Departmental Morbidity & Mortality Review

Date of Review_____ Department_____ UR _____

Date of Admission _____ Date of Discharge_____

Admission Diagnosis_____

Reason for review_____

Definitions:
Adverse Events- An Adverse Event is defined as an incident in which harm resulted, or could have resulted, to a person receiving health care. This is caused by health care management rather than the patient's disease.

1. Trigger Questions

Question	Yes	No	Comments
Was there a delay in diagnosis/assessment?			
Was there a delay in initiating treatment?			
Was the deterioration in the patient recognized and responded to in a timely manner?			
Was there incorrect or misinterpretation of information?			
Did the care management deviate from the Policy/CPG?			
Was there a complication due to treatment/procedure/operation?			
Was there a medication error?			
Was there a lack or misuse of equipment?			
Is the adverse event documented in the notes?			
Was there a delay in accessing appropriate resources/assistance to treat the patient?			
Were the appropriately skilled staff available?			
If YES to any, complete section 2 below (add to table if required) If you believe an Independent case review is indicated, contact the quality.data@rch.org.au			

2. Recommendations

Problem	Solution/ Recommendation	Person Responsible	Due Date	Completed

If a death has occurred please complete section 3 & 4

Please submit completed forms by the end of the following month to quality.data@rch.org.au

Cause of Death _____ Date of Death _____

Reportable Deaths & Medical Procedure – The revised definition ***includes deaths occurring during or following a 'medical procedure'*** *where the death was not reasonable expected by the treating medical practitioner. (This replaces the reference to anaesthetic related deaths). [s4(2)(b)]* ***'Medical procedure' is defined*** *as being a procedure performed by (or under the general supervision of) a registered medical practitioner and includes imaging, internal examination & surgical procedures. [s3] (Coroners Act 2008)*

3. Death Classification: (Circle the MOST appropriate classification)

Classification	Description
1	Death was a likely outcome and all appropriate management was undertaken
2	Death was reasonably expected and all appropriate management was NOT undertaken. It is **mandatory** that this death is reported to the coroner Person Reporting to the Coroner…….. Date Reported……
3	Death was NOT reasonably expected and all appropriate management was undertaken It is **mandatory** that this death is reported to the coroner Person Reporting to the Coroner…….. Date Reported……
4	Death was NOT reasonably expected and all appropriate management was NOT undertaken It is **mandatory** that this death is reported to the coroner Person Reporting to the Coroner…….. Date Reported……

4. Expected Death Questions (Complete if the death was reasonably expected Rating 1 or 2)

Question	Yes	No	Unsure	Comments
Was there adequate discussion with the family regarding the outcome?				
Was withdrawal or limiting treatment discussed with the family?				
Did the child have an advance care plan?				
Was a timely referral made to palliative care?				
Was organ or tissue procurement considered?				
Was pain and suffering effectively controlled for the child?				
Were the GP and the referring doctor informed of the death?				

Links

If you are unsure if a death requires reporting to the coroners, please refer to
http://www.rch.org.au/clinicalguide/guideline_index/Death_of_a_child/

Coroners Act 2008- What has changed?
http://www.coronerscourt.vic.gov.au/

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