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MORTALITY REVIEW BULLETIN March 2019

Hospital deaths

[Impact of the new medical examiner role on patient safety](#)

Fletcher A. et al

BMJ. 2018 Dec 14;363:k5166. doi: 10.1136/bmj.k5166.

Outlines how the new medical examiner system could create a world leading mortality review system if implemented appropriately

[Quality Improvement Initiatives to Reduce Mortality: An Opportunity to Engage Palliative Care and Improve Advance Care Planning](#)

Flieger, S.P. et al.

American Journal of Hospice and Palliative Medicine, February 2019, Vol.36(2), pp.97-104

Despite substantial efforts to integrate palliative care and improve advance care planning, both are underutilized. Quality improvement initiatives focused

Neonate, infant and maternal deaths

[Addressing maternal mortality: the pregnant cardiac patient](#)

Wolfe, Diana S. ; Hameed, Afshan B. ; Taub, Cynthia C. ; Zaidi, Ali N. ; Bortnick, Anna E.

American Journal of Obstetrics and Gynecology, February 2019, Vol.220(2), pp.167.e1-167.e8

Cardiac disease in pregnancy is the number one indirect cause of maternal mortality in the United States. We propose a triad solution that includes universal screening for cardiovascular disease in pregnancy and postpartum women, patient education, and institution of a multidisciplinary cardiac team. Additionally, we emphasize essential elements to maximize care for the pregnant cardiac patient based on our experience at our institution in Bronx, NY.

on reducing mortality may offer an opportunity for facilitating engagement with palliative care and advance care planning. Clinicians who participated in an initiative to reduce AMI mortality highlighted the challenges associated with decision-making regarding interventions, systems for documenting patient goals of care, and broader engagement with palliative care. Quality improvement initiatives focused on mortality may offer a meaningful and feasible opportunity for engaging palliative care. Primary palliative care training is needed to improve discussions about patient and family goals of care near the end of life.

[Autopsy Standardized Mortality Review: A Pilot Study Offering a Methodology for Improved Patient Outcomes](#)

Early, C.A. et al.

Academic Pathology 2019, 6: 2374289519826281

A standardized mortality review of hospital autopsies identified discrepancies between clinical diagnoses and autopsy findings, unexpected deaths, adequacy of diagnostic workup, presence of adverse event, and type of a quality issue if present. Class I discrepancies, where a diagnosis found at autopsy might have improved survival had it been made pre-mortem, were identified in 16% of cases. Categories associated with increased discrepancy rates included unexpected deaths, inadequate workup, abnormal labs or imaging not addressed, and certain quality issues. Deaths not expected at admission but expected at the time of death, those with adverse events, those within 48 hours of a procedure, those within 48 hours of admission, those with physician-specific quality issues, and those with system or process issues were not significantly related to diagnostic accuracy

[A Wake-Up Call for Routine Morbidity and Mortality Review Meeting Procedures as Part of a Quality Governance Programs in Radiation Therapy Departments: Results of the PROUST Survey](#)

Belkacemi, Y. et al

Practical Radiation Oncology 2018 September 28
Morbidity and mortality review (MMR) meetings in radiation therapy (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 aims of the Prospective Registration of Morbidity and Mortality, Individual Radiosensitivity and Radiation Technique (PROUST) survey were to make an inventory of existing MMR procedures and to describe their procedures. MMRs are not systematically implemented in RT departments worldwide. In France and in Europe,

[Ethnic-specific mortality of infants undergoing congenital heart surgery in England and Wales.](#)

Knowles RL

Arch Dis Child. 2019 Mar 1. pii: archdischild-2018-315505.

To investigate ethnic differences in mortality for infants with congenital heart defects (CHDs) undergoing cardiac surgery or interventional catheterisation. Infants of British Asian and 'all other' non-white ethnicity experienced higher postoperative mortality risk, which was only partly explained by socioeconomic deprivation and access to care. Further investigation of case-mix and timing of risk may provide important insights into potential mechanisms underlying ethnic disparities.

[Contributory factors and potentially avoidable neonatal encephalopathy associated with acute peripartum events: An observational study](#)

Sadler, L.C. et al

Australian & New Zealand Journal of Obstetrics & Gynaecology 2019 February 12

In 25% of affected babies, neonatal encephalopathy results from acute peripartum events, but rigorous review of these cases for quality improvement is seldom reported. New Zealand has maintained a national database of all babies diagnosed with Sarnat moderate and severe neonatal encephalopathy since 2010 under the Perinatal and Maternal Mortality Review Committee. There is significant potential to improve quality and safety in acute peripartum care to reduce the risk of neonatal encephalopathy. Human factors were not well captured by the clinical notes or review tool. Attention to human factors by improved methodology can enhance review of neonatal encephalopathy.

[Improve Healthcare quality through Mortality Committee: Retrospective analysis of Bambino Gesù Children Hospital's ten years' experience 2008-2017](#)

Offidani, C. et al.

