

Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee

1. PURPOSE

The purpose of the Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee (“the Committee”) is to:

- a. Collect and analyse clinical information regarding perioperative and periprocedural anaesthetic mortality in Queensland to identify state-wide specific trends.
- b. Make recommendations to the Director-General, Queensland Health on standards and quality indicators of perioperative and periprocedural anaesthetic clinical care to enable health providers in Queensland to improve safety and quality.
- c. Assist with the adoption of such standards in both public and private sectors.

2. FUNCTIONS

The Committee with respect to perioperative and periprocedural anaesthetic mortality will:

- Function under the authority of *Hospital and Health Boards Act 2011*, Part 6 Safety and quality, Division 1 Quality assurance committees.
- Obtain qualitative and quantitative clinical information primarily from Queensland Health Information Management, Queensland Health information systems and the Queensland Health Patient Safety and Quality Improvement Service and where required, public and private health facilities, in a secure and confidential manner.
- Receive clinical information from other statutory or regulatory bodies for consideration and recommendation.
- Register, investigate and classify deaths occurring during, as a result of, or within 30 days of a procedure performed under anaesthesia or sedation.
- Determine whether further information is required to complete the above investigation, and if so to request such information under guarantee of confidentiality from the attending practitioner(s).
- Examine information acquired and identify any issues of management which were instrumental in the patient’s death.
- Report the Committee’s findings confidentially to the practitioners involved in the patient’s care.
- Report annually to the Department of Health, Director-General, Queensland Health through the Patient Safety and Quality Improvement Service, drawing attention to any matters which require action to improve the safety of anaesthesia and sedation in Queensland.
- Acquaint the medical profession in general and anaesthetists in particular with any matters to which special attention needs to be paid to ensure the safety of anaesthesia and sedation.
- Submit for publication in appropriate peer-reviewed journals the results of the Committee’s investigations in such a way as to preserve undertakings of confidentiality given to respondents.
- Make available the expertise of its members to the Hospital and Health Services and Clinical Excellence Queensland in pursuit of systemic improvements to patient care in the fields of anaesthesia and sedation.
- There is significant overlap between those cases that occur as surgical deaths and anaesthetic deaths, therefore coordination after initial stratification will be necessary.
- Investigate and monitor trends in the incidence and cause of perioperative and periprocedural anaesthetic mortality to identify issues that need action and / or further study.
- In partnership with the Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNet), monitor and assist in the adoption of standards and quality activities relating to perioperative and periprocedural anaesthetic care across Queensland.
- Work collaboratively with like organisations (state-wide, nationally and internationally) including:
 - Patient Safety and Quality Improvement Service

- Queensland Ombudsman
 - Chief Health Officer
 - Healthcare Purchasing and System Performance
 - Statistical Services Branch
 - Retrieval Services Queensland
 - Queensland Quality Assurance committees
 - Australian Institute of Health and Welfare (AIHW)
 - Australian and New Zealand College of Anaesthetists
 - Anaesthetic mortality review committees across Australia
 - Australian Society of Anaesthetists
 - Queensland private hospitals (eg. Mater, Wesley etc.)
- Initially, the committee will review mortality only however the inclusion of morbidity may be considered in the future.

3. AUTHORITY

The Committee functions under the authority of the *Hospital and Health Boards Act 2011*, Part 6, Safety and quality, Division 1 Quality assurance committees, the purpose of which as defined in Section 81, is to improve the safety and quality of health services by providing protections for quality assurance committees established under the division.

The Committee provides advice to the Director-General, Queensland Health via an annual report and on a needs basis. The Committee functions collaboratively with the SWAPNet and other related clinical networks as required.

Decision making:

- Committee recommendations are made by majority decision.
- In the event that a majority consensus is not reached the chair will have the casting vote.

Issue escalation:

- Issues unable to be resolved by the Committee will be escalated to the Patient Safety and Quality Improvement Service, SWAPNet and other relevant clinical networks as required.
- Issues outside the scope of the Committee will be referred to the appropriate authority.

4. GUIDING PRINCIPLES

The *Hospital and Health Boards Act 2011*, Part 1, Division 2, Object of Act sets out the principles that are intended to guide achievement of the Act's objectives. These principles, the *Private Health Services Act 1999*, and any other legislation relevant to anaesthesia, perioperative and periprocedural health care, will guide all deliberations of the Committee.

