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MORTALITY REVIEW BULLETIN
June 2018

Learning disabilities

Mortality review makes for tough reading.
Dean, Erin
Learning Disability Practice; May 2018; vol. 21 (no. 3); p. 8-9
The author conveys his concerns on the growing number of people with learning disabilities and poor care and reports that nearly one in 10 learning disability nurses has left the register from 2014 to 2018, according to Nursing and Midwifery Council.

Hospital deaths

Mortality review as a teaching tool in the tropics.
Wang, Shuang; Vogt, Alexander
The clinical teacher; Feb 2018; vol. 15 (no. 1); p. 78-80
Morbidity and mortality meetings (M&Ms) have evolved to become an established part of clinical good

Neonate, infant and maternal deaths (cont.)

Pregnancy-Related Deaths, Florida, 1999-2012: Opportunities to Improve Maternal Outcomes.
Hernandez, Leticia E; Sappenfield, William M; Harris, Karen; Burch, Deborah; Hill, Washington C; Clark, Cheryl L; Delke, Isaac
Maternal and child health journal; Feb 2018; vol. 22 (no. 2); p. 204-215
To examine pregnancy-related deaths (PRDs) in Florida, to identify quality improvement (QI) opportunities, and to recommend strategies aimed at reducing maternal mortality. Gaps in clinical care or health care systems were assessed as the primary factors in over 40% of PRDs leading the PAMR Committee to generate QI recommendations for clinical care and health care systems.

PARENTS 2 study protocol: pilot of Parents' Active Role

practice in hospitals worldwide. Originating from surgical and anaesthetic roots,1 M&Ms have been adopted as a fundamental tool for global health organisations in reviewing maternal and perinatal health outcomes with the universal goal of improving patient safety and outcomes.2 Our own experiences of M&Ms in developed settings varied in structure, content and quality, with usefulness dependent on facilitator style, participant involvement and organisational structure. In low-resource settings, however, there is often limited experience and understanding of its application and purpose.3 In our workplace, a rural hospital in Tanzania, informal discussions with staff during hospital meetings suggested that many perceive the concept as a platform for judgement and a means for punitive consequences, stemming from different cultural and social perceptions towards accountability and confronting errors. In this short insight, we wish to reflect and advocate our experience of using mortality review as an educational tool within low-resource settings.

Surveying Care Teams after in-Hospital Deaths to Identify Preventable Harm and Opportunities to Improve Advance Care Planning.
Lucier, David; Folcarelli, Patricia; Totte, Cheryle; Carbo, Alexander R; Sokol-Hessner, Lauge
Joint Commission journal on quality and patient safety; Feb 2018; vol. 44 (no. 2); p. 84-93
Reviewing in-hospital deaths is one way of learning how to improve the quality and safety of care. Postdeath surveys sent to the care team for patients who died may have a role in identifying opportunities for improvement. As part of a quality improvement initiative, a postdeath care team survey was developed to explore how it might augment the existing process for learning from deaths. Postdeath care team surveys can augment mortality review processes to improve the way hospitals learn from deaths. Free-text comments on such surveys provide information not otherwise identified during traditional mortality review processes, including the importance of advance care planning and the strain on clinicians whose patients die.

Neonate, infant and maternal deaths
State-based Review of Maternal Deaths: The Ohio Experience.
Shellhaas, Cynthia; Conrey, Elizabeth
Clinical obstetrics and gynecology; Jun 2018; vol. 61 (no. 2); p. 332-339

and ENgagement in the review of Their Stillbirth/perinatal death.
Bakhbakhi, Danya; Siassakos, Dimitrios; Storey, Claire; Heazell, Alexander; Lynch, Mary; Timlin, Laura; Burden, Christy
BMJ open; Jan 2018; vol. 8 (no. 1); p. e020164
The perinatal mortality review meeting that takes place within the hospital following a stillbirth or neonatal death enables clinicians to learn vital lessons to improve care for women and their families for the future. Recent evidence suggests that parents are unaware that a formal review following the death of their baby takes place. Many would welcome the opportunity to feedback into the meeting itself. Parental involvement in the perinatal mortality review meeting has the potential to improve patient satisfaction, drive improvements in patient safety and promote an open culture within healthcare. Yet evidence on the feasibility of involving bereaved parents in the review process is lacking. This paper describes the protocol for the Parents' Active Role and Engangement iN the review of their Stillbirth/perinatal death study (PARENTS 2) , whereby healthcare professionals' and stakeholders' perceptions of parental involvement will be investigated, and parental involvement in the perinatal mortality review will be piloted and evaluated at two hospitals.

