

Clinical and scientific letters

OVERVIEW

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Reviewing post-discharge mortality improves morbidity and mortality processes for patients with a general medical hospital admission

All NHS hospital trusts are required to operate morbidity and mortality (M&M) meetings as a part of their clinical governance. Typically, these review deaths occurring among inpatients and are regarded as an important patient safety measure despite heterogeneous approaches and a lack of proven effectiveness.^{1,2} We describe a simple method to detect outpatient deaths following discharge and show that, among general medical patients, this increases identification of deaths of potential interest (DOPIs) approximately seven-fold, while only increasing the number of case notes to review by 24%. We show that patients at risk of dying following discharge are generally older and have multiple comorbidities. Inclusion of deaths following discharge in M&M meetings is simple, practical and brings significant benefits to clinical governance processes.

We reviewed the inpatient and outpatient mortality outcomes relating to 5,621 emergency general medical admissions between January 2013 and March 2015. Of these encounters, 212 inpatient deaths occurred and there were 127 deaths within 28 days of discharge. Inpatient deaths were already reviewed under standard NHS trust M&M processes.

Discharges home from admitted patient spells in Addenbrooke's hospital were identified using the hospital's patient administration system (PAS). Using demographic information also from the PAS, the patients were traced as a batch using the personal demographics service (PDS). The PDS looks up each patient against the NHS Spine database and returns basic demographic information, including date of death. The database is maintained by GP surgeries and is updated with death notifications, which may come from a range of care settings. The two datasets are combined and date of death can be compared with date of discharge from the admitted spell to determine deaths occurring within a specified timescale after discharge.

As GP surgeries typically update the NHS Spine within a fortnight of a death, this process permits detection of outpatient deaths within an appropriate timeframe for analysis by the same clinical team providing care.

After careful case note review, a total of eight inpatient deaths of interest were identified; clinical deterioration in the patient was not anticipated by the clinical team. We defined these eight deaths as inpatient DOPIs.

We identified a total of 127 deaths occurring within 28 days of discharge from general medical admission. Of these deaths, 73 patients (57%) had palliative care measures in place, whereas the remaining 54 deaths appeared unanticipated by the clinical team. We defined these 54 deaths as outpatient deaths of potential interest (outpatient DOPIs). These patients were representative of the acute medical take. They were generally

older patients (median age 89 years) taking a large number of medications (median number of discharge medications was nine) and with a high prevalence of dementia and chronic disease who had initially presented with common medical conditions – particularly cardio-respiratory illnesses.

Conclusion

Recently, attention has focused on improving standard M&M processes.^{3,4} Here, we show that implementing a process to identify patients who die within 28 days of discharge is simple and can be conducted using data already freely available to NHS trusts. Reviewing the case notes of patients who die after discharge significantly enhances the clinical governance process and the ability of clinical teams to detect DOPIs from which lessons may be learned.

We recommend that trusts consider adopting these processes as a part of their routine M&M meetings. ■

Conflicts of interest

The authors declare no conflicts of interest

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