

# Reviewing in-hospital mortality

Thursday 24th June 2010

## About the seminar:

Review of in-hospital deaths is an integral part of good clinical practice. Audit provides the opportunity to learn about and improve practices and processes of care. Despite widespread recognition of its importance, there remains no 'gold standard' approach to conducting mortality review.

In this seminar we will hear a range of views about how to undertake an effective mortality review. Importantly, a range of leaders from both acute health and forensic medicine will discuss how they use information derived from these reviews to improve practice and processes of care.

Our keynote speaker at the seminar is Dr Raj Behal via videolink from Rush University Medical Center in USA. Dr Behal has considerable work experience in developing a data-driven framework for improving patient safety and clinical outcomes.

## Who should attend:

This seminar will be of relevance to clinicians, quality and risk managers, and senior executive personnel working particularly in the acute health sector or in policy development.

**Venue:** Ella Latham Lecture Theatre,  
Royal Children's Hospital,  
Flemington Road (cnr Gatehouse Street),  
Parkville Vic 3010.

**Seminar date:** Thursday 24th June, 2010

**Seminar time:** 9:30am - 4:30pm  
(Registration opens at 9:00am)

**Cost:** \$165 per person (incl. of GST)

Further venue details, accommodation and parking information can be found on our website at:  
[www.crepatientsafety.org.au](http://www.crepatientsafety.org.au)

Enquiries to Catherine Pound on +61 3 9903 0891  
or [catherine.pound@monash.edu](mailto:catherine.pound@monash.edu)



## Speaker and Facilitator details

(in order of appearance)

**Professor Peter Cameron** is a Consultant Emergency Physician and Director of the Centre of Research Excellence in Patient Safety (CRE-PS). He has a strong research background in epidemiology and health services and systems research. He has presented and published widely with over 200 peer-reviewed publications. As well as successfully managing a large number of research and contract grants for clinical and health services research, he also consults widely on health policy and health service development.

**Mr Neville Board** is Strategy Manager at the Australian Commission on Safety and Quality in Health Care. Current projects include developing a national reporting strategy for safety and quality in health care, guidelines for the evaluation and safe implementation of electronic medication management systems in hospitals (with the National E-Health Transition Authority), and data standards for surveillance of healthcare associated infections. At the Cancer Institute NSW (2003-2008), he established the NSW Clinical Cancer Registry Program, and the National Round Table for Structured Pathology Reporting for Cancer. He also led the development in NSW of cancer datasets, and established the Standard Cancer Treatments program (CI-SCaT).

**Dr Raj Behal** is Associate Chief Medical Officer/ Senior Patient Safety Officer and Assistant Professor, Department of Medicine, and Health Systems Management at the Rush University Medical Center in Chicago, Illinois. Dr Behal is responsible for developing the organisational quality agenda, and for implementing a data-driven framework for improving patient safety and clinical outcomes. He is adapting safety science and behavioural economics concepts to develop novel improvement methods. Prior to joining Rush, Dr Behal evaluated and facilitated performance improvement at more than 40 U.S. academic medical centers. His work has resulted in reduced mortality rates, improved performance on national quality indicators, greater participation of medical staff in performance improvement, and realignment of quality infrastructure with the strategic goals.

**Dr Paul Ireland** is Manager of the Victorian Quality Council and the Knowledge Management unit in the Victorian Department of Health's Quality, Safety and Patient Experience branch. He has extensive experience in evidence-based quality and safety improvement, having previously worked as Program Director at the National Institute of Clinical Studies and Deputy Director at the National Cancer Control Initiative. In 1996, he completed a PhD in nutritional epidemiology at Monash University.

**Professor Rick Iedema** (PhD USyd) is Research Professor and Director of the Centre for Health Communication at the University of Technology

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Speaker profiles

Sydney. His research covers the link between clinical communication and hospital organisation. His work spans across organisation studies, health care quality and safety, and health services and health policy research. His target areas of research are clinical incident disclosure and clinical handover communication. In partnership with academic colleagues and clinicians, Rick has published 170 research publications, including 3 edited books and 1 monograph, with two monographs forthcoming.

