Quarterly report on Learning from deaths

1. This report forms part of the requirement to report on the review of deaths. The analysis refers to Q4 (January 2018 to March 2018). Deaths in adult services in Luton Community Services were reviewed.

2. Ninety three deaths were reported on SystmOne in Luton during Q4. 48 of the patients who died were females and 45 were males. The age breakdown is as follows:

Age band	**40 & under**	**41-50**	**51-60**	**61-70**	**71-80**	**81-90**	**91-100**	**100 & over**	**TOTAL**
Females	1	1	2	3	11	22	7	1	48
Males	0	1	2	9	13	18	2	0	45

The screening tool of the Learning From Deaths Policy was used to analyse SystmOne. 43 clinical records from the 93 deaths were reviewed.

3. The key findings from the review are:

3.1 All the deaths were expected as per the definition in section 4.1 of the policy. None of the deaths reviewed met the criteria for further review by Root Cause Analysis in section 5.3 of the policy. However, it was difficult to see if any of the patients had a learning disability as this status is not recorded. This is noted in the learning section of this report.

3.2 The assessment and care delivered were well documented for each patient. There were numerous instances where it was noted that the family members or relatives were involved in communication and their wishes met. For example, the staff responded generally well to family requests for visits and for pain management.

3.3 There was very good communication between teams and with the GPs and Luton Borough Council. The staff supported the families in contacting the GPs or Council on their behalf. Staff supported one family member whilst the referral to Social Care colleagues was processed.

3.4 A number of patients can be cared for using a particular model of planned care when nearing the end of their lives. The Gold Standard Framework involves multi disciplinary team advanced planning and is therefore not appropriate for

patients where for a variety of reasons it has not been possible to plan in advance of their death. The GSF is a process for supporting the patients and their families through physical symptoms control e.g. anticipatory drugs for pain and sickness; patient choice for place of care; support and information and the community & primary care team working well together for the patient.

3.5 Of the deaths reviewed, 25 were on GSF; 18 died in their preferred place of deaths; in 5 cases, it was noted that it was not appropriate to discuss the preferred of deaths or the relatives/patients refused to discuss the matter. In 2 cases, the preferred places of deaths were not recorded.

3.6 Of the 18 non-GSF patients who died, 6 died at home, 5 in hospital, 3 in care homes, 1 in a hospice and 3 were not recorded. Those who attended hospital were because they became acutely unwell or referred there by other agencies.

3.7 The good practice noted included:

- The ability to communicate with the patient/relatives or when an interpreter is required. For example, it was noted in one patient records that the sibling must be contacted prior to a visit so that he could be present to interpret.
- Staff offered advice on bereavement and made calls following the deaths to enquire of the families; a bereavement card was sent on one occasion
- Staff followed up queries from relatives; for example by ensuring that visits took place or by contacting other partners on their behalf

3.8 One family expressed their thanks to the staff for the care and support. One other family was quoted as saying :" very pleased and felt supported during this difficult time". Another family mentioned : "their appreciation to the OOHS staff…very pleased…all staff were professional and very helpful at all times".

3.9 The learning points from the review included:

- Our services review the ways in which they are notified of patient deaths to ensure a timely response to the family. On two occasions, staff attended the household where a patient had died and had not been notified.
- Learning Disability notifications were not recorded on the records reviewed.
- The place of death was not recorded in a small number of cases
- Staff should be mindful to record next of kin and their contact details as on one occasion, it was not recorded in the appropriate place
- Staff should prioritise end of life care patients
- Staff should ensure that pain management remains a priority for patients who are not following the GSF. There was no diamorphine available during one visit and another patient waited for a scheduled visit to receive pain medication.

- The preferred place of care/death was not routinely recorded for non-GSF patients. Staff should consider the process for obtaining the information, following discussions with the patients or relatives.

4. The next steps are:
   4.1 to share the findings from this quarterly review with the staff in the adult services in Luton to inform discussions at the next Quality & Risk Group meeting
   4.2 to update the policy in the light of experience of reviewing the learning from deaths
   4.3 to ensure that the review is ongoing at the end of each month
   4.4 To investigate ways to identify patients with Learning Disability on our clinical systems
   4.5 to review Learning From Deaths in all services in the Trust.

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April 2018.