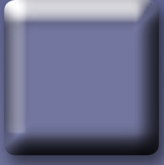

Western Australian Review of Mortality

Policy and Guidelines for Reviewing Inpatient Deaths

2008 edition

Delivering a **Healthy WA**

Acknowledgments

The Office of Safety and Quality in Healthcare acknowledges and appreciates the input of all individuals and groups who have contributed to the development of this document. In particular we recognise the guidance provided by individual clinicians, the medical directors of health services, and the Health Consumers' Council for their advice and constructive feedback.

The Western Australian Council for Safety and Quality in Health Care together with the Office of Safety and Quality in Healthcare will provide a leadership role in monitoring and evaluating the implementation of this policy by hospitals and health services across the Western Australian health system, thus promoting the delivery of consumer-focused, safe, quality health care in Western Australia.

Foreword

Western Australians currently enjoy good health care. Since 2003, the Western Australian Council for Safety and Quality in Health Care (Council) has worked closely with the Office of Safety and Quality in Healthcare (OSQH) and the Area Health Services to promote and enhance the delivery of safe, quality care within the Western Australian health system.

This has been achieved through the successful development and implementation of two WA Strategic Plans for Safety and Quality in Health Care and the successful deployment of an integrated Clinical Governance Framework across the WA public health system.

A third *Western Australian Strategic Plan for Safety and Quality in Health Care 2008-2013* has now been released. This five-year Strategic Plan builds on previous two documents and focuses on achieving tangible benefits in six strategic initiatives. These are the two key Strategic Drivers, *Leadership* and *Governance Structures and Processes*; and the four Clinical Governance Pillars, *Consumer Value*, *Clinical Performance and Evaluation, Clinical Risk*, and *Professional Development and Management*.

A key element of the ***Clinical Performance and Evaluation pillar*** is the establishment of clinical audit and review processes in WA hospitals. The clinical audit/review of patients who have died under medical care is a core strategy of the Strategic Plan and is fundamental to improving safety and quality for future generations of patients.

The WA Review of Mortality (WARM) Policy has now been revised and updated. The 2nd edition of the WARM Policy promotes a standardised process for health services to review and audit deaths with the ultimate aim of improving the complex systems and processes intrinsic to the delivery of health care.

The WARM Policy should be read in conjunction with other relevant policies and guidelines, including the:

- Clinical Incident Management Policy for WA Health Services using the Advanced Incident Management System (AIMS);
- Sentinel Event Policy;
- Qualified Privilege Guidelines; and the
- WA Open Disclosure Policy: Communicating in times of stress (pending release).

All of the above can be accessed via the Office of Safety and Quality in Healthcare website. Hard copies may be obtained by contacting the Office of Safety and Quality in Healthcare on 9222 4080.

As the safety and quality field is dynamic and rapidly changing, updates of this policy will be available on the Office of Safety and Quality in Healthcare website (www.safetyandquality.health.wa.gov.au/policies).

We encourage all health service staff to read these policies and participate in the continuous drive to improve the safety of health care.

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Western Australian Review of Mortality

Policy and Guidelines for Reviewing Inpatient Deaths

1. Purpose of Policy

This document provides policy and guidance for establishing a consistent approach to the classification and review of deaths as part of a mortality audit process. It aims to reduce preventable deaths by ensuring all inpatient deaths are systematically reviewed and that recommendations for improvement arising out of mortality (death) reviews are considered regularly for implementation.

2. Scope of Policy

This policy applies to:

- all deaths that occur in public hospitals and licensed private health care facilities in Western Australia;
- all deaths that occur in the community under the care of Hospital in the Home (HITH) and Rehabilitation in the Home (RITH) services;
- all deaths involving Nursing Home Type category and Care Awaiting Placement patients in Western Australian Government Hospitals;
- 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 (see Section 3.1).

This policy does not apply to Commonwealth funded residential aged care facilities.

