

Improving the use of mortality data – King’s PSSQ project summary

Overview:-

Deaths in hospitals have hit the headlines in recent years, and concerns have been raised nationally about unnecessary fatalities.

Understanding how and why patients die, checking that they got the right care at the right time, and making sure that any shortcomings are understood and put right in the future are vital in providing high quality health services.

“The chief executive and board need to know what is happening clinically on the front line, that patients are safe and potential problems are corrected,” says researcher Juliet Higginson.

We have been undertaking research with clinical staff at King’s College Hospital NHS Foundation Trust to review their mortality and morbidity meetings, where patients’ deaths are discussed.

Meetings have traditionally been educational, enabling doctors to reflect and learn from their professional practice. They have tended not to look at the wider processes of caring for patients. When a patient moved wards, for example, was the transfer done in the best way? Did staff communicate important information to each other? Did the patient’s notes get passed to the right people?

Working with doctors from three areas in both the general and emergency medicine division and the liver and renal division, we have created a mortality review form and simple database to use in their meetings that:

- Identifies unexpected deaths
- Highlights any factors - clinical or to do with wider processes - that may have made a death more likely
- Record any changes made to put things right.

An emerging view in the hospital is that collecting this standard information, which can be compared and analysed over time, is useful. The data from the forms is used to report upwards as far as board level, so feeding into a management focus on improving safety and quality.

Michael Marrinan, Medical Director, King’s College Hospital NHS Foundation Trust says: “Monitoring and reducing mortality rates is of fundamental importance to King’s College Hospital. The mortality review process developed by PSSQ research supports this in a practical way. The study provides an external, objective view of the situation here in the hospital and allows for comparisons between divisions.”

Since our study began:-

- Plans are afoot to use the form across the hospital in the electronic patient record
- Staff appear to welcome the opportunity to consider the broader context in which deaths occurred, as well as clinical matters
- We have been approached by another NHS hospital wanting to use the form in their efforts to improve death rates.