

# SESLHD GUIDELINE COVER SHEET



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<b>KEY TERMS</b>	Death screening, death review, unexpected death, Morbidity and Mortality (M&M) meetings.
<b>SUMMARY</b>	This document provides a guideline for the screening and review of patient deaths that occur within SESLHD facilities and services.

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## Death Screening and Review

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## Section 1 - Background

### 1. POLICY STATEMENT

The *NSW Health Patient Safety and Clinical Quality Program* (PD2005\_608) requires each Local Health District to have a system in place for conducting a timely review of the medical record of all patients who have died whilst receiving care within its facilities. This includes inpatient deaths and deaths occurring in the community under the direct clinical management of a South Eastern Sydney Local Health District (SESLHD) facility or service.

A robust system of death screening and review ensures that:

- Appropriate and timely mandatory reporting and review of patient deaths occurs
- Significant clinical incidents are identified and reviewed
- Deficiencies in end of life care management are identified
- Systemic risks to safe effective patient care are identified
- Changes in practice required to improve the safety and quality of patient care in SESLHD can be made.

## Section 2 - Aim

### 2. AIM

To provide a framework for the review of inpatient and non-inpatient deaths within SESLHD, outlining minimum standards with regards to death screening, death review and the monitoring of recommendations and actions arising from these reviews.

#### 2.1 Death Screening aims

- To identify appropriate clinical incidents and potential cases for review, as well as ensuring that SESLHD meets all mandatory reporting requirements including SAC 1 and referral of patient deaths to:
  - The Coroner
  - The NSW Maternal and Perinatal Committee (Ministry of Health)
  - The NSW Special Committee Investigating Death Under Anaesthesia (SCIDUA)
  - The Collaborating Hospitals Audit of Surgical Mortality (CHASM)

#### 2.2 Death Review aims

- To ensure that any issues of care and/or adverse events that occur as part of the episode of care underway at the time of the patient's documented death are identified, reported and reviewed.
- To ensure that key learnings can be identified, as well as providing an opportunity to improve patient safety and quality of care.

### **2.3 System improvement aims**

- To ensure that there is an effective process in place to facilitate investigation of system issues identified through the death review process, and the implementation of recommendations arising out of those reviews.

### **2.4 Public assurance aims**

- To provide assurance to the community that SESLHD has an effective governance framework in place in relation to death screening and review, and that feedback on the outcomes of review, and that system improvements and learnings will be communicated to staff and patients' families where appropriate.

## Section 3 - Definitions

### 3. DEFINITIONS

CHASM (Collaborating Hospitals' Audit of Surgical Mortality)	<p>A systematic peer review audit of the deaths of patients who were under the care of a surgeon during their hospital stay, regardless of whether an operation was performed.</p> <p>Surgeon participation in CHASM has been mandated by the Royal Australasian College of Surgeons (RACS).</p>
Death screening	<p>The initial process of checking the medical records of all patient deaths occurring against key safety criteria, identifying whether those patients suffered specific harm during their last episode of care, or if the death was associated with an intervention. Screening identifies deaths that should be referred as per 2.1 mandatory reporting requirements and those cases for further clinical review.</p>
Descriptive Event Classification System (DECS)	<p>A structured framework developed by Dr Raj Behal which helps to identify factors that have contributed to patient mortality and morbidity, and can be used to undertake trend analysis.</p>
Maternal deaths	<p>Any death which occurs during pregnancy, labour or within the first year (365 days) following cessation of pregnancy.</p>
Morbidity and Mortality Review Committees (M&Ms)	<p>M&amp; M review meetings provide clinicians with the opportunity to review cases in an open manner, discuss management decisions, provide a learning opportunity focussed on system thinking and identify opportunities to improve patient safety and quality of care. M&amp;Ms are ideally multidisciplinary.</p>
Perinatal deaths	<p>All neonatal deaths, regardless of gestational age at birth, and stillbirths of at least 20 weeks or 400 grams birth weight.</p>
Death Review	<p>A structured forum which allows for an open examination of all deaths, usually M&amp;M. A secondary review may be conducted by</p> <ul style="list-style-type: none"> <li>• Peer review committee</li> <li>• RCA Team</li> <li>• Patient Safety Managers</li> <li>• Directors of Clinical Services</li> </ul>
SCIDUA (Special Committee Investigating Deaths under Anaesthesia)	<p>The death of a patient is referred to SCIDUA if it occurs while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure or an</p>

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	operation or procedure of a like nature, but not deaths associated with a local anaesthetic administered solely for the purpose of facilitating a procedure for resuscitation from apparent or impending death (see s84 of the <i>Public Health Act</i> (NSW) 2010).
SAC 1 – Severity Access Code 1	Where a death is unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or suspected suicide, or unexpected intra-partum stillbirth. NSW MOH Incident Management Policy 2014_004.