Current Pharmaceutical Biotechnology 2019 February 11

Healthcare quality improvements are one of the most important goals to reach a better and safer healthcare system. Reviewing in-hospital mortality data is useful to identify areas for improvement, and to monitor the impact of actions taken to avoid preventable cases, such as those related to healthcare associated infections (HAI). Introduction of the mortality review committee has proved to be a valid instrument to improve the quality of the care provided in a hospital,

few departments with quality assurance programs have implemented MMRs. This survey showed that a large majority of centers are interested in implementing an MMR with a formalized procedure. Our project could help increase the interest of the RT community worldwide in this topic.

[A resident-driven mortality case review innovation to teach and drive system-based practice improvements in the United States](#)

Radhakrishnan N. et al.

Journal of Educational Evaluation for Health Professions 2018, 15: 31

Traditionally, Morbidity and Mortality Conference (M&MC) are forums where medical errors are discussed. Though M&MC can lead to identification of opportunities for system wide improvements, there is little in the literature to describe the use for this purpose, particularly in residency training programs. This paper describes the use of M&MC case review as a quality improvement activity that teaches systems-based practice and can engage residents in improving systems of care. A resident-driven mortality review curriculum can lead to improvement in systems of care. This type of novel curriculum can teach systems-based practice. The recruitment of teaching faculty with expertise in quality improvement and mortality case analyses is essential for such a project.

[Preventing patient harm via adverse event review: An APSA survey regarding the role of morbidity and mortality \(M&M\) conference.](#)

Berman L. et al.

J Pediatr Surg. 2019 Jan 18. pii: S0022-3468(18)30845-5.

Peer-review endeavors represent the continual learning environment critical for a culture of patient safety. Morbidity and mortality (M&M) conferences are designed to review adverse events to prevent future similar events. The extent to which pediatric surgeons participate in M&M, and believe M&M improves patient safety, is unknown. Most pediatric surgeons participate in M&M, but many doubt its effectiveness. We identified attributes of M&M conferences that are perceived to be effective. Further investigation is needed to identify how to optimally utilize peer-review programs to prevent adverse events and improve patient safety.

[Quantifying recall bias in surgical safety: a need for a modern approach to morbidity and mortality reviews](#)

Alsubaie, H. et al.

allowing early identification of care gaps that could lead to an increase in mortality rates.

[Examination of a Death due to Cardiomyopathy by a Maternal Mortality Review Committee](#)

Shellhaas, C.S. et al.

American Journal of Obstetrics and Gynecology 2019 January 22

Deaths related to pregnancy were relatively common in the United States (U.S.) at the beginning of the twentieth century. A dramatic reduction of 99% in maternal mortality - from 850.0 to 7.5 per 100,000 live births between 1900 and 1982-is one of the most noteworthy public health success stories of the time period. This plateau continued until the late 1990s when maternal mortality began to rise again. The reasons for this increase are unclear. Vital statistics data alone cannot answer the many questions surrounding this increase. The need for detailed and reliable information about causes of death and underlying factors has led to the development of state- and urban-based maternal death reviews. Although processes may vary, an expert panel is convened to review individual cases and make recommendations for systems change. Review of maternal deaths is considered to be a core public health function

[PARENTS 2 Study: a qualitative study of the views of healthcare professionals and stakeholders on parental engagement in the perinatal mortality review-from 'bottom of the pile' to joint learning](#)

Bakbakh, D. et al.

BMJ Open 2019 February 22, 8 (11): e023792

Engaging bereaved parents in the review process that examines their care before and after a perinatal death might help parents deal with their grief more effectively and drive improvements in patient safety. The objective of this study is to explore whether healthcare professionals would accept or support parent engagement in the perinatal mortality review process. Healthcare professionals strongly advocated engaging bereaved parents in the perinatal mortality review: empowering parents to ask questions, providing feedback on care, helping generate lessons and providing them with the opportunity to discuss a summary of the review conclusions with their primary healthcare professional contact. The participants agreed it is time to move on from 'a group of doctors reviewing notes' to active learning and improvement together with parents, to enable better care and prevention of perinatal death.

Canadian Journal of Surgery. Journal Canadien de Chirurgie 2019 February 1, 62 (1): 39-43

Despite recent investments into reducing errors and adverse events in health care, methods for quality improvement in surgery are outdated and ineffective. Most current efforts in this field are centred around morbidity and mortality conferences (MMCs), which have remained unchanged for over 100 years. The present study aimed to quantify the recall bias associated with details from surgical cases. Despite recent investments into reducing errors and adverse events in health care, methods for quality improvement in surgery are outdated and ineffective. Most current efforts in this field are centred around morbidity and mortality conferences (MMCs), which have remained unchanged for over 100 years. The present study aimed to quantify the recall bias associated with details from surgical cases.

[Self-rated health \(SRH\) in young people and causes of death and mortality in young adulthood. A prospective registry-based Norwegian HUNT-study.](#)

Vie T.L. et al.

