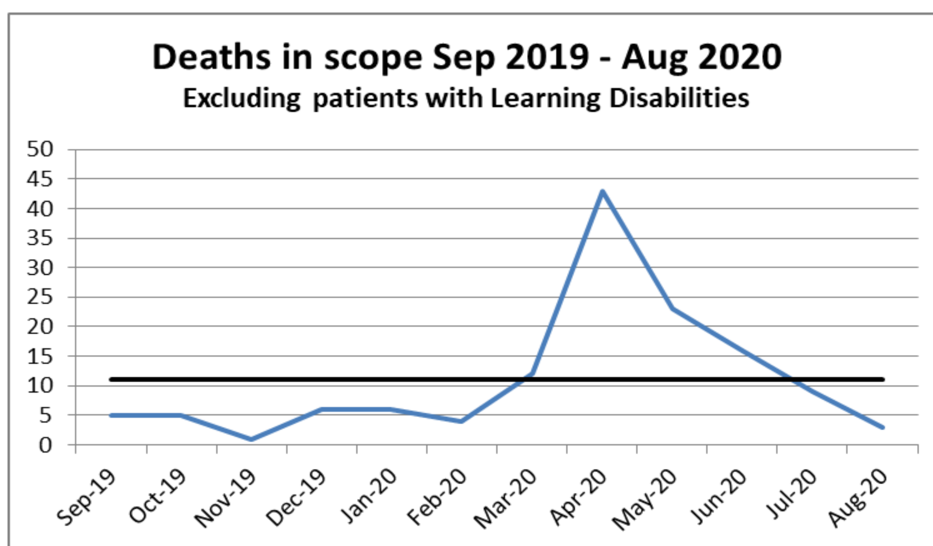
3. August Dashboard

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

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		9	15*		0	0	0
This Quarter (QTD)		Last Quarter	This Quarter (QTD)		Last Quarter	This Quarter (QTD)	Last Quarter
12		85	15		55	0	0
This Year (YTD)		Last Year	This Year (YTD)		Last Year	This Year (YTD)	Last Year
119		65	84		66	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.*

3.2 The graph below shows the number of deaths in scope by month over the last year, along with the average.



4. Learning from Mortality Reviews

4.1 The table below outlines key areas of good practice identified in reviews completed over the last quarter, which reflect the emerging themes from the whole year.

4.2 All areas of good practice and areas for learning are reported at monthly matrons'/clinical leads meetings in East and West Kent 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). An outline of emerging issues is sent for information weekly to the Patient Safety Summit.

Areas of Good Practice aligned to the Five Priorities for Care of the Dying Person	
Recognise Many examples of good clinical practice were documented in mortality reviews including: • Early recognition and implementation of end of life care • Clear documentation of end of life care plans and appropriate review of medication required at the end of life. In one notable case there was prompt review of a deteriorating patient with appropriate initial trial of active treatment whilst also considering	**Involve** • Frequent examples of patient involvement in decisions about care were documented during completion of care plans, treatment escalation plans, DNACPR discussions and advance care planning. **Support** • Frequent evidence of support provided to enable visiting during End of Life care whilst maintaining COVID-19 IPC precautions were

the probability that the patient may continue to deteriorate and require end of life care. • There was also good evidence of use of the Treatment Escalation Plans implemented during COVID -19 to support advance care planning	documented. There were also examples of efforts made to ensure contact by phone or virtual link where possible and supportive care provided to patients who did not have visitors. • In one particular case there was excellent documentation of the compassion shown by a nurse who stayed with the patient, played gentle background music and stroked her hair to give comfort as she died.
Plan & Do • Very frequent examples of clear assessment and responsive management plans were documented during reviews. It was noted that on some occasions the intervention of the discharge support team ensured that patients were transferred from the acute with appropriate handover.	**Communicate** • Clear documentation and communication with family were frequently recorded during reviews with good examples of using alternative methods of communication during COVID. There were also good examples of clear communication with other providers to support good patient care.

4.3 Recurring themes around areas for learning and improvement identified throughout the past year are recognition of end of life, medications, DNA CPR and TEPs, transfers of care, general documentation and verification of death issues. These are summarised below along with ongoing or planned actions. Graphs can be seen in Appendix 1 showing the frequency of each problem type, in line with RCP reporting categories and the way that themes are reported to the Patient Safety Summit.

Themes for Learning	Comments/Actions
Recognition of End of Life There have been recurring themes of missed opportunities for early recognition of end of life, for example: • Possible missed opportunities to reconsider management goals and reflect patient wishes not to return to the acute hospital. • Notes unclear that the dying phase	Teams involved advised to utilise the end of life assessment tool on CIS for capturing decisions in place and for monitoring symptoms. At one community hospital, measures were put in place to support medical staff involved, including training

<table>
<tr><td>was recognised
No clear evidence of advance care planning
NEWS scores still being recorded at end of life</td><td>regarding treatment escalation planning.

