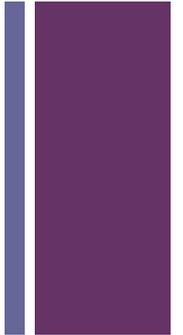


POMRC's history

Leona Wilson
Chair

+ Predecessors



- Anaesthetic Mortality Review Committee (AMAC), ANZCA and NZSA
 - Set up 1981
 - Folded (late 1980s) after report sub-poena'd by police
- And associated audits:
 - Australian and New Zealand Audit of Surgical Mortality (ANZASM), RACS
 - Australian state Anaesthesia Mortality Committees
 - (UK) Confidential Enquiry into Perioperative Deaths
 - (NZ) Maternal Deaths Committee superseded by PMMRC
 - Other NZ MRCs now under HQSC

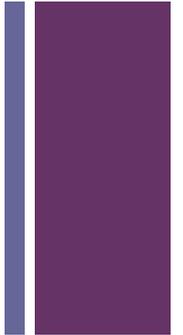


Mortality review committees



- NZPHD ACT 2000 (legal powers)
- Ministerial -> HQSC (monitor and report on safety and quality)
- Advocacy from/response to:
 - The professions
 - Mortality issues
- 3 committees preceded:
 - CYMRC
 - PMMRC
 - FDVRC
- 1 further under consideration - suicide

+ Challenges in set up



- Defining perioperative procedures:
 - No agreement on outer boundaries:
 - Outside the operating theatre,
 - By non-surgeons,
 - No specific codes
- Very few models of multi-disciplinary review
 - Usually service specific
 - Often based in one profession
- Estimated 6,000+ deaths per year

+ Philosophy

- Perioperative death:
 - Is rare
 - Can happen post discharge from hospital
 - Can have multiple causes / predisposing factors
 - Not a frequent occurrence for any single health practitioner
 - Collating across NZ allows identification of trends
 - Notifications of hazards
- Learn from the care of those who died to:
 - Improve the care of subsequent patients
 - Prevent further such deaths
 - Strengthen the QI processes within the institutions
 - Who: procedure specific rates, including risk rating
 - Why: what should we change



+ Annual reports



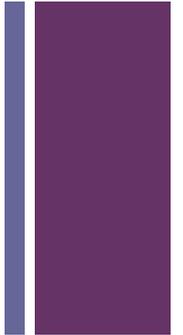
- Information for the profession
- Developing community-friendly materials
- Two aims,
 - Epidemiology information
 - Understanding causes and making recommendations
- Confidentiality -> no real cases
 - 4 composite cases first time this year

+ Epidemiology (who)

- (National minimum dataset and national mortality collection)
 - (To be augmented by data from local reporting)
- Investigate deaths related to specific procedures, patients and complications
 - Informed consent
 - Benchmarking
- Track common procedures year-by-year
 - Provide international comparisons to 'benchmark' NZ
- Report on perioperative mortality to WHO
- The future, investigating:
 - Standardized mortality rates
 - Risk calculator based on NZ data

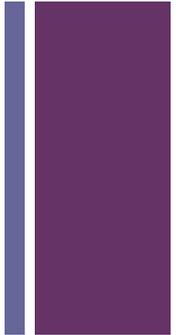


+ Developing local review (why)



- **Criteria re process:**
 - Able to be implemented in different institutions
 - Multi-disciplinary, with all professions 'empowered' to speak out
 - Active involvement by 'scalpel-face' clinicians
 - Applicable to different types of procedures
 - Not time consuming
- **Criteria re data to be submitted to POMRC on each death:**
 - Essential to analysis
 - Contributory to prevention of future deaths
 - Future-proofed
 - Able to be analyzed
 - Compatible with other data sources

+ Progress so far (local review)



First decision (after trialing a very complex form)

- 2 levels:
 - Tier 1, all deaths, thus limited data that can be analyzed by IT
 - Tier 2: deaths of particular interest, changing annually
- Tier 1 (iterative process for development)
 - Initial version trialed last year
 - Latest version for today
 - Working group from interested hospitals
 - Assessing IT proposal for database set up

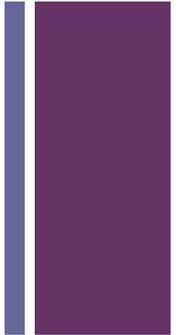


Tier 1 form challenges/decisions



- 6,000+ per year in NZ
- Preventability?
 - Improvements to care?
- Separate input from nursing, surgeons and anaesthetists
- Cause of death?
 - Complications
- Initial analysis locally
 - Loses independence
 - Strengthens local QI processes
 - Greater visibility of systems issues

+ Tier 2:



- To follow tier 1 implementation
- Detailed information of certain categories of deaths
 - Specific procedures
 - Specific post-op complications / causes of death
 - Specific illnesses / surgical conditions
 - Changing regularly
 - Topic responsive to issues, trends

+ Many thanks to HQSC staff

- HQSC Board and CE
- HQSC staff (mortality unit):
 - Owen, Clifton, Dez, Shelley, Jan, Cristina, Joanna
- Committee
 - Retiring members: Phil Hider, Digby Ngan Kee, Jean-Claude Theis,
 - Joining members: Ian Civil, Keri Parata-Pearse, Rob Vigor-Brown
- You, your colleagues and our community we serve



