RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Using the Care Review Tool for mortality reviews in Mental Health Trusts

Guidance for reviewers

Overview

Learning from deaths is an essential part of quality improvement work for organisations. Since September 2017, all Trusts in England have been required to have a process in place for mortality reviews, following the publication of the CQC review in December 2016, *Learning, candour and accountability: a review of the way Trusts review and investigate the deaths of patients in England* and the National Guidance on learning from deaths published by the National Quality Board in March 2017.

This Care Review Tool was developed by the Royal College of Psychiatrists through its Centre for Quality Improvement, with funding from NHS England. It is based on the Structured Judgement Review methodology, originally developed by the Royal College of Physicians.

The Care Review Tool is suitable for supporting mortality reviews for patients who were under the care of mental health Trusts and it can be adapted for use by joint mental health and community Trusts.

The Care Review Tool has been developed to look at care at different phases of a patient's contact with services, and ensures that good care is able to be recognised, judged and recorded in the same detail as problematic care. The object of the structured judgement review method is to look for strengths and weaknesses in the process of the patient's care and treatment, to provide information about what can be learned when care goes well, and to identify gaps, problems or difficulties in the care received by the patient.

The tool allows explicit judgements around a patient's care to be made, with a score given for each phase of care. The aim of this tool is to make it possible for Trusts to screen all deaths of patients in contact with mental health services and, through thematic analysis of a number of completed forms, to:

1. Determine areas of good care that can be recognised and further developed

2. Recognise areas where care can be improved

The tool has two sections:

- Section 1 should be completed as soon as possible after a patient's death and could be completed by the treating team.

- Section 2 should be completed for deaths that are selected for a structured judgement review, which would be those deaths that have a 'red flag' (defined on the next page), those where Trusts have identified local need for review, or those deaths that have

been randomly selected. It is expected that the review would be conducted within 60 days of the death being reported.

Principles

The principles of the mortality review process are:

- All deaths are appropriately reviewed to assess if there is potential for organisational learning.
- The deaths selected for further review have a structured judgement review completed.
- The review of deaths is undertaken in a spirit of openness and transparency, and organisational learning, rather than blame.
- The review of deaths will involve families and those close to the deceased, where possible.

Families

The Care Review Tool has been designed to support Trusts in being able to respond to concerns from carers, families and staff about any aspect of the patient's care. It is anticipated that the review will be completed by experienced staff with the relevant experience.

The guidance, released by the National Quality Board in July 2018, "Learning from deaths. Guidance for NHS Trusts on working with bereaved families and carers should be followed, which includes an expectation that Trusts should explain to the families of all deceased patients that they routinely carry out case note reviews on a proportion of all deaths. Families and carers should be given information on how to raise concerns. These concerns should be addressed and, if new or additional concerns are raised by use of the Care Review Tool, the family should be informed.

Other processes

There may be occasions where completion of the Care Review Tool identifies a problem in care that would mean an in depth clinical review or serious incident investigation may be required. Where these problems are identified the local Trust processes for serious incident investigations should be followed **instead of** the Care Review Tool process. The Care Review Tool is not intended as a replacement for the other processes.

It is also important to note that there are currently recognised processes and programmes which focus on deaths of children, maternal deaths, deaths of people with learning disabilities, and homicides linked to mental disorder. The Care Review Tool should therefore not be used in these circumstances as the other processes should be followed.

Section 1: Identification of patients

Each Trust should have a method to identify all deaths, for example using NHS Spine. To support the identification of the individual deaths, which will require a more detailed review, Section 1 of the care review tool may be used as a brief screening instrument and it may be completed by the treating team. Section 1 covers demographic details. Past medical history should be recorded under co-morbidities and, where the ICD-10 code is known, it should be stated. The patient summary may include: relevant symptoms, past psychiatric history and treatment, past medical history, medication, and a background history in addition to relationships.

The diagnosis is the primary diagnosis that the patient was receiving treatment for, covering both mental and physical health.

Patients would be classed as being within the last 12 months of life if there was a documented discussion about end of life care planning or it was documented that palliative care processes were utilised, for example the Gold Standards Framework was applicable.

The purpose of Section 1 is to identify which deaths should be subject to further review.

Mandatory criteria, 'red flags', have been developed to ensure that particular patients' notes are reviewed. Those patient deaths which meet these 'red flag' criteria should be subject to a care review process if they are not already subject to a clinical review or a serious incident investigation. It is expected that all Trusts would review the deaths of:

- All patients where family, carers, or staff have raised concerns about the care provided.

- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death.

- All patients who were an in-patient in a mental health unit at the time of death or who had been discharged from in-patient care within the last month.

- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.