5. SUB-COMMITTEES

To assist the Committee in discharging its responsibilities, the Committee may establish sub-committees to undertake specific tasks related to review of these areas. Sub-committees will be chaired by a Committee member, and all members shall be Committee members or other duly gazetted persons. Establishment of additional subcommittees will only occur after consultation with the Patient Safety and Quality Improvement Service and SWAPNet to determine necessity.

6. REPORTING

- The Committee will provide an annual report to the Director-General, Queensland Health via the Patient Safety and Quality Improvement Service.
- The annual report will:
 - identify trends and issues relating to perioperative and periprocedural anaesthetic mortality

- recommend quality improvement activities and methodologies for their implementation to improve the safety and quality of health services.
- The endorsed annual reports will be provided to the SWAPNet Steering Committee for review and other relevant clinical networks as required for promulgation to member facilities and organisations for consideration (See Item 16).
- Organisations that request the consideration of the Committee such as the Queensland Ombudsman will receive reports as required in addition to the annual report.
- Where it is otherwise relevant to their statutory functions, regulatory authorities will be notified of summary findings and recommendations of the annual reports.
- Matters relevant to a single hospital and health service or a single private health facility may be referred to the relevant Executive Director of Medical Services or equivalent of the hospital and health service or private health facility by the Committee chair.
- The AIHW will be provided with non-identifiable summary data regarding perioperative and periprocedural anaesthetic mortality as required for national reporting of such matters.
- The Committee will provide de-identified data to the Australian and New Zealand College of Anaesthetists (ANZCA) for inclusion in the national triennial report.

7. MEMBERSHIP

Membership eligibility is determined by a duly constituted selection panel (see appendix 1).

Chair:

The Chair is appointed for a term of 4 years and may serve no more than two consecutive terms as chairperson of the Committee.

Members:

The Committee shall consist of a maximum of 12 members (ten permanent members and two provisional members, relevant to the cases under review).

Permanent membership of the Committee will comprise of:

- A medical practitioner nominated by Queensland Health who will act as Chairperson of the Committee.
- A specialist anaesthetist nominated by the State Branch of the Australian and New Zealand College of Anaesthetists.
- A specialist anaesthetist nominated by the Australian Society of Anaesthetists.
- A specialist anaesthetist nominated by the Australian Medical Association.
- Chair or nominated delegate, Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNet)
- GP Rural Generalist / specialist anaesthetist, regional/rural Queensland nominated by SWAPNet.
- An anaesthetic assistant (technician or nurse) nominated by SWAPNET.
- Two specialist surgeons nominated by the State Branch of the Royal Australasian College of Surgeons.
- A pathologist nominated by the Royal College of Pathologists of Australasia - Australian College of Pathology.

Provisional membership of the Committee may comprise:

- A specialist obstetrician and gynaecologist nominated by the State Branch of the Australian Council of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
- Two general practitioners with a special interest in anaesthesia, nominated by the State Branch of the Royal Australian College of General Practitioners.
- A registered midwife nominated by the State Branch of the Royal Australian Nursing Federation.
- A dental practitioner nominated by the State Branch of the Australian Dental Association.
- A physician (gastroenterologist or cardiologist) nominated by the State Branch of the Royal Australasian College of Physicians.

- An emergency medicine specialist nominated by the State Branch of the Royal Australasian College of Emergency Medicine.
- A fellow from the College of Intensive Care Medicine of Australia and New Zealand (Queensland Branch).
- An epidemiologist nominated by Queensland Health.

Proxies:

- Proxies may not attend meetings due to privacy and confidentiality requirements.

Terms and Conditions:

- Members are appointed by the selection panel for a term of four years.
- Members may serve no more than two consecutive terms.
- A member may terminate his or her Committee membership at any time, in writing to the Chair.
- Members shall not misuse the information provided to them by virtue of their membership of the Committee.
- Members will be expected to take a strategic view of issues and not seek to take advantage of their membership of the Committee to canvass personal or institutional issues.
- Any member who has a real or perceived conflict of interest in any matter under discussion at the Committee shall be expected to declare that conflict and exempt himself/herself from the discussion.

8. OTHER PARTICIPANTS– Guest speakers or expert advisors

Where agreed by the Committee, guest speakers or expert advisors may present advice in specialist areas to the Committee. However, such persons do not assume membership or participation in any decision- making processes of the Committee.