3. Responsibility and Accountability

The place of death defines which Area Health Service has operational responsibility under the terms of this policy. When a patient is transferred from one facility to another, the Area Health Service with governance over the place of death retains reporting responsibility and can choose to either engage the transferring agency in the review process or supply the Hospital Executive of the transferring agency with recommendations arising out of any investigation.

All Area Heath Services must nominate a senior officer within the organisation as the officer accountable for ensuring the organisation's compliance with this policy.

3.1 Obligations and requirements

This policy does not supersede or replace any of the existing obligations and requirements that arise from the death of a patient. These include:

3.1.1 Professional obligations

- Communication with the family and/or carer of the deceased.
- Participation in quality improvement activities under the *Terms and Conditions of Indemnity for Salaried Medical Officers* and *Terms and Conditions of Indemnity for Non-Salaried Medical Officers* (available at www.health.wa.gov.au/indemnity/indemnity).

3.1.2 Statutory requirements

- Maternal deaths must be reported to the Executive Director, Public Health (s336 of *Health Act 1911*, and Operational Circular 1453/01).
- Perinatal and infant deaths must be reported to the Executive Director, Public Health (s336A of *Health Act 1911*, and Operational Circular 1454/01).
- Deaths of persons under anaesthesia must be reported to the Executive Director, Public Health (s336B of *Health Act 1911*, and Operational Circular 1197/99).
- Deaths which require notification to the Coroner (*Coroner's Act 1996*, and Information Circular 0008/07).
- Certification of death (s44 of *Births, Deaths and Marriages Registration Act 1998*, and Operational Circular 1652/03).
- Death as a result of suspected child abuse (please refer to Operational Circular 2102/06).

3.1.3 Mandated requirements as per Department of Health (WA) Policy

- Under the *Mental Health Act 1996*, the Chief Psychiatrist has responsibility for the medical care and welfare of all involuntary patients. With respect to other patients, the Chief Psychiatrist is required to monitor the standards of psychiatric care provided throughout the state. Consequently, serious incidents and deaths, which occur in mental health services throughout Western Australia, must be reported to the Chief Psychiatrist (refer Operational Circular 2061/06).
- Serious adverse events that result in a medico-legal claim or have the potential to result in a medico-legal claim must be reported to the appropriate bodies (refer Operational Circular 1850/04: Non-salaried Medical Practitioners' Protocol for Notifying and Managing Medical Treatment Liability Claims/Potential claims (non-teaching hospitals)).

4. WA Review of Mortality (WARM) Standards

WARM should be managed at the Area Health Service level with supporting departmental structures, reporting and governance. This policy acknowledges that Area Health Services have established systems for mortality review that vary across the health system depending on resources, work practices, and case-mix.

Whilst recognising the above, it is expected that mortality review systems must comply with the following **10 minimum standards** in accordance with **timelines** set out in Appendix 1.

4.1 Assessment and referral

1. After the death of a patient, an initial assessment should be made using Health Round Table (HRT) criteria to facilitate referral of possible **category 4 and 5 deaths** for further investigation (refer to **Appendix 2**). The responsibility for this assessment lies with the clinician who had primary responsibility for the patient, and/or with local clinical teams (comprising medical and senior nursing staff) where the death occurred in a country health service.
2. The initial assessment and referral is supported by a clinically independent peer of the clinician who had primary responsibility for the patient, or local clinical teams comprised of independent medical and senior nursing staff.
3. The initial assessments of all patients plus the referral of possible HRT **category 4 and 5 deaths** are tabled at clinical team meetings that review mortality and morbidity.

4.2 Investigation

4. Clinical teams reviewing mortality and morbidity have the discretionary power to investigate the death of any patient who falls within the department's clinical duty of care.
5. All deaths referred as **possible HRT category 4 and 5** must be notified and investigated under qualified privilege, such as a notification via the Clinical Incident Management System (currently AIMS).
6. All deaths referred as **possible HRT category 4 and 5** are investigated consistent with the referenced investigation standards. Referenced investigation standards include the London Protocol, Root Cause Analysis, and a completed WAASM audit.
7. Investigations into deaths referred as **possible HRT category 4 and 5** should include at least one independent clinically relevant expert.
8. The results of all investigations are tabled at clinical team meetings which undertake reviews of morbidity and mortality.

