NSW Health

Clinical Excellence Commission

Mortality Review in NSW:
The Way Forward
Compendium of documents: July 2014

A listing of the CEC's publications is available at http://www.cec.health.nsw.gov.au

Clinical Excellence Commission

Board Chair: Associate Professor Brian McCaughan AM
Chief Executive Officer: Professor Clifford F Hughes AO

Any enquiries about or comments on this publication should be directed to:

> Clinical Excellence Commission
> Locked Bag A4062
> Sydney South NSW 1235
>
> Phone: (02) 9269 5500
>
> Email: info@cec.health.nsw.gov.au

FOREWORD

Patients admitted to NSW hospitals receive a high standard of care by dedicated professionals who are committed to quality and safety. Unfortunately, not every life can be saved and every day, some patients die in our hospitals. While the majority of these deaths are expected and unavoidable, some are not. It is therefore important that all deaths are reviewed, with lessons learned and shared to improve care and avoid untimely death.

NSW has two Special Committees which review surgical deaths, that are coordinated by the Clinical Excellence Commission (CEC). The Collaborating Hospitals Audit of Surgical Mortality (CHASM) has been in place since 2008, with high participation from surgeons in active operative practice in NSW. The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) program is one of the longest running programs of its type in the world and reviews all deaths associated with an anaesthetic. Both committees benefit our patients by providing clinicians and managers with information to improve the healthcare system, the care provided by healthcare professionals, and the experience of patients and their families. They also complement other incident analysis and review activities undertaken by the CEC.

The following compendium outlines initiatives currently underway to standardise and improve mortality review processes within the NSW health system. Tools and resources are provided to help meet this goal.

I encourage you to join with us in helping achieve a truly integrated process to ensure we review and learn from each death and continue to provide the best possible care to our patients.

Professor Clifford Hughes, AO
CHIEF EXECUTIVE OFFICER
CLINICAL EXCELLENCE COMMISSION

TABLE OF CONTENTS

Attachment 1: Final Report Of The Nsw Mortality Review Working Group

Attachment 2: Recommended Admitted Patient Death Screening Tool

Attachment 3: Recommended Admitted Patient Death Screening Tool Guidelines

Attachment 4: Recommended Guidelines For Conducting And Reporting Clinical Review / Mortality
& Morbidity Meetings

Clinical Excellence Commission Programs / Projects

INTRODUCTION

Mortality review is a process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined. Having a standardised mortality review approach in a system focused on quality can set the stage for, and facilitate, the improvement process[1].

The NSW Heath Patient Safety and Clinical Quality Program (PSCQP, 2005) requires each public health organisation to have in place a system for screening medical records of all patients who have died in their service. The intent of the process is to "*ensure appropriate mandatory reporting and review of patient deaths; and determine whether changes in practice are needed to improve the safety and quality of patient care.*"

Local health districts (LHDs) currently have a variety of systems in place for death review, ranging from well-designed databases to paper-based forms. Many LHDs have called for this activity to be coordinated centrally, i.e. to have a statewide minimum mortality review data set that encompasses indicators relating to *Between the Flags* and the quality of dying with regard to comfort, pain management and the level of patient and/or carer involvement in decision making.

To progress the establishment of a standardised mortality review process within the NSW public health system, a working group of key stakeholders met between August 2009 and April 2010. The aim of the group was to review current processes and propose recommendations to the (then) NSW Department of Health on the approach required for inpatient medical record death screening and review. The final report of the working party was disseminated to LHDs and has been utilised by many facilities and districts to develop and implement their mortality review process.

In 2012, the working party's report and its recommendations were revisited in light of system changes. This found that many of the original recommendations in the report had been acted upon, and reiterated the need for a statewide policy or guideline to provide a standardised approach for the review of inpatient deaths by NSW public health organisations.

In 2013, the following three major reports were released in NSW, which reinforced the need for the development and implementation of a standardised, statewide mortality review process within the NSW health system:

- Safer Systems Better Care – Quality Systems assessment Statewide Report 2012 (CEC)
- Care for the Dying in NSW (CEC)
- Advance Planning for Quality Care at End of Life: Action plan 2013 – 2018 (NSW Ministry of Health)

This compendium has been compiled to review the key recommendations and progress against the Mortality Review Working Group's report, and to provide direction and supporting resources for clinicians and managers within the NSW health system in line with the above documents. Its aim is to facilitate a standardised approach and improvements to mortality review, encompassing:

- a standardised process for mortality review within NSW health care facilities
- identification and analysis of unavoidable deaths

---

[1] Rachel, MM, Stewart, MW. (2009). Establishing a mortality review process. Journal Nursing Care Quality, Jul-Sep; 24 (*3*):211-212.

- improved processes for mortality review at the local level

- improved processes for referral to statewide mortality and incident review committees, and

- timely data comparisons for clinicians, managers, and administrators at a local and statewide perspective.

The compendium includes:

- Final Report of the NSW Mortality Review Working Group (Attachment 1)

- Admitted patient death review screening tool (Attachment 2)

- Guidelines to completing the admitted patient death review screening tool (Attachment 3)

- Guidelines for conducting and reporting Clinical Review / Mortality and Morbidity meetings (Attachment 4).

Scope

The tools outlined in the Compendium are available for the review of:

- All deaths that occur in public hospitals in New South Wales (*this includes patients not for resuscitation; palliative care patients and those patients that die in the Emergency Department*)

- All deaths that occur in the community under the care of Hospital in the Home / APAC services

These tools are for use by:

- All health service employees and contract staff, including both salaried and non-salaried visiting medical practitioners. Participation in the mortality review process is a designated quality improvement activity.

Alignment with key report requirements

Guidance and tools outlined in this Compendium are in alignment with recommendations made by recent major reports relating to mortality review in NSW Health.

Report	Recommendation	Meets obligation
Final Report of the NSW Mortality Review Working Group (2010)	Risk Assessment • Mechanism for appropriate assessment of clinical risks in the NSW public health system arising from mortality review	✓
	Governance and reporting • NSW Policy outlining minimum standards re mortality review	✓
	• Clarify governance and accountability at the state level	✓
	• Database developed in conjunction with the policy to provide for data collection and reporting and thereby support the management of the mortality review process at all levels.	✓
	• NSW DOH develop performance measures including:	
	o Screening within 45 days after admitted patient death	✓
	o Data entry into Admitted Patient Death Screening Database within 45 days of the admitted patient death	✓

	Screening	
	• Universal screening process for all inpatient deaths using a simple screening tool which collects a minimum dataset and is a first step in the mortality review process	✓
	• Each facility / service to screen deaths using standardised Admitted Patient Screening tool	
	Secondary Review	
	• Deaths referred for second level review reviewed by a properly constituted committee or officer e.g. Mortality & Morbidity, death review committee or nominated officer e.g. Director Medical Services. The outcome must be documented and responsibility for actions and or implementation of recommendations assigned. Implementation of recommendations must be monitored	✓
	• A formalised structure for who is responsible for reporting clinical risks identified in the mortality process should be developed to ensure appropriate escalation of these risks occur	✓
	• Mortality and Morbidity guidelines developed by the working group adopted by NSW Department of Health as a standard	✓
	End of life management	
	• In each second level review process, patient's end of life management should be reviewed with regard to comfort, pain management and the level of patient and/or carer involvement in decision making.	✓
Safer Systems Better Care: Quality Systems assessment Statewide Report 2012 (CEC)	**Mortality review**	
	• Policy and guidance should be developed around death review for PHOs to implement, and PHOs should have in place a consistent and timely death review process which includes an independent review of the medical record, where appropriate. A centralised approach to collate outcomes of these review meetings would improve learning across the organisation and inform risk stratification and control measures at facility and organisation level	✓
	• Death review policy and guidance for PHOs to implement should include consideration of implementation factors such as communications targeted to units which care for dying people more often, monitoring strategies and access to independent reviewers	✓
	Clinical review meetings	
	• LHDs should ensure all clinical review meetings report to the facility or district Clinical Governance Committee or equivalent to ensure LHDs can identify and respond to service-wide issues	✓
	• Multi-disciplinary clinical review structures are needed to ensure risks are reviewed and necessary change is adopted. Facilities and units should ensure clinical review meeting participation form a diverse and relevant range of health professionals and support these structures in acting on identified clinical risks	✓
Care for the Dying in NSW (CEC)	Implement a state-wide death review approach exploring the circumstances of the death, including symptom management in the last 24-48 hours of life	✓
Advance Planning for Quality Care at End of Life: Action plan 2013 – 2018 (NSW Ministry of Health)	**Outcome 3, Action 3.5:** Measure the quality of care provided to dying patients and implement improvements where possible	✓
	Outcome 3, Action 3.6. Enhance local death audit:	✓
	3.6.1 Improve audit tools to include evidence of Advance Care Planning and quality of dying and their use in target populations.	✓
	3.6.2 Determine how death audits will be reviewed at a local level, based on predicted, as well as unexpected, hospital deaths.	✓
	3.6.3 Review the care of dying patients in regular hospital mortality and morbidity review meetings.	✓

The implementation of the recommended guidelines for both Admitted Patient Death Screening and conducting and reporting Mortality and Morbidity/ Clinical Review meetings will enable the CEC and Ministry to meet the obligations to the NSW health system.

Existing processes in place for mortality review in NSW health

Currently, there is a variety of systems in place for death review at the local health district (LHD) level. The aim of this compendium is to provide guidance and support to LHDs, to facilitate more effective and standardised mortality review processes at local and statewide levels.

The Clinical Excellence Commission, on behalf of the NSW health system, is responsible for leading quality and safety improvement in NSW public hospitals. It plays a central role in reviewing serious incidents and deaths occurring in NSW public hospitals, with a view to identifying and addressing risks, and opportunities for improvement. Some of the key initiatives relating to mortality review are outlined below.

Incident Management

The NSW Health Incident Management policy (PD2014_004) guides clinical incident management processes in the NSW health setting.

