Here is the latest Mortality Review Bulletin. The bulletin covers the latest information on mortality review and comes out quarterly. Next edition is due in March 2019. Older editions are available as pdfs on the Keeping Up To Date library guide (http://libguides.bodleian.ox.ac.uk/Keeping_up_to_date)

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MORTALITY REVIEW BULLETIN December 2018

Hospital deaths	Neonate, infant and maternal deaths
Use of Structured Presentation Formatting and NSQIP Guidelines Improves Quality of Surgical Morbidity and Mortality Conference. Endicott, K.M. et al **The Journal of surgical research**; Jan 2019; vol. 233 ; p. 118-123 Surgical Morbidity and Mortality (M&M) conference lacks a standardized structure across institutions. We compared implementation of structure and National Surgical Quality Improvement Program's (NSQIP) definitions to organize our M&M and identify cases for discussion versus the usually used method at many centers of case identification by an attending surgeon	[Impact of organizational factors on the cesarean delivery occurrence in a low-risk population] [Article in French] Duvillier C. et al **Gynecol Obstet Fertil Senol**. 2018 Nov;46(10-11):706-712. doi: 10.1016/j.gofs.2018.09.005. Epub 2018 Oct 11. Huge differences in cesarean delivery rate exist between maternities in a same region. In recent years, the cesarean delivery rate has increased in the low-risk population. The objective of this study was to assess the impact of organizational factors on the cesarean

or resident. Incorporation of a clearly defined structure using NSQIP definitions for morbidity and identification of every mortality in our M&M conference standardized identification of adverse events thus improving conference quality. Consideration of the use of this structure should be given to other surgical departmental M&Ms.

A "Wake-Up Call" For Routine Morbidity And Mortality Review Meetings Procedure As Part Of A Quality Governance Program In Radiotherapy Departments: Results Of The Proust Survey.
Belkacemi Y. et al
Pract Radiat Oncol. 2018 Sep 27. pii: S1879-8500(18)30267-4. [Epub ahead of print]
Morbidity and mortality review (MMR) meetings in Radiotherapy (RT) departments aim to monitor radiation-induced toxicities and identify potential factors that may be correlated with their development and severity, particularly treatment planning errors. The aim of the PROUST Survey was to make an inventory of existing MMR procedures and to describe their procedures. MMRs are not systematically implemented in the worldwide RT departments. In Europe, few departments with quality assurance programs have implemented MMRs. This survey showed that a large majority of the centers are interested in implementing an MMR with a formalized procedure. Our project could help to increase interest of the worldwide RT community in this topic.

National Mortality Case Record Review (NMCRR): Annual report 2018
National Mortality Case Record Review Programme
Royal College of Physicians. October 2018
The National Mortality Case Record Review's annual report is intended to be of general interest to all healthcare professionals but is specifically aimed at those who are responsible for quality improvement within healthcare in addition to patient groups and healthcare users. The NMCRR programme's primary aim is to introduce a validated method of retrospectively reviewing deaths in the acute hospital setting. It uses a structured judgement methodology tool known as the structured judgement review (SJR).

Using a structured judgement review methodology to evaluate care following discharge from ICU
Vollam S. et al

delivery occurence in a low-risk population. In our global low-risk population, no organizational factors appeared to be associated with an increase in cesarean delivery rate. On the other hand, in the low-risk nulliparous population, the private status of the maternity and a high number of births by delivery room were associated with more cesarean deliveries. Increasing the number of delivery rooms could be a way to reduce the number of cesarean deliveries. Future researches should also try to identify specific factors that can reduce differences in cesarean delivery rates between private and public maternities.

On the Future of Maternal Mortality Review in Rhode Island
Spelke, B. et al
Rhode Island Medical Journal. October 2018
According to the RI Department of Health Center for Health Data and Analysis, the maternal mortality ratio in Rhode Island is 11.2 per 100,000 live births. As obstetricians in Rhode Island, this number raises more questions than it answers. Were these deaths accurately reported? Were they pregnancy-related or accidental? And most importantly, could they have been prevented? A recent report compiling standardized data from state MMRCs found that 60% of their maternal deaths were preventable. By increasing our own capacity for maternal death review, Rhode Island would once again be poised to lead the country towards the elimination of preventable maternal deaths

PARENTS 2 Study: consensus report for parental engagement in the perinatal mortality review process
Bakhbakhi, D. et al
Ultrasound in Obstetrics & Gynecology 2018 October 7
Following a perinatal death, a standardised multidisciplinary review should take place. Learning from these deaths and engaging parents in this process could help prevent future perinatal deaths in line with United Kingdom (UK) national and international targets to reduce the number of such deaths by 2020. Moreover, it would support parents in understanding events around the death of their baby. An earlier study (Parents' Active Role and ENgagement in The review of their Stillbirth/perinatal death - PARENTS 1 study) found that parents would endorse the opportunity to give feedback into the perinatal mortality review process (PNMR). In subsequent focus

Intensive Care Medicine Experimental; Oct 2018; vol. 6
The mortality rate for patients discharged from ICUs in the UK is higher than other hospitalised groups considered to be at high risk, and is more than five times the annual number of UK road traffic accident deaths1. The Recovery Following Intensive Care Treatment (REFLECT) study is a UK based multicentre mixed methods exploratory study examining ward care delivery to patients discharged from intensive care. One of the methods used to evaluate ward care delivery was a Retrospective Case Record Review (RCRR). This approach has been used extensively in other patient groups, but not previously in this population. A multidisciplinary case records review of patients discharged from ICU was a successful approach in identifying areas of care where changes could alter patient outcome. The multidisciplinary approach enabled identification of a diverse range of care

