Metro North - wide

Policy

Effective from: January 2021
Review date: January 2024

Death Review 004446

Policy Statement

All hospital deaths will be reviewed to:

- identify potential preventable harm, and/or triggers of concern
- prevent future harm and identify opportunities for improvement/ clinical excellence

The legislative requirement for management of a death within Metro North Hospital and Health Service (Metro North) are identified in this document under the section *Legislation and other authority.*

Purpose and Intent

Death review is a systematic, critical analysis of the events and quality of care that is reviewed by independent expert/s and/or health professionals to identify key lessons and elements of good practice in preventing and reducing future avoidable deaths, against explicit criteria. Death review is used to ensure appropriate mandatory reporting, and further to inform and improve clinical practice with the goal of improving the quality of care for patients. The purpose of this policy is to ensure that all hospital deaths, are reviewed and categorised in terms of potential preventability and/or requirement for further review, and that preventable deaths identified via a review are reported as a Severity Assessment Code (SAC) 1 clinical incident and investigated as per the Metro North Clinical Incident Management Procedure 02044.

The review and monitoring of all hospital deaths will ensure continued care for the deceased and the bereaved; identify opportunities to review systems and delivery of care and identify opportunities for improvement. Review of death can provide assurance that patients have not died from unrecognised sub-optimal care and provide family and caregivers with an avenue to understand the reasons for death.

This policy establishes the principles for ensuring Clinical Directorates have an established Death Review process, with accurate identification and uniform, consistent review and reporting in accordance with legislation, National Standards and the intents of the Metro North Clinical Governance Policy and associated framework.

Scope and target audience

This procedure applies to all deaths that occur in hospitals, services, or outreach models of care governed by Metro North, including care provided in a Residential Aged Care Facility, Correctional Centre or other environment; including patients, where identified, who have died within 30 days of discharge.

This procedure relates to all Metro North employees (permanent, temporary and casual, including VMOs) and all organisations and individuals engaged with or by Metro North (including but not limited to contractors, consultants, health practitioners and volunteers).

This procedure has particular relevance to Executive Directors of Clinical Directorates, Executive/Directors of Medical Services (E/DMS), Safety and Quality leads, Professional Leads, Clinical Stream Leads, Medical Directors and Medical Officers, Hospital Bed Managers and Patient Safety Officers.

Principles

Previously the Health Quality and Complaints Commission (HQCC) implemented the Review of Hospital Related Deaths Standards. Metro North continue to use the principles of this standard to ensure transparent and standardised processes for reviewing hospital related deaths[1]. This standard requires a review of all hospital-related deaths to:

- Ensure that death certificates are accurate and complete
- Ensure that reportable deaths are identified and reported to the Coroner
- Identify and act upon improvements for the safety and quality of care.

The standardised review of a death provides an important opportunity to examine the care afforded to a patient, and to identify areas for improvement or excellence. Death reviews are conducted to identify if the patients' end of life wishes have been met in accordance with relevant legislation and regulation. Death reviews form one component of the Metro North safety and quality improvement process and specifically form part of a broader audit and peer review model within the Clinical Governance Framework. It is recognised that Mortality and Morbidity Committees are strongly linked to the process, which also facilitate the review of deaths that were caused by or associated with a healthcare intervention. The process complements the reporting and management of clinical incidents and the investigation of patient complaints and is intended to set and maintain the highest standards of care at the clinical level.

Whilst the process of death review is an important one, the response to the death of any person must always be sensitive, appropriate and include ensuring the cultural and religious beliefs and practices of the person and their family are respected. Metro North's values in action should be demonstrated alongside respect, protection and promotion of Human Rights in accordance with the Human Rights Act 2019 (Qld) throughout the death review process.

Mandatory Requirements

1. All hospital deaths are to be reviewed.
2. Metro North Directorates will ensure systems and processes are in place to provide support and care to the bereaved when involved in the death review process.
3. The death review process does not supersede or replace any existing obligation or requirements that may arise following the death of a patient, including but not limited to reportable deaths to the Coroner (in accordance with the *Coroners Act* 2003), clinical incident management reporting and procedures or professional obligations to the bereaved.