Sevenoaks Hospital has requested support in recognising end of life so work is being scoped to address this need.</td></tr>
<tr><td>Medicines

Examples of medication issues included:
Incorrect dosing of subcutaneous glycopyrronium due to discrepancy on palliative end of life medication chart which did not allow for 200mcg dose to prescribed even though this is the recommended starting dose
Medicines charts not always completed in full, abbreviations used and not as per guidelines found on each chart.
Regular medication recorded as omitted or unable to take without any clear review or reconciliation of medication with the clinical situation</td><td>All medicines issues are fed back to the Pharmacy team, in addition to the usual feedback channels.

Re the glycopyrronium discrepancy, an internal alert was issued in response, with stickers over the incorrect dosage on the charts prior to issue from Pharmacy, and re-issue of electronic charts.</td></tr>
<tr><td>Transfer of Care Issues

There have been a number of Transfer of Care issues from the acute. Many of those relate to missing or incomplete DNACPR and TEP forms, which will be listed separately under the DNACPR/TEP heading below.

Transfer of care issues in relation to lack of documentation or advance care planning are noted to be particularly problematic when late transfers occur and have in some instances led to inappropriate escalation of care in patients for whom end of life care would have been appropriate.</td><td>Issues identified in mortality reviews are fed through to the Transfers of Care group. Regular meetings are now being held between KCHFT’s Deputy Medical Director and MTW’s Deputy Director of Clinical Governance to raise any issues. Representatives of EKHUFT are due to attend the next KCHFT Transfers of Care Task & Finish meeting in September.</td></tr>
</table>

DNA CPR forms and TEPs On several occasions, incomplete or poor quality DNACPR forms have been received from the acute. Problems include: • DNACPR undated, unsigned and identity of clinician not clear • DNACPR omits any summary of discussion with the patient or family • KCHFT staff not always aware of when it would be best practice to review and re-write a DNACPR form e.g. capacity has changed, form sent by the acute does not include discussion with family • Treatment Escalation Plan not fully completed with no documentation of frailty or WHO performance status on document and no comment on patients personal preferences	The referral handover and admission checklist has been amended to include questions in relation to MCA, End of Life, Treatment Escalation Plans and DNAR, which should aid staff in recognising when documentation is missing on transfer. An MS Teams meeting where a mortality review will be presented to staff to promote learning from deaths has been set for 29 September. The theme for this meeting will be best practice regarding the writing and reviewing of DNACPR forms.
General documentation issues • Issues include handwritten notes without clearly identified staff entries and incomplete patient details, lack of documentation around capacity and some lack of consistency between electronic and written notes. • In one case there was no apparent documentation of the patient's significant mental health history or of any specific needs. Not documented in the GP SCR record or in any patient handover documentation. Rapid transfer service Ready to Transfer form also had box ticked to state patient had no mental health history.	Implementation of the new electronic patient record system is due on 19 October 2020 so it is hoped that this will reduce or eliminate some of the recurring documentation issues. All cases involving patients with Serious Mental Illness are shared with KMPT.

Verification of Death	
Earlier in the year a number of issues around verification of death were identified. A workshop was held in January 2020 involving community nursing teams from both East and West Kent to try to understand the causes. Problems discussed included: • Time pressures for night nurses and fluctuating workloads depending on the number of end of life patients • Lack of staff on shift trained to verify. • Need for greater clarity in the Trust policy and some confusion among staff between verification and certification.	Working closely with the End of Life care specialists, the Verification of Death policy has been updated and clarified. Since the onset of COVID-19, guidance for remote verification of death has been developed and online training for verification of death is now available to Trust staff.

4.4 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, all community deaths where a complaint or concern has been raised are reviewed. 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.

4.5 Between September 2019 and August 2020, 19 of these ‘other’ in-scope deaths have been reviewed. This slowed down significantly during the COVID-19 crisis as the focus was necessarily on community hospital deaths. Since July, the rate of review for these other deaths is picking up again. Areas of good practice and learning from these cases were consistent with those identified across the Trust generally.

5. Learning Disability (LD) Mortality Reviews
Report from Mandy Setterfield, Specialist Practitioner

5.1 In response to the Coronavirus pandemic, Kent and Medway made a decision to pause the LeDer programme and mortality reviews from March 2020 to June 2020 to prevent added pressure on GPs, hospitals and families.

During this time, we introduced the Rapid Covid19 Review which is a review for anyone with a Learning Disability who had died with suspected or confirmed Covid19.
The review template used for all rapid reviews was developed by the London Boroughs and more recently adapted by the LeDer South East Regional Coordinator. The rapid review does not replace the full LeDer review it will be used as supporting documentation.

The rationale for the rapid reviews is to:

- Quickly gain local knowledge regarding deaths from Covid19
- Disseminate the evolving themes to try to avoid further deaths
- Support care homes and providers
- Gain softer intelligence that can inform other areas of Covid19 across health and social care.