4.3 Reporting

9. Recommendations arising from investigation of deaths (using the sentinel event or clinical investigation pathways) must be reported at local and systems level. Lessons learned should be communicated to local staff. Recommendations that may have system-wide application should be identified by Area Health Services in their reports to the Director, Office of Safety and Quality in Healthcare, within six months of the date of death.
10. Every three months Area Health Services will be required to provide reports (see **Appendix 5**) to the Director, Office of Safety and Quality in Healthcare.

4.4 Three investigation pathways

Preventable deaths identified within the scope and standards of WARM should be investigated:

1. as a Sentinel Event;
2. under the Western Australian Audit of Surgical Mortality (WAASM); and/or
3. by a clinically relevant body that includes members of the local clinical team where the death occurred (e.g., clinical department or a regional multidisciplinary team).

4.4.1 Sentinel Events

Many deaths referred as possible **HRT category 4 and 5** will have already been reported as Sentinel Events. The Area Health Service has responsibility for managing investigations into deaths that are Sentinel Events.

Note that deaths classified as Sentinel Events must be reported to the Director, Office of Safety and Quality in Healthcare in accordance with the Sentinel Event Policy which is available at www.safetyandquality.health.wa.gov.au/policies

4.4.2 Western Australian Audit of Surgical Mortality (WAASM)

All deaths that occur whilst the patient is under the care of a surgeon are currently notified to the WAASM. Surgeons voluntarily participate in clinical audit activities managed by WAASM. A full WAASM audit includes participation of the managing surgeon and fulfils the investigation standards of this policy.

Any death that occurs whilst the patient is under the care of a surgeon that does not progress to a full WAASM audit within three months of the date of death must be identified and reviewed by the particular Area Health Service in accordance with their local mortality review process.

4.4.3 Clinical department or other clinically relevant body

This policy provides discretionary power to the clinical department or clinically relevant body in the particular Area Health Service to investigate the death of **any** patient that falls within its sphere of duty of care.

All **possible HRT category 4 and 5** deaths being investigated by this pathway must have an investigation completed within **three months** of the date of death. *Note: Confirmed preventable deaths identified as an outcome of such an investigation must be subsequently reported as a Sentinel Event and treated in accordance with the Sentinel Event Policy.*

4.5 Reporting responsibilities

4.5.1 Hospital or Health Service Clinical Governance Committee

A hospital or health service's Clinical Governance Committee or the equivalent should maintain the following information on **all deaths** (where applicable) that fall within the scope of this policy:

- patient reference or de-identified code;
- date of death;
- date of review;
- categorisation level;
- type of investigation used where appropriate (e.g. root cause analysis);
- date of completion (including deaths with an incomplete WAASM audit);
- recommendations for system change; and
- implementation status of recommendations.

The Clinical Governance Committee or equivalent is responsible for proposing relevant recommendations for system-level change to the organisation's Executive.

4.5.2 Area Health Services

Area Health Services are required to report to the Director, Office of Safety and Quality in Healthcare on a quarterly basis the following (in addition to Performance Indicators):

- Proportion of deaths with a completed assessment/review.
- Proportion of deaths requiring further investigation (possible **HRT category level 4 or level 5**).
- Proportion of surgical deaths with a completed WAASM audit (where WAASM is the investigation pathway of choice for all surgical deaths).
- For each of the deaths undergoing further investigation, a report containing a brief description of the event and circumstances of the death (de-identified).

Once a death has been confirmed as a preventable death, it needs to be reported as a sentinel event .

Refer to **Appendix 5** for a proforma for quarterly reporting. Quarterly reporting dates are accessible via the Office of Safety and Quality in Healthcare website www.safetyandquality.health.wa.gov.au/mortality/warm_reporting.cfm

5. Qualified Privilege

Qualified privilege refers to the provision of safeguards to protect certain information from disclosure and to protect persons who are involved in quality assurance/quality improvement activities from civil liability.