Following a death it may be apparent that healthcare factors may have contributed to the outcome which should lead to notification of a clinical incident into the Incident Information Management System (IIMS). A Severity Assessment Code (SAC) is used to determine the appropriate level of incident analysis, action and escalation. SAC 1 clinical incidents include all clinical incidents/near misses where **serious harm or death** is or could be specifically caused by health care rather than the patient's underlying condition or illness. All SAC 1 clinical incidents require investigation via a robust methodology (such as Root Cause Analysis) to identify contributory factors and enable the development of recommendations to prevent the recurrence of a similar incident.

All SAC 1 incidents and RCAs are reviewed by the Clinical Excellence Commission, and findings shared throughout the system.

Statewide committees reviewing serious incidents and mortality

Clinical Risk Action Group (CRAG)

The NSW Health Clinical Risk Action Group (CRAG) is responsible for the assessment and management of the Reportable Incident Brief (RIB) system including the RIBs prepared for the Committee's purposes. The Committee is afforded privilege under section 23 of the Health Administration Act (1982) for the purpose of conducting research or investigations into morbidity and mortality occurring within NSW.

Material created for and by the CRAG cannot be disclosed or released without the approval of the Minister for Health or the Minister's authorised delegate.

The committee's role includes:

- Accessing information relevant to serious clinical incidents and incident trends
- Identifying unsafe practices or systems issues which may compromise patient safety and impact on morbidity and mortality

- Ensuring appropriate action occurs to manage identified risks, minimise the impact of their consequence and prevent future occurrence, and

- Advising the NSW Ministry of Health Senior Executive Forum on measures to address clinical risk and patient safety.

Collaborating Hospitals' Audit of Surgical Mortality (CHASM)

CHASM is a systematic peer-review audit of deaths of patients, who were under the care of a surgeon at some time during their hospital stay in NSW, regardless of whether an operation was performed. The CHASM program is supported by the Royal Australasian College of Surgeons (RACS). The RACS' Continuing Professional Development Manual 2010-12 outlines a requirement "to participate in the Australian and New Zealand Audit of Surgical Mortality if a surgeon is in operative-based practice, has a surgical death and an audit of surgical mortality is available in the surgeon's hospital." .Annual reports by RACs show participation rates consistently over 90%.
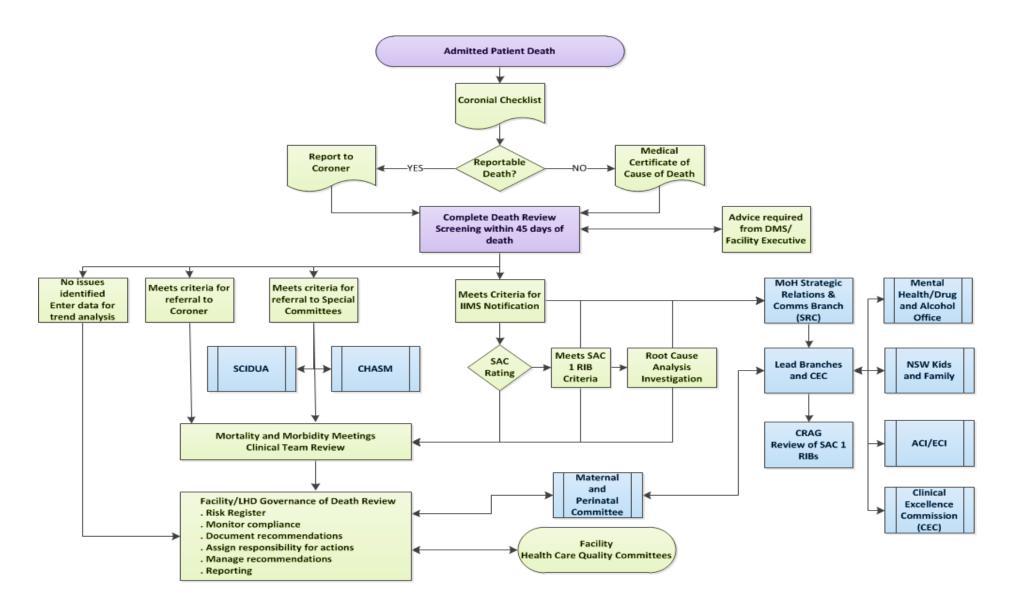
Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)

SCIDUA is an expert committee appointed by the Minister for Health under Section 20 of the NSW Health Administration Act 1982. From 1 September 2012, the Act requires the health practitioner who is responsible for the administration of the anaesthetic or sedative drug, where the patient died while under, or as a result of, or within 24 hours after the administration of an anaesthetic or sedative drug for a medical, surgical or dental operation or procedure, to report the death to the Secretary of Health via the SCIDUA. Since its inception in 1960, SCIDUA has received notification of more than 10,000 deaths. In the overwhelming majority of these cases, investigations reveal that the death was not in any way attributable to the anaesthesia.

Statewide Mortality Review Database

The Clinical Excellence Commission has developed a web-based intranet online database (work flow management, data collection and analysis) which will provide a means to improve medical management and examine adverse events, complications, and errors that have led to illness or death in patients.will be available for all LHDs. The database is currently being piloted for broader system rollout..

The interaction of mortality review with NSW health clinical incident processes and referral to special committees

SYSTEM PROGRESS IN RELATION TO MORTALITY REVIEW:
JULY 2010 TO DECEMBER 2013.

There has been considerable change and progress made within the NSW health system since the 2010 report recommendations. Progress made and areas still to be actioned are outlined below:

2010 Recommendation	Progress to date	To do
Risk Assessment		
→ New South Wales DOH ensures mechanism exists for appropriate assessment of clinical risks in the NSW public health system arising from mortality review → Recommended that Reportable Incident Review Committee (RIRC) undertake this role.	✓ Advance Planning for Quality Care at End of Life (EOL): Action plan 2013 – 2018 (NSW Ministry of Health) released in 2013 ✓ NSW EOL implementation advisory committee convened to provide oversight of Action Plan ✓ AMBER care bundle pilot commenced in October 2013 in 8 NSW acute care facilities ✓ Local Health District/Networks have governance processes in place to oversee issues identified from mortality review ✓ The Reportable Incident Review Committee (RIRC) is now called the Clinical Risk Action Group (CRAG) ✓ CRAG is the primary committee responsible for monitoring and reviewing information on serious clinical incidents to agree statewide implications and actions.	• Endorsement of the recommended Admitted Patient Death Screening Tool • Rollout to Local Health District/Networks recommended M&M/Clinical review process • Rollout to Local Health District/Networks death review database • Formalise governance and accountability of the screening process and results at state level
Governance and reporting		
→ A NSW Policy outlining the minimum standards for all facilities relating to mortality review should be developed based on the working group's proposed model	✓ A screening tool has been developed which will provide minimum standards for mortality review as well as provide indicators for care of the dying	• Endorsement of the recommended Admitted Patient Death Screening Tool

2010 Recommendation	Progress to date	To do
→ The NSW Department of Health should clarify governance and accountability at the state level relating to adherence to policy		• Rollout to Local Health District/Networks recommended M&M/Clinical review process
→ A database should be developed in conjunction with the policy to provide for data collection and reporting and thereby support the management of the mortality review process at all levels.		• Formalise governance and accountability of the screening process and results at statewide local levels
→ The NSW DOH should develop performance measures including: • Screening to be conducted within 45 days after the admitted patient death • Data entry into the Admitted Patient Death Screening Database within 45 days of the admitted patient death	✓ Database developed based on recommended screening tool ✓ Performance measures in place regarding screening patients medical record within 45 days after death	• Pilot and rollout to Local Health District/Networks death review database

Screening

→ There should be a universal screening process for all inpatient deaths using a simple screening tool which collects a minimum dataset and is a first step in the mortality review process	✓ A screening tool has been developed which will provide minimum standards for mortality review as well as provide indicators for care of the dying	• Endorsement of the recommended Admitted Patient Death Screening Tool • Formalise governance and accountability of the screening process and results
→ Each facility / service must screen deaths using the standardised Admitted Patient Screening tool and this must be undertaken by a designated local member of staff or suitably skilled personnel	✓ Initial consultation undertaken in 2009 and screening tool developed and agreed by working group. Consultation undertaken again in 2012 – tools amended to reflect changes / progress around policy	• Rollout to Local Health District/Networks recommended standardised mortality review process and audit tool
→ The Admitted Patient Screening tool developed by the working group is adopted in the policy.		• Pilot and rollout to Local Health District/Networks death review database

2010 Recommendation	Progress to date	To do
Secondary Review		
→ Deaths referred for second level review are reviewed by a properly constituted committee or officer e.g. Mortality & Morbidity, death review committee or nominated officer e.g. Director Medical Services. The outcome of second level review must be documented and responsibility for actions and or implementation of recommendations assigned. Implementation of recommendations must be monitored	✓ 2012 QSA self-assessment found 97% of facilities have a process in place to review and identify all inpatient deaths ✓ 2012 QSA self-assessment found 94% of departments/clinical units routinely meet to discuss quality & safety issues including deaths. ✓ M&M guidelines cover all these recommendations around secondary review	• Make available to all facilities and/or clinical departments the recommended Mortality and Morbidity guidelines developed by the CEC • Formalise governance and accountability of the screening process and results
→ A formalised structure for who is responsible for reporting clinical risks identified in the mortality process should be developed to ensure appropriate escalation of these risks occur	✓ All LHD/Ns have a peak quality committee that provides oversight for outcomes from mortality review	
→ The Mortality and Morbidity guidelines developed by the working group should be adopted by NSW Department of Health as a standard	✓ Mortality and Morbidity guidelines were developed by the 2009/10 working group and updated in 2012 following second consultation	
End of life management		
→ In each second level review process, such as, Morbidity & Mortality Meeting, Team Meeting or Case Conference the patient's end of life management should be reviewed with regard to comfort, pain management and the level of patient and/or carer involvement in decision making.	✓ Mortality and Morbidity guidelines were developed by the 2009/10 working group ✓ Review criteria included in admitted patient death screening tool to provide quality indicators for care of the dying ✓ 2012 QSA self-assessment found 80% of departments/clinical units routinely reviewed a patients end of life management ✓ Standardised adult and paediatric resuscitation plan developed and tested by MoH	• Endorsement of the recommended Admitted Patient Death Screening Tool • Formalise governance and accountability of the screening process and results • Rollout to Local Health District/Networks recommended standardised mortality review process and audit tool Rollout to Local Health District/Networks recommended M&M/Clinical review process
	✓ Advance Planning for Quality Care at End of Life: Action plan 2013-2018 released by MoH	• Multiple agencies given responsibility for various aspects of EOL in NSW • ACI Palliative Care models of care • HETI education modules on ACP • CEC introduction of the AMBER care bundle into acute care facilities – pilot program Oct 2013-April 2014

Final Report of the NSW Mortality Review Working Group

June 2010

Clinical Excellence Commission

Board Chair: Prof Brian McCaughan

Chief Executive Officer: Prof Clifford F Hughes, AO

Revision History

Revised by:	Date:	Revision Control:
Bernadette King Dr Charles Pain	June 2010	Initial report and tool development
Dr Maree Bellamy	August 2012	Review and update

Executive Summary

- This document is the final report of the mortality review working group. This group was convened by the Clinical Excellence Commission and NSW Health Quality and Safety Branch to provide recommendations to the NSW Department of Health for the development of a statewide mortality review process for all public health organisations.