Learning from deaths: Parents' Active Role and ENgagement in The review of their Stillbirth/perinatal death (the PARENTS 1 study).
Bakhbakhi, Danya; Siassakos, Dimitrios; Burden, Christy; Jones, Ffion; Yoward, Freya; Redshaw, Maggie; Murphy, Samantha; Storey, Claire
BMC pregnancy and childbirth; Oct 2017; vol. 17 (no. 1); p. 333
Following a perinatal death, a formal standardised multi-disciplinary review should take place, to learn from the death of a baby and facilitate improvements in future care. It has been recommended that bereaved parents should be offered the opportunity to give feedback on the care they have received and integrate this feedback into the perinatal mortality review process. However, the MBRRACE-UK Perinatal Confidential Enquiry (2015) found that only one in 20 cases parental concerns were included in the review. Although guidance suggests parental opinion should be sought, little evidence exists on how this may be incorporated into the perinatal mortality review process. The purpose of the PARENTS study was to investigate bereaved parents' views on involvement in the perinatal mortality review process. Parents were unaware that a review of their baby's death took place

Ohio established a Pregnancy-Associated Mortality Review system in 2010 to ensure that all maternal deaths are identified and preventive actions developed. The need for detailed and reliable information to supplement vital statistics data has led to the development of state-based and urban-based maternal death reviews. Although processes vary from state to state, in general, an expert panel is convened to review individual cases and make recommendations for systems change. This article describes the development and operation of Ohio's state-based maternal death review including interventions developed and actions taken based on review data.

Maternal mortality statistics: Data collection methods are improving but still a challenge.
WETZEL, LINDA MARIE
Contemporary OB/GYN; Jan 2018; vol. 63 (no. 1); p. 24-26
The article discusses the challenges in enhancing the methods of collecting maternal mortality data. Topics mentioned include the increase in the rate of maternal mortality in the U.S. and in the third world countries, the definition of maternal mortality, indirect deaths, maternal mortality ratio, later maternal death, lifetime risk, and the establishment of the Maternal Mortality Review Committees to gather, compile and manage statistics on maternal mortality in the U.S.

The Perinatal Mortality Review Tool implementation support- review once, review well
Prince S.; Kurinczuk J.J.
BJOG: An International Journal of Obstetrics and Gynaecology; Apr 2018; vol. 125 ; p. 101
The Perinatal Mortality Review Tool (PMRT) is a national standardised review tool to support high quality local reviews of stillbirths and neonatal deaths. The PMRT is designed to facilitate robust, systematic, multidisciplinary reviews with parental involvement and come to a clear understanding of why each baby died and whether with different actions the death of their baby might have been prevented. The tool development is an iterative process and we welcome feedback on how it can be improved to help units deliver high quality reviews to better understand why babies die and how future deaths can be prevented.

A Service evaluation of a hospital child death review process to elucidate understanding of contributory factors to child mortality and inform practice in the English National Health Service.
Magnus, Daniel S; Schindler, Margrid B; Marlow, Robin D; Fraser, James I
in the hospital. Parental involvement in the perinatal mortality review process would promote an open culture in the healthcare system and learning from adverse events including deaths. Further research should focus on designing and evaluating a perinatal mortality review process where parental feedback will be integral.

Parent participation in morbidity and mortality review: Parents and physicians disagree
De Loizaga S.; Clarke-Myers K.; Khoury P.; Hanke S.
Journal of the American College of Cardiology; Mar 2018; vol. 71 (no. 11)
Partnership with families improves experience and quality of health care. The morbidity and mortality (M&M) review may offer a venue for increased partnership. We sought to describe practices for engaging families in M&M and examine physician and parent beliefs around parent involvement in M&M. Current practice does not include parents in the M&M process. Parents and physicians support transparency but disagree on collaboration in the M&M process; parents desire active participation while physicians are uncertain or oppose such measures.