## Section 4 - Responsibilities

### TARGET AUDIENCE

- Medical Staff
- Registered Nurses and Midwives
- Medical Records/Clinical Information Departments
- Facility Directors of Clinical Services
- Director Clinical Governance
- Facility Clinical Practice Improvement Units

#### 4.1 Medical Department Heads

- It is recommended that Medical Department Heads have a structured process for the screening and review of all patient deaths occurring in their Department, with the mechanism for a multidisciplinary team meeting
- The [CEC – Recommended Guidelines for Conducting and Reporting Mortality and Morbidity / Clinical Review Meetings](#) can be used as a guide where appropriate
- It is recommended that all deaths are reviewed, classified and reported using the DECS tool
- Regular reports of outcomes of M&M/Peer Review meetings should be provided to the appropriate person/committees using a facility approved M&M Reporting Form within 30 days of the meeting
- Progress of actions arising from death reviews should be reported as per facility processes.

#### 4.2 Medical Officers

- It is recommended that all Medical Officers participate in the analysis and review of the circumstances surrounding patient deaths (eg. clinical reviews and/or Morbidity and Mortality Meetings) including making recommendations for improvement either as part of their routine departmental activities or as directed by their Facility
- Where appropriate, Medical Officers should implement agreed changes in practice that have arisen from recommendations of case reviews.

#### 4.3 Directors of Medical/Clinical Services

- Directors of Medical/ Clinical Services should provide oversight for the death screening and review processes within their Facility
- Participate in death screening and review as per their facilities agreed processes
- Provide advice/guidance to medical officers concerning the requirements of Coronial referral and mandatory reporting.

#### 4.4 Facility CPIU / Clinical Governance Units

- Oversee the monitoring and reporting of actions on and implementation of recommended changes in practice arising from clinical reviews.

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#### 4.5 The Director of Clinical Governance

- Act as executive sponsor for the SESLHD Death Screening and Review Framework
- Facilitate consistent rules/definitions for the DECS classification tool across the SESLHD to ensure consistent and comparable data
- Identify opportunities to undertake District-wide improvement initiatives that arise from issues identified across the District.



## Section 5 - Principles

### 5.1 General Principles

- Universal screening of all deceased patients aims to:
  - Identify cases that require reporting to external bodies as per mandatory reporting requirements (refer Section 2.1 above) within a timely manner
  - Ensure the integrity of death certificates
  - Identify cases requiring further clinical review in relation to clinical care processes.
- All SESLHD facilities should have a clear and well communicated process for all staff to be able to identify and refer cases of concern for further consideration and review.
- All SESLHD facilities should have in place an effective structured process for the initial screening and subsequent review of all inpatient deaths using the standardised death screening and reporting tools. This includes patients who are not-for-resuscitation (NFR), palliative care patients, and patients who die (or present as dead on arrival) at an Emergency Department (ED).

### 5.2 Death Screening

- The approved screening tools for use within SESLHD is the Death Screening Form SEI010.570 and the Coronial Checklist SMRO10513.
- Death screening within SESLHD will be managed at the facility level. It is the responsibility of each facility to ensure that their initial death screening processes are sufficiently robust so that any issues of concern or deficiencies in care will consistently be identified through the screening process.
- Facilities must have a system in place to screen all deaths within two to three working days using the [Death Screening form](#) and [Coronial Checklist](#).
- Cases that identify potential deficiencies in care must be referred the Responsible Officer. This should occur regardless of whether or not the deficiency in case has contributed directly to the patient's death.
- All cases that meet one or more triggers on the Death Screening Form should then be forwarded to the designated Responsible Officer for further consideration and referral for clinical review as required.
- All cases that are considered for mandatory reporting should be reported to the Department Head and /or facility Director Medical/Clinical Services.
- The completed death screening form and Coroner's checklist are to be filed in the patient's clinical record.

### 5.3 Death Review

- Death review is a structured forum which allows for an open examination of all cases where a patient has died whilst under the care of SESLHD. The review allows for; collective learning from events by providing an opportunity for reflection that may result in clinicians resolving to adopt different approaches with the next similar patient and identification of lessons for system improvements to enhance patient management and quality of care.