- The NSW Heath Patient Safety and Clinical Quality Program requires each Area Health Service to have in place a system for screening the medical records of all patients who have died

- There is no NSW policy on the minimum standards required for the clinical audit / review of patients who have died under medical care in NSW hospitals

- The working group reviewed current practice in NSW through a survey and found all PHOs undertake some form of mortality review but approach is variable and responsibility and feedback loops occur on a mostly ad hoc basis

- Mortality review policies and procedures were also examined in other states to gain insight into their experience of implementation

- The group concentrated on four areas which included

    - Governance

    - Medical record screening

    - Secondary review and

    - End of life management

- Two subgroups were convened to undertake analysis of the role of mortality and morbidity meetings in the death review process and how end of life management issues could be included in the policy development. The findings of both subgroups contributed to the recommendations in the final report

- The working group concluded that there should be universal screening of all inpatient deaths using a simple screening tool which collects a minimum dataset; can be used by a variety of staff; and is supplementary to the M&M process. The review should be a two stage process: the screening tool would act as primary review of the medical record; secondary review of the patient's management is the responsibility of treating department.

- Where appropriate the M&M meeting should be the main venue for review of a department's activities and be used to critically analyse the circumstances surrounding outcomes of care. These outcomes should include selected deaths, serious morbidity, and significant aspects of regular clinical practice and outcomes of open disclosure.

- The report contains five main recommendations

    1. Risk management

    2. Governance and reporting

    3. Screening

    4. Secondary review

    5. End of life management

Key Recommendations

1. Risk Assessment

- It is recommended that the New South Wales Department of Health (DOH) ensures that a mechanism exists for the appropriate assessment of clinical risks in the NSW public health system such as those arising from the Area mortality review process or by State committees such as CHASM and SCIDUA or by the Coroner

- It is further recommended that the DOH consider the Reportable Incident Review Committee (RIRC) undertake this role.

2. Governance and reporting

The purpose of mortality review is to focus on the identification of system issues, to learn from these events and to improve patient management and quality of care. Where serious concerns arise regarding a pattern of performance of an individual, these should be managed through appropriate operational management for action in accordance with the "Complaint or Concern about a Clinician" policy directive (PD2006-007).

- A NSW Policy outlining the minimum standards for all facilities relating to mortality review should be developed based on the working group's proposed model (page 10)

- The NSW Department of Health should clarify governance and accountability at the state level relating to adherence to departmental policy

- A database should be developed in conjunction with the policy to provide for data collection and reporting and thereby support the management of the mortality review process at all levels.

- The NSW DOH should develop performance measures including:

  1..1. Screening to be conducted within 45 days after the admitted patient death

  2.4.2 Data entry into the Admitted Patient Death Screening Database within 45 days of the admitted patient death

3. Screening

- There should be a universal screening process for all inpatient deaths using a simple screening tool which collects a minimum dataset and is a first step in the mortality review process (page11)

- Each facility / service must screen deaths using the standardised Admitted Patient Screening tool and this must be undertaken by a designated local member of staff or suitably skilled personnel (page 11)

- The Admitted Patient Screening tool developed by the working group is adopted in the policy (page 20: Appendix 3).

4. Secondary Review

- Deaths referred for second level review are reviewed by a properly constituted committee or officer e.g. Mortality & Morbidity, death review committee or nominated officer e.g. Director Medical Services. The outcome of second level review must be documented and responsibility for actions and or implementation of recommendations assigned. Implementation of recommendations must be monitored (page 12)

- A formalised structure for who is responsible for reporting clinical risks identified in the mortality process should be developed to ensure appropriate escalation of these risks occur

- The Mortality and Morbidity guidelines developed by the working group should be adopted by NSW Department of Health as a standard (page 26: Appendix 4).

5. End of life management

- In each second level review process, such as, Morbidity & Mortality Meeting, Team Meeting or Case Conference the patient's end of life management should be reviewed with regard to comfort, pain management and the level of patient and/or carer involvement in decision making (page 12).

Introduction

In October 2007the Clinical Excellence Commission (CEC) conducted the initial baseline multi-level Quality Systems Assessment (QSA) of each Public Health Organisation in New South Wales. This involved a self-assessment on the level of implementation of various clinical quality and safety policy requirements developed by the NSW Department of Health. A key finding of this process was a lack of policy or guidelines for the review of inpatient deaths. Analysis of responses demonstrated that while death review was occurring across the system there were no clearly defined purposes, and there was significant variability in policy, procedures, tools and approach taken.

The Clinical Excellence Commission reported these findings in the *2007 QSA state-wide report: Summary of findings from the Area Health Services and the Children's Hospital Westmead* and made the recommendation*:*

> *The NSW Department of Health develop policies and guidelines around death reviews for Area Health Service (AHS) to implement*
>
> *Area Health Services must have in place a consistent and timely death review process for all in-patient deaths. Where appropriate, this may require an independent case review of the medical record*

In response a working group was established by the CEC in conjunction with the NSW Health Quality & Safety Department. The aim of the group was to review current activities relating to mortality review and to make recommendations to the NSW Department of Health on the approach required for development of guidelines for inpatient medical record death screening and review. The working group met 5 times between August 2009 and April 2010 and was co-chaired by Professor Cliff Hughes, Dr Peter Kennedy and Dr Charles Pain (Working group members: Appendix 1).

NSW Health Policy

The NSW Heath Patient Safety and Clinical Quality Program (PSCQP) requires each Area Health Service (AHS) to have in place a system for screening the medical records of all patients who have died in their service. The intent of the process is to:

- Ensure appropriate mandatory reporting and review of patient deaths
- Determine whether changes in practice are needed to improve the safety and quality of patient care

While the PSCQP does not mandate the minimum requirements and standards for inpatient death review, NSW does have policies and guidelines that outline the requirements for reporting and review of a specific cohort of those patients under the management of the health system.

NSW Mandatory Reporting Responsibilities

The mandatory reporting requirements in NSW are:

- Deaths which require notification to the NSW Coroner outlined in NSW Department of Health Policy Directive 2010_054: Coroner's Cases and the Coroners Act 2009
- Perinatal deaths, defined as all neonatal deaths, regardless of gestational age at birth, and stillbirths of at least 20 weeks or 400grams birth weight are reported to the NSW Maternal and Perinatal Committee outlined in NSW Department of Health Policy Directive 2006_006: Deaths - Perinatal - Hospital Procedures for Review and Reporting of Perinatal Deaths
- Maternal deaths, defined as any death which occurs during pregnancy, labour or within the first year (365 days) following cessation of pregnancy are reported to the NSW Maternal and Perinatal Committee

outlined in NSW Department of Health Policy Directive 2005_219: Deaths – Reporting of Maternal Deaths to the NSW Department of Health

• Deaths associated with the administration of anaesthesia are notified to the NSW Special Committee Investigating Death under Anaesthesia (SCIDUA) outlined in NSW Department of Health Policy Directive 2005_325: Coroner's Cases and Amendments to Coroner's Act 1980. Specifically deaths reportable to the coroner under section 12B (1) (e) "the person died while under, or as a result of, or within 24 hours after the administration of anaesthetic administered in the course of a medical, surgical or dental procedure or an operation or procedure of a like nature, other than a local anaesthetic administered solely for the purposes of facilitating a procedure of resuscitation from apparent or impending death"

• Deaths within 30 days of and associated with surgery that meet the criteria for referral to (SCIDAWS) and which are reviewed by CHASM

• Mental Health deaths are reported on a Client Death Report Form and sent to the Mental Health and Drug and Alcohol Office

Review of current practice

NSW Public Health Organisations (PHO) survey

In July 2009 a survey was sent to each PHO Chief Executive requesting details relating to their organisations death review practice. The aim was to gain an overview of how each PHO approached the screening and review of inpatient deaths and use the results to inform the working party's approach to appropriate guideline development. All NSW PHOs were sent the audit in July 2009 and requested to respond by 14th August 2009: 7 out of 11 responded (64%) (Appendix2).

Issues that were raised from the audit included:

• some PHOs have a screening tool but no policy or guideline for death review

• some PHOs review deaths at Area / State level while in others responsibility for death review is at facility level

• individual facilities determine the level and depth of review of deceased patient medical records

• the reporting and feedback processes are not well defined both up to senior management and down to clinicians

• Justice Health undertakes a Root Cause Analysis (RCA) or a death review on all deaths in custody

• NSW Ambulance Service has one standard policy across the State and the review process is conducted centrally by a specialised team, the Clinical Review Group

> *It should be noted that both Justice Health and NSW Ambulance Service mortality review processes are particular to their services and as such any policy developed should reflect this*

North Coast AHS (NCAHS) death review process

NCAHS developed a standardised death review process for the Area Health Service in 2006.

