Working with SHAs case study: Reflecting on mortality cases to improve care

Overview

Reflective practice is the capacity to reflect on actions so as to engage in a process of continuous learning. This could be reflecting on a positive experience or reflecting on an incident and whether the situation could have been handled differently. In healthcare it can play an essential role in improving quality and safety. Clinical teams want to be able to reflect on the quality of the care they provide, but a sensible and rational way to do this is not always easily found. At Salisbury NHS Trust a multidisciplinary team, lead by Dr William Garrett, have developed a method that enables clinicians to reflect and the entire organisation to learn from their experience.

Project details

In 2009, Salisbury NHS Trust leadership decided to focus on the quality of care that had been received by patients who had died. The project lead was selected and began by reviewing all deaths that had occurred in the trust over the previous 18 months. Initially the IHI Global Trigger Tool was used, but because this method looks at harm across an organisation, rather than supporting a professional's own reflection on care, it was decided that a bespoke tool should be created.

They formed a multidisciplinary team (which included a project lead, clinical staff, medical director and other key members) to design an approach for mortality review that promoted reflection. Together they created a systematic method that the trust can use after every death at the hospital, or when a death occurs within 30 days of the patient leaving the hospital.

The review process

The responsible consultant completes a summary of the details concerning the patient's death, including the cause of death, whether there was any harm to the patient or if anything contributed to the patient's death, whether anything could have been done to improve the patient's care and what can be learned from the patient's death. The information is loaded online to the trust's IT network, all consultants across the trust can assess it. Reports from the data that is held in the system can be reviewed at an individual consultant level, by department or trust wide.

Impact

Individual consultants

The tool is gradually being rolled out across each department. Early informal feedback shows that those involved in the project find the tool has a positive impact on their practice, and that the approach to patient review is systematic and easy to use.

It is also being used for clinical governance sessions and to support those writing formal reports on patient deaths.

Departments

Departments have mortality information available for their teams at the click of a button to facilitate their clinical governance meetings.

Trust wide

The project lead uses the system to give an annual trust-wide mortality update. By drawing on the collected review information, lessons that have been learnt can be shared across the Trust.

Learning

Leadership support and momentum has helped this project succeed. Those involved were able to discover how best to conduct the mortality review and have created an easy-to-use tool that can be rolled out to every department. The trust's mortality group (which has representation from the clinical director, medical director and clinicians from across the hospital) meets every two months and has helped to keep this project moving forward.

This project lead has shared the learning and tools with the strategic health authority. Hospitals across the region are now interested in incorporating this approach to mortality reviews into their practices.