9. RELEVANT PERSONS

The Committee authorise the staff of the Health Statistics Centre, Department of Health, as relevant person(s) under section 84 of the *Hospital and Health Boards Act 2011* to receive information to enable the Committee to perform its functions.

The role of relevant persons may include receiving information relating to the investigation of anaesthetic related deaths, obtaining and/or collating information from hospitals and other sources relating to anaesthetic related deaths, identification of cases, receiving anaesthetic related death data from the Committee for the purposes of secure data storage and provision of ongoing access to such data by members of the Committee.

10. QUORUM

A quorum for a committee is the number equal to one-half of the number of its members or, if one-half is not a whole number, the next highest whole number. In the absence of a quorum the meeting may continue at the Chair's discretion with any items requiring decision to be deferred and circulated, following the meeting, to members as an out-of-session item.

11. PERFORMANCE

The Committee will be evaluated in terms of its performance against the Terms of Reference and work plan through an annual self-assessment process. See Appendix 2: Annual Self-Assessment.

12. CONFIDENTIALITY

Members of the Committee will be in receipt of information that is regarded as 'commercial in confidence', clinically confidential or have privacy implications. Members acknowledge their responsibility to maintain confidentiality of all information.

The Committee is established as an approved quality assurance committee (AQAC) pursuant to Part 6, Division 1 of the *Hospital and Health Boards Act 2011*. The Committee is therefore prohibited from

providing a report or information that discloses the identity of an individual who is a patient or a health service provider, unless that individual has consented in writing to the disclosure.

All information held by the committee is managed in accordance with the *Hospital and Health Boards Act 2011*, Part 6, section 84 Disclosure of information and Part 7, Confidentiality. The *Hospital and Health Boards Act 2011*, Part 6 and Part 7 replace the disclosure of information and confidentiality provisions in the repealed *Health Services Act 1991*. The provisions were modified to reflect the new public health structure.

Part 6, Section 84, Disclosure of information (1) of the *Hospital and Health Boards Act 2011* stipulates that a person who is or was a member of an AQAC must not disclose to someone else information acquired by the person as a member of the committee, other than:

- a. for the purpose of exercising the functions of a member of the committee; or
- b. to members of another committee if the information is relevant to the functions of the other committee; or
- c. to a prescribed patient safety entity under section 85; or
- d. If the person is a registered health practitioner – for notifying the National Agency about information in relation to a reasonable belief of the person that another registered health practitioner has behaved in a way that constitutes public risk notifiable conduct; or
- e. to comply with a requirement of an inspector made of the person under this Act, if the requirement relates to an offence under this division; or
- f. under regulation made under section 91.

Protection from documents and information

Section 81 (2) states that the document or information cannot be accessed under any order, whether of a judicial or administrative nature, and, is not admissible in any proceeding, other than a proceeding for an offence under this division.

Section 81 (3) states that a person must not, and cannot be compelled to, produce the document or information, or to give evidence relating to the document or information, in any proceeding, other than a proceeding for an offence under this division.

Protection from liability

Part 6, Section 88 (1) of the *Hospital and Health Boards Act 2011* stipulates that a person who is or was a member of the committee, or relevant person for a committee, is not civilly liable for an act done, or omission made, honestly and without negligence under this division.

Members of the Committee are bound by provisions in the section mentioned above with respect to any information provided by private health facilities.

13. SECRETARIAT

- Secretariat support to be provided by the Queensland Health, Clinical Excellence Queensland.

14. MEETING SCHEDULE

- Two monthly (or as required)
- Tuesday
- Two hours
- The Chair will determine the time and place for meetings.
- The Chair may delegate the Chair to another Committee member.
- A chairperson is to preside at all meetings.

A meeting may be conducted wholly or partially by electronic means, whereby some or all participants can be heard and can hear but are not necessarily in the same location. All other requirements of these Terms of Reference apply to the meeting.