• The scope of the process is to identify all the deaths of admitted patients with the Patient Administration System. Using re-identifiable information (MRN), it is possible to be sure that 100% of deaths are screened

• Standardised death screening and referral for death review was developed

   ◆ *Death screening is conducted at the facility where the death occurred, using the standardised process*

   ◆ *This enabled best use of existing death review processes e.g. M&M meetings, RCA, statutory committees.*

• Reports from the death screening process can be provided to clinical units, facilities, clinical networks & streams, Area and State levels

   ◆ The clinical unit M&M meeting is the principal customer of death screening

- ♦ The reports to higher levels of the organisation focus upon the death screening process itself

- Governance – monitoring of the system is achieved through reports provided to governance forums throughout the Area Health Service.

Other states mortality review policy

Western Australia - Western Australian Review of Mortality (WARM) – Policy and Guidelines

Senior staff from the Western Australian Office of Safety and Quality were contacted to discuss the introduction and uptake of the *WARM – Policy and Guidelines.* It was reported that WARM is a simple process because:

- Primary screening of all inpatient deaths is undertaken by clinical teams

- Charts with positive criteria undergo second review (through Department M&M meeting)

- SAC1 cases are sent to RCA and recommendations or findings are sent to the clinical department to discuss at M&M meeting (less duplication)

- Reporting obligations are to the WA Office of Safety and Quality in healthcare via AHS

  ### Issues

- It can be seen as a subjective process as it's an internal review with clinicians engaged to review their practice based on M&M meetings. Conversely it has seen positive clinician engagement with opportunities to improve practice identified

- Western Australian Audit of Surgical Mortality (WAASM) is mandatory and part of the WARM policy i.e. all surgical deaths are referred to WAASM with no obligation to discuss at M&M meetings

- There has been increased discussion relating to AHSs wanting review of deaths to go through WARM rather than WAASM due to lack of timely review and lack of feedback. It was reported that there was issues relating to the WAASM process not addressing system issues and having a surgical bias

- No local funding or resourcing is provided by the State

- There was no database developed or IT resourcing planning in conjunction with policy release and this has now become a priority to enable data collection and report generation

Overall the buy in and establishment of a formalised statewide death review policy has been positive with a contributing reason thought to relate to the fact that clinical governance structures were already embedded in AHS prior to roll out. The value and effect of the policy is unknown as it has only been in place for a short period.

Queensland - Queensland Health Quality and Complaints Commission standard – Review of hospital related deaths

This policy was released in 2007 and outlines the process for all (100%) inpatient deaths to be reviewed. There is a structured / tiered approach and reporting lines defined. The value and effect of the policy is unknown as it has only been in place for a short period.

Scope of working group

The working group agreed that the purpose of a death review process must be clearly defined and the features of the process must include:

- standardised definitions and tools

- decreased duplication and delineation of processes especially as deaths can go onto Root Cause Analysis (RCA) or Special Committees review

- end of life management issues must be identified and discussed

- there must be a clear specification of resource commitment

Four main areas were chosen by the group to concentrate on:

- Governance

- The medical record screening process

- Secondary review of patients medical record and the role of the morbidity and mortality meetings (M&M)and

- End-of-life management

Findings of working group

Policy development - mortality review model

There is a need for NSW to have a formal process to monitor outcomes of management following an in-patient's death. The aim of the policy would be to:

- provide a standardised approach for the screening of admitted patient deaths

- the identification of adverse outcomes and care that does not meet acceptable standards and

- referral to appropriate department to review

The policy would apply to[2]:

- All deaths that occur in public hospitals in New South Wales (this includes patients not for resuscitation; palliative care patients and those patients that die in the Emergency Department)

- All deaths that occur in the community under the care of Hospital in the Home / APAC services

- All health service employees and contract staff, including both salaried and non salaried visiting medical practitioners. Participation in the mortality review process in accordance with this policy is a designated quality improvement activity

Key features of NSW mortality review model

Screening
- Independent
- Comprehensive
- Standardised criteria
- Links to local Review
- Links to External Review

Secondary Review
- Multidisciplinary team focus (M&M)
- Feedback to system and individuals
- Close the loop on action
- Local governance & alignment to incident management

External Review
- State level confidential review
- Special review
- Feedback to individual
- Feedback to system (not about individual)
- Governance

---

[2] Adapted from Western Australian Review of Mortality – Policy and Guidelines for Reviewing Inpatient Deaths; 2008

Data collection

Quality monitoring contributes to the organisation's quality cycle with the ultimate product being the availability of reliable information to allow successful decision-making. Important information about the patterns of illness and deaths becomes available as well trends in mortality and related statistics demonstrate how the health status of a population is changing. This enables the effect of health policies, services and interventions to be monitored and evaluated[3].

Principles for data collection

- Provides minimum dataset for all hospitals
- Operational definitions give inter-rater reliability
- State-wide data can be collected and reported
- Data linkages can be developed
- Formal process for referring cases to RCA; coroners; state-wide committees; and M&M meetings established
- Data is used to establish practice guidelines, issue safety alerts
- Data used in strategic planning to identify state-wide improvement goals

Recommendation:

- A NSW Policy outlining the minimum standards for all facilities relating to mortality review should be developed based on the working groups proposed model
- A database is developed in conjunction with the policy to provide for data collection and reporting and thereby support the management of the mortality review process at all levels

Screening

The North Coast AHS, Greater Western AHS and Greater Southern AHS screening tools were reviewed by the working group. It was agreed that one tool was required to provide a standardised approach to the review of medical records and collection of mortality data but needed to be simple and applicable for all types of services and levels of clinical experience of the screener. A tool was developed that was adapted from the NCAHS tool. This was disseminated for consultation within the group and to the Directors of Clinical Governance with agreement in principle gained (Appendix 3).

Statement of purpose for screening

The screening process serves **two** purposes

i. Initial review to identify deaths worthy of further assessment in context of improvement process

ii. Identify cases that should have been referred to external bodies as per mandatory requirements *i.e. the tool should not be relied on as the main means of identifying Coroners cases but as an audit tool to monitor whether the case was referred to the Coroner*

The review is a two stage process: the screening tool would act as *primary review of the medical record*; secondary review of the *patient's management* is the responsibility of the treating department.

Suggested role of screener:

1. The screener would undertake the first stage review of the patient's medical record using a standardised screening tool and refer the case to the appropriate body for further / secondary review

---

[3] Victorian Government Health Information: Clinical Engagement
http://www.health.vic.gov.au/clinicalengagement/pasp/clinicalpracticetoolkit.htm

- ♦ Duties would include: perform review of medical records, hospital procedures and other documentation to identify and communicate variations of care based on specific criteria

2. The person would need to have:

   - ♦ Demonstrated audit skills and an ability to understand and interpret complex clinical information accurately

   - ♦ must be able to access clinical advice as required

Recommendation:

- There should be a universal screening process for all inpatient deaths using a simple screening tool which collects a minimum dataset, can be used by a variety of staff, and is a first step in the mortality review process

- Each facility / service must screen deaths using the standardised Admitted Patient Screening tool and this must be undertaken by a designated local member of staff or suitably skilled personnel

- The Admitted Patient Screening tool developed by the working group is adopted in the policy (Appendix 3).

Secondary Review

Secondary review is a structured forum for the open examination and review of cases which have led to illness or death of a patient, in order to collectively learn from these events and to improve patient management and quality of care. The working group agreed that the role and function of such a forum, especially Mortality and Morbidity (M&M) meetings, should be an important factor in mortality review.

 A subgroup met where the role and main principles of M&M meetings were developed. These are:

- It is a forum for discussion of deaths as well as other clinical events

- Outcomes from Open Disclosure will be discussed

- It must have multidisciplinary input

- It must have clear reporting lines established with recommendations and actions developed and designated person allocated

The Sydney West AHS (SWAHS) M&M guideline was reviewed by the group. This document outlines a clear process for M&M as well as managing SAC1 events. The issue of resources such as secretarial support of meetings and the tracking and managing recommendations and their impact need more clarity particularly if the recommendations have implications broader than the specialty group.

These guidelines were adapted with reporting templates included and was disseminated for consultation with the Directors of Clinical Governance with agreement in principle gained (Appendix 4).

Recommendation:

- Deaths referred for second level review are reviewed by a properly constituted committee or officer e.g. Mortality & Morbidity, death review committee or nominated officer e.g. Director Medical Services. The outcome of second level review must be documented and responsibility for actions and or implementation of recommendations assigned. Implementation of recommendations must be monitored

- A formalised structure and reporting responsibility for clinical risk identified in the mortality review process is developed to ensure appropriate escalation of these risks occur

- The Mortality and Morbidity guidelines developed by the working group should be adopted by NSW Health as standard. These guidelines include clear explanation in relation to multidisciplinary input to the meeting, reporting lines and Terms of Reference (Appendix 4)

End of life (EOL) management

Whilst many services review deaths to determine if they are preventable or not, or whether their change in condition was detected and acted upon, few review the quality of dying for patients who may be expected to die but for whom the quality of care provided should be a key objective of good care. A subgroup was formed to examine issues relating to 'quality of death' or 'quality of end of life management' and consider ways to include the opportunity to examine aspects of the care delivered to dying patients in the death review process. The subgroup recommended that 2 questions in relation to EOL management be included on the proposed screening tool as well as be included in the M&M discussion (Summary of findings Appendix 5).

Recommendation:

In each second level review process, such as, Morbidity & Mortality Meeting, Team Meeting or Case Conference the patient's end of life management should be reviewed with regard to comfort, pain management and the level of patient and/or carer involvement in decision making

Governance

Governance of the mortality review process is vital to ensure there is clarity regarding who has responsibility for identification and management of risks originating from the review process and that each level of the organisation / system has a role.