Infant Mortality Lessons Learned from a Fetal and Infant Mortality Review Program.
Brown, Haywood L; Smith, Mark; Beasley, Yvonne; Conard, Teri; Musselman, Anne Lise; Caine, Virginia A
Maternal and child health journal; Dec 2017; vol. 21 ; p. 107-113
Reviews fetal and infant deaths from women enrolled in Indianapolis Healthy Start using the National Fetal and Infant Mortality Review (FIMR) methods to provide strategies for prevention. A number of the infant deaths in this review could have been prevented with preconception and inter-conception education and by improving the quality and content of prenatal care.

Reducing Maternal Mortality and Severe Maternal Morbidity Through State-based Quality Improvement Initiatives.
Main, Elliott K
Clinical obstetrics and gynecology; Jun 2018; vol. 61 (no. 2); p. 319-331
State Perinatal Quality Collaboratives (PQCs) represent a major advance for scaling up quality improvement efforts for reducing maternal mortality and severe maternal morbidity. The critical roles of partners, rapid-cycle low-burden data systems, and linkage to maternal mortality review committees are reviewed. The choice of measures is also explored. California's

BMJ open; Mar 2018; vol. 8 (no. 3); p. e015802
To describe a novel approach to hospital mortality meetings to elucidate understanding of contributory factors to child death and inform practice in the National Health Service. Hospital child death review meetings attended by professionals involved in patient management across the healthcare pathway inform understanding of events leading to a child's death. Using a bioecological approach to scrutinise contributory factors the multidisciplinary team concluded most deaths occurred as a consequence of underlying illness. Although factors relating to service provision were commonly identified, they rarely provided a complete explanation for death. Efforts to reduce child mortality should be driven by an understanding of modifiable risk factors. Systematic data collection arising from a standardised approach to hospital reviews should be the basis for national mortality review processes and database development.

Challenges and Opportunities in Identifying, Reviewing, and Preventing Maternal Deaths.
St Pierre, Amy; Zaharatos, Julie; Goodman, David; Callaghan, William M
Obstetrics and gynecology; Jan 2018; vol. 131 (no. 1); p. 138-142
Despite many efforts at the state, city, and national levels over the past 70 years, a nationwide consensus on how best to identify, review, and prevent maternal deaths remains challenging. We present a brief history of maternal death surveillance in the United States and compare the three systems of national surveillance that exist today: the National Vital Statistics System, the Pregnancy Mortality Surveillance System, and maternal mortality review committees. We discuss strategies to address the perennial challenges of shared terminology and accurate, comparable data among maternal mortality review committees. Finally, we propose that with the opportunity presented by a systematized shared data system that can accurately account for all maternal deaths, state and local-level maternal mortality review committees could become the gold standard for understanding the true burden of maternal mortality at the national level.

experience with its PQC, data center, quality improvement efforts, and promising results for reduction of maternal mortality and morbidity from hemorrhage are presented. Early data from other states is also shared.

Building U.S. Capacity to Review and Prevent Maternal Deaths.
Zaharatos, Julie; St Pierre, Amy; Cornell, Andria; Pasalic, Emilia; Goodman, David
Journal of women's health (2002); Jan 2018; vol. 27 (no. 1); p. 1-5
In the United States, the risk of death during and up to a year after pregnancy from pregnancy-related causes increased from ~10 deaths per 100,000 live births in the early 1990s to 17 deaths per 100,000 live births in 2013. While vital statistics-based surveillance systems are useful for monitoring trends and disparities, state and local maternal mortality review committees (MMRCs) are best positioned to both comprehensively assess deaths to women during pregnancy and the year after the end of pregnancy, and identify opportunities for prevention. Although the number of committees that exist has increased over the last several years, both newly formed and long-established committees struggle to achieve and sustain progress toward reviewing and preventing deaths. We describe the key elements of a MMRC; review a logic model that represents the general inputs, activities, and outcomes of a fully functional MMRC; and describe Building U.S. Capacity to Review and Prevent Maternal Deaths, a recent multisector initiative working to remove barriers to fully functional MMRCs. Increased standardization of review committee processes allows for better data to understand the multiple factors that contribute to maternal deaths and facilitates the collaboration that is necessary to eliminate preventable maternal deaths in the United States.