15. BUSINESS RULES

The Committee's business rules and functionality are defined in the following documentation:

Appendix 1: Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee (QPPAMRC) Business Rules

Appendix 2: QPPAMRC Flow Chart

Appendix 3: QPPAMRC Annual Self-Assessment

Appendix 4: Confidentiality Agreement

Attachment 1: QPPAMRC Reporting Form QA1

Attachment 2: QPPAMRC Reporting Form QA2

16. MODUS OPERANDI OF COMMITTEE RECOMMENDATION DEVELOPMENT

The Committee will seek expert clinical input to proposed recommendations prior to their promulgation and reporting (see item 6), from SWAPNET, other relevant clinical networks and the PHAQ as appropriate.

The Committee will regularly review endorsed recommendations and follow up to ensure required action has been undertaken.

APPENDIX 1: Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee Business Rules

1. Agenda and records

- Members wishing to place items on the agenda must notify the Secretariat at least 10 working days prior to the scheduled meeting.
- Papers, submissions and reports are to be received by the Secretariat no later than 10 working days prior to the meeting via email.
- Agenda and relevant papers will be sent out to all members five (5) working days prior to the meeting in accordance with the Privacy Policy.
- Late agenda items and papers will be tabled at the discretion of the Chair. Requests or urgent / late items should be submitted to the Secretariat in the first instance.
- Minutes will be distributed to members within 10 working days of the meeting.
- Minutes of meetings shall be submitted to Committee members for ratification at the next subsequent meeting of the Committee.
- When confirmed, minutes shall be signed by the Chair and will be taken as evidence of the meeting.
- Minutes will be stored for at least 10 years.

2. Role of the Secretariat

- At all times, act upon and undertake committee work in accordance with Quality Assurance Committee confidentiality and privacy and legislative requirements.
- Act as the central contact for the committee in relation to enquiries and information distribution.
- In consultation with the committee chair, manage and facilitate a biannual recruitment and selection process.
- Manage and maintain electronic and paper-based files.
- Manage the mortality review database in accordance with privacy and legislative requirements.
- Manage formal and informal enquiries and maintain a correspondence register.
- Arrange meetings and venues and advise members accordingly.
- Prepare and distribute meeting agendas and supporting papers as per section 1.
- Maintain a record of all the Committee minutes, action items, correspondence and other documentation regarding the Committee's deliberations.
- Maintain records of attendance.
- Notify relevant stakeholders of actions arising which require their attention.
- In consultation with the committee chair, prepare and distribute feedback and reports as required.
- Develop and maintain an accurate, up to date website.

Support systems:

- Secure data storage (data base), supported by Information Services.
- Designated (restricted access) email account (QPPAMRC@health.qld.gov.au).
- Secure (restricted access) electronic storage (on the AIS drive).
- Secure hard copy storage (Committee Secretariat is the single key holder).
- Designated facsimile machine (copier, scanner and printer) located with Committee Secretariat.
- Website (accurate and up to date).

3. Special meetings and out-of-session papers

- Special meetings may be called at the discretion of the Chair
- Urgent issues may arise which require Members to consider papers out-of-session

- In these instances, the Member putting forward the urgent matter will be required to liaise with the Secretariat and ensure that all Members are appropriately briefed to enable informed deliberations to be made
- Any urgent matters unable to be deferred until the next Committee meeting can be managed as an out-of-session paper. The out-of-session paper and cover sheet will be sent to Members via email with a requested response date
- For a resolution to be approved, the majority of Members must indicate their endorsement by the response date
- If approved, the resolution will be entered into the minutes of the next meeting
- If not endorsed by a majority of Members, the item is deferred until the next Committee meeting.

4. Induction and development

The following information is to be provided to new Members prior to their first Committee meeting:

- Terms of Reference
- Business rules and guidelines for meeting conduct
- Queensland Health Governance Committees structure
- Contact details of the Committee members
- Advance schedule of meetings
- Copies of significant policy or other documents that relate to issues discussed by the Committee, as relevant at the time of induction
- The Committee annual work plan.

Members may be requested to attend nominated training relevant to the level of responsibilities discharged as a Committee member.

5. Recruitment of members

- A call for nominations to serve on the Committee will be promulgated every two years or in the event of a mid-term resignation of a Committee member via relevant professional and consumer bodies. These will include:
 - SWAPNet
 - Other relevant clinical networks
 - Australian Society of Anaesthetists
 - Australian and New Zealand College of Anaesthetists
 - Australian College of Operating Room Nurses
 - Australian Medical Association.
 - State Branch of the Royal Australasian College of Surgeons.
 - Royal College of Pathologists of Australasia - Australian College of Pathology.