There are two regulated qualified privilege schemes:

1. The State qualified privilege scheme via the *Health Services (Quality Improvement) Act 1994*. The purpose of this Act is to encourage and promote the establishment of formal quality improvement committees to review, assess and monitor health services with a view to improving the standard of health care in Western Australia.
2. The Commonwealth qualified privilege scheme via the *Health Insurance Act 1973*. The investigation and analysis of clinical incidents reported to the Advanced Incident Management System (AIMS) is protected under the *Health Insurance Act 1973*.

Quality improvement investigations undertaken without qualified privilege expose documents generated in the investigation process to availability under the *Freedom of Information Act 1992 (WA)* or by discovery in legal proceedings.

To ensure that investigations are adequately protected, it is recommended that all deaths (within the scope of this policy) referred as possible **HRT category 4 and 5** be reported to AIMS. Decisions about additional qualified privilege options and whether certain investigations should be conducted with the protection of legal professional privilege must be made at an organisational level.

For information on:

- The State qualified privilege scheme, including the disclosure of information, refer to the *Qualified Privilege Guidelines* available at www.safetyandquality.health.wa.gov.au/policies/index.cfm
- The protection of the investigation and analysis of clinical incidents reported to AIMS, refer to the *Clinical Incident Management Policy for WA Health Services* using the AIMS available at www.safetyandquality.health.wa.gov.au/policies/index.cfm

For further information on qualified privilege please contact the Office of Safety and Quality in Healthcare by telephone on 08 9222 4080.

6. Disclosure of Information

Information arising from reviews or investigations is subject to restrictions with respect to what can be disclosed to the carer or nominated relative.

Furthermore, health professionals have a duty of confidentiality to the (deceased) patient and information must not be disclosed where there would be a breach of confidentiality. Refer to Operational Circular 2050/06 for further details.

Public hospitals and health services are advised to refer any draft correspondence written to the patient's carer or nominated relative for review by their medico-legal departments or the Department of Health's Legal and Legislative Services Division to ensure that disclosure of the information is appropriate.

7. Updates and Review of Policy

This policy is the current relevant policy document and arises from a review of the WARM 2007 policy. The WARM 2007 policy established a mortality review process to comply with the standards outlined in this policy.

This policy may be updated periodically. The latest version of the policy can be found on the Policies and Publications site of the Office of Safety and Quality in Healthcare website at www.safetyandquality.health.wa.gov.au/policies/index.cfm

