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.	• Make available to all facilities and/or clinical departments the recommended Mortality and Morbidity guidelines developed by the CEC
	✓ M&M guidelines cover all these recommendations around secondary review	• 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	• Endorsement of the recommended Admitted Patient Death Screening Tool
	✓ Review criteria included in admitted patient death screening tool to provide quality indicators for care of the dying	• Formalise governance and accountability of the screening process and results
	✓ 2012 QSA self-assessment found 80% of departments/clinical units routinely reviewed a patients end of life management	• Rollout to Local Health District/Networks recommended standardised mortality review process and audit tool
	✓ Standardised adult and paediatric resuscitation plan developed and tested by MoH	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

This publication is part of the CEC's Information Management Series. A complete list of CEC publications is available from the Director, Corporate Services (address above) or via the CEC's web site www.cec.health.nsw.gov.au

Suggested citation

Clinical Excellence Commission (CEC) 2012. - *Final Report of the Mortality Review Working Group June 2010*

ISBN: 978-1-74187-761-8

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

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