[1] State Coroners Guidelines 2012 (p13). https://studylib.net/doc/8288310/investigation-of-health-care-related-deaths

4. Scope for the independent review of a death must exist in the review processes. Examples include Mortality and Morbidity Committees or review by a clinician who was not part of the team or whom did not have primary responsibility for the deceased patient.
5. A Basic Death Review may identify the need for a Complex Death Review.
6. All Clinical Directorates will have documented procedures in place to manage:
    - death forms;
    - Basic Death Reviews; and
    - Complex Death Reviews.
7. Basic Death Reviews must occur within 14 business days of the date of death (notwithstanding the immediate actions of identified clinical incidents) (Metro North reporting requirements and principle within *the State Coroners Guidelines 2012*),.
8. Complex Death Reviews must occur, where triggered by a Basic Death Review or another trigger as outlined below.
9. Recommendations arising from a review of death must be documented within a register and local processes must be in place to monitor and confirm the completion of recommendations.
10. Death Review is undertaken to identify opportunities to improve systems and quality of care.
11. Where a Death Review demonstrates findings and recommendations for opportunities to improve systems and quality of care, the findings should be made available to relevant family or bereaved. This should follow the Metro North Disclosure Management Procedure and occur as soon as practicable after the Death Review has been completed.

Mandatory Reporting Obligations

The death review process does not supersede or replace any of the existing obligations and requirements that may arise following the death of a patient. Professional obligations include communication with the family and/or carer of the deceased and the clinician and/or a family meeting regarding disclosure of clinical incidents that may have contributed to the death as per the Metro North Disclosure Management Procedure. Disclosure to the community should not occur until appropriate expert advice - including legal is sought to ensure lessons learned are provided in a de-identified and culturally appropriate manner.

All Clinical Directorates are required to maintain records in relation to the following information on all hospital deaths (where applicable) that fall within the scope of this procedure:

- Patient reference or de-identified code (UR Number);
- Date and time of death;
- Date of commencement of review;
- Type of Death Review (Basic or Complex);
- Date of completion;
- Recommendations identified; and
- Implementation status of recommendations.

A local Death Review Process must occur for all deaths. An external report does not satisfy this requirement.

Death Forms

The purpose of death forms is to guide compliance with legislation and support the bereaved, during the

immediate post-death period.

	Purpose	Outcome
Death Forms	**Legal compliance *and* care of bereaved**	**Official documentation *and* bereavement support**
Basic Death Review	All deaths reviewed, within 14 business days of the date of death (Metro North reporting requirements and principle within *the State Coroners Guidelines 2012*),	To identify potential preventable harm, and/or triggers of concern
Complex Death Review	Detailed analysis of cases with triggers.	To prevent future harm and identify opportunities for improvement/ clinical excellence.

The minimum form set includes:

1. *Life extinct certificate*.
2. Decision prompts for Coroner's referral criteria in Appendix 1 .
3. *Cause of death certificate* – if not a coroner's case, within two days of death, **or**

   Coroners form 1A (Medical Practitioner report of death to a coroner).
4. Decision prompts for consideration of a prompt burial – e.g. Jewish, Islamic, Indigenous, Taoist, Hmong.
5. *Information sheets for the bereaved* to provide direction on how to access post-death and bereavement supports. Each work unit should consider the use of support information for groups with specific needs e.g. foetal, neonatal, paediatric and Aboriginal and Torres Strait Islander deaths.

Types of Death Reviews

Basic Death Review

A Basic Death Review is undertaken for all hospital deaths, with the purpose being to identify potential preventable harm and/or triggers of concern, and/or generate process, system or health care quality improvement opportunities. This review is to be completed within 14 business days of death (Metro North reporting requirements and principle within *the State Coroners Guidelines 2012*), by a non-treating clinician (*see definition)*. Although not involved in the Basic Death Review, treating clinicians are encouraged to separately review the death of patients they treat, as part of their own clinical audit.

Set criteria/triggers will identify the requirement for Complex Death Review and Clinical Directorates are required to develop processes to define these criteria/ triggers (see Appendix Two for a non-exhaustive list of potential Trigger Events).