- All facilities must have in place appropriate processes and forums for clinical review of all deaths. This should include processes both at a Department/Specialty and at a Facility level. Processes should ideally be multidisciplinary. There are a range of formats that may be appropriate depending on the nature of the case(s) involved. These include:
  - Department / Divisional Mortality and Morbidity (M&M) meeting
  - Established Peer Review Committee
  - Ad hoc Specific Incident Review Committees
  - RCA Reviews
- Outcomes and actions arising from the death review are to be clearly documented by the reviewer(s) using a facility approved M&M Clinical review reporting form and summarised using the Descriptive Event Classification System (DECS) as described in Section 6.1. Meetings should be used to critically analyse the circumstances surrounding outcomes of care. These outcomes should include selected deaths, serious morbidity and significant aspects of regular clinical practice
- Responsibilities for escalating any risks that have been identified, and for the implementation of actions/recommendations arising from the death review must be clearly assigned to nominated individuals with an appropriate time-frame for completion. This should be monitored by the Facility Clinical Councils/CPIU/Clinical Governance Units/Patient Safety and Quality Committees
- M & M meetings should be held regularly with the scheduled frequency dependent upon the number of deaths occurring each month within the specific clinical unit. Deaths that have been flagged for review must not be delayed and Facilities/Departments must have a process in place for scheduling ad hoc meetings where required
- A sample of expected deaths should as be reviewed to assess the quality of the death from the end of life care perspectives

## Section 6 - Reporting

It is important that individual Facilities and the District as a whole have an efficient and consistent process for the collection of information and the reporting of all death screening and review that has been undertaken. The availability of accurate data ensures that:

- Effective screening and review routinely occurs across all facilities
- Clinical issues identified are managed appropriately, with evidence of M&M actions being documented and completed
- Clinical incident trends both within and across facilities can be identified, communicated and benchmarked so that issues can be managed pro-actively
- Service safety and quality improvement activities are based on accurate data.

### 6.1 'DECS' classification

- In order to facilitate the identification of clinical trends and to ensure consistent and comparable data collection across all facilities, SESLHD will utilise the DECS system (Appendix A) for classifying clinical factors arising from reviews. The DECS system is designed to count the number of issues and to identify trends to focus improvement efforts
- All M&M and clinical reviews must record any identified incidents using the DECS classification system
- The classification of a case against the DECS framework is the responsibility of the department conducting the death review. Multiple selections should be made if there is more than one contributing factor
- Departments/Divisions are to retain copies of their own case DECS classifications to inform local quality improvement activities
- All completed case DECS classifications are to be forwarded to the relevant Facility CPIU/ Clinical Governance Unit for monitoring and analysis.

### 6.2 Reporting Schedule

#### 6.2.1 Death Screening

- Analyses of all initial death screens should be collated and reported to the appropriate Hospital Executive Committee, such as the Facility Clinical Council or Patient Safety and Quality Committee (or equivalent) on a quarterly basis.
- The following performance measures should be reported by Facility:
  - Number of deaths
  - Number of death screens completed
  - Number of cases referred to the Coroner
  - Number of cases referred to other mandatory reporting authorities (eg CHASM, SCIDUA)
  - Number of cases not referred to the coroner within 24 hours
  - Number of cases with identified issues referred for clinical review as per the screening form
  - Number of SAC 1.

### 6.2.2 Death Review

- Facilities should have an effective process for reporting the outcomes of all clinical review meetings, whether these are M&Ms, Peer Review, RCAs or Individual Incident Reviews
- Outcomes of all Department M&Ms, Peer Reviews or Individual Incident Reviews should be reported through the agreed process within 30 days of the meeting date using an approved form
- Facility CPIU or Clinical Governance teams should provide quarterly reports to the agreed Facility Committee(s) in relation to:
  - Number of reviews completed/outstanding
  - Issues identified and plan
  - Actions / recommendations and progress of implementation.
- Each Facility will provide a report to the SESLHD Clinical and Quality Council on a quarterly basis. Reports should be submitted via the District Clinical Governance Unit. The quarterly report will include:
  - Progress of actions arising from death reviews
  - A detailed report based on the DEC's classification tool. This should ideally be a collated summary of all Morbidity and Mortality reviews.

## Section 7 – Documentation, References, Revision and Approval History

### Documentation

- [Coronial Checklist SMR010.513](#)
- [Death Screening Form SEI010.570](#)
- Report of Death of a Patient to the Coroner (Form A) SMR010.510
- Report of Death Associated with Anaesthesia/Sedation (Form B) SMR010.511 ('SCIDUA Notification Form')
- DECS Classification System

### References

- Institute for Healthcare Improvement, *Move Your Dot: Measuring, Evaluating, and Reducing Hospital Mortality Rates (Part 1)*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003 (Available on [www.IHI.org](http://www.IHI.org))
- [Mortality Review in NSW: The Way Forward \(Clinical Excellence Commission, 2014\)](#)
- [NSW Health Policy Directive PD2010\\_054 Coroners Cases and the Coroners Act 2009.](#)
- [NSW Health Policy Directive PD2015\\_040 Death – Verification of Death and Medical Certificate of Cause of Death](#)
- [NSW Health Policy Directive PD2014\\_004 Incident Management Policy](#)
- [St George/Sutherland Hospitals and Health Services Clinical Business Rule SGSHHS CLIN014, Death Screening \(2013\)](#)
- *SWSLHD\_PD2013\_036 Death Review* (South Western Sydney Local Health District, 2013)
- *Public Health Act 2010*
- [CEC – Recommended Guidelines for Conducting and Reporting Mortality and Morbidity / Clinical Review Meetings](#)

