

Western Australian Review of Mortality

Policy and Guidelines for Reviewing Inpatient Deaths

Delivering a Healthy WA



Office of Safety and Quality
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Acknowledgments

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The Western Australian Council for Safety and Quality in Health Care together with the Office of Safety and Quality in Health Care 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 enjoy excellent health care. To ensure the ongoing delivery of safe, quality care the Western Australian Council for Safety and Quality in Health Care, in consultation with clinicians, developed the *Strategic Plan for Safety and Quality in Health Care in Western Australia 2003/04 to 2007/08*. This strategic document sets the agenda for continuous improvement of health care across the State. It is built around four important interlinked strategic areas of clinical governance: consumer-focused health care, clinical practice improvement, risk management, and system improvement and accountability. Central to clinical practice improvement is the clinical audit process.

The clinical audit of patients who have died under medical care is fundamental to improving safety and quality for future generations of patients. This document 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.

This 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;
- Open Disclosure Policy; and
- Qualified Privilege Guidelines.

All of the above are available on the Office of Safety and Quality in Health Care website. Hard copies may be obtained by contacting the Office of Safety and Quality 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 Health Care website (<http://www.health.wa.gov.au/safetyandquality/publications>).

I 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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1. Purpose of Policy

This document provides guidance for establishing a consistent approach to the classification and review of deaths as part of a clinical 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 occurring in public hospitals and licensed private health care facilities that provide services for public patients in Western Australia; and
- all health service employees and contract staff, including 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).

For the purpose of this policy, hospitals and health services are not obliged to conduct the mortality review process on sentinel events or deaths reported to WA Audit of Surgical Mortality (WAASM). Clinical Governance committees or equivalent should be notified of inpatient deaths reviewed solely by the WAASM process in order to ensure they fulfil specific requirements as detailed in Appendix 1. All other inpatient deaths should be reviewed in accordance with this policy.

3. Other Obligations and Requirements

An inpatient death can give rise to many reporting requirements including professional obligations to the family and/or carer(s) of the deceased, statutory reporting requirements and mandatory reporting requirements as per Department of Health (WA) policy. Some of these are outlined below. It should be noted that regardless of these other requirements, this policy applies to all deaths as defined in the scope unless otherwise specified in the document.

3.1 Professional obligations

- Communication with the family and/or carer of the deceased. Please see Operational Circular 2050/06 regarding Patient Confidentiality and the Open Disclosure Policy.
- Participation in the WA Audit of Surgical Mortality. For further information please see Appendix 1.
- 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 <http://www.health.wa.gov.au/indemnity/indemnity>

3.2 Statutory requirements

- Maternal deaths must be reported to the Executive Director, Public Health. Refer to *Health Act 1911*, s336, and Operational Circular 1453/01.
- Perinatal and infant deaths must be reported to the Executive Director, Public Health. Refer to *Health Act 1911*, s336A and Operational Circular 1454/01.

- Deaths of persons under anaesthesia must be reported to the Executive Director, Public Health. Refer to *Health Act 1911*, s336B, and Operational Circular 1197/99.
- Deaths which require notification to the Coroner. Refer to *Coroner's Act 1996* and Operational Circular 2066/06.
- Certification of death. Refer to *Births, Deaths and Marriages Registration Act 1998*, s44, and Operational Circular 1652/03.
- Death as a result of suspected child abuse. Refer to Operational Circular 2051/06.

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

- Deaths classified as sentinel events must be reported to the Chief Medical Officer. For further information see the Sentinel Event Policy which is available at <http://www.health.wa.gov.au/safetyandquality/publications>.
- Under the *Mental Health Act 1996*, the Chief Psychiatrist has responsibility for the medical care and welfare of all involuntary patients. In respect of other patients, the Chief Psychiatrist is required to monitor the standards of psychiatric care provided throughout the state. Consequently, serious incidents and deaths that occur in mental health services throughout Western Australia must be reported to the Chief Psychiatrist. Refer to 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 to Operational Circular 1850/04: Non-salaried medical practitioners - protocol for notifying and managing medical treatment liability claims/potential claims (non-teaching hospitals).

