Reviewing Deaths to Save Lives: A Standardized Approach to Mortality Review

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PROBLEM

Medical Error is thought to be the 3rd leading cause of death in the United States.

To help identify opportunities to enhance care and improve patient safety, a systematic approach to mortality review can be used to unlock many of the factors that may have contributed to the death of a patient. It can also be used to identify greater system-wide issues that need to be addressed.

Although mortality review was being completed throughout the health system in a variety of ways, the process was not standardized. Duke University Health System set out to:

- Review all inpatient deaths
- Designate a variety of members of the care team for input
- Standardize the review process
- Create a level of peer protected trust
- Identify system-wide issues for improvement
- Report and share the findings
- Create a multi-disciplinary group to review cases that had patient safety/system issues identified
- Improve the departmental/divisional Mortality & Morbidity (M&M) Conference process

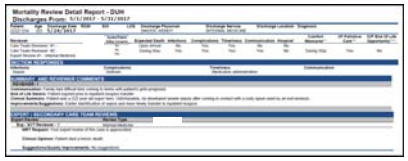
INTERVENTIONS

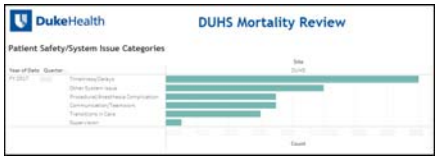
- Online Mortality tool built into OnBase
- Process begins with a review of the death by the discharging attending using a standardized mortality instrument
- Providers summarize the case, note if there were any patient safety/system issues present or if there were any opportunities related to End of Life issues, identify areas for improvement, list additional reviewers and forward to Risk Management (if indicated). Completed reviews are triaged and aggregated centrally to identify themes and lessons
- Review process is peer review protected and confidential

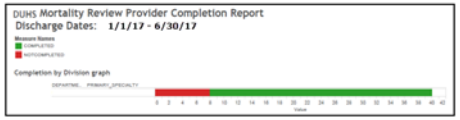
IMPLEMENTATION

- Mortality review was piloted at Duke University Hospital on General Medicine and MICU in 2012-13 and expanded to all health system inpatient deaths in January 2015

- Developed specific report types to aid provider participation, assist with case identification for M&M conferences, and to give a high level summary of aggregate trends (see figures)







Note: Simulated data for presentation purposes only

RESULTS

Reporting Period (July – June)	%DUHS Inpatient Deaths Reviewed
FY2016	86%
FY2017	95%

LESSONS LEARNED

- A structured, systematic review of mortality using front line providers has helped to identify opportunities to improve care delivery not readily identifiable from chart review or administrative data sets alone
- Feedback and culture are important to continue to engage providers to participate in the process as well as to submit meaningful reviews

NEXT STEPS

- Increase integration between mortality review, local M&M activity, and hospital/health system patient safety and performance improvement work
- Improve integration of mortality review with safety reporting, PSIs, and other safety listening posts