Colchester Hospital University NHS Foundation Trust: Learning from Deaths Dashboard - December 2017-18

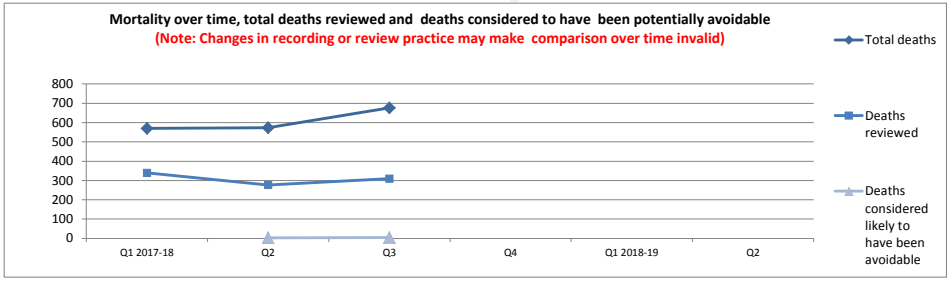
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Potentially Due to Problems in Healthcare (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total No. of deaths considered to have been possibly due to problems in healthcare (Score <=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
224	247	140	90	2	2
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
676	573	309	277	4	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1819	0	925	0	7	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2



Total Deaths Reviewed by Mortality Methodology Score

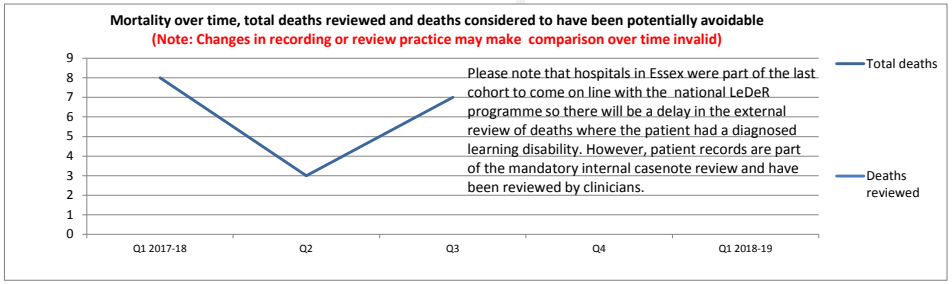
Score 1 Definitely due to problems in healthcare			Score 2 Strong evidence there were problems in healthcare			Score 3 Probably due to problems in healthcare (more than 50:50)			Score 4 Probably due to problems in healthcare but not very likely			Score 5 Slight evidence that death was due to problems in healthcare			Score 6 Death was definitely not due to problems in healthcare		
This Month	0	0.0%	This Month	0	0.0%	This Month	2	1.5%	This Month	2	1.5%	This Month	4	3.1%	This Month	123	93.9%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	4	1.4%	This Quarter (QTD)	3	1.0%	This Quarter (QTD)	9	3.1%	This Quarter (QTD)	270	94.4%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	7	0.8%	This Year (YTD)	7	0.8%	This Year (YTD)	21	2.5%	This Year (YTD)	805	95.8%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Due to Problems in Healthcare for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total No. of deaths considered to have been potentially due to problems in healthcare	
This Month	Last Month	This Month	Last Month	This Month	Last Month
7	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	3	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
18	0	0	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Trust	Colchester Hospital University NHS Foundation Trust
Org Code	432
Month	December
Year	2017-18

Total deaths include inpatients, paediatrics, maternity, ED & SHMI pts
Total deaths also includes patients with LD reviewed under SJR criteria

The total number of deaths listed below includes deaths within 30 days of being discharged from hospital. Not all deaths are subject to mandatory review.

