

West Australian Review of Mortality (WARM)

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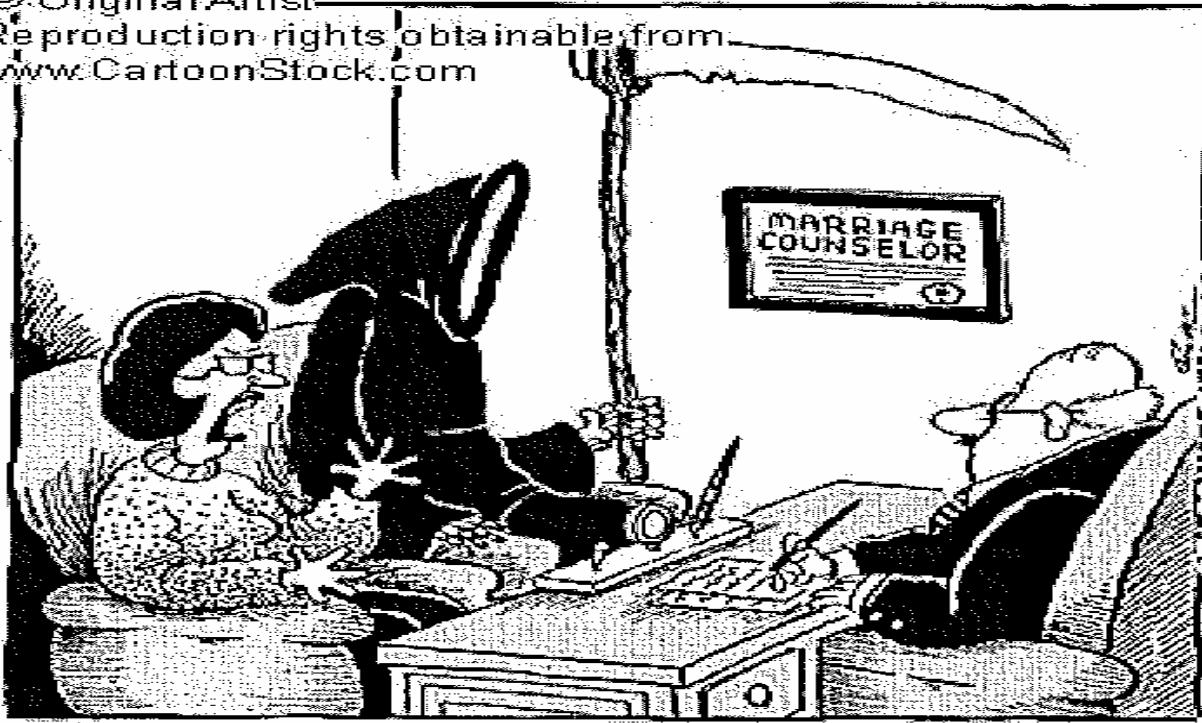


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Life of a Mortality Reviewer



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SAATCHI & SAATCHI

"Death, death, death! That's all he ever talks about!"



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Overview



- Why mandatory mortality review in WA?
- Policy & reporting structure
- Implementation
- Results
- Clinical Lessons Learned
- Strengths and Flaws
- Future



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Why does WA have mandatory mortality review ?

- Clinical Governance Framework 2001
- SASM, Bristol, KEMH, Australian Health Care Study.
- WAASM 2001 – peer review surgical deaths
- 2004 – WAASM successes
- 2004 Bundaberg report, Shipman Inquiry
- 2005 No consistent review of “ medical” deaths
- 2006 Decision by DG to ‘review all deaths in WA health’



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Policy & reporting structure

- Clinical ownership / Executive responsibility
- Quality protection
- Initial peer reviewed screen using Health Round Table categories (Cat 1-5)
- Second stage incident investigation (Cat 4 & 5)
- PIs linked to Health Service performance



Implementation



- Policy development and clinical trial 2006
- Operational instruction Jan 2007
- Clinical Governance structure in hospital & AHS
- Clinical support for policy
- PI driven
- Use of PMI as audit tool
- Policy revision 2008- Standards based
- Private sector adoption and licensing



Results - 2007 @ 31 March 2008 (PI deadline)



- 4596 deaths within scope
- 83% of all deaths categorized
- 2% of categorized deaths progressed to second stage review (HRT 4 or 5)
- Only 1 in 5 of second stage reviews completed and reported.
- Completed reviews provide high value quality improvement information



“From Death We Learn”

<http://www.safetyandquality.health.wa.gov.au/policies/index.cfm#F>

- Antibiotic use
- Emergency Department Overcrowding
- Abnormal investigations
- Medical Emergency Teams and resuscitation
- Communication
- Nursing staffing
- Falls prevention



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Fair and foul



- Death is a credible driver
- The role of the clinician
- Standards of review
- WAASM
- Multiple incident investigations pathways (WAASM, WARM, Sentinel events)
- Resources vs Timelines
- Incident based
- Escalating reporting or escalating incidents