Morbidity and Mortality Review Meetings Procedure for Radiation Therapy Departments as Part of a Quality Governance Program and Organization: The French "Proust" Survey.
Belkacemi, Y. et al.
International Journal of Radiation Oncology, Biology, Physics; Nov 2018; vol. 102
Many hospitals have integrated morbidity and mortality review (MMR) meetings into their governance. MMR meetings in Radiotherapy (RT) departments aim to monitor radiation-induced early and late toxicities and identify potential factors that may be correlated with their development, particularly treatment planning errors. In France systematic MMR is not mandatory in daily practice. The first aim of the PROUST project was to make an inventory of existing MMR meetings in the French RT departments and to describe their procedure when are implanted. We present herein the first results of the PROUST French survey. In France, MMR meetings are not systematically organized in the RT departments. Less than half the departments that have quality assurance programs discuss during the CREx toxicity review without a formal procedure. A large majority of the centers are interested in implanting an institutional MMR procedure and register their data in the PROUST project that will include clinical, physical and individual radiosensitivity criteria of patients presenting severe toxicity after RT.

groups, healthcare professionals were positive about parental engagement, although they considered there may be significant challenges. The objective of this study was to develop core principles and recommendations for parental engagement in PNMR in the UK. Key national stakeholders were unanimously supportive of parental engagement and agreed on core principles to make it feasible, meaningful and robust process. A six-month pilot of parental engagement in the perinatal mortality review process (PARENTS 2 Study) in two UK units took place after the consensus on core principles. In collaboration with the National Perinatal Epidemiology Unit, findings will inform the national standardised perinatal mortality review tool (PMRT).

Reversing The Rise In Maternal Mortality.
Kozhimannil KB1.
Health Aff (Millwood). 2018 Nov;37(11):1901-1904.
The author discusses initiatives in the U.S. to reverse the growth in maternal mortality. Medicaid was established in 1965 and a separate eligibility category for pregnant women was added in 1984 to improve birth outcomes. The establishment of a national maternal mortality review committee is said to be the initial step toward making childbirth safer again. The track record of California in reversing the rise in maternal mortality is mentioned.

The Failure of United States Maternal Mortality Reporting and Its Impact on Women's Lives
Macdorman M.F.; Declercq E.
Obstetrical and Gynecological Survey; Nov 2018; vol. 73 (no. 11); p. 615-616
Maternal mortality is a significant public health problem and an important indicator of the quality of health care both nationally and internationally. The death of a mother during pregnancy, childbirth, or postpartum is one of the greatest tragedies that can occur within a family, with wide-ranging consequences for the index child, other family members, and the larger society.

Learning disabilities
The government response to the Learning Disabilities Mortality Review (LeDeR) programme second annual report.
Department of Health and Social Care and NHS England 12 September 2018

Quality gaps identified through mortality review
Kobewka, D.M. et al
BMJ Quality and Safety; Feb 2017; vol. 26 (no. 2); p. 141-149
Hospital mortality rate is a common measure of healthcare quality. Morbidity and mortality meetings are common but there are few reports of hospital-wide mortality-review processes to provide understanding of quality-of-care problems associated with patient deaths. Our institution-wide mortality review found many quality gaps among decedents, in particular inadequate discussion of goals of care.

A matter of life and death: Controversy at the interface between clinical and legal decision-making in prolonged disorders of consciousness
Turner-Stokes, Lynne
Journal of Medical Ethics: Journal of the Institute of Medical Ethics; Jul 2017; vol. 43 (no. 7); p. 469-475
Best interests decision-making and end-of-life care for patients in permanent vegetative or minimally conscious states (VS/MCS) is a complex area of clinical and legal practice, which is poorly understood by most clinicians, lawyers and members of the public. In recent weeks, the Oxford Shrieval lecture by Mr Justice Baker ('A Matter of Life and Death', 11 October 2016) and its subsequent reporting in the public press has sparked debate on the respective roles of clinicians, the Court of Protection and the Mental Capacity Act 2005 in decisions to withhold or withdraw life-sustaining treatments from patients with disorders of consciousness. The debate became polarised and confused by misquotation and inaccurate terminology, and highlighted a lack of knowledge about how patients in VS/MCS die in the absence of court approval. This article sets out the background and discussion and attempts to give a more accurate representation of the facts.

The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas across England to review the deaths of people with a learning disability, to draw out learning from those deaths and to put that learning into practice. We want all local areas to improve the quality of the health and social care services provided to people with a learning disability, and to address the persistent health inequalities they face. LeDeR is the first national programme in the world set up to systematically review the deaths of all people with a learning disability aged four years and above which are notified to it and to embed mortality review processes across the country.

Swept under the carpet?
Peate, Ian
British Journal of Nursing; Nov 2018; vol. 27 (no. 20); p. 1147-1147
The article discusses the release of the National Health Service (NHS) England annual report Learning Disabilities Mortality Review (LeDeR) for 2018. Topics include the lack of access to the information in the report, the role of the agency Health Quality Improvement Partnership (HQIP) in commissioning the report, and the relatively short lifespans of people with learning disabilities in Great Britain.

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