Small units may elect to have their Basic Death Reviews undertaken by clinicians from the same clinical specialty from another facility. General Specialty cases e.g. General Surgery or General Medicine should have Basic Death Review conducted by corresponding general clinicians. Likewise, sub-specialty cases e.g. Colorectal Surgery or Cardiology, should have Basic Death Reviews by corresponding sub-specialty clinicians.

Each facility should have a documented protocol, clarifying the requirements for clinicians performing Basic Death Reviews. This protocol should be communicated to new staff as part of local orientation.

Complex Death Review

Complex Death Reviews are carried out as a result of a hospital death meeting set criteria/triggers. As mentioned above, Clinical Directorates are required to develop processes to define criteria/triggers leading to a Complex Death Review.

There are multiple methods to conduct Complex Death Reviews. The method of Complex Death Review selected is influenced by local governance structures and resources. Local scoring tools may be used to guide the selection, as can be found in the Metro North Clinical Incident Management Procedure 002044.

The decision on which method is selected is made within the accountability of the Executive Director of the Clinical Directorate. Local protocols may set out the delegation of this decision making where appropriate. The selected method needs to be documented as part of the Complex Death Review process. A suite of example triggers for a Complex Death Review are provided in Appendix 2.

The purpose of a Complex Death Review is to identify the reasons behind a trigger. The issues identified, and lessons learnt must result in quality improvements for future care.

Types of Complex Death Reviews include:

- Root Cause Analysis (RCA) – commissioned by the Executive Director;
- Human Error and Patient Safety Analysis (HEAPS);
- Formal Clinical Review – commissioned by the Executive Director;
- Clinical Incident Analysis (Clinical Review Report); and
- Mortality and Morbidity meetings (single or multi-disciplinary).

RCAs and Formal Clinical Reviews may only occur following formal commissioning by the appropriate delegate.

Where more than one medical specialty is involved, consideration should be given to a multi-specialty complex death review method.

Who can perform a death review:

- The reviewers should reflect the staff mix which would usually have been present in that facility and had impact on the trigger for the review.
- The reviewers should collectively decide on whether to review the trigger event **or** the whole case. In medium and high death areas, trigger event analysis may be preferable. There may be circumstances where it is advantageous to batch similar cases and trigger events, to enhance the understanding and learning.
- The treating practitioner cannot be the only reviewer in a Complex Death Review:
    - In small work units where this is problematic, consider arranging Complex Death Review ‘swaps’ with a similar sized work unit elsewhere **or** arrange for combined mortality meetings (with similar work units).
    - If the swap or combined work unit is located outside of Metro North, prospective permission needs to be sought from the directorate E/DMS and/or Executive Director.
- Treating clinicians have valuable information, insights and reflections which should contribute to the Complex Death Review. It is the responsibility of the complex death reviewer/s to make contact with the treating clinicians to gather further information. This contact will usually occur before any complex death review team meetings; however, it can occur afterwards, but must be gathered before any conclusions are made.
- Health consumer representatives can form part of these teams. Their presence adds depth of perspective, understanding and potential solutions. Queries regarding involvement of a consumer representative, their Clinical Directorate / facility, individual backgrounds, training and

reimbursement can be found at Metro North Consumer Engagement online homepage.

Outcomes:

After the completion of a Complex Death Review, the following outcomes are expected:

1. A list of issues identified during the review which contributed to the trigger event; and
2. Where appropriate, recommendations addressing the contributory factors; and
3. Where recommendations are made, a complete quality improvement loop, where the outcome is assessed after implementation. Results of analyses should roll up into organisation wide reporting and be shared with the senior leadership, the board and the public
4. The Death Review and/or incident management process needs to be continuously monitored to ensure that it is effective and reliable. Consistent monitoring helps identify areas for further improvement.

Governance

Positions within Clinical Directorates	Responsibility
Executive Director	Under the authority of the Chief Executive, they are to ensure that the Mandatory Principles for the system and processes of death review, as outlined in this procedure, are implemented within the relevant Clinical Directorate. For Clinical Directorates without a dedicated Executive/Director Medical Services *or* Safety and Quality lead, the Executive Director is to assign the appropriate officer/s responsible for Death Review clinical governance and the coordination of the Complex Death Review and reporting processes. These arrangements should be documented, referencing this procedure as the overarching procedure.
Executive/Director of Medical Services	The clinical governance and compliance with the system of death reviews.
Safety and Quality lead (or delegate)	Coordinating the Complex Death Review and reporting processes.