4. Definitions of Key Terms

'Clinical audit' means a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria (National Institute for Health and Clinical Excellence, 2002, *Principles for best practice in clinical audit*).

'Mortality review' means a two-stage process which involves the categorisation of death followed by a detailed investigation and review of selected patients with the aim of identifying deficiencies of care in the clinical setting and making recommendations for change.

'Mortality review team' means a committee of a clinical department, which reports to the organisational committee responsible for clinical governance. The mortality review team conducts inpatient death reviews in accordance with this policy.

5. Mortality Review Process

The implementation of the Mortality Review process should be managed at the Area Health Service level and reflect local structures, reporting and governance.



Prior to the mortality review process occurring, the appropriate personnel must determine the following:

- if the death is a sentinel event and reported to the Chief Medical Officer; and/or
- if the death can be reported to the WA Audit of Surgical Mortality.

If the death is a sentinel event and/or can be investigated by the WA Audit of Surgical Mortality (in accordance with this policy, refer to Appendix 1) the mortality review process as outlined in this document need not be undertaken.

For all other inpatient deaths a review must be conducted. Refer to Appendix 2 for a flow chart of the mortality review process.

5.1 Mortality review teams

In a department with registrars, the mortality review team should include the following:

- the consultant responsible for managing or supervising the case;
- the registrar responsible for managing or supervising the case;
- one or more consultants with relevant skills or experience who were not directly involved in the care of the patient; and
- one or more registrars who were not directly involved in the care of the patient.

In a department without registrars, the mortality review team should include the following:

- the doctor responsible for managing or supervising the case; and
- two or more doctors with relevant skills or experience who were not directly involved in the care of the patient.

This mortality review team structure represents a minimum requirement. However, as deaths occur under different teams in multidisciplinary settings, departments are encouraged to include additional senior medical staff as well as nursing and allied health staff as additional members of a mortality review team.

5.2 Categorising death

All inpatient deaths should be categorised on the basis of the Health Round Table criteria (*Death Audits: 2001, The Health Round Table*).

Category 1: Anticipated death

- 1a) due to terminal illness (anticipated by clinicians and family); 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.



In addition to categorising the death as per the Health Round Table Criteria, the mortality review should also consider any statutory or mandated reporting requirements as outlined in 3.2 and 3.3.

If the mortality review team determines the death is a sentinel event it must be reported to the Chief Medical Officer and investigated in accordance with the Sentinel Event Policy which can be found at <http://www.health.wa.gov.au/safetyandquality/publications>.

In the case of a missed potential organ donor, the death should also be reported to the Head of the Intensive Care Unit of the relevant hospital and the Medical Director of DonateWest. DonateWest may be contacted by email on donatewest@health.wa.gov.au.

5.3 Detailed clinical review

Inpatient deaths categorised as a level 4 or a level 5 and are not sentinel events must undergo a detailed clinical review by the mortality review team to make recommendations for improvements where appropriate. Deaths categorised as a level 1, 2, or 3 may also undergo a detailed clinical review at the discretion of the mortality review team.

A detailed clinical review of an inpatient death should involve a comprehensive and systematic analysis of the facts to identify contributing factors and develop recommendations for local and/or system change. These changes can help prevent similar events occurring in the future.

For the 06/07 year and until policy review, a minimum standard has not been specified for how a detailed clinical review should be conducted. In practice, mortality review teams are encouraged to follow evidence-based principles with respect to the assessment of the standard of care.

Hospitals/Health Services can refer to the Clinical Incident Investigation Standard, which can be found at <http://www.health.wa.gov.au/safetyandquality/publications>.

5.4 Timeframe for review

The review of level 4 or 5 deaths should be completed within three months of the date of death. This is to ensure that recommendations for improvement are relevant and contemporaneous.

5.5 Reporting

The aim of reporting is to ensure that:

- all deaths undergo an appropriate level of review;
- where a detailed review identifies an adverse event, that these are managed appropriately as per local protocols;
- where changes are recommended, they are implemented in a timely manner as per local Area Health Service policies; and
- system-level recommendations are given appropriate consideration.