					Deaths judged to have been due to problems in healthcare					Deaths judged not due to problems in healthcare				Review of manadatory case records				
					Defin	Evidnc	>50/50	<50/50	Slight									
Financial Year	**Month**	**Total Deaths (not LD)**	**Total Deaths Reviewed (not LD)**	**Deaths Avoidable > 50% (not LD)**	**1**	**2**	**3**	**4**	**5**	**6**	**LD Deaths**	**LD Deaths Reviewed**	**LD Deaths Avoidable > 50%**	**No. deaths subject to case record review**	**No. reviews returned**	**% Case record reviews completed**	**No. case record reviews outstanding**	**No. deaths investigated as SIs**
2017-18	April	185	110	0	0	0	0	0	3	93	2	0	0	52	52	100%	0	2
2017-18	May	184	124	0	0	0	0	2	2	109	3	0	0	65	65	100%	0	2
2017-18	June	201	105	0	0	0	0	0	1	88	3	0	0	29	29	100%	0	0
2017-18	July	197	101	2	0	0	2	1	2	87	1	0	0	43	35	81%	8	4
2017-18	August	186	91	0	0	0	0	0	2	81	2	0	0	41	32	78%	9	0
2017-18	September	190	85	1	0	0	1	1	2	77	0	0	0	27	23	85%	4	0
2017-18	October	205	79	0	0	0	0	0	1	71	0	0	0	30	23	77%	7	2
2017-18	November	247	90	2	0	0	2	1	4	76	0	0	0	44	27	61%	17	3
2017-18	December	224	140	2	0	0	2	2	4	123	7	0	0	51	39	76%	12	1
2017-18	January																	
2017-18	February																	
2017-18	March																	

Learning from Deaths – Themes and Actions

Issue - hyperglycaemia monitoring
Action - this has been escalated to the consultant diabetologist who has agreed to review the blood glucose chart so that possibly the upper range could be extended to reflect lab results (current ceiling is 20), to provide better sign-posting for staff on the form as to when and to whom the patient should be escalated if there is no improvement and to look at incorporating the paperwork into the drug chart to increase visibility for doctors.

Issue - failure to screen and subsequently treat for sepsis.
Action - compliance with the sepsis screening tool is closely monitored. The sepsis screening tool has been updated to help improve compliance with documentation and treatment; this was rolled out in January 2018. The new Adult Treatment and Escalation Plan (TEP) will make clear those patients for whom screening and treatment would not be appropriate.

Issue – missed cord compression.
Action - New oncology standard operating procedure; spinal cord compression pathway to be shared with A&E; known oncology patients to have immediate referral to oncology team; once trauma has been excluded, metastatic spinal cord compression (MSCC) should be excluded by a whole-spine MRI as soon as possible; where there are treatment options available for a health condition, such as MSCC, that span across two specialities there should be robust communication channels and there should be collaboration to achieve the most appropriate treatment options for the patient.

Issue – symptom control for patients approaching end of life/pre-emptive prescribing of medication.
Action – there is access to the specialist palliative care team 24/7 and this has been widely publicised; better recognition of anticipatory medicines has been noted with increased uptake of the Individual Care Record for the Last Days of Life (ICRLDL).

Issue – earlier consideration/recognition of last days of life/completion of DNACPR forms.
Action – although it is acknowledged that there are elements of 'hindsight bias' with mortality reviews, there is work ongoing to encourage the regular review of the patient's response to treatment and prognosis including use of the Adult TEP.

Issue – poor uptake of the ICRLDL in some areas.
Action - there are pockets of excellence but it is acknowledged that use of the tool is not delivered consistently well across the Trust. This is being monitored by the palliative care team and the compliance target has been exceeded for the last six months.

Issue – high mortality rates for pneumonia
Action – the pneumonia care bundle produced by the British Thoracic Society has been trialled in the Emergency Department and the Emergency Assessment Unit since November 2017 to make sure that patients are appropriately diagnosed and treated.

Issue – ensuring patients are looked after in their preferred place of care.
Action – there has been good uptake with registering patients on the My Care Choices register and staff access is monitored closely to ensure that the patient's wishes are complied with, but it is not always possible to achieve a rapid discharge home/to the hospice.

Issue – good documentation of discussion with families and carers
Action – reviews have picked up an increasing standard of documentation of consultation with families and carers. Families are being consulted, treatment limits considered and ceilings established. There is good evidence of symptom control to allow quality time with relatives as the patient approaches end of life .