6. Termination of membership

- The Committee may terminate the membership of a Member if they are no longer eligible for the position to which they were nominated (e.g. no longer registered as a medical practitioner).
- The Committee may, by two thirds majority, determine that a Member is no longer a Member of the Committee.
- Circumstances where this would occur may include, but are not limited to, persistent non-attendance without reasonable excuse (3 consecutive meetings).
- The Committee will formally discuss and recommended actions regarding termination of Committee members.

The Committee must, as soon as practicable after an individual becomes, or ceases to be, a member of the Committee, provide the Patient Safety Unit with a written notice containing the following information:

- When an individual becomes a member:
 - the individual's full name and qualifications
 - the individual's office or position
 - a summary of the individual's experience that is relevant to the Committee's functions
 - the date the individual became a member
- When an individual ceases to be a member:
 - the individual's full name
 - the date the individual ceased to be a member.

7. Interpretation of Terms of Reference

For the purposes of the Terms of Reference of the Queensland Perioperative Periprocedural Mortality Review Committee, *perioperative/periprocedural mortality deaths* include:

- a) A death that occurred after an operative procedure
 - i) within 30 days
 - ii) after 30 days but before discharge from hospital to home or a rehabilitation facility.
- b) A death that occurred whilst under the care of a surgeon in hospital and an anaesthetist was consulted.

For the purpose of this definition:

- a) An operative procedure is defined as any procedure requiring anaesthesia (local, regional or general) or sedation.
- b) A surgeon is defined as a doctor who has achieved vocational registration with the Australian Health Practitioner Regulatory Authority in a speciality of surgery (including oral surgery) or has special skill listed of Surgery under General practice registration.
- c) For the removal of doubt, gastroscopies, colonoscopies, and cardiac or vascular angiographic procedures (diagnostic or therapeutic) carried out in designated endoscopy or radiological rooms would be included in this definition.

Any dispute or difference which may arise as to meaning or interpretation of these Terms of Reference and as to the conduct of a meeting shall be resolved by the Chair.

8. Definitions (QPPAMRC Glossary of Terms – Case Classification)

Scale of Anaesthetic Risk (physical status of the patient)

- I A normal healthy patient.
- II A patient with mild systemic disease.
- III A patient with severe systemic disease.
- IV A patient with severe systemic disease that is a constant threat to life.
- V A moribund patient who is not expected to survive without the operation.
- E Patient requires an emergency procedure.

Mortality Review Category

Death attributed to anaesthesia

Category 1	Where it is reasonably certain that death was caused by the anaesthesia or other factors under the control of the anaesthetist.
Category 2	Where there is some doubt whether death was entirely attributable to the anaesthesia or other factors under the control of the anaesthetist.
Category 3	Where death was caused by both surgical and anaesthesia factors.

Explanatory Notes:

- The intention of classification is not to apportion blame in individual cases but to establish the contribution of the anaesthesia factors to the death.
- The classification is applied regardless of the patient's condition before the procedure. However, if it is considered that the medical condition makes a substantial contribution to the anaesthesia-related death, subcategory H should also be applied.
- If no factor under the control of the anaesthetist is identified which could or should have been done better, subcategory G should be applied.

Death in which anaesthesia played no part

Category 4	Death where the administration of the anaesthesia is not contributory and surgical or other factors are implicated.
Category 5	Inevitable death, which would have occurred irrespective of anaesthesia or surgical procedures.
Category 6	Incidental death which could not reasonably be expected to have been foreseen by those looking after the patient, was not related to the indication for surgery and was not due to factors under the control of the anaesthetist or surgeon.

Un-assessable death

Category 7	Those that cannot be assessed despite considerable data but where the information is conflicting or key data are missing.
Category 8	Cases that cannot be assessed because of inadequate data.

Causal or contributory factors in categories of deaths**Note:**

It is common for more than one factor to be identified in the case of anaesthesia attributable death.

Sub-categories**A. Pre-operative**

(i) Assessment	This may involve failure to take an adequate history or perform an adequate examination or to undertake appropriate investigation or consultation or make adequate assessment of the volume status of the patient in an emergency. Where this is also a surgical responsibility the case may be classified in Category 3.
(ii) Management	This may involve failure to administer appropriate therapy or resuscitation. Urgency and the responsibility of the surgeon may also modify this classification.