The Head of Department is responsible for ensuring that the mortality review team provides a quarterly written report on its activities to the hospital or health service's Clinical Governance Committee or equivalent. The quarterly reports should include the following information:

- patient identification (or code assigned by the mortality review team);

- date of death;
- date of review;
- categorisation level;
- type of investigation used (e.g. root cause analysis);
- date of completion;
- recommendations for system change; and
- implementation status of recommendations.

The patient identification field does not need to contain patient details, but rather a patient ID or code that is assigned by the mortality review team to distinguish between deaths. See Appendices 3 and 4 for sample proformas for recording and reporting the outcomes of the process for an individual death and quarterly summaries.

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

Area Health Services are required to report the following to the Chief Medical Officer via the Office of Safety and Quality on a quarterly basis:

- the number of deaths categorised as level 4 or level 5;
- for each of the reviewed deaths, a report containing a brief description of the event/ circumstances of the death (de-identified), a brief summary of the outcome of the review, and any relevant recommendations and comments that may have statewide relevance.

The template for reporting recommendations arising from sentinel events may be used as a guide to satisfy this reporting requirement.

6. Qualified Privilege

Qualified privilege refers to the provision of safeguards to protect certain information from disclosure and to protect persons involved in the quality assurance/quality improvement activity from civil liability. Some hospitals and health services currently conduct quality improvement activities (including the investigation of sentinel events) using qualified privilege.

There are two types of qualified privilege schemes that a mortality review team can access.

1. The State qualified privilege scheme via the *Health Services (Quality Improvement) Act 1994*. The object of the *Health Services (Quality Improvement) Act 1994* 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*.

It should be noted that a mortality review team can undertake an inpatient death review without qualified privilege, in which case all documents generated via the investigation process are not necessarily protected and may be available under the *Freedom of Information Act 1992 (WA)* or by discovery in legal proceedings.



The decision about the most appropriate qualified privilege option for an individual organisation should continue to be made at an organisational level. It should also be recognised that reviews or investigations in some cases may also be conducted with the protection of legal professional privilege. When making a decision about qualified privilege it should be noted that for investigations carried out under privilege there are restrictions on the disclosure of information arising from the investigation. This includes information protected from disclosure by statutory prohibitions and confidential patient information.

For information on:

- the State qualified privilege scheme, including the disclosure of information, refer to the Qualified Privilege Guidelines, available at: <http://www.health.wa.gov.au/safetyandquality/publications>
- 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: <http://www.health.wa.gov.au/safetyandquality/publications>

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

7. Disclosure of Information

Information arising out of reviews or investigations is subject to restrictions with respect to what can be disclosed to the carer or nominated relative. For further information please refer to the Department of Health policy on Open Disclosure Policy available at: <http://www.health.wa.gov.au/safetyandquality/publications>

Health professionals also 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 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.

8. Performance Indicators

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 used as an outcome performance measure.

Performance 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 reducing preventable deaths. Hospitals and Area Health Services should begin to assess and report on their performance using the performance indicators provided (see Appendix 5). It is anticipated that after the collection of baseline data, the health system will be in a position to report on its performance against reducing preventable deaths.



9. Updates and Review of Policy

This policy may be updated from time to time. The latest version of the policy can be found on the policies and publications page of the Office of Safety and Quality in Health Care website at <http://www.health.wa.gov.au/safetyandquality/publications>

This policy will be reviewed between January-June 2008. Particular items for review will include the:

- reporting timeframe;
- role of the WA Audit of Surgical Mortality and other audits in relation to mortality review;
- need to mandate nursing staff and/or allied health staff on mortality review teams;
- minimum standards for Mortality Review;
- development of thresholds and targets for a reduction of category 4 and 5 deaths; and
- Mortality Review of recently discharged patients and patients on community care programs (e.g. Hospital In The Home).