NSW Department of Health Responsibility

The NSW Department of Health will be responsible for:

- management of clinical risk identified through mortality review process

- determining where data is centrally reported

- ensuring appropriate identification, management and reporting of state-wide issues

- management of non-compliance with policy

Organisational Responsibility

The AHS/Organisation is responsible for:

- Implementation of the policy for screening admitted patient deaths

- Provision and maintenance of Network or facility databases to store data and generate reports associated with the admitted patient death screening

- monitoring that identified deaths are referred to the Coroner and other appropriate NSW State-wide committees

- Provision of regular reports to the AHS peak Health Care Quality Committee

Management Responsibility

Network, Facility and Clinical Stream Managers and Head of Departments are responsible for:

- Ensuring that where appropriate deaths are reviewed according to the NSW Health Incident Management Policies

- Ensuring that identified deaths are referred to the Coroner and other appropriate NSW State-wide committees

- Ensuring that the policy and facility based procedures for screening of admitted patient deaths are implemented

- Ensuring all deaths are screened within 45 days using the Admitted Patient Death Screening Tool

- Continual monitoring of compliance with the policy and procedure

- Provision of quarterly reports of performance measures in relation to admitted patient death screening to the Health Care Quality Committee

- Establish appropriate review structure and process with facility at department level i.e. delegate authority HOD to run M&M meeting according to guideline

- Ensure appropriate recommendations are made and acted upon in relation to death review findings

- Maintain risk register of all risk identified though death review process

Individual clinician responsibilities

- Participate in department M&M meeting

- Refer appropriate deaths to the Coroner and other appropriate NSW State-wide committees

- Play a role in implementing recommendations from committee review

Recommendation:

- It is recommended that the New South Wales Department of Health (DOH) ensure that a mechanism exists for the appropriate assessment of clinical risks in the NSW public health system such as through Area mortality review processes, by State committees such as CHASM and SCIDUA and by the Coroner.

- It is further recommended that the DOH consider the Reportable Incident Review Committee (RIRC) undertake this role.

- The NSW Department of Health clarify governance and accountability at the state level relating to adherence to departmental policy

- The NSW DOH develops performance measures including:
  - Screening to be conducted within 45 days after the admitted patient death
  - Data entry into the Admitted Patient Death Screening Database within 45 days of the admitted patient death

References

- NSW Department of Health Policy Directive 2010_054: Coroner's Cases and the Coroners Act 2009; NSW Department of Health; 1 September 2010. Available from: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_054.html

- NSW Department of Health Policy Directive 2005_608: Patient Safety and Clinical Quality Program; NSW Department of Health; 26 July 2005. Available from: http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_608.pdf

- NSW Department of Health Policy Directive 2005_609: Patient Safety and Clinical Quality Program Implementation Plan; NSW Department of Health; 26 July 2005. Available http://www0.health.nsw.gov.au/policies/pd/2005/PD2005_609.html

- NSW Department of Health Policy Directive 2006_006: Deaths - Perinatal - Hospital Procedures for Review and Reporting of Perinatal Deaths; NSW Department of Health; 25 January 2006. Available from: http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_006.pdf

- NSW Department of Health Policy Directive 2007_061: Incident Management Policy http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_061.pdf

- NSW Department of Health Policy Directive 2005_219: Reporting of Maternal Deaths to the NSW Department of Health. http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_219.pdf

- Western Australian Review of Mortality: Policy and Guidelines for Reviewing Inpatient Deaths – 2008 edition

- NCAHS Area Policy Statement; Admitted Patient Death Screening

Members of Facility Level Mortality Review Working Group & Sub Groups

Working group

PHO	Member
Clinical Excellence Commission (CEC)	Prof Cliff Hughes (Chair)
	Dr Peter Kennedy
	Dr Charles Pain
	Wendy Jamieson
	Bernadette King
GSAHS	Wendy Wilkinson
	Dr Lyn Currie
GWAHS	Sue Anne Redmond
	Di Wykes
HNEAHS	Dr Anne Duggan
NCAHS	Dr David Hutton
NSCCAHS (QaRNS)	Rosemary Sullivan
SSWAHS	Dr Maree Bellamy
	Dr Amanda Walker
SWAHS	Dr Andrew Baker
CHW	Dr Raymond Chaseling
NSW DoH	Deb Hyland
	Paul Curtis
GMCT	Dr Hunter Watt
SESIAHS	Gail Smith

Sub groups

M&M sub group	End of life management sub group
Charles Pain	Amanda Walker
Peter Kennedy	Anne Duggan
Hunter Watt	Rosemary Sullivan
Wendy Jamieson	John Collins
Jo Montgomery	Peter Cleasby
Bernadette King	

SUMMARY OF FINDINGS FROM DEATH SCREENING AND REVIEW POLICY AUDIT

1.1 Is there an AHS policy / Guideline for the screening and/or review of deaths?

All respondents to the survey stated that they have either guidelines / death review policy in place, these included:

- Policy

- Standard of practice for screening inpatient deaths

- M&M guidelines where responsibility is at clinical unit level

- There is variation in all Areas in who undertakes death review / the extent of the review / reporting processes to Area level and clinicians / different processes

1.2 Do you have a system in place to reconcile that all deaths have been screened?

6 out of 7 have an Area system to reconcile inpatient death screened which includes reporting of deaths or the outcome of review processes to the Clinical Governance Unit (CGU)

Area where responsibility is at unit level (M&Ms) no reconciliation occurs

2.1 & 2.2

Do all Facilities have their own local Death Screen and / or Review Policy or Guideline?

Do all Facilities follow a standard process for Death Screen and / or Review or are different processes used in each Facility?

Facilities at 3 of the AHS have their own policy / process in relation to the review of inpatient deaths which usually relates to the size and delineation of the site.

The review of deaths at both Justice Health and Ambulance Service are centrally coordinated at state level

2.3 Is information found via Death Screening and / or review at the Facility level reported to the Area?

Five of the AHS note facilities report results to the Area level. The feedback of information from facilities to clinical units / clinicians involved appears to be undertaken on an ad hoc basis. From the responses there appears to be no clear system to ensure this happens due to no standardised process for clinical review (except 1 AHS who has devolved the responsibility to clinical departments and developed M&M guidelines)

2.4 Is information found via Death Review at Facility level reported to the clinical Unit where the patient was cared for?

As above

2.5 Do you have a Facility that performs Death Screening / Review well and who would be willing to share their experiences with the CEC?

4 Areas offered processes to be shared

2.6 What difficulties do you encounter with Death Screening / Review?

- Lack of standardised operational definitions e.g. what is a preventable death?

- Level of experience of initial reviewer

- Recommendations not reported to Area level therefore unable to identify trends

- Lack of staff resources to undertake record review

- Coroner report delays

- Medico legal aspects e.g. privilege in relation to review

3.1 What would make an ideal model of death screening and / or review?

- Standardised process to the approach of death review

- Clear definitions in relation to death review e.g. which deaths are to be screened / what are the 'flags' to constitute in-depth review

- Standardised tools (evidence based)

- Minimum dataset collection requirements / Simplification of reporting mechanisms

Streamline process due to concurrent death review / reporting processes e.g. Coroner / CHASM / SCIDUA / SERC and timely feedback to the Areas from these committees

Recommended Admitted Patient Death Screening Tool

<table>
<tr><td>

Insert

LHD/SN logo here

Facility:

Clinical Excellence Commission
**ADMITTED PATIENT
DEATH REVIEW SCREENING TOOL**
Version 1.0

</td><td>

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

</td></tr>
</table>

Date of Admission: ___ / ___ / _____ Admission Status: ☐ Emergency ☐ Elective

Admitted From: ☐ Home ☐ Nursing Home ☐ Hostel ☐ Other Hospital _____ ☐ Other _____

Admitting Specialty: _____ Discharge Specialty: _____

Admitting Reason: _____

Date of Death: ___ / ___ / _____ Time of Death: ___ : ___ Age at Death: ___ years

Cause of Death *(or attach a copy of the Medical Certificate of Cause of Death)*

a) _____ Duration: _____

b) _____ Duration: _____

c) _____ Duration: _____

d) _____ Duration: _____

e) _____ Duration: _____

Other Significant Conditions

a) _____ Duration: _____

b) _____ Duration: _____

End of Life Management/Resuscitation Status	
1. Did the patient have any YELLOW Zone observations or additional criteria in the 24 hours prior to death?*	☐ Yes ☐ No
1a. If yes, when was a Clinical Review or other CERS call documented?	Date: ___ / ___ / _____ Time: ___ : ___
2. Did the patient have any RED Zone observations or additional criteria in the 24 hours prior to death?*	☐ Yes ☐ No
2a. If yes, when was a Rapid Response call documented?	Date: ___ / ___ / _____ Time: ___ : ___
3. Date and time of last recorded observations taken prior to death	Date: ___ / ___ / _____ Time: ___ : ___
4. Was there an advance care plan documented prior to patient's death?	☐ Yes ☐ No
4a. Date and time of plan	Date: ___ / ___ / _____ Time: ___ : ___
5. Was there a "Not for CPR" order/resuscitation plan documented prior to patients death?	☐ Yes ☐ No
5a. Date and time of order/plan	Date: ___ / ___ / _____ Time: ___ : ___
6. Were any symptoms of patient discomfort or distress documented in the medical record in the 48 hours before death?*	☐ Yes ☐ No
6a. If yes, were these symptoms managed by the treating team	☐ Yes ☐ No
7. Was the patient seen by the Palliative Care Team during this admission?	☐ Yes ☐ No
8. Was the patient (with capacity) involved in the decision making process related to treatment plans and goals of care (including but not limited to discussion regarding CPR)?	☐ Yes ☐ No ☐ N/A
8a. If no, was the substitute decision maker carer or family of the patient involved in the decision making process related to treatment plans and goals of care?	☐ Yes ☐ No ☐ N/A
If answered yes to any of these questions, refer case to appropriate department M&M meeting.	