**Associate Professor David Ranson** is the Deputy Director of the Victorian Institute of Forensic Medicine and an adjunct Associate Professor in the Department of Forensic Medicine at Monash University. He is a specialist in Forensic Pathology and Clinical Forensic Medicine with a strong professional interest in Medical Law. In the last 10 years he has been particularly involved in the establishment and working of a number of specialist death investigation and research units aimed at preventing avoidable death and injury. These units include the National Coroners' Information System, the Clinical Liaison Service (adverse medical event investigation unit) the Workplace Death Investigation Unit and the Consultative Committee into Road Traffic Fatalities. He has been a member of the Anaesthetic Morbidity and Mortality Council in the State of Victoria. He is the Victorian State Councillor of the Royal College of Pathologists of Australasia, a Member of the Forensic Science advisory committee of the National Association of Testing Authorities and a member of the Australian Ministerial advisory committee into suicide prevention. Together with Dr Ian Freckleton he is joint author of "Death Investigation and the Coroners Inquest" published by Oxford University Press.

**Ms Claudia Retegan** is the manager of the Victorian Audit of Surgical Mortality project. She began her research career at the Clinical Trials Research Unit, Auckland University as a data manager on a large scale international multi-centre randomised clinical trial in cardiac disease. She then became the data centre manager at the Cardiovascular Disease Prevention Unit, Baker Heart Research Institute in Melbourne where she was involved in clinical trials, registries and clinical audit programs. Keen for new challenges, she joined the Royal Australasian College Of Surgeons and began managing the Victorian Audit of Surgical Mortality. She has also supported the Australian Health Research Data Managers Association (AHRDMA) since 2003, and held several positions as the Victorian Regional Secretary, Victorian Regional Coordinator, Victorian 2005 ASM Convener, National Treasurer, Vice President and as AHRDMA President.

**Dr Graeme Duke** is Clinical Director of the Intensive Care Department at The Northern Hospital in Melbourne. Graeme has led a large program of work using in-hospital death data from across tertiary, metropolitan and regional hospitals to develop a model capable of predicting hospital outcomes.

**Dr Anna Barker** is a research fellow at Monash University. She has been involved in the development and application of the Critical Care Outcome Prediction Equation and Hospital Outcome Prediction Equation in her role as a senior researcher at the Northern Clinical Research Centre. In her work with the CRE-PS she has been involved in a project investigating the validity of the National hospital performance indicator 'Death in Low Mortality DRG'.

**Associate Professor Ian Scott** is a Consultant general physician and Director of the Department of Internal Medicine and Clinical Epidemiology at the Princess Alexandra Hospital in Brisbane, and Associate Professor of Medicine at the University of Queensland. He is a current member of the Queensland Health Patient Safety and Quality Executive Committee and its VLAD Subcommittee. He is also Adjunct Associate Professor of Medicine at Monash University and is an associate researcher with the Centre of Research Excellence in Patient Safety.

**Professor Joseph Ibrahim** is a Consultant Physician with the Clinical Liaison Service and the Work Related Investigation Service Specialist Investigations Unit at Victorian Institute Forensic Medicine & State Coroners Office, investigating the system failures associated with health care and work related deaths respectively. He is also an Associate Director with NHMRC Centre of Research Excellence in Patient Safety and an Adjunct Professor, Australian Centre for Evidence Based Aged Care at La Trobe University, Faculty of Health Sciences.

**Associate Professor Caroline Brand** is a Consultant Rheumatologist who has spent 15 years working in private practice and in VMO Rheumatology positions at RMH and Alfred Hospital and later, completed a Master of Public Health. Her roles have included Director of the Clinical Epidemiology & Health Services Evaluation Unit at Melbourne Health and more recently in a research role within CRE-PS at Monash University. Caroline's personal research interests reside in clinical and health services research focusing on clinician engagement in a systems approach to patient safety, models of care for management of chronic rheumatic disease, implementation of evidence into practice and use of data linkage to inform assessment and monitoring of quality and safety in healthcare.

