Let's Talk about Death: Implementing Guidance on Learning from Deaths at Homerton Hospital

W Teranaka1, I Harrod2
1. Central and North West London NHS Foundation Trust; 2. Geriatric medicine department, Homerton Healthcare NHS Foundation Trust

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NHS Foundation Trust

How did it start?

2016 Care Quality Commission found that learning from deaths was not prioritised within the NHS.

2017 The National Quality Board published the first Guidance on Learning from Deaths. It stated the aim of the mortality review process across NHS Trusts and provided a framework in identifying, reporting, investigating and learning from deaths in care.

2017 Building a foundation

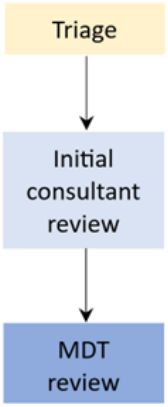
At Homerton Hospital (part of Homerton Healthcare NHS Foundation Trust), paper-based mortality reviews had already been conducted by some specialties. However, there was no Trust-wide process to record data and learnings. Therefore, a scoring methodology to document quality of care and impact on outcome was incorporated; CESDI (Confidential Enquiry into Stillbirths and Deaths in Infancy):

CESDI score	
CESDI 0	No suboptimal care
CESDI 1	Suboptimal care, but different management would not have made any difference to the outcome
CESDI 2	Suboptimal care; different management may have made a difference to outcome
CESDI 3	Suboptimal care; different care would reasonably be expected to have made a difference

2018 An in-house web-based Mortality Review Tool (MRT) was built by clinicians and the IT team

What does the Mortality Review Tool do?

The MRT allows reporting of Trust-wide mortality data. It is a live database extracted from our Electronic Patient Records and allows standardised documentation of all in-hospital deaths using a 3-stage process:



1) Patients are triaged for additional review through learning disability or mental health scrutiny
2) Consultants provide an initial review, learning points and allocation of CESDI score
3) Second independent consultant review or MDT review in departmental meeting with multidisciplinary attendance. Multispecialty discussion for select patients are encouraged.

The MRT allows us to:

- Identify areas of good practice and areas of improvement
- Draw common themes and learning
- Capture family concerns
- Link in with wider governance processes including Serious Incidents and Structured Judgement Review for select patients
- Audit data: refer back retrospectively

What has improved?

Completion of initial consultant reviews and further MDT or second independent consultant reviews increased with the implementation of the MRT in comparable quarters as below:

	Q1 2018/2019	Q1 2022/2023
Completion of initial consultant reviews	82%	99%
Completion of MDT/2nd consultant reviews	76%	98%

It has also led to:

- Culture of open discussion with wider multidisciplinary team members who were involved in patient care. For example, speech and language therapist input for a person who had a complex feeding decision.
- New leadership role in the geriatric medicine department. A registrar now organises and chairs mortality review meetings including inviting relevant specialties for individual case discussion.

Trust-wide learning

Death can be a difficult subject to talk about. To address some of the barriers, a quarterly mortality newsletter entitled "Let's Talk About Death" was launched in July 2018. It uses anonymised clinical case examples to illustrate learning points and teaching on death and dying.

Key messages are contributed by teams including palliative care and edited by a registrar in geriatric medicine under consultant supervision. It is published on the intranet available for all members of the Trust. Previous topics include:

- SWAN model of end of life care
- different trajectories of deterioration such as for frailty versus organ-specific or malignancy-related
- holistic management of a dying patient with Parkinson's Disease
- working with community services
- the role of chaplaincy.

Mortality reviews and learning continued throughout the height of the pandemic. Several consultants from different medical specialties volunteered to support mortality reviews in areas with highest COVID pressures. The small number of nosocomial COVID deaths were also reviewed in focused meetings involving senior nursing, medical professionals and the Head of Patient Safety and Quality. Since then, the additional use of Structured Judgement Review -for example for a patient with learning disability -was piloted then rolled out in 2021. In 2022, it was added to the MRT.

Conclusion

The Trust's response to the Guidance has resulted in measurable improvement in data recording and engagement with mortality reviews across all specialties. Building on the foundations, from 2017 to 2023, further development has strengthened the review process and encouraged a culture of learning from deaths in care.