ADMITTED PATIENT DEATH REVIEW SCREENING TOOL

DO NOT INSERT THIS DOCUMENT INTO THE MEDICAL RECORD

<table>
<tr>
<td rowspan="3">Insert LHD/SN logo here

Facility:</td>
<td rowspan="3" colspan="2">CLINICAL EXCELLENCE COMMISSION</td>
<td colspan="2">FAMILY NAME</td>
<td>MRN</td>
</tr>
<tr>
<td colspan="2">GIVEN NAME</td>
<td>☐ MALE   ☐ FEMALE</td>
</tr>
<tr>
<td>D.O.B. _____ / _____ / _____</td>
<td colspan="2">M.O.</td>
</tr>
</table>

			ADDRESS

Clinical Excellence Commission
ADMITTED PATIENT
DEATH REVIEW SCREENING TOOL

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Screening Criteria

Criteria	Tick if Yes	Rationale/Comments/Description
Readmission within 28 days from previous hospitalisation	☐	
Unplanned transfer to ICU during admission	☐	
Under the care of a surgeon at the time of death	☐	
Operative procedure in the 30 days prior to death	☐	
Unplanned return to theatre	☐	
Anaesthesia/sedation in the 24 hours prior to death	☐	
Healthcare associated infection *(note type)*	☐	
Technical procedure	☐	
Possible missed diagnosis	☐	
Possible delay in diagnosis	☐	
Possible delay in treatment	☐	
Possible clinical management error	☐	
Transfer to higher level of care not activated	☐	
Retrieval problems	☐	
Fall	☐	
Adverse drug event	☐	
Transfusion reaction	☐	
Pregnancy, labour or within 365 days of pregnancy	☐	
Perinatal	☐	
IIMS completed	☐	
Suspected suicide	☐	
Other	☐	

Outcome of Screening

Adapted from Wilson R et al, Quality in Aust Health Care Study, Med L Aust 1995	Tick if YES (one only)
1. Death may have resulted from medical intervention	☐
2. Death is unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management *(If yes to 1 or 2 ,the case must be entered into IIMS and be referred to the appropriated department M&M meeting)*	☐
3. Unexpected death not reasonably preventable with clinical intervention	☐
4. Unexpected death despite known preventive measures taken in an adequate and timely fashion	☐
5. Death following cardiac or respiratory arrest which occurred before patients arrival at hospital	☐
6. Anticipated death due to disease progression	☐
Open disclosure occurred?	☐ Yes ☐ No ☐ N/A

<table>
<tr><td colspan="2">
Insert LHD/SN
logo here
</td><td>CLINICAL
EXCELLENCE
COMMISSION</td><td colspan="2">
FAMILY NAME

GIVEN NAME

D.O.B. _____ / _____ / _____　　M.O.

ADDRESS
</td><td>
MRN

☐ MALE　　☐ FEMALE
</td></tr>
<tr><td colspan="3">
Facility:

Clinical Excellence Commission
ADMITTED PATIENT
DEATH REVIEW SCREENING TOOL
Version 1.0
</td><td colspan="3">
LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE
</td></tr>
</table>

Referral Following Screening			
Referral Destination	**Tick if YES**	**Comments/Explanation**	**Referral Date**
DMS/Facility Executive	☐		___ / ___ / _____
Clinician Review/Morbidity & Mortality Group	☐		___ / ___ / _____
Coroner referral arising from death screening	☐		___ / ___ / _____
Collaborating Hospitals' Audit of Surgical Mortality in NSW (CHASM)	☐		___ / ___ / _____
NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)	☐		___ / ___ / _____
NSW Maternal & Perinatal Committee	☐		___ / ___ / _____
IIMS notification arising from death screening	☐		___ / ___ / _____
Reportable Incident Brief (RIB)	☐		___ / ___ / _____
Root Case Analysis (RCA) Investigation	☐		___ / ___ / _____
NSW Health Mental Health/Drug and Alcohol Office	☐		___ / ___ / _____
Clinical Governance/Patient Safety for further investigation	☐		___ / ___ / _____
Other (describe)	☐		___ / ___ / _____

Comments/Case Summary

Death screen completed within 45 days of patient death?	☐ Yes ☐ No
Completed by:　　　　　　　Position:	Date Screening Completed: ___ / ___ / _____
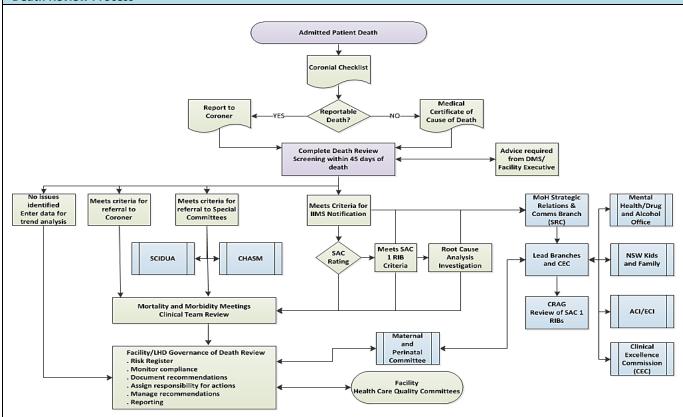
Death Review Process

NSW Health Policies Relating to Death Review

GL2005_056: Using Advance Care Directives
GL2005_057: End-of-Life Care and Decision-Making Guidelines
GL2007_007: Open Disclosure Guidelines
GL2008_018: CPR - Decisions Relating to No Cardiopulmonary Resuscitation Orders
IB2010_058: Coronial Checklist
PD2005_121: Suicidal Behaviour - Management of Patients with Possible Suicidal Behaviour
PD2005_219: Deaths - Reporting of Maternal Deaths to the NSW Department of Health.
PD2005_608: Patient Safety and Clinical Quality Program
PD2005_609: Patient Safety and Clinical Quality Program Implementation Plan
PD2005_634: Reportable Incident Definition under section 20L of the Health Administration Act
PD2006_058: Research and Investigation under the Health Administration Act 1982
PD2007_025: Stillbirth - Management and Investigation
PD2007_036: Infection Control Policy
PD2007_040: Open Disclosure
PD2007_061: Incident Management
PD2007_084: Infection Control Policy: Prevention & Management of Multi-Resistant Organisms (MRO)
PD2008_070: Death - Management of Sudden Unexpected Death in Infancy
PD2010_054: Coroners cases and the Coroners Act
PD2010_072: Perinatal Data Collection (PDC) Reporting and Submission
PD2010_077: Prevention of Venous Thromboembolism
PD2011_031: Inter-facility Transfer Process for Adults Requiring Specialist Care
PD2011_076: Deaths - Review and Reporting of Perinatal Deaths
PD2012_016: Blood - Management of Fresh Blood Components
PD2012_036: Death – Extinction of Life and the Certification of Death – Assessment
PD2013_049: Recognition and Management of Patients who are Clinically Deteriorating

Recommended Admitted Patient Death Screening Tool Guidelines

GUIDE TO COMPLETING THE ADMITTED PATIENT DEATH REVIEW SCREENING TOOL

DRAFT V2, JANUARY 2014

The Clinical Excellence Commission's (CEC's) Death Review Database is a quality and safety tool that supports local health districts and speciality networks (LDH/SN) to screen and review deaths that occur within their service. It will provide statewide information to drive improvement and supports compliance with numerous NSW Health policy directives. Key functions of the database are to facilitate data access, standardise the minimum dataset for mortality review and automate reporting. Measurements of death review will also provide local evidence of compliance with many of the National Safety and Quality Health Service Standards (NSQHSS).

The screening tool within the database establishes a minimum data set for commencement of the process of mortality review. Data includes an admission profile, end of life and resuscitation management review, screening criteria, and subsequent outcomes of screening and referral.

This guide aims to assist you in completing the tool with additional explanations and alignment with NSW Health policy and the national accreditation standards.

Field	Guide / Policy / Standards
ADMISSION DETAILS	
Admitting Specialty Discharge Specialty	• Measures the patient's clinical journey • Compares initial plan of care to outcome of care through speciality
Admitting Reason Cause of Death	• Measures the patient's clinical journey • Compares the initial medical reason for care to cause of death
END OF LIFE MANAGEMENT/RESUSCITATION STATUS	
Yellow zone observations or additional criteria Red zone observations or additional criteria Last recorded observations	• *Between the Flags* key performance indicators • Used to assess the effectiveness and timing of end of life and resuscitation management *PD2013_049: Recognition and Management of Patients who are Clinically Deteriorating* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.2)*
Advance care plan "Not for CPR" order /resuscitation plan	• Used to measure the time between either advance planning for end of life care, or resuscitation decisions and the patient's death *GL2005_056: Using Advance Care Directives* *GL2005_057: End-of-Life Care and Decision-Making -Guidelines* *GL2008_018: CPR - Decisions Relating to No Cardiopulmonary Resuscitation Orders* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.2, 9.8)*
Any symptoms of patient discomfort or distress documented? Who managed the patient's symptoms?	• Are there signs of patient distress or discomfort (including grimacing, pain behaviours, restlessness or agitation) recorded in the 48 hours prior to death, and who managed them? *GL2005_057: End-of-Life Care and Decision-Making - Guideline*
Was the patient (with capacity) involved in the decision making process related to treatment plans and goals of care?	• Is there an indication that the patient was involved in decision making regarding any change in treatment goal from active management to one of palliation, comfort and dignity? *GL2005_057: End-of-Life Care and Decision-Making Guidelines* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.8)*
Was the carer or family of the patient involved in the decision making process related to treatment plans and goals of care?	• Is there an indication that the patient's family/carer was involved in decision making regarding any change in treatment goal from active management to one of palliation, comfort and dignity? *GL2005_057: End-of-Life Care and Decision-Making Guidelines* *Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (9.8)*

Field	Guide / Policy / Standards
SCREENING CRITERIA	

Readmission within 28 days from previous hospitalisation	• Define reason due to:
	  o same or new problem
	  o avoidable or unavoidable
	• Was there evidence of complications or failure to prevent, diagnose or treat the previous admitting diagnosis or directly related problems?
	PD2007_061: Incident Management

Unplanned transfer to ICU during admission	• Was the patient admitted to ICU due to:
	  o deterioration in condition appropriately
	  o after presentation to the emergency department
	  o after presentation from another hospital
	PD2007_061: Incident Management