**Ms Margaret Way** is the Director of Clinical Governance at Alfred Health. She has over 20 years experience as a senior manager within the Victorian Health care system. Margaret is a member of the Victorian Department of Health Clinical Risk Management Reference Group and was instrumental in developing and delivering the Victorian Root Cause Analysis Training Program. She has obtained a range of research and development grants from University, Government and not-for-profit agencies that have enabled safety and quality improvements to be implemented in health services across Victoria.

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Time	Speaker	Organisation	Area covered
0900		<b>REGISTRATION</b>	
Session 1:	Policy, international perspective		Facilitator: Prof Peter Cameron
0930 - 0940	Mr Neville Board	Australian Commission on Safety and Quality in Health Care	Opening address
0940 - 1020	Dr Raj Behal	Senior Patient Safety Officer, Rush University Hospital in Chicago, USA	Via WebEx: How should we be reviewing hospital deaths?
1020 - 1040	Questions		
1040 - 1110		<b>MORNING TEA (30 minutes)</b>	
Session 2:	Methods for doing review		Facilitator: Dr Paul Ireland
1110 - 1130	Prof Rick Iedema	University of NSW	Investigating clinical incidents using 'Root Cause Analysis': Towards In Situ Practice.
1130 - 1150	A/Prof David Ranson	Victorian Institute of Forensic Medicine	What technique does the Coroner use and can we apply it to hospital deaths?
1150 - 1210	Ms Claudia Retegan	Victorian Audit of Surgical Mortality (VASM)	Reviewing surgical deaths: how can death review drive quality improvement.
1210 - 1240	Panel Discussion		
1240 - 1325		<b>LUNCH (45 minutes)</b>	
Session 3:	What data should we use?		Facilitator: Mr Neville Board
1325 - 1345	Dr Graeme Duke	The Northern Hospital	The clinician's perspective on how we can use hospital mortality data in clinically useful ways.
1345 - 1405	Dr Anna Barker	Monash University	Death in low risk DRG.
1405 - 1425	A/Prof Ian Scott	Queensland Health	What form of in-hospital review is best?
1425 - 1455	Panel Discussion		
1455 - 1515		<b>AFTERNOON TEA (20 minutes)</b>	
Session 4:	Hospital review and discussion		Facilitator: Prof Joe Ibrahim
1515 - 1535	A/Prof Caroline Brand	Royal Melbourne Hospital	Process of review and action
1535 - 1555	Ms Marg Way	Alfred Health	Perspective of the Quality Manager.
1555 - 1625	Panel Discussion: What have we learned from today? Should we monitor in-hospital mortality? If so, how? Panel members: Mr Neville Board, Dr Graeme Duke, A/Professor Ian Scott, A/Professor Caroline Brand, Ms Marg Way		
1630	CLOSE		

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### REGISTRATION FORM



Centre of  
Research Excellence  
in Patient Safety

**COST - \$165 per person (incl. of GST)**

Payment can be made by cheque payable to Monash University, or by credit card. Cheque payments must be forwarded independent of any other payments. A copy of your registration must be included with your payment.  
(You will be notified by email within 10 working days of receipt of registration).

**EMAIL** completed registration forms to [catherine.pound@monash.edu](mailto:catherine.pound@monash.edu) (preferred and recommended method)

**OR**

**FAX** completed registration forms to: +61 3 9903 0181

**POST** cheques or money orders to:  
CRE Patient Safety Seminar - Catherine Pound  
Department of Epidemiology & Preventive Medicine  
Monash University  
The Alfred Centre, Commercial Road  
Melbourne Victoria 3004

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**Please keep a copy of this form as a tax invoice/receipt**

**Monash University ABN 12 377 614 012**

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### Payment details

(We are unable to accept Amex or to issue tax invoices)

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Total amount paid \_\_\_\_\_

Name on card \_\_\_\_\_

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Expiry date -- -- / -- --

Signature \_\_\_\_\_