


Name of Policy: Morbidity and Mortality Review Policy Number: 3364-87-06 Approving Officer: Chief of Staff Responsible Agent: Chief Medical Officer Scope: University of Toledo Medical Center and University of Toledo Physicians, LLC Clinical Premises		 Effective date: Original effective date: 3/14/2001	
Key words: Confidentiality, Access to Proceedings, Records of Peer Review Committees, Credential Files, Medical Staff			
<input type="checkbox"/>	New policy proposal	<input type="checkbox"/>	Minor/technical revision of existing policy
<input checked="" type="checkbox"/>	Major revision of existing policy	<input type="checkbox"/>	Reaffirmation of existing policy

(A) Policy statement

~~It is the policy of the University of Toledo Medical Center and its Medical Staff that all deaths in the hospital and all unusual or unexpected adverse outcomes of procedure or care be reviewed by the medical staff.~~

This mortality review process supports the organization's Quality Assessment and Performance Improvement (QAPI) program. All mortality reviews are conducted in a timely manner to identify opportunities for clinical, operational, or system-level improvement.

(B) Purpose of policy

The medical staff is responsible for assuring that high quality care is rendered to all patients and that unusual or adverse outcomes are reviewed in the context of the community standard of care.

This policy applies to inpatient and emergency department deaths occurring within UTMC that meet one or more of the following criteria:

- In-hospital surgical death within 30 days of surgery
- Early deaths with a length of stay (LOS) \leq 3 days without DNR
- Readmission to UTMC within 7 days of previous discharge
- Return to the ED within 3 days of discharge
- Unexpected deaths (deaths not anticipated based on clinical trajectory)
- OR deaths
- Failure to rescue deaths (cardiac arrest events without ROSC in non-ICU inpatient units)
- Maternal deaths (intrapartum or postpartum)
- Unanticipated death of full-term infant or patient < 18 years old

(C) Procedure

- (1) ~~All inpatient and emergency department patient deaths will be identified by the UPMC registration database.~~ The UPMC patient discharge report will be used to identify deaths of inpatient and emergency department patients. The patient-specific information will be entered into the Patient Safety Mortality Module with a ~~non-physician~~ review summary. Those patients meeting criteria for “expected mortality” do not require a physician review unless a quality-of-care issue is identified. Those patients with “expected mortality” include those presenting with hospice, DNRCC, DNRCC-A without intubation, Stage IV cancer, end stage HIV, end stage COPD, end stage CHF [EF<10%], end stage dementia, and severe liver disease [varices/DIC] upon admission, poor prognosis as noted by MD at the time of admission, death on arrival to ED, death on arrival to ED, patients deemed dead on arrival, ~~trauma that expires on arrival~~, out of hospital cardiac arrests with unknown or prolonged downtime, anoxic brain injury, irreversible neurologic damage, and at the discretion of the Quality RN in consultation with the Quality Director. All other cases will be forwarded for further physician review. Physicians will receive email notification to complete a Case Review.
- (2) ~~The designation of “expected mortality” shall be applied only after review of relevant clinical documentation by the Quality RN or designee. Patients designated as “expected mortality” may still be reviewed further if a potential quality of care concern is identified during initial screening.~~
- (3) ~~All mortality reviews conducted under this policy are protected as part of the hospital’s peer review and quality improvement activities under Ohio Revised Code § 2305.25. Records, proceedings, and deliberations of the mortality review process are confidential and privileged and shall not be disclosed except as permitted by law.~~
- (4) The Chief Medical Officer will review all mortality Case Review Outcomes that do not meet “acceptable medical care” as designated with a level one or two by the physician reviewer. Should the reviewer or the Chief Medical Officer determine that care was not appropriate, then the case will be referred for evaluation to the Professional Improvement Committee and/or the Standard of Care Committee.

<p>Approved by:</p> <p>_____</p> <p>Daniel Barbee Chief Executive Officer</p> <p>_____</p> <p>Date</p> <p>_____</p> <p>Puneet Sindhvani, MD Chief of Staff</p> <p>_____</p> <p>Date</p> <p>_____</p> <p>Michael Ellis, M.D. Chief Medical Officer</p> <p>_____</p> <p>Date</p> <p><i>Review/Revision Completed by:</i> <i>Chief Medical Officer</i> <i>Medical Executive Committee</i></p>	<p>Policies Superseded by This Policy:</p> <ul style="list-style-type: none">• <i>MS-006 Morbidity and Mortality Review</i> <p>Initial effective date: 3/14/2001</p> <p>Review/Revision Date:</p> <p>01/21/04 09/13/06 07/21/09 08/22/12 03/26/14 03/01/17 05/01/20 08/29/22</p> <p>Next review date:</p>
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