B. Anaesthesia Technique

(i) Choice or application	There is inappropriate choice of technique in circumstances where it is contra-indicated or by the incorrect application of a technique which was correctly chosen.
(ii) Airway maintenance including pulmonary aspiration	There is inappropriate choice of artificial airway or failure to maintain or provide adequate protection of the airway or to recognise misplacement or occlusion of an artificial airway.

(iii) Ventilation	Death is caused by failure of ventilation of the lungs for any reason. This would include inadequate ventilator settings and failure to reinstitute proper respiratory support after deliberate hypoventilation (eg. bypass).
(iv) Circulatory support	Failure to provide adequate support where there is haemodynamic instability, particularly in relation to techniques involving sympathetic blockade.

C. Anaesthesia Drugs

(i) Selection	Administration of a wrong drug or one which is contra-indicated or inappropriate. This would include 'syringe swap' errors.
(ii) Dosage	This may be due to incorrect dosage, absolute or relative to the patient's size, age and condition and practice is usually an overdose.
(iii) Adverse drug reaction	This includes all fatal drug reactions both acute such as anaphylaxis and the delayed effects of anaesthesia agents such as the volatile agents.
(iv) Inadequate reversal	This would include relaxant, narcotic and tranquilising agents where reversal is indicated.
(v) Incomplete recovery	Eg. prolonged coma.

D. Anaesthesia Management

(i) Crisis Management	Inadequate management of unexpected occurrences during anaesthesia or in other situations which, if uncorrected, could lead to death.
(ii) Inadequate monitoring	Failure to observe minimum standards as enunciated in the ANZCA Professional Documents or to undertake additional monitoring when indicated eg. use of a pulmonary artery catheter in left ventricular failure.
(iii) Equipment failure	Death as a result of failure to check equipment or due to failure of an item of anaesthesia equipment.
(iv) Inadequate resuscitation	Failure to provide adequate resuscitation within recognised limits.
(v) Hypothermia	Failure to maintain adequate body temperature within recognised limits.

E. Post-operative

(i) Management	Death as a result of inappropriate intervention or omission of active intervention by the anaesthetist or a person under their direction (eg. recovery or pain management nurse) in some matter related to the patient's anaesthesia, pain management or resuscitation.
(ii) Supervision	Death due to inadequate supervision or monitoring. The anaesthetist has ongoing responsibility, but the surgical role must also be assessed.
(iii) Inadequate resuscitation	Death due to inadequate management of hypovolaemia or hypoxaemia or where there has been a failure to perform proper cardiopulmonary resuscitation.

F. Organisational

(i) Inadequate supervision, inexperience or assistance	These factors apply whether the anaesthetist is a trainee, a non-specialist or a specialist undertaking an unfamiliar procedure. The criterion of inadequacy of supervision of a trainee is based on the ANZCA Professional Document on supervision of trainees.
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(ii) Poor organisation of the service	Inappropriate delegation, poor rostering and fatigue contributing to a fatality.
(iii) Failure of interdisciplinary planning	Poor communication in peri-operative management and failure to anticipate need for high dependency care.

G. No Correctable Factor Identified

Where the death was due to anaesthesia factors, but no better technique could be suggested

H. Medical Condition of the Patient

Where it is considered that the medical condition was a significant factor in the anaesthesia related death.

Excluded notifiable conduct

Part 6, section 86 of the *Health and Hospitals Act 2011* defines 'excluded notifiable conduct' as meaning a registered health practitioner has:

- a. practised the practitioner's profession while intoxicated by alcohol or drugs; or
- b. practised the practitioner's profession in a way that constitutes a significant departure from accepted professional standards, but not in a way that has placed the public at risk of substantial harm; or
- c. engaged in sexual misconduct in connection with the practice of the practitioner's profession.

Public risk notifiable conduct

Part 6, section 86 of the *Health and Hospitals Act 2011* defines 'public risk notifiable conduct' as meaning that a registered health practitioner has placed the public at risk of substantial harm:

- a. in the practitioner's practice of the profession because the practitioner has an impairment; or
- b. because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

An 'impairment' is defined in section 5 of the Health Practitioner Regulation National Law (Queensland) as meaning a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect:

- a. the capacity of a registered health practitioner or applicant for registration in a health profession, to practise the profession; or
- b. a student's capacity to undertake clinical training:
 - i. as part of the approved program of study in which the student is enrolled; or arranged by an education provider.