Partnering with consumers

The results of the Death Review should be communicated to the relevant next of kin of the deceased where the review results in findings and recommendations. The communication should be through a single point of contact and occur as soon as practicable at the completion of The Basic Death Review or Complex Death Review. This may involve disclosure; in these instances, the Metro North Disclosure Management Procedure can be utilised. The MN “Conversations in Health” philosophy can be utilised as an approach to deliver information that is meaningful to the bereaved (Appendix 3: Conversations in Health).

Family members and/or carers are to be encouraged and given the opportunity to ask questions, clarify information and identify concerns. Staff are responsible for providing information in a way that is understandable and respects, protects and promotes human rights in accordance with the Human Rights Act 2019 (Qld); that meets their needs and are to ensure that the consumer understands the discussion.

Partnering with consumers demonstrates respect, integrity and compassion and Metro North's commitment to values in action and providing high quality healthcare outcomes that matter to patients.

Aboriginal and Torres Strait Islander considerations

The end stage of life is a very sensitive and significant time for patients and their loved ones. For Aboriginal and Torres Strait Islander people, the time before and following death are subject to a number of customary practices. These practices have meanings that are sacred to Aboriginal and Torres Strait Islander people. Metro North recognises and supports the rights of Aboriginal and Torres Strait Islander peoples to practise their cultural and spiritual traditions and customs without discrimination or judgement (Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (version 2) Published by the State of Queensland (Queensland Health), December 2015).

Legislation and other authority

Coroners Act 2003 (Qld)

State Coroner's Guidelines 2013

Cremations Act 2003 (Qld)

Hospital and Health Boards Act 2011

Births, Deaths and Marriages Registration Act 2003 (Qld)

Human Rights Act 2019 (Qld)

QH-HSDGCL- 032-2 Health Service Directive – Guideline for Clinical Incident Management

QH-HSD-032:2014 Health Service Directive - Patient Safety

QH-POL-295:2015 Department of Health Fraud Control policy

003358 Metro North Clinical Governance policy

002090 Metro North Risk Management policy

002089 Metro North Risk Management procedure

References

- Australian Commission on Safety and Quality in Health Care. National Consensus Statement: essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC, 2015. Australian Commission on Safety and Quality in Health Care Core, Hospital-based Outcome Indicators.
- Australian Commission on Safety and Quality in Health Care, Audit Tools and Quality Measures for Recognition and Response Systems – Audit and Evaluation Tools.
- Best practice guide to clinical incident management, June 2014Queensland Clinical Senate and Health Consumers Queensland, End of Life report 2014
- NSW Clinical Excellence Commission guideline for conducting and reporting clinical review
- State Coroners Guidelines 2012
- IHI Global Trigger Tool for Measuring Adverse Events
- IHI Reducing Hospital Mortality Rates
- Government of Western Australia Department of Health Operational Directive: The Review of Death Policy

Related documents

Queensland Health Quality Assurance Committees Guidelines

Metro North Clinical Governance Policy

Metro North Clinical Incident Management procedure

Metro North Disclosure Management procedure

Metro North Safety and Quality Performance Reporting and Monitoring procedure

Metro North Quality Improvement procedure

Strategy for inclusive engagement, involvement and partnerships 2016-18

Appendix 1 - Definitions

Term	Definition
Hospital Death	Patient who has died while an inpatient or within 30 days of discharge from a Metro North hospital or facility (Metro North reporting requirements and principle within *the State Coroners Guidelines 2012*).
Basic Death Review	All deaths are to be reviewed within 14 days business and deaths that occurred within 30 days of discharge by non-treating Senior Medical Officers. The review is to identify potential preventable harm and identify opportunities for improvement or clinical excellence (Metro North reporting requirements and principle within *the State Coroners Guidelines 2012*).
Complex Death Review	Detailed analysis of cases with concern or other triggers for complex review, to be undertaken by Patient Safety Officer and Morbidity and Mortality Committee or other relevant committee to prevent future harm and identify opportunities for improvement or clinical excellence.
Trigger event	Event or circumstance leading to the commencement/requirement for a Complex Death Review. See Appendix 2 for a non-exhaustive list of trigger events.
Non-treating clinician	Non-treating clinicians are clinicians who were not involved in the care of the patient and may be within or outside the Clinical Directorate and include senior medical staff or mortality review officers.