8. Appendices

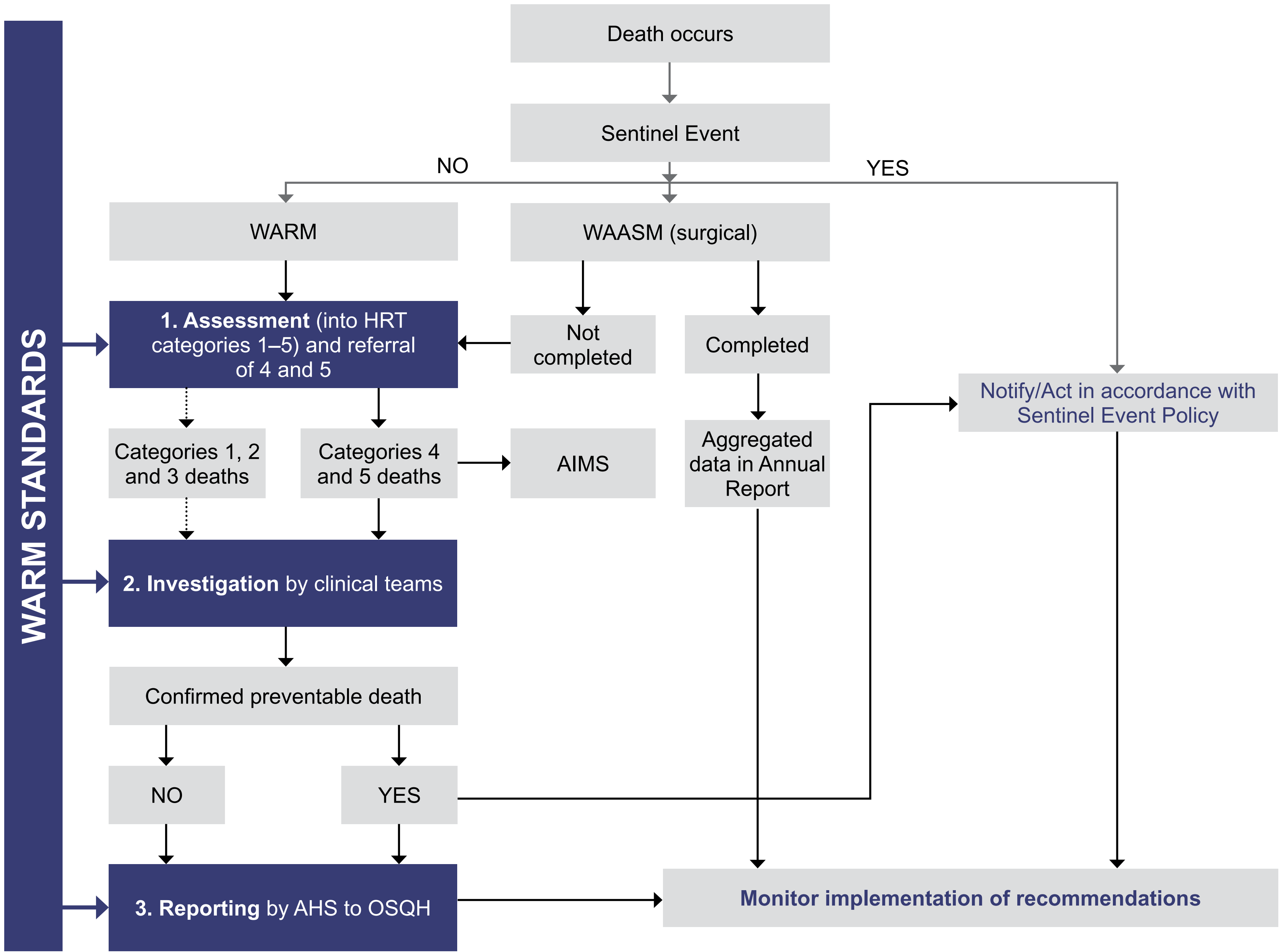
Appendix 1. WA Review of Mortality: Standards Implementation Guide

by July 2008	*In addition to standards implemented by July 2008, the following should be achieved by* June 2009
Assessment/Referral After the death of a patient, an initial assessment should be made using Health Round Table (HRT) criteria to facilitate referral of possible **category 4 and 5 deaths** for further investigation (refer to **Appendix 2**). The responsibility for this assessment lies with the clinician who had primary responsibility for the patient and/or with local clinical teams (comprising medical and senior nursing staff) where the death occurred in a country health service. All deaths referred as **possible HRT category 4 and 5** must be notified and investigated under qualified privilege, such as a notification via the Clinical Incident Management System (currently AIMS).	***Assessment/Referral*** The initial assessment and referral is supported by a clinically independent peer of the clinician with primary responsibility for the patient or local clinical teams which are comprised of medical and senior nursing staff. The initial assessments of all patients plus the referral of possible **HRT category 4 and 5 deaths** are tabled at clinical team meetings that review mortality and morbidity.
Investigation Investigations into deaths referred as possible **HRT category 4 and 5** should include at least one independent clinically relevant expert.	***Investigation*** The results of all investigations of deaths are tabled at clinical team meetings that review morbidity and mortality. Clinical teams reviewing mortality and morbidity have the discretionary power to investigate the death of any patient that falls within the department's clinical duty of care. All deaths referred as **possible HRT category 4 and 5** are investigated consistent with the referenced investigation standards. Referenced investigation standards include the London Protocol, Root Cause Analysis, and a completed WAASM audit.
Reporting All recommendations should be reported at local and systems level. Lessons learned should be communicated to local staff. Recommendations that may have system-wide application should be identified by the particular Area Health Service in their report to the Director, Office of Safety and Quality in Healthcare within six months of the date of death. Every three months Area Health Services provide Performance Indicator reports (see Appendix 4) to the Director, Office of Safety and Quality in Healthcare.	