SSM Popul Health. 2019 Jan 23;7:100364. doi: 10.1016/j.ssmph.2019.100364. eCollection 2019 Apr. Self-rated health (SRH), which is frequently used in epidemiological research, has consistently been shown to be a strong predictor of morbidity and mortality, even after controlling for demographic, social and medical risk factors. However, less is known about the relationship between SRH and all-cause and cause-specific mortality in young adulthood. SRH predicts all-cause mortality in young adulthood, with poor SRH being associated with death in young adulthood. The findings also indicate different causes of death for different SRH. This knowledge is important for identifying groups at risk for later disease, which can potentially be used to prevent morbidity in the adult population.

Learning disabilities

[Obscuring effect of coding developmental disability as the underlying cause of death on mortality trends for adults with developmental disability: a cross-sectional study using US Mortality Data from 2012 to 2016.](#)

Landes SD, Stevens JD, Turk MA.

BMJ Open. 2019 Feb 24;9(2):e026614.

To determine whether coding a developmental disability as the underlying cause of death obscures mortality trends of adults with developmental disability. Death certificates that recorded the developmental disability in Part I of the death

["Every Newborn-INDEPTH" \(EN-INDEPTH\) study protocol for a randomised comparison of household survey modules for measuring stillbirths and neonatal deaths in five Health and Demographic Surveillance sites](#)

Baschieri A. et al.

J Glob Health. 2019 Jun;9(1):010901

Under-five and maternal mortality were halved in the Millennium Development Goals (MDG) era, with slower reductions for 2.6 million neonatal deaths and 2.6 million stillbirths. The Every Newborn Action Plan aims to accelerate progress towards national targets, and includes an ambitious Measurement Improvement Roadmap. Population-based household surveys, notably Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys, are major sources of population-level data on child mortality in countries with weaker civil registration and vital statistics systems, where over two-thirds of global child deaths occur. This large-scale study is the first randomised comparison of two methods to capture pregnancy outcomes. Results are expected to inform the evidence base for survey methodology, especially in DHS, regarding capture of stillbirths and other outcomes, notably neonatal deaths, abortions (spontaneous and induced), birthweight and gestational age. In addition, this study will inform strategies to improve health and demographic surveillance capture of neonatal/child mortality and pregnancy outcomes.

[Determinants and causes of maternal mortality in Iran based on ICD-MM: a systematic review.](#)

Zalvand R. et al.

Reprod Health. 2019 Feb 8;16(1):16.

No systematic review has explored the causes of and factors associated with maternal mortality in the context of Iran. This study reviewed determinants and causes of maternal mortalities during pregnancy, delivery and the puerperium using the International Classification of Diseases-Maternal Mortality (ICD-MM), introduced by the World Health Organization. This study, provided an updated summary of evidences on the causes and determinants of maternal death in Iran, which is critically important for the development of interventions and reduction of the burden of maternal mortality and morbidities.

[Pregnancy course, infant outcomes, rehospitalization, and mortality among women with intellectual disability.](#)

Mueller B.A. et al.

certificate were more likely to code disability as the underlying cause of death. While revising these death certificates provides a short-term corrective to mortality trends for this population, the severity and extent of this problem warrants a long-term change involving more precise instructions to record developmental disabilities only in Part II of the death certificate.

[Mortality and cause of death of Australians on the autism spectrum.](#)

Hwang YIJ et al

Autism Res. 2019 Feb 25.

Rates of death are higher for autistic individuals compared to the general population. There is higher risk of death for autistic individuals who have additional mental and physical health conditions. The leading causes of death for autistic individuals with and without ID are "nervous system and sense disorders", which includes epilepsy and "injury and poisoning", respectively. To minimize risk of death, it is important to manage the mental and physical health individuals on the autism spectrum and to better understand the circumstances surrounding preventable deaths for this population.

Disabil Health J. 2019 Jan 20. pii: S1936-6574(19)30004-4.

Pregnant women with intellectual disability (ID) may have greater levels of comorbidity and decreased care access, social support, or ability to monitor their status and communicate needs, but few studies have examined their pregnancy course and outcome, and little is known about their longer-term maternal and infant health. Reasons for increased preeclampsia and gestational diabetes among pregnant women with ID are unclear. Barriers to inadequate prenatal care are multifactorial and warrant further study, with consideration that wellness during pregnancy and other times involves social, familial and clinical support systems responsive to each woman's needs.

[Incidence of adverse events, preventability and mortality in gynaecological hospital admissions: A systematic review and meta-analysis.](#)

Tanaka K. et al

Aust N Z J Obstet Gynaecol. 2019 Jan 20.]

Adverse events (AEs) are unintended consequences of healthcare management that result in temporary or permanent disability, death or prolonged hospital stay. The incidence of AEs has been reported to be higher in surgical specialties compared to medical specialties but information on the incidence of AEs in gynaecology is sparse. Evidence on AEs in gynaecological hospital admissions is limited. Available evidence suggests that approximately one in ten gynaecological inpatients suffer at least one AE and half of AEs are considered preventable. Further research is needed to determine strategies regarding how the incidence of preventable AEs can be reduced.

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