Appendix 2: Suite of example Complex Death Review triggers

The following list is provided for information and consideration. Each clinical unit may consider a suite of death related quality measures, then monitor and integrate these into their quality improvement system (Death Review and Morbidity & Mortality processes). Triggers may require a complex death review, or be utilised to inform the Morbidity & Mortality quality improvement process.

A suite of possible metrics to choose from is in the table below. Other external sources of measures include specialty colleges, specialty death registries and benchmarking organisations.

Time

Category	*Measure*	*Source*
L	Cause of death certificate written within two working days (death from)	BDMA
V	Delayed coroner's case referrals; >48 hours from death (form 1A or basic death review)	CorAct
L	Death review within 14 days (basic death review)	Principle within the State Coroners Guidelines 2012,
L	Complex death review report <56 days, if case is subject to an external review	Principle within the State Coroners Guidelines 2012,
L	RCA report completed <90 days	HHBA
VS	Time lapse between deciding to palliate OR referring to specialist palliative care UNTIL death (*not* included in proposed suite of forms)	ACSQHC

Care

Category	*Measure*	*Source*
V	Complaints related to body handling or release processes, including from coroner	CGSQR
VS	Whether triggers to identify patients approaching the end of life were correctly used and applied.	ACSQHC
VS	Effectiveness of treatment of symptoms	ACSQHC
VS	Documentation of the patient's wishes and alignment of the patient's expressed wishes with actual care	ACSQHC
VS	Real-time feedback on patient experiences of care	ACSQHC
VS	Feedback on their experiences from families and carers of patients who received end-of life care	ACSQHC
VS	Whether any existing advance care directive or plan was enacted	ACSQHC
VS	Transfers of care in the last week of life	ACSQHC

V	Patient's wishes for death recorded; expected deaths with ARP or AHCD	QCS HCQ
V	Dying with dignity; expected death with evidence of comfort care plan	QCS HCQ

Outcomes

Category	*Measure*	*Source*
V	Changes in death certificate required. Eg. as % of last 50 deaths	CGSQR
V	Number of general + facility triggers with concern responses. Eg. as % of last 50 deaths	CGSQR
VS	In-hospital death rates	ACSQHC
S	Hospital standardised mortality ratio (HSMR)	ACSQHC
S	Death in low-mortality Diagnosis Related Groups (LMDRGs)	ACSQHC
S	In-hospital mortality for acute myocardial infarction (AMI), stroke, fractured neck of femur and pneumonia	ACSQHC
VS	Category of death; expected OR unexpected	ACSQHC
VS	Unexpected in-hospital death rates	ACSQHC
VS	Unexpected cardiopulmonary arrest rates	ACSQHC
VS	Rates of failed escalation with mortality	ACSQHC
VS	Rapid response activation rates	ACSQHC
V	Ryan's Rule activation where death occurred <30 days	CGSQR
V	CHADx diagnoses with death <30 days	*CGSQR*

Resources

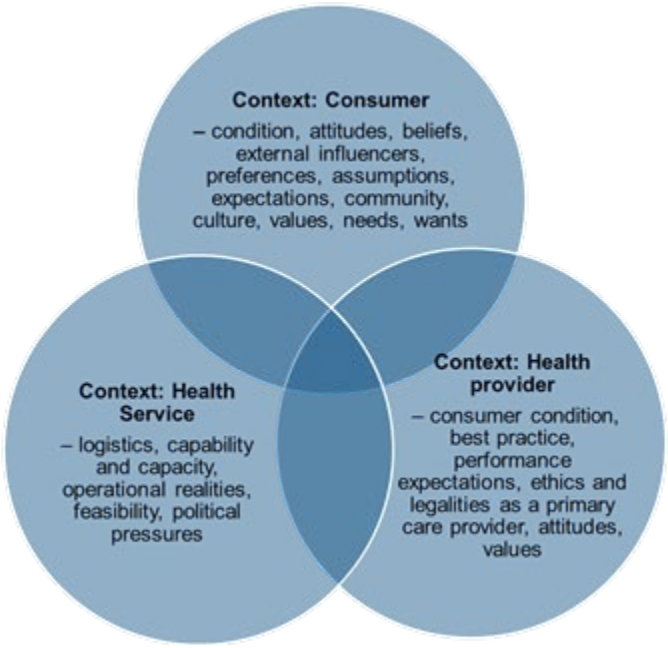
Category	*Measure*	*Source*
V	Staff resource *and* supervision inadequate to maintain favourable metric levels	CGSQR