The KCHFT LeDer team reviewed 26 deaths which were Covid19 confirmed or suspected. From the reviews we were able to identify:

5.2 Evolving Themes

- 6 people had Diabetes
- 5 people had Downs Syndrome
- 6 people were prescribed antibiotics for infections in the community a week to 10 days before going into hospital. Evidence of this has come from the person's provider or the hospital.
- Rapid health deterioration within 24 hours when symptoms of covid19 appeared.
- Lack of PPE and understanding in care homes re guidance.
- 18 of the case called 999 direct, only 3 went through to 111. Reasons given included waiting over an hour for call back from 111 and then being told to ring GP the next day.
- Good care in hospital

5.3 DNACPR

- 8 people already had a community DNACPR. 9 DNACPR orders were put in place in hospital due to covid19.
- 6 people were on end of life before being confirmed with covid19. Checks on CIS and KCC system would indicate that the DNACPR's for end of life were appropriate and reviewed regularly.

5.4 Lessons Learnt

- Care homes could have benefited from more support advice around government guidance and PPE in the earlier days of the pandemic.
- Communication and Hospital passports were not always taken to the hospital with the person. Where these were with the person, they could not be moved around the hospital with the person e.g. ward to ward due to infection risk.
- A number of people were prescribed antibiotics for infections in the community in the week before being admitted to hospital, indicating a potential missed opportunity for earlier detection of Covid19.
- People were admitted to hospital alone and died without family or carers with them.

5.5 Actions taken

Following rapid reviews, it was recognised there was a need for some immediate changes, these included:

- Supporting care homes with the government guidance and where to get PPE.
- Feeding into the vulnerable adults spreadsheet.
- Weekly data is fed into KCC commissioning for social care spreadsheet.
- Softer intelligence from reviews highlighted to KCC where people had been living in older persons homes for them to follow up.
- Covid19 passports were laminated so they could move around hospital sites.
- Care home initiative was set up to support residential service, this included train the trainers for PPE users to increase care homes and supported livings' understanding of how to use PPE.
- We worked with carers to think more clinically and to inform GPs that people with a learning disability may have a lower body temperature than the norm
- KCC Commissioning suggested that care homes purchased oximeters due the risk of silent hypoxia.
- Encouraged the use of tablets in hospital for staff who knows the person well to be able to identify for nurses/doctors when behaviour was out of character behaviour. This has been used locally and worked well.

NHSE are analysing 200 Covid19 reviews nationally, 7 of which are from Kent & Medway. Findings from these reviews will be reported in late October.

5.6 Reset Plans status of LeDer programme

The KCHFT LeDeR team resumed business as usual from July 2020.
We have now been asked by the Kent & Medway CCG to review deaths from April to end of August to minimise a further backlog of reviews occurring. Alongside this work we are preparing to finalise what a permanent LeDer team would look like going forward.

5.7 Improvements to internal processes

Originally there were two sets of reviews happening; one for LeDer and one for KCHFT. We have now dovetailed this work and will be using the LeDer mortality review for KCHFT Learning Disability Deaths. This will stop duplication of work and streamline the process.

Discussions are ongoing as to how the Kent & Medway care record which is due to come on line next year will be of benefit for the mortality reviews and we are having input into this.

Data collection for KCHFT mortality reviews is now in line with the rest of KCHFT; we are using the same dashboard slightly modified to collect data specific to Learning Disability.

6. Mortality Surveillance Group (MSG)

6.1 The MSG continues to meet bi-monthly and has oversight of mortality review processes, with regular input from Non-Executive Director Pippa Barber.

6.2 The MSG receives bi-monthly reports from the following:

- Safeguarding – presenting the Action Tracker for Case Reviews and Serious Case Reviews
- Learning Disabilities – presenting process updates, themes and trends from mortality reviews of patients with Learning Disabilities
- Healthcare Insight Specialist from Dr Foster – presenting mortality, step-up and step-down statistics benchmarked against peer trusts
- Work is ongoing to obtain regular learning from the Child Death Overview Panel

6.3 Membership includes representation from Patient Safety, Legal, Pharmacy and End of Life teams to enable cohesive working.

6.4 Currently, two sample mortality review forms (de-personalised) are presented at each MSG for oversight, comment and challenge.

7. Joint working and future plans

7.1 The Mortality Review and Responding to Deaths policy was amended to reflect recent process changes and was ratified on 3 April 2020. Additional minor changes to include the COVID-19 SOP and reference to liaison with the Legal team were added in August 2020.

7.2 Relationships continue to be built with other providers. A regular meeting every 6 – 8 weeks is now taking place between KCHFT's Deputy Medical Director and MTW's Deputy Director of Clinical Governance, to raise any issues identified in mortality reviews including transfers of care, and to share learning from reviews of mutual patients.

7.3 In January 2020 a meeting was held with KMPT and channels are now in place to share learning from mortality reviews of mutual patients with Serious Mental Illness (SMI).

7.4 A pilot Learning from Deaths webinar is planned for 29 September to celebrate compassionate practice from a sample mortality review case, as well as to open a discussion around recurring issues with DNA CPRs. If well received, it is hoped that these will become a regular event.

7.5 Virtual reviews as described in 2.1 will continue for the foreseeable future but the process remains subject to change and will evolve as necessary to offer robust assurance and learning, with wider staff involvement, with the appropriate approval of the Quality Committee.

Dr Lisa Scobbie - Deputy Medical Director
and **Melissa Ganendran - Mortality Review Project Lead**
On behalf of **Dr Sarah Phillips - Medical Director**
September 2020

Appendix 1