A METHODOLOGY TO CONDUCT MORTALITY REVIEWS

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ACKNOWLEDGEMENT

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INTRODUCTION

What is a mortality review?

This is a detailed assessment of all the patients that have died. Information is systematically collected and then presented in a manner that can be understood.

Why are mortality reviews important?

Because they measure the size of the problem (the number of people who die) and indicate where the problem lies (what causes the deaths). If you do not know where the problems lie, it is very unlikely that you will be able to solve the problems. You may not even know that there is a problem. By understanding the problem better (what errors might have been made) solutions can often be found to reduce the risk of similar deaths in future. By decreasing the number of patients who die, the standard of care will improve.

What is a mortality review meeting?

This is a meeting, attended by as many of the medical and nursing staff as possible, where all the facts relating to the deaths are carefully examined. These meetings are needed so that the management of patients who have died can be reviewed. At the mortality meeting a cause of each death must be looked for and possible avoidable factors identified for each person who has died. Regular meetings provide motivation for data collection and are associated with a fall in mortality rates.

If possible, all the staff, including doctors and nurses, who work in that service (hospital or clinic or a hospital and its attached clinics) should attend. Unfortunately, some staff on duty and most of the staff off duty will not be able to attend. The findings of the mortality review meeting should be made known to all staff.
What problems may occur with mortality review meetings?

1. Patients who die at home after discharge are not included.
2. Some staff involved in particular cases cannot attend.
3. Individual staff may feel threatened if problems of management are discussed.
4. Problems of confidentiality may occur.
5. It can become a witch-hunt to find the staff that made a mistake.
6. Patient notes cannot be found or are incomplete.
7. The cases and data are not prepared properly.
8. Lessons learned are not used to improve care.

Is a mortality review meeting a good opportunity for teaching and learning?

It is a wonderful opportunity and excellent method of teaching and learning. When the cases are presented, the participants at the meeting should identify problems and errors in the management. They should also suggest what should have been done to avoid the problem or manage the problem better. Learning from one’s mistakes is very effective.

Where and when should a mortality review of a health care service be conducted?

At a single clinic or hospital or a single hospital together with the attached clinics.

Who conducts a mortality review?

The responsibility for conducting a mortality review lies with the authority responsible for providing the service. However, everyone working in that service should be interested and involved in finding out where problems lie and in helping to find answers to those problems.
A methodology to conduct mortality reviews

Who should arrange mortality review meetings?

As they are an integral part of a clinical service, the person in charge of the service or facility is responsible for the meetings. In practice, it is usually a senior person working in the service who arranges the mortality review meeting.

How is a mortality review meeting arranged?

All the staff should be informed about the nature, importance and benefits of a mortality review meeting. They should then be invited by the person arranging the meeting. The most suitable time and venue should be decided upon after discussion with as many of the staff as possible. Usually a waiting room, lecture room or boardroom is most suitable. The most convenient time is often over lunch or in the late afternoon. Each service should agree on a time and venue where most staff can attend.

How often should mortality review meetings be held?

In big services with deaths every few days, mortality review meetings are best held every week. In smaller hospitals and clinics with few deaths, meetings are usually held once a month. With weekly meetings, it is easier for the staff to remember the details of the patient’s problem and management.

Why are good patient notes important?

When assessing the causes and avoidable factors in a death, it is essential that detailed, accurate notes be kept.
METHODOLOGY

What are the important steps of a mortality review?

1. Documenting the number of deaths.
2. Collecting the basic information on the people who have died.
3. Calculating important mortality rates.
4. Determining the causes of mortality.
5. Looking for avoidable factors and missed opportunities.
6. Planning ways in which these deaths can be avoided in the future.

How can it be determined why a patient has died?

All the information about the patient must be carefully reviewed. Only then can a likely cause of death be decided on. This information consists of:

1. The history.
2. The examination of the patient.
3. Special investigations.
4. A post mortem examination, if this has been done.

What information should be collected for a mortality review meeting?

1. Number of deaths, if any.
2. The mortality rates.
How should the death be presented?

1. The clinical record must be carefully summarised.
2. The summary is presented at the meeting.
3. Any points of uncertainty are clarified.
4. Each death is discussed.

How are deaths discussed at a mortality review meeting?

1. The primary cause and final cause of death should be identified.
2. Any avoidable factors, missed opportunities, or substandard care should be identified and discussed. Could the death have been prevented?
3. A management plan must be discussed and agreed upon which could prevent a similar death in the future.

All participants of the meeting should together identify the problems and find the best answers.

Should all deaths be discussed?

It is important that the number of deaths to be presented and the causes and avoidable factors in all deaths be agreed upon. However, if there are many deaths, there is often not enough time to discuss each in detail. Deaths with obviously avoidable factors must be discussed. Deaths where important lessons can be learned must also be included.

In view of the large number of deaths because of the HIV/AIDS epidemic it has been suggested that a SELECTIVE mortality review be done. According to this approach the medical manager or head of the clinical domain could review all deaths that occur and then he/she should decide which deaths should be discussed.
A methodology to conduct mortality reviews

Guideline summary sheets for neonatal, paediatric and adult mortality are shown in the Appendices.

What is a "Great Save"?

This is when a good diagnosis was made and good care prevented a death. As mortality review meetings can become very depressing, it is helpful to mention a few as part of the meeting to emphasize the good care that was given.

In summary, what are the steps in managing a mortality review meeting?

1. A time and venue must be agreed upon and the venue booked.
2. All relevant staff should be invited and every effort made to ensure that they attend.
3. A chairperson must be chosen to lead the meeting.
4. A secretary must be chosen to keep minutes of the meeting (see point 11).
5. All the deaths must be identified.
6. Someone must be identified to prepare and present the cases.
7. The clinical records of patients who have died must be found, read and summarised.
8. Summaries of the cases must be prepared for the meeting. They may be written or typed out with a copy handed to each participant or presented with an overhead projector.
9. It is best to use a standard form to present the summary of each case.
10. The deaths are discussed after any errors in the summary are corrected.
11. A summary should be kept of the cases discussed, the findings and the management plan agreed upon (see point 4). This summary should include the avoidable and unavoidable factors implicated in the death.
12. It is important to discuss the problem and NOT the staff involved.
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A methodology to conduct mortality reviews

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