BENDIGO HEALTH	**Mortality Review Protocol**
Scope	• Medical Services Stream • Surgical Services Stream • Community and Continuing Care Stream • Medical Staff
Responsible Department	Chief Medical Officer
Approved By	Executive Committee
Authorised By	Group Clinical Standards Committee

PURPOSE

A structured mortality review process, integrated with the organisation's Risk Management Plan, meets the organisations quality assurance & risk management requirements as well as the quality assurance & clinical training needs of clinical departments.

The purpose of this protocol is to define the governance structure for Mortality Review within Bendigo Healthcare Care Group, the responsibilities of Clinical Departments for review of the death of patients in their care, and process by which that review shall occur.

INTRODUCTION

Mortality review of inpatient hospital deaths provides an opportunity to examine systems of care, and inform system redesign if deficiencies are identified. The framework of mortality review must serve the needs of both the organisation and the clinical staff. The organisation needs mortality review to assist in identifying system deficiencies, while clinical staff require mortality review for the purposes of both peer review and education requirements to assure clinical competence.

POLICY

- The clinical care of all patients who die whilst in the care of the Bendigo Health Care Group is to undergo review by the department(s) where the patient was receiving care at the time of their death.
- Each inpatient death within a department is to undergo a review using the Mortality Screening Tool by either the consultant responsible for the patient at the time of death or the Clinical Director.
- Each Clinical Director or craft group head will ensure that every inpatient deaths that occur within their service is reviewed using a standardised framework with formal Mortality Review Steam Committee TOR
- Deaths occurring in Hospice and Residential Services are exempted from this protocol.

- Deaths occurring within the Psychiatric Services Stream are to be managed in accordance with policy specific to Psychiatric Services (Notification Process & Mortality Review for a Death of a Registered Psychiatric Patient).

Departmental Review Process:

1. Each inpatient death is rated using the following scale and completion of required departmental actions:

Rating of Death Scale		Class	Departmental Response
1a	Anticipated death due to terminal illness	**Terminal**	Nil
1b	Death following cardiac or respiratory arrest before arriving at hospital		
2	Not unexpected death that occurred despite known preventative measures taken in an adequate and timely fashion		
3	Unexpected death that was not reasonably preventable with medical intervention	**Multi-factorial**	Identify any actions required
4	Unexpected & preventable death where steps were not taken to prevent it	**Causal**	• Complete an incident report in VHIMS • Notify CMO & divisional Executive Director • Identify issues • Nominate recommendations for DPC
5	Unexpected death resulting from medical intervention		

2. Two groups of inpatient deaths require presentation at a mortality meeting:

i. Deaths rated as 3, 4 or 5 (the rating can subsequently be altered at the mortality meeting).

ii. Deaths having system issues ("red flags") identified as:

- Where the treating consultant does not agree with the cause of death documented on the Certification of Death
- Deaths referred to the Coroner
- Planned (elective) admission deaths
- Re-admitted within 72 hours of discharge from Bendigo Health
- Death causally related to a medication error / reaction
- Presence of a hospital-acquired infection during the episode of care
- Presence of a complication during the episode of care
- Death in a patient without a Limitation of Medical Treatment
- Breached MET criteria without a MET being called in the 48 hours before death

3. Mortality meeting presentation occurs within 4 weeks of the death. The structure of the presentation should be –

a) Preparation of a case presentation
   i. Prepare a case timeline identifying any critical events
   ii. Identify preceding action / inaction

b) Map clinical processes and systems to the case presentation using the Mortality Review Checklist

c) Following review, any recommended actions are documented and the form forwarded to the Risk manager.

4. The Deteriorating Patient Committee reviews all mortality reports. Any feedback is sent to the Clinical Director, the treating consultant and the appropriate Executive Director.

5. Referred deaths

- The Clinical Director may nominate any death not identified through the screening process for review for the purpose of peer education.
- The Clinical Director may also consider cases for presentation that have been referred by clinical staff. This would include patient deaths not initially identified by the screening process as warranting further review or adverse outcomes not reported on the reporting system.
- The Clinical Director may also refer deaths occurring in other departments where the referring Clinical Director believes that the patient's outcome may have been contributed to by the care provided in that department.

6. Frequency of meetings

Departments listed below should conduct a departmental M&M meeting at least monthly.

- General Medicine
- General Surgery
- Orthopaedics
- Intensive Care
- Emergency Department
- Obstetrics & Gynaecology (Perinatal, Maternal & Gynaecology)
- Paediatrics
- Anaesthetics

All, other departments / units, having few deaths over a year, should hold clinical review meetings within one month of any death, in addition to any other departmental meetings.

7. Attendance

- Participation should be multi-disciplinary with representation from Medical and Nursing staff from the department involved. This may include extending the invitation to Medical Students at the discretion of the Chair of the Clinical Review.
- Cases should be discussed in the presence of the senior doctors with primary responsibility for the care of the patient. Where appropriate, the Chair may extend an invitation to members of other departments that provided care during the patient's admission.
- The aim of clinical review is to identify system level errors. Where there may be performance concerns with an individual staff member, discussion about the case should be halted and the matter referred to the Chief Medical Officer who will inform the divisional Executive Director.