Appendix 2. Categorising death

The following is a categorisation based on the Health Round Table criteria (*Death Audits: 2001, the Health Round Table*). In WARM it should be used by the clinician with primary responsibility for the patient (or local team in the country health services) as a screening tool for referring possible **category 4 and 5 deaths** for further investigation.	
Category 1:	Anticipated death 1a: due to terminal illness (anticipated by clinicians and family at that time); and/or 1b: following cardiac or respiratory arrest before arriving at the hospital.
Category 2:	Not unexpected death, which occurred despite the health service taking preventative measures.
Category 3:	Unexpected death which was not reasonably preventable with medical intervention.
Category 4:	Preventable death where steps may not have been taken to prevent it.
Category 5:	Unexpected death resulting from a medical intervention.

Appendix 3. Flow Chart of the WARM Process



Appendix 4. Performance Reporting

An organisation's incidence of death is likely to depend upon a number of variables including patient type and presentation. However, the incidence of preventable deaths can be linked with quality improvement activities and thus may be utilised as an outcome performance measure.

Performance measures/indicators can be used as tools to track progress and provide a basis for the health system to evaluate and improve performance with respect to learning lessons from investigations of preventable deaths.

Hospitals and Area Health Services should assess and report on their performances based on the following measures. Reporting should be expressed as cumulative proportion.

Mortality Review PI 1:	Percentage of deaths in an Area Health Service with a completed review[1] (within six months of the date of death).
Numerator:	Number of deaths that had a completed review within six months of the date of death.
Denominator:	Total number of deaths for the reporting period with hospitals in the Area Health Service.
Multiplier:	100
Annual Target	2008/09 = 90%
Responsibility:	Area Health Service

Mortality Review PI 2:	Percentage of possible preventable deaths (e.g. category 4 & 5) investigated to confirm preventability within 3 months of the date of death.
Numerator:	Number of deaths confirmed as preventable within three months of the date of death.
Denominator:	Total number of deaths for the reporting period categorised as possible category 4 and 5.
Multiplier:	100
Annual Target	2008/09 = 70%
Responsibility:	Area Health Service

[1] Completed review indicates a death a) where no further investigation is required; b) with a completed WAASM audit c) sentinel event notification following confirmation of a preventable death.

Appendix 4 (cont) Performance Reporting

Mortality Review PI 3:	Percentage of deaths reported to WAASM with an audit completed.
Numerator:	Number of deaths referred to WAASM that have had audit completed within three months of the date of death.
Denominator:	Total number of deaths audited by WAASM.
Multiplier:	100
Annual Target	2008/09 = 75%
Responsibility:	WAASM

Appendix 5: Proposed Quarterly Reporting Proforma*

Note:

1. *This proforma may be updated during the implementation phase of this policy. Updates will be placed on the Office of Safety and Quality in Healthcare website*
2. *The first report using this proforma will be required in January 2009: July – September 2008 (Q 1) quarter*
3. *Cumulative reporting will be required during each financial year.*

Period: *July 2008 to Month 200X*

Name: Area Health Service

#	Performance Measures	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Total
1	Total # deaths					
2	Percentage of deaths with a completed review					
3	Percentage of death referred for further investigation[2]					
4	Percentage of potential category 4 and 5 with preventability confirmed[3] and remedial action agreed within three months of date of death					

[2] Further investigation is mandatory for potential category 4 and 5 deaths. All recommendations arising from investigation into potential category 4 and 5 deaths are to be reported at a local and system level. Further investigation of any category 1-3 deaths are to be managed at the local level.

[3] Should be reported as a Sentinel Event and recommendation submitted in accordance with Sentinel Event Policy.

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