Registered health practitioner

The *Health and Hospitals Act 2011* defines a 'registered health practitioner' as meaning an individual who:

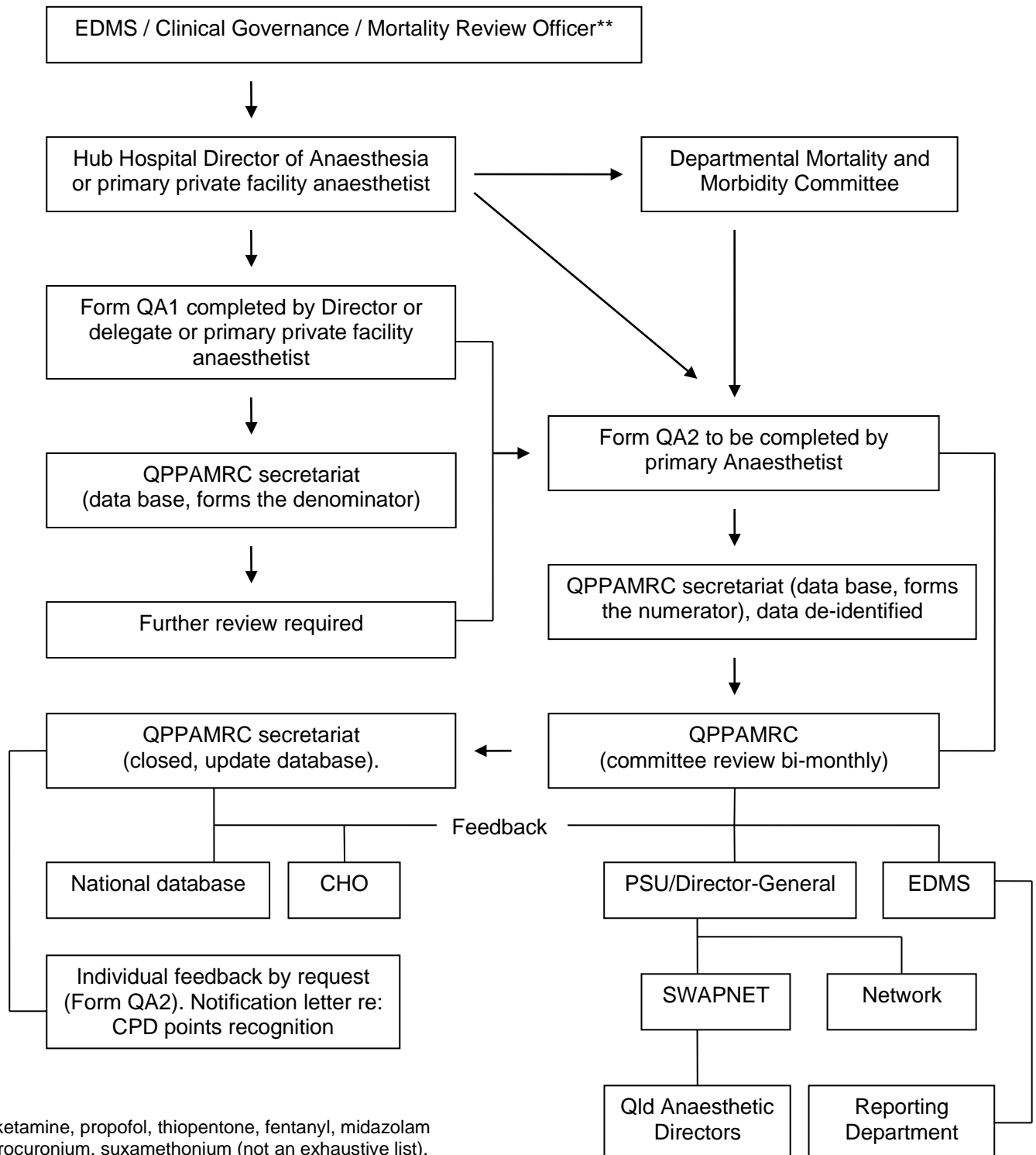
- a. is registered under the Health Practitioner Regulation National Law to practise a health profession, other than as a student; or