### Revision and Approval History

Date	Revision no:	Author and approval
Date	Revision No.	Author and Approval
25 January 2016	0	Vanessa Paterson, Clinical Governance Unit
20 May 2016	1	Kim Brookes, A/Director Clinical Governance
7 December 2016	2	Kim Brookes, A/Director Clinical Governance
1 June 2018	3	Kim Brookes, Director Clinical Governance
11 July 2018	3	To SESLHD Clinical and Quality Council for discussion
July 2018	3	Changed from policy to guideline – approved by Executive Sponsor
August 2018	3	Processed by Executive Services prior to publishing
August 2018	3	Endorsed by Clinical and Quality Council

## Appendix A:

### DECS Classification Tool

<b>D</b> Descriptive		<b>E</b> Event		<b>C</b> Classification		<b>S</b> System	
D1	Delay in recognition of condition	E1	Error-knowledge based	C1	Care setting inappropriate	S1	Supervision of junior staff
a.	Missed/Delayed PACE	a.	Trend (deteriorating) not acted upon/escalated	a.	Transfer location clinically inappropriate acuity of patient.	a.	No registrar response to PACE 1 (that escalates to a T2)
b.	T1 activation with T2 criteria	b.	T1 activation with T2 criteria	b.	Transfer of patient meeting PACE criteria	b.	No registrar response to a PACE 2.
				c.	Delayed transfer to appropriate location.		
D2	Delay in response	E2	Error-technical	C2	Complexity-burden of illness	S2	Selection of patient
a.	No response within 30min (T1)	a.	Incomplete Observation sets	a.	Transfer location clinically inappropriate acuity of patient.	a.	Nominated post review process.
b.	Evidence of delayed consult	b.	Required charting not completed	b.	Transfer of patient meeting PACE criteria		
c.	Delayed response to RR (5min)						
D3	Decision-making	E3	Error-omission	C3	Compliance with policy, procedure	S3	Selection of treatment (indications)
a.	Observations not increased in line with acuity	a.	Missed/Delayed PACE	a.	Observations not done 6/24	a.	Nominated post review process.
b.	Inappropriate PACE modification	b.	Observations not done 6/24	b.	Missed/Delayed PACE		
		c.	Observations not increased in line with acuity	c.	No response within 30min (T1)		
				d.	Delayed response to RR (5min)		
				e.	No registrar response to PACE 1 (that escalates to a T2)		
				f.	Inappropriate PACE modification (not done by Registrar/ in DW team)		
D4	Diagnosis error	E4	Error-producing condition: human factors	C4	Communication or teamwork	S4	System-latent error
a.	Nominated post review process.	a.	Nominated post review process.	a.	Handover issue identified	a.	
				b.	i.e. NFR/ NFP status not adequately communicated.		
				c.	Safe handover checklists from high acuity areas to ward environments not completed		
D5	Documentation of care: Absent	E5	Error-producing condition: census, staffing	C5	Consent-improper	S5	System-off hours
a.	Documentation of management plan pre or post clinical event absent	a.	Nominated post review process.	a.	Nominated post review process.	a.	Delay in accessing specialty review due to service not on site (after hours)
						b.	Delay in Mx due to A/H resourcing/
D6	Documentation of care: Inadequate	E6	Equipment, supplies	C6	Credential or privileges of staff		
a.	Documentation of management plan pre or post clinical event incomplete	a.	Non availability of equipment/ supplied	a.	Working outside of designated scope of role/ duties.		
b.	Multiple PACE (>3 within 48 hrs of clinical event)	b.	Delayed availability of equipment/ supplies	b.	Nominated post review process.		
D7	Documentation of EOL	E7	Escalation-failure	C7	Iatrogenic Injury/ event		
a.	RR call resulting in change to NFR/ NFP	a.	Delayed PACE/ Missed PACE	a.	Hospital Acquired Infection		
b.	RR call with NFR/NFP in place	b.	T1 activation with T2 criteria	C8	Significant (notifiable) clinical event whilst in hospital		
c.	NFR order not documented despite medical Mx plan	E8	Escalation-non rational	b.	In patient Cardiac Arrest (resulting in death)		
		a.	RR call with NFR/NFP in place	c.	In hospital fall resulting in harm		
		E9	Environment- external	d.	DVT/PE Whilst in hospital		
		E10	End of life condition (expected death)				