L – Legal S – Standard (mandatory) V – Voluntary VS – Voluntary standard

BDMA *Births, Deaths and Marriages Act*
CorAct *Coroners Act*
HHBA *Health and Hospital Boards Act*
ACSQHC *Australian Commission of Safety and Quality in Heath Care*
QCS HCQ *Queensland Clinical Senate and Health Consumers Queensland End of Life report 2014*
CGSQR *Clinical Governance, Safety, Quality and Risk (Metro North)*
CHADx *Classification of Hospital Acquired Diagnoses*

Appendix 3: Conversations in Health

The Metro North Health Literacy Approach is about creating an environment in which Conversations in Health are at the core of everything we do, because information is only useful to people when it is meaningful to them. Shared decision-making comes from meaningful conversations between clinicians and consumers, for a better understanding of the person and their condition. Medical treatment isn't just about physical wellbeing - you can't separate mental and physical wellbeing. Accessing healthcare can be really daunting, so we have to understand how people are feeling in order to be understood. Conversations in Health has been designed to empower consumers to become partners in, rather than recipients of, their own healthcare. Metro North Health Literacy Approach is about empowering consumers and their loved ones to take the lead role in their own health journey. Our ideal future state is a healthcare system that successfully brings together the context surrounding the consumer, health provider and health service.



Document history

Author	Medical Administration Registrar Metro North
Custodian	Deputy Executive Director Medical Services Metro North
Compliance evaluation and audit	Compliance will to be audited against criteria in Appendix 1. 1. Each facility will establish an audit schedule, approved by the relevant Safety and Quality Committee. 2. The selection of deaths will review every work unit each year, and to include a selection of basic and complex death reviews. 3. The schedule and number of deaths audited will depend on the clinical unit. The findings will be reporting through the safety and quality governance structures and committee reporting.
Replaces Document/s	Death Review procedure 004446 V2.0

Changes to practice from previous version	Full Scheduled review: minor changes. Changed from procedure to a policy • Included Aboriginal and Torres Strait Islander section • Added Definitions
Education and training to support implementation	Communication through Safety and Quality Units and unit/ward meetings is sufficient
Consultation	**Key stakeholders** Executive Director of Clinical Governance, Safety, Quality and Risk Executive Directors/ Directors of Medical Services Medical Executive Committee (MEC) Patient Safety Officers **Broad consultation** Metro North Aboriginal and Torres Strait Islander Leadership Team Metro North Information Technology Metro North Nursing and Midwifery Metro North Allied Health Metro North Finance Metro North Engage Metro North Workplace Health and Safety Metro North Legal Services Metro North Risk and Compliance Officer Metro North Emergency Medicine and Access Coordination Stream Clinical Operations Strategy Implementation Unit Clinical Directorate Safety and Quality Units Clinical Skills Development Centre
Marketing Strategy	The policy will be posted on the Metro North Policy and Procedure webpage. The policy will be circulated to all Executive/Directors Medical Services, Clinical and Medical Directors, Medical Workforce Units. Clinical Directorate to distribute to all SMOs and RMOs. Marketing through email to all key stakeholders, for operationalisation.
Key words	Death, basic, level 1, complex, level 2, mortality, review, quality, governance, end of life, mortuary, morbidity, coroner.

Custodian Signature Date

Deputy Executive Director, Medical Services, Metro North Hospital and Health Service

Authorising Officer Signature Date

Executive Director, Medical Services, Metro North Hospital and Health Service

AUTHORISATION

Signature Date

Chief Executive, Metro North Hospital and Health Service

The signed version is kept in file at Clinical Governance Safety Quality and Risk, Metro North.