PICU /PCCS Morbidity and Mortality Review

The aim of this review is to identify any gaps in systems and processes that have contributed to an inpatient death, ward cardiopulmonary arrest or significant unanticipated patient harm in order to inform quality improvement activities to close those gaps.

Date review presented:		NHI:	
Reason for review:	Death	Cardiopulmonary arrest	Morbidity
Review done by *(Ensure representation from multidisciplinary team and clinical services as appropriate)*		Supervising SMO *(required for registrar mortality presentations)*	

Situation
Patient Demographics: Age Gender Ethnicity
Date of admission: Date of death/cardiopulmonary arrest/discharge:
Admission diagnosis:
Primary team:
Other clinical teams involved:

Background
Pertinent clinical summary

Assessment			
For all patients	Yes	No	Comments
Was there a delay in transfer to or within the hospital?			
Was there a delay in diagnosis/assessment?			
Was there a delay in initiating appropriate treatment?			
Was there a delay in recognition and response to patient deterioration?			
Was there a complication due to treatment / procedure / operation?			
Did care deviate from an established treatment protocol?			
Was there a medication error?			
Was there an avoidable infection?			
Was there a delay in accessing resources – ward, ICU, OR availability?			
Was there a clear plan for management?			
Were there any communication issues – between or within services?			
Were there any documentation issues?			
Was any adverse event documented in the clinical record?			

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For ward unexpected deaths and cardiopulmonary arrest	Yes	No	Comments
How many sets of vital signs were documented in the 24 hours before the death/cardiopulmonary arrest?			
Were all PEWS parameters documented every time?			
Were all PEWS scores calculated every time?			
If care was escalated in the 24hours before death/cardiopulmonary arrest, was the response: • Timely? (per the escalation pathway) • Appropriate? (the right responder) • Effective? (the interventions, treatments and ongoing plan met the patient's immediate clinical needs and any necessary follow up was provided)			
Did the primary medical team review the patient in the 24 hours before the event? If yes, did the plan of care demonstrate: • Appropriate recognition of the severity of illness? • An appropriate plan for monitoring the patient? • A clear plan for required interventions and treatments? • Appropriate indications for further review?			
Did the patient speak English as a first language? If no, was a translator involved in the 24hours before death/cardiopulmonary arrest?			
Was there documented evidence of patient, family or whanau concern in the 24 hours before death/cardiopulmonary arrest? If yes, was this concern: • Recognised? • Acted on? • Communicated to the appropriate seniority of clinician?			
Were there documented issues of care or documented family or whanau concern **earlier** than 24hr before the event? If yes, was this concern: • Recognised? • Acted upon? • Communicated to the appropriate seniority of clinician?			

For patients who died:	Yes	No
Was this an expected death?		
Was this reported to the Coroner?		
Was a post mortem performed?		
Was the patient receiving palliative care?		
Were the GP and referring doctor informed of the death?		
Was organ donation discussed with the family? If no, give reason:		
Were there limitations of therapy in place at the time of death		
If yes, did care at this time align with the documented limitations?		
Place of death		

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Any other issues noted that are not covered by the above.
Summary of system vulnerabilities /discussion

Recommendations

	Action	Responsibility	By when	Date Completed
1.				
2.				
3.				
4.				

Add recommendations to the service clinical excellence action register.

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.
3	Death was **NOT** reasonably expected and all appropriate management was undertaken.
4	Death was **NOT** reasonably expected and all appropriate management was **NOT** undertaken.

9. Is there a need for a separate review – e.g. Clinical Case Review, SMO team review? Y / N

10. Is there learning for the wider Child Health Directorate Y / N

If yes to 10, please email a copy of this form to the Leader, Safe Care Programme.

Attach a copy to the safety management system (Datix) record (if applicable) and save to a local Service Clinical Excellence folder.