Appendix 1 *Western Australian Audit of Surgical Mortality*

The WA Audit of Surgical Mortality (WAASM) is an external, independent peer review of deaths of patients under the care of a surgeon (whether or not a procedure has taken place). The process is voluntary and involves two stages of confidential reviews by anonymous, independent surgeons.

The first-line review is to determine whether deficiencies of care may have occurred and whether there are useful lessons to be learnt to improve future health care. Where a more detailed review is required, a second-line review is undertaken by one or more different surgeons to identify those associated deficiencies or lessons.

Many surgeons already participate in WAASM, which provides feedback in the following ways:

- individual surgeons receive feedback from first- and/or second-line assessors on their cases;
- all surgeons receive summaries of second-line reviews, newsletters and copies of annual reports;
- participating hospitals receive reports on aggregated anonymous data that relate specifically to their hospital; and
- annual WAASM reports that summarise the latest results are made available on the WAASM website (www.surgeons.org). Information is aggregated and anonymous.

The WAASM process is limited to peer review without routine access to other team participants or information, so there is a risk that any potential team, system or organisational contributors to the death will be missed.

By being based on a foundation of system improvement, the Mortality Review Process is complementary to the WAASM. A mortality review has the capacity to involve all team members in the death review and to identify any contributors to the death arising from the team, clinical environment or organisation. The structure of the Mortality Review Process allows for recommendations for change to be made at the team, departmental or organisational level and then implemented. Further, regular reporting of incidents and associated recommendations at the State level will allow for analysis to occur across and between departments and organisations.

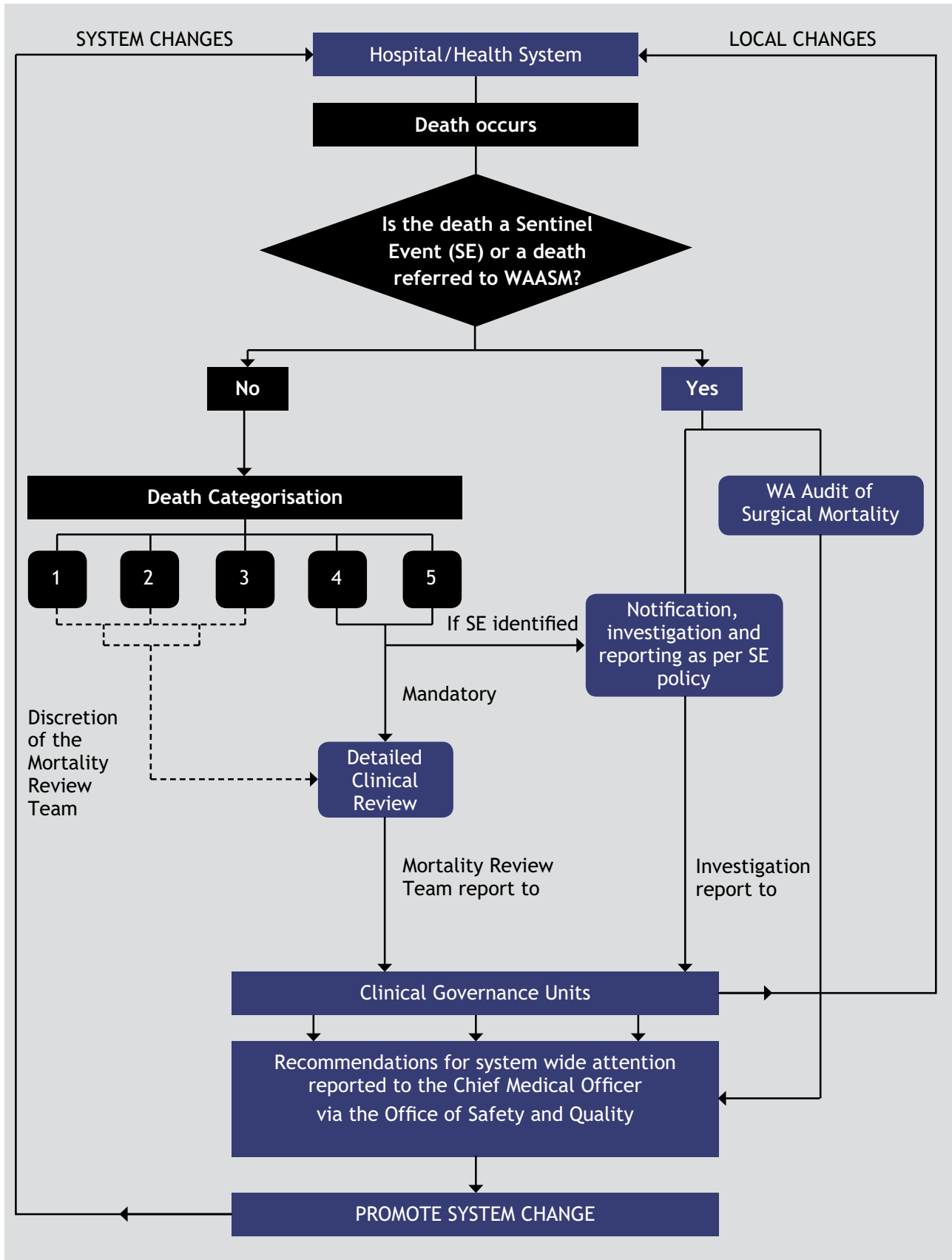
However, in recognition of the benefits of the WAASM process and the potential for expansion of the WAASM process to include key elements of the Mortality Review as outlined above, it is proposed for 2006/07 that health services will determine whether or not WAASM is an acceptable audit process for each organisation. If health services consider that participation in WAASM is an acceptable audit process then the Clinical Governance Committee must be able to:

- identify which deaths have been fully reviewed through WAASM; and
- demonstrate application of WAASM recommendations.

The role of WAASM in relation to the Mortality Review will be reviewed following implementation in 2006/07 to assess the practicality, the leakage rates (audits not completed), timeliness and potential impact on patient safety.



Appendix 2: Flow Chart





Appendix 3: Individual Death Review Documentation Sample Proforma

For use by Mortality Review Teams

Hospital/Health Service _____

Clinical Department _____

Head of Department _____

Patient and medical team details:

Patient ID/code	Date of Death	Medical team

Mortality Review Team

Name	Role

First-Stage Review – Categorisation

Date: _____

A. Is the death a known reported Sentinel Event or a case reported to WAASM in accordance with this policy?

- Yes No further review by the mortality review team required.
- No Proceed to Part B.

B. The Mortality Review Team should categorise the death using the following categories:

- 1. Anticipated death due to terminal illness (anticipated by clinicians and family) and/or following cardiac or respiratory arrest before arriving at the hospital;
- 2. Not unexpected death, which occurred despite the health service taking preventative measures;
- 3. Unexpected death, which was not reasonably preventable with medical intervention;



Appendix 5: *Proposed Performance Indicators (PI)*

Mortality Review PI 1:	Percentage of hospitals in an Area Health Service with a Mortality Review process in place.
Numerator:	Number of hospitals in Area Health Service with a Mortality Review process as defined by this policy.
Denominator:	Total number of hospitals in Area Health Service
Multiplier:	100 Target 2006/07: 100% Responsibility: Area Health Service level
Mortality Review PI 2:	Percentage of deaths reviewed
Numerator:	Number of hospital inpatient deaths reviewed* within 3 months of death occurring.
Denominator:	Total number of inpatient deaths in hospital.
Multiplier:	100 Target 2006/07 = 80% Responsibility: Hospital level
Mortality Review PI 3:	Percentage of deaths in category 4 and 5 deaths
Numerator:	Number of inpatient deaths categorised as category 4 or 5 within Area Health Service.
Denominator:	Total number of inpatient deaths in Area Health Service Baseline data collection only
Mortality Review PI 4:	Proportion of recommendations (arising from category 4/5 deaths) progressed toward implementation.
Numerator:	Number of recommendations being progressed.
Denominator:	Total number of recommendations endorsed for local implementation.

* For death, classified as categories 4 and 5, reviews must be completed within 3 months in order to meet the PI.