There may also be locally determined 'red flags', which can be identified by individual organisations, depending on local needs. For example, some areas may wish to review deaths of patients with a substance misuse diagnosis, or quality of end of life care in dementia may be reviewed through this process. In these cases, a decision could be made within the organisation about whether to complete a care review tool for all of these patients, or whether a sample of this patient group should be selected. Trusts should all select a random sample of case notes to review the care that the patient received and this review will provide valuable learning. Learning disability was not included as a red flag as all deaths of people with learning disability are reviewed by the LeDeR programme.

In cases where the serious incident investigation criteria are met, the serious incident process should be followed and the mortality review process would not be necessary. There may be cases that begin as a mortality review and it becomes clear that the death should have been treated as a serious incident. A serious incident process should be triggered at that stage.

Section 2: Structured judgement review

Once Section 1 is completed, a decision can be made about whether or not to proceed to the next section. Section 2 should be completed by a senior clinician who was not involved in the patient's care. In this section, judgements should be made about different phases of care. Not all phases of care will be relevant in individual cases and only the relevant sections need to be completed.

Phases of care include:

2.1 The allocation and initial review or assessment of the patient

2.2 The ongoing care of the patient, including both physical health and mental health

2.3 Care during admission

2.4 Care at the end of life

2.5 Discharge planning

2.6 An option for organisations to rate particular aspects of care the reviewers feel is necessary for that individual

2.7 Overall care

In the text box in each section, the reviewers should make explicit judgements about the relevant area of care and then rate the overall quality of the phase of care in question. The judgement should be based on current professional standards, such as the National Institute for Health and Care Excellence guidelines, or the reviewers' professional perspective based on their own experience. It is important that the people conducting the review have the appropriate expertise to make such judgements. Additional expertise may need to be sought at times, for example input from a pharmacist.

Ideally, these explicit judgement statements should be short and to the point. Examples include:

- "Physical observations were not completed regularly"
- "A significant deterioration in physical health was not recognised"
- "The patient's blood sugars were monitored appropriately and appropriate action was taken when issues were identified"
- "There was evidence of good multidisciplinary working to support the individual's needs and wishes"
- "There was evidence of good end of life discussions and consideration of the patient's wishes, with involvement of the key family members"

Reviewers must also specify if care was judged to be excellent, good, adequate, poor, or very poor for each phase of care, as well as for the overall care. There are a wide range of situations which the reviewers will need to judge the care on. Care that covers the essential aspects of what is required would be adequate care. Where the team have gone above and beyond the usual care, the care may be rated very good or excellent. Poor care will be rated when the overall issues in that section were below the standard expected.

It is important to consider whether there was any harm that occurred to the patient, to note areas of good practice, and to identify areas where learning may occur from the deaths. The learning may be identified from areas of good practice as well as from poor practice.

Determining which point in care to commence the care review from is a clinical decision, and there is no timescale set nationally. For example, the review could commence from the point of referral to services, the last relapse of their illness, the lead up to a hospital admission, or a point of deterioration or change in the patient's health.

Working with other organisations

There is a recognition that patients with mental illness may have physical healthcare needs that are looked after by their GPs and other secondary healthcare teams. Social services may also be involved in their care. Appropriate information governance arrangements should be in place to facilitate access to relevant information that is required to complete a care review. Consideration should be given to arranging meetings with other local organisations to support the process of learning from deaths. Acute Hospital Trusts may also be reviewing the deaths of the same patients, and collaborative working would be appropriate in these cases. When themes emerge relating to cross-organisational working, or another team would be more able to address a particular issue, then agreement should be reached with the other organisation to support joint working or review of those aspects of care, as deemed appropriate.

Adaptability of the tool, using dementia as an example

Trusts can amend the tool as appropriate for their own requirements. For example, the review of deaths due to dementia may be more focused on the quality of end of life care, especially if the death was expected, and the end of life care section may be the main part of the tool that would be completed. Issues such as avoidance of inappropriate invasive treatments, recognition of end of life care, advance care planning, and appropriate completion of DNA-CPR forms are important in these cases and may create areas of learning. A random sample of deaths of patients with a diagnosis of dementia would be helpful in quality improvement work around end of life care. Consideration may be given to reviewing the deaths of dementia patients where the following applies:

- Death within weeks of a diagnosis being given
- The death was a surprise to the family
- Sudden death
- Antipsychotic use within the last month before death, which is not prescribed as part of the anticipatory medications

Training and support

Ideally, reviewers should all receive training on the review process. In addition, it would be helpful to establish a local peer group of

reviewers, and for this group to meet and discuss cases to ensure that similar processes are being followed in each organisation.

Learning from deaths

Trusts should have a way to bring together lessons learned, such as through a thematic analysis. The themes identified can then link with the Trust action plans and quality improvement initiatives to improve patient care and improve learning.

It was felt that local and national thematic analysis to identify further learning would be helpful.