Bendigo Health Related Documents

- Mortality Review Steam Committee TOR
- Mortality Screening Tool
- Mortality Review Checklist

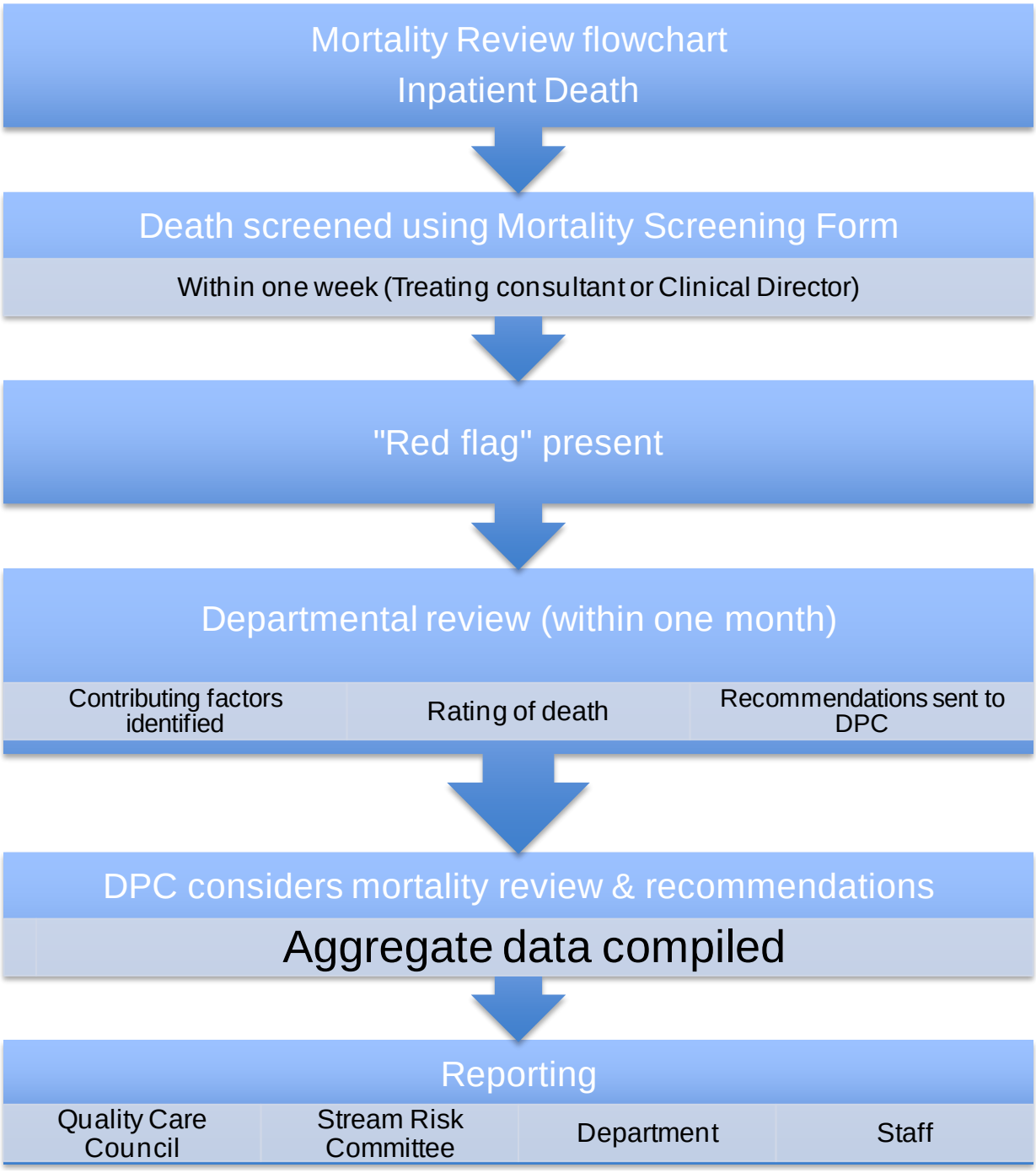
REFERENCES and ASSOCIATED DOCUMENTS

- Procedure for Conducting a Mortality Review - Southern Health
- Guidelines for Morbidity and Mortality review meetings – Royal Children's Hospital
- Procedure - Mortality Audits within Clinical Units – Melbourne Health
- VMIA & Melbourne Health – Mortality and Morbidity Review Project Report
- VMIA & Alfred Health: Learning from Death – A guide to in-hospital mortality review
- National Safety and Quality Health Service Standards
- Reason, J (1997). Managing the Risks of Organisational Accidents. Ashgate Publishing Co., Burlington, VT.
- Jarman B, Nolan T, Resar R (2003). Move Your Dot: Measuring, Evaluating, and Reducing Hospital Mortality Rates (Part 1). Institute for Healthcare Improvement. Cambridge, MA.

MANDATORY INCLUSION

Personal information and health information as defined in the relevant Victorian law, which is required to be collected, used, disclosed and stored by BHCG in order to achieve the Purpose of this policy, will be handled by the Group and its employees in accordance with their legal obligations.

When developing this policy, BHCG has taken all reasonable steps to make its content consistent with the proper discharge of its obligations under the Charter of Human Rights and Responsibilities Act 2006.


Mortality Review flowchart
Inpatient Death
Death screened using Mortality Screening Form
Within one week (Treating consultant or Clinical Director)
"Red flag" present
Departmental review (within one month)
Contributing factors identified
Rating of death
Recommendations sent to DPC
DPC considers mortality review & recommendations
Aggregate data compiled
Reporting
Quality Care Council
Stream Risk Committee
Department
Staff