Under the care of a surgeon at the time of death	• Meets criteria for referral to NSW Collaborating Hospitals' Audit of Surgical Mortality (CHASM) if patient was admitted under a surgeon even if NO operation was performed during the admission *PD2006_058: Research and Investigation under the Health Administration Act 1982*
Operative procedure in the 30 days prior to death	• Meets criteria for referral to NSW Collaborating Hospitals' Audit of Surgical Mortality (CHASM) if patient was admitted under a surgeon and the patient has an operative procedure within 30 days of death *PD2006_058: Research and Investigation under the Health Administration Act 1982*
Unplanned return to theatre	• Includes any return visit to the operating room or delivery room for bleeding, infection, wound dehiscence or disruption, foreign body, or other complication caused by treatment *PD2007_061: Incident Management*
Anaesthesia/sedation in the 24 hours prior to death	• Meets criteria for referral to NSW Special Committee Investigating Death under Anaesthesia if the patient has an anaesthetic or is given sedation within 24 hours of death *PD2006_058: Research and Investigation under the Health Administration Act 1982*
Healthcare associated infection *(note type)*	• Patient records indicate that a healthcare associated infection may have been/was present • An infection is considered to be hospital acquired once the patient has been in hospital for forty eight hours or more *PD2007_036: Infection Control Policy* *PD2007_084: Infection Control Policy: Prevention & Management of Multi-Resistant Organisms (MRO)* *Standard 3: Preventing and Controlling Healthcare Associated Infections (3.2)*
Technical procedure	• Technical procedures include invasive line insertion, angiogram, bronchoscopy etc. *PD2007_061: Incident Management*
Possible missed diagnosis	• Is there evidence of a possible missed diagnosis? For example, due to lack of follow up of tests *PD2007_061: Incident Management*
Possible delay in diagnosis	• Is there evidence of a possible delay in diagnosis? *PD2007_061: Incident Management*
Possible delay in treatment	• Is there evidence of a possible delay in the commencement or continuation of treatment? *PD2007_061: Incident Management* *PD2010_077: Prevention of Venous Thromboembolism*
Possible clinical management error	• Is there evidence of a possible clinical management error? *PD2007_061: Incident Management*
Transfer to higher level of care not activated	• Was there a need for transfer to higher level of care identified but process not activated/commenced? *PD2007_061: Incident Management*

Field	Guide / Policy / Standards
SCREENING CRITERIA	
Retrieval problems	• Was there a delay or inability to retrieve or transfer patient? For example, transport problems, availability of personnel or unavailability of a bed at receiving facility *PD2007_061: Incident Management* *PD2011_031: Inter-facility Transfer Process for Adults Requiring Specialist Care*
Fall	• Was there a fall during the admission? • Review IIMS record related to fall *PD2007_061: Incident Management* *Standard 10: Preventing Falls and Harm from Falls (10.2)*
Adverse drug event	• Is there evidence of an adverse drug event? For example, a medication error or a reaction to a drug, that caused deterioration in the patient's condition, or that caused injury • National Sentinel Event: Medication error leading to death *PD2007_061: Incident Management* *Standard 4: Medication Safety (4.4)*
Transfusion reaction	• Is there evidence of a reaction to blood or blood products? • National Sentinel Event: Haemolytic blood transfusion reaction *PD2007_061: Incident Management* *PD2012_016: Blood - Management of Fresh Blood Components* *Standard 7: Blood and Blood Products (7.3, 7.6)*
Pregnancy, labour or within 365 days of pregnancy	• A maternal death includes pregnancy, labour or within 365 days of pregnancy. For example, ectopic pregnancy, following termination of pregnancy, any deaths with incidental pregnancy found • National Sentinel Event: Maternal death or serious morbidity associated with labour or delivery *PD2005_219: Reporting of Maternal Deaths to the NSW Department of Health* *PD2007_061: Incident Management*
Perinatal	• Includes liveborn babies within 28 days of birth, regardless of gestational age at birth, and stillbirths of at 20 weeks gestation or 400 grams birth weight *PD2011_076: Deaths - Review and Reporting of Perinatal Deaths*
IIMS completed	• Have any IIMS been completed during this admission? For example, fall, medication error *PD2007_061: Incident Management Policy* *Standard 1: Governance for Safety and Quality in Health Service Organisations (1.14)*
Suspected suicide	• Did the patient possibly suicide? • Did the patient receive care or treatment for a mental illness within 7 days prior to death? • National Sentinel Event: Suicide of an inpatient *PD2005_121: Suicidal Behaviour - Management of Patients with Possible Suicidal Behaviour* *PD2007_061: Incident Management* *PD2010_054: Coroner's Cases and the Coroners Act 2009*
Other	• Are there other elements that the screener has identified in the case, that require further review? *PD2007_061: Incident Management*
OUTCOMES OF SCREENING	

The outcome of screening arises from your review of documentation to support one of the following conclusions:

1. Death may have resulted from medical intervention
2. Death is unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management
3. Unexpected death not reasonably preventable with clinical intervention
4. Unexpected death despite known preventive measures taken in an adequate and timely fashion
5. Death following cardiac or respiratory arrest which occurred before patients arrival at hospital
6. Anticipated death due to disease progression.

Recommended Guidelines for Conducting and Reporting

Clinical Review / Mortality and Morbidity Meetings

Introduction

Effectively run clinical audit and peer review processes, incorporating analysis of mortality and morbidity (M&M), contribute to improved patient safety. These guidelines aim to provide practical advice to clinical departments on establishing and running M&M meetings. It is recognised that different departments will have different requirements and aims in relation to M&M meetings. There will be no "one size" which fits all.

Some services may choose to apply another title to their M&M meeting however the purpose, outcomes, principles and documentation are required.

Purpose and Scope

This document describes a comprehensive list of functions for M&M meetings, and individual departments will need to decide how to apply these most effectively in their circumstances.

Related Legislation, NSW Health Circulars, Area Policies, Other Documents

These guidelines draw upon a number of NSW Health documents:

- NSW Health Clinician's Toolkit for Improving Patient Care GL2005-062

- NSW Health Incident Management Policy PD 2007-061

- NSW Health Complaint or Concern about a Clinician PD2006-007

- NSW Health Patient Safety & Clinical Quality Program PD2005-608

Principles

All clinical departments are expected to adhere to the following principles:

1. M&M meetings should be held on a regular, scheduled basis.

2. Meetings should be multidisciplinary, including clinicians from nursing, medical and allied health.

3. Meetings should be used to critically analyse the circumstances surrounding outcomes of care. These outcomes should include selected deaths, serious morbidity and significant aspects of regular clinical practice.

4. The focus of these meetings should be on the systems and processes of care and not on individual performance.

5. Recommendations arising from individual cases should focus on measures that can prevent similar outcomes or adverse incidents, or that will improve the processes of care provided to this group of patients. These recommendations should not apportion blame to individuals.

6. Actions to implement the recommendations should be initiated and it is the responsibility of the Chair of the meeting to oversee progress in their implementation.

7. Outcomes and decisions of these meetings should be documented in a brief meeting report.

Guidelines

Responsibility for M&M Meetings

- Participation in morbidity and mortality meetings should be considered a 'core' activity for all clinicians. The responsibility for ensuring this occurs resides with the duly appointed clinical department head.

- Oversight of this activity will occur through the appropriate Network Director / Facility Manager and the Network / Facility Patient Safety and Quality Committee.

Organisation and Conduct of M&M Meetings

- Meetings should be held on a regular basis. The expectation is that this will be at least monthly, unless specified otherwise by the appropriate Network Director / Facility Manager.

- The meetings should be scheduled well in advance, (i.e. 6-12 months) with a set day, time and venue to maximise the clinicians' availability to attend. A reminder should be advertised in the clinical area at least one week in advance of each meeting.

- Terms of Reference should be developed and a copy given to all committee members. TOR are to be updated annually (an example is attached in Appendix A)

- All levels of staff involved in the care of these patients – both junior and senior – should be involved. They should be multi-disciplinary so that clinicians from all of the relevant specialties and professional backgrounds (i.e. medical nursing allied health) can attend. In determining membership, consideration should be given to clinicians from related specialties with whom the department frequently interacts.

- A person should be elected as the Chairperson, and there should be a designated person to take notes of key findings at each meeting, which will assist in the compilation of a Meeting Report (Appendix B).

- The Chairperson, who should be a senior and respected member of the Department, will have the role of initiating discussion and ensuring that every opportunity is taken to identify and document actions for improvement. The Chairperson may be different to the person presenting individual cases.

- The Chairperson is responsible for creating an atmosphere that is conducive to open discussion and should ensure all members have an opportunity to contribute.

A standing agenda should be developed which should incorporate the following elements:

- Review of previous minutes
- Review of progress of outstanding recommendations/actions
- Review of deaths
- Review of serious adverse events
- Presentation of clinical indicators
- Review of IIMS incidents (particularly those with principle Incident type of Clinical Management)
- Review of complaints
- Review of cases requiring open disclosure
- Review of Risk Register

Review of Deaths in M&M Meetings

- Death review must include all deaths in which the death was caused by or associated with a health care intervention, rather than a result of the natural course if the illness. At minimum, these cases should be itemised and the opportunity to discuss any case should exist. Depending on volume, the chair may wish to highlight specific cases for presentation or more detailed discussion.

- A common practice is for a nominated clinician to review all deaths prior to the meeting and in conjunction with the chair, decide which cases will benefit from detailed presentation and discussion. Where this happens, the opportunity must still exist for clinicians to raise concerns about any other deaths that have not been presented in detail.

- Some deaths must be reported to external bodies (e.g. Coroner, SCIDUA, CHASM, Peri-natal Mortality committee). The fact that an external report has occurred should not be a reason for dispensing with local review.

- When presenting information about death or adverse events, either in detailed or summarised tabular format, the information should be de-identified (that is, patients should not be referred to by name)

- Where cases are identified for presentation, clinicians from outside the department who played a significant role in the patients care should be invited to attend.

- Focus should be placed on identifying the issues related to any processes or systems of care that contributed to the death, and not on the individuals who provided the care. Primary questions to consider for each case are:

  - *What happened?*

  - *If there was a breach of a standard of care or an error, why did it happen?*

  - *What can be done to prevent a recurrence?*

  - Discussions should focus on measures that can be recommended or implemented to prevent a similar incident or adverse outcome.

  - If issues that are raised represent substantial risks to the Department's ability to deliver its service, or to provide safe care, they should be referred to the Network / Facility Patient Safety and Quality Committee for inclusion on the Network / Facility Risk Register. The Department must consider and document actions that can be taken to manage or minimize the risk

SAC 1 Deaths identified in M&M Meetings

The Area Health Service has a legislative responsibility to report SAC 1 deaths through the Incident Information Management System (IIMS) by means of a Reportable Incident Brief (RIB) to the Department of Health. These are deaths associated with health care intervention in which it is though that:

1. an error

2. a breach of an accepted standard of care

3. a systems failure contributed to the cause of death.

A Root Cause Analysis (RCA) must be conducted into all SAC 1 deaths.

- SAC 1 Deaths are usually identified close to the time of death, entered into IIMS and an RCA initiated by the Clinical Governance Unit. Typically an RCA will be underway by the time the case is being considered at an M&M meeting. This does not preclude discussion by the M&M meeting. The death should stay on the agenda until the meeting has had the opportunity to review the outcome and recommendations of the RCA.

- In the event that a death, which has not been previously identified as a SAC 1, is reviewed, and the meeting concludes that it satisfies the criteria for SAC 1, the death should be entered into IIMS and Clinical Governance should be notified as soon as possible.

End of life Management

In each Morbidity & Mortality Meeting / Team Meeting or Case Conference, for each death, team members should consider:

- The circumstances of the death itself including; symptom control - was the patient settled and peaceful? And privacy - in what setting did they die?

- The preparation for it - were family made aware the patient was dying?

- Prompts for discussion points can include:

  - *Did the patient appear comfortable?*

  - *Were their symptoms well controlled?*

  - *Did the nurses have access to medications to control symptoms - were terminal care prn medications charted and available?*

- *Were the patient and family afforded privacy?*
- *Were family made aware the patient was dying?*

Referral of Issues outside M&M Meetings

Discussions should be used for educational purposes and not for apportioning blame to the individuals. Where serious concerns arise regarding a pattern of performance of an individual, the Chairperson should raise the matter confidentially and independently of the M&M process, with the Clinical Department Head, who is responsible for addressing performance management issues. In addition, the Director of Clinical Governance should be notified in accordance with the "Complaint or Concern about a Clinician" policy directive (PD2006-007)

Reporting

- A brief Meeting Report should be compiled after each meeting, which identifies the cases which were discussed (identified either by MRN, or by initials and date of death) and the actions that must be taken as a result of the review and discussions. If there are no recommendations for action this should be recorded and all action items should be placed on the agenda for the next meeting.
  - *The report should be distributed within the Department*
  - *A quarterly report must be submitted to the Network Director / Facility Manager, the Network / Facility Patient Safety and Quality Committee (A suggested specific reporting format is provided: Appendix C).*
  - *Where actions recommended by the M&M meeting cannot be implemented, this must be specifically highlighted to the Network Director / Facility Manager and the relevant Facility or Cluster Management.*

Review of Other Quality and Patient Safety Matters

M&M meetings provide a valuable opportunity for departments to review the quality of the care that is being provided and to identify any opportunities for improvement. A key means by which such opportunities can be identified is by reviewing:

- Other serious adverse events (other than deaths)
- Clinical indicators which reflect performance
- Review of IIMS incidents (particularly those with principle Incident type of Clinical Management)
- Review of complaints
- Review of cases requiring open disclosure
- Review of Risk Register

It is particularly valuable for departments to identify recommendations arising from such reviews and ensure that actions occur in relation to these recommendations.

Qualified Privilege

M&M meetings have no special legal privilege. Although the Health Administration Act allows the minister to nominate approved quality assurance committees, which attract qualified privilege, approval is rarely sought or granted for individual departmental M&M committees. Therefore, minutes of meetings should be written from the assumption that they could potentially become public documents. This means writing the minutes in a style which avoids statements of blame and concentrates on the actions arising from the deliberations.

References and Links

SWAHS – Guidelines - Conduct of Morbidity and Mortality meetings

Purpose

To contribute to improved clinical quality and patient safety through:

- Critical analysis by a multidisciplinary group of clinicians of the circumstances surrounding the outcomes of care. These outcomes will include selected deaths, serious morbidity and significant aspects of regular clinical practice.

- Making recommendations which focus on measures that can prevent similar incidents or adverse outcomes, or for improving the processes of care provided to this group of patients. Recommendations will avoid apportioning blame to individuals.

- Initiating action on these recommendations and overseeing the progress of these actions.

- Ensuring progress on these actions is made known to the Network/Cluster/Facility patient Safety and Quality Committee

In particular the committee will review or provide the opportunity to review:

- All deaths associated with a health care intervention and which are not an expected manifestation of the disease process

- Individual or aggregate data regarding adverse outcomes or clinical events which are agreed by the committee as providing useful insight into the quality of care provided

- Statistical indicators of the departments performance against agreed benchmarks

- IIMS clinical incidents

- Patient complaints received by the department

- Open Disclosure cases involving major adverse events

The committee will consider whether any issue raised needs to be recorded and maintained on a Network /Cluster/Facility or Departmental Risk Register

Membership

- All senior medical staff appointed to the Department

- All junior medical staff appointed or allocated on rotation to the Department

- All CNCs, CNSs or CNEs related to the Department's activity

- Nursing staff associated with the Departments dedicated wards

- Allied health staff dedicated to the Department's activity

- Clinicians from other Departments with which there is frequent interaction

Modus Operandi

- The meeting will occur monthly.

- The schedule of meetings will be published well in advance.

- The meeting will elect a Chairman. This election will be ratified by the Department Head.

- The office of chair will be reviewed annually but may be extended.

- An agenda will be circulated in advance of the meeting.

- Actions notes will be kept and circulated to members after the meeting.

- The chair will conduct the meeting so as to ensure that it focuses on health care service improvement and not on individual blame

Reporting Lines

The committee reports directly to the Network/Cluster Director / Facility Manger and will submit minutes to the Network/Cluster/Facility Patient Safety and Quality Committee, and relevant Network/Cluster/Facility managers.

Appendix B: Morbidity and Mortality Meeting Report

Department:_____

Network/Cluster/Facility: _____

Date:_____   Time:_____ to _____ hours

Venue:_____

Attendees (name & designation)

_____
_____
_____

1. Actions from Previous Meeting:

Action	Outcome to Date	Person Responsible	Keep on Agenda?

2. Case Reviews
   (Listing of specific cases reviewed by MRN – unless covered under item 4)

3. Recommendations and Actions from this month's Case Reviews:

Recommendation	Action Required	Person Responsible	Timeframe

4. Referrals

   (Issues which specifically need to be highlighted to bodies external to the committee)

SAC 1 Referrals (any case determined to be SAC 1 & not previously assessed as such – identify by MRN or IIMS id)

Specific Issues - (any issue unable to be resolved by the M&M committee which needs to be highlighted to the Network/Cluster/Facility Patient Safety and Quality Committee)

Additions to Risk Register

5. Attachments

(attach any list of de-identified cases presented to the committee for review)

Distribution of M&M Meeting Report

1. Copy to all Department members

2. Quarterly summary report of outcomes to Network/Cluster Director / Facility Manager for inclusion on Network/Cluster/Facility Patient Safety Quality Committee Agenda

Appendix C: Quarterly Morbidity and Mortality Summary Report

For: _____department/service

Date from: _____ / _____ / _____ to : _____ / _____ / _____

GENERAL MORBIDITY & MORTALITY INFORMATION

What were the number of:

Cases reviewed:	_____	Medication incidents:	_____
Cases unresolved:	_____	Infection control incidents:	_____
'Rapid' death reviews:	_____	Communication incidents:	_____
Coroner's reports:	_____	Blood and blood products incidents:	_____

Summary of Key Issues Identified from Morbidity & Mortality Reviews

Outstanding Issues from other Departments

Outstanding Issues to other Departments

Recommendations to Clinical Review Committee for Clinical Practice Changes

Actions from Previous CRC Recommendations

Morbidity & Mortality Case Presentation Summary

CLINICAL EXCELLENCE COMMISSION
PROGRAMS / PROJECTS

The **AMBER care bundle** helps patients and clinicians clarify goals of care in the context of clinical uncertainty

Between the Flags Program aims to reduce the risk of hospital patients deteriorating unnoticed and ensure they receive appropriate care in response if they do

BloodWatch Program co-ordinates the implementation of improvements in transfusion practices across NSW.

Chartbook   As part of its goal to provide assurance through credible public reporting, the CEC publishes an annual chartbook of health system indicators.

Clinical Leadership Program has a focus on improving patient safety and clinical quality by supporting and developing clinical leaders in the workplace.

Collaborating Hospitals' Audit of Surgical Mortality (CHASM) is systematic peer review audit of patient's deaths that were under the care of a surgeon at some time during their hospital stay in NSW.

The **NSW Falls Prevention Program** extends Statewide across hospitals, community and residential aged care

Hand Hygiene The CEC leads the National Hand Hygiene Initiative based on the "5 Moments for Hand Hygiene" promoted by the World Health Organisation (WHO) – World Alliance for Patient Safety

The **Healthcare Associated Infections (HAI)** program assists local health districts to improve systems to manage and monitor the prevention and control of HAIs

In Safe Hands is based on the simple premise that clinical teams are the units that deliver care, so the health system must be oriented towards understanding their needs and supporting them in performing to the best of their ability

Medication Safety The medication safety/quality use of medicines program focuses around the provision of tools and resources which enable hospitals to analyse and improve their medication management systems

Partnering with patients program fosters the inclusion of patients and family as care team members to promote safety and quality.

Patient Safety and incident management The patient safety program utilises Incident Information Management System (IIMS) and Root Cause Analysis (RCA) reports, to identify opportunities for improvements in the safety and quality of clinical care.

Pressure Injury Prevention Project has been established to foster best practice in the prevention and management of pressure injuries in NSW

The **Quality Use of Antimicrobials in Healthcare** program is designed to facilitate and support antimicrobial stewardship initiatives in NSW public health facilities.

Quality Systems Assessment The QSA aims to evaluate the systems and processes which organisations have in place to control risks to patient safety using self-assessment and independent verification.

SCIDUA's primary function is to investigate deaths that occur while under, as a result of, or within 24 hours after the administration of an anaesthetic or sedation administered for a medical, surgical, dental or like procedure

Sepsis Kills program - Improving the recognition and management of severe infection and sepsis - a project to improve the recognition of severe infection and sepsis and promote faster treatment for patients in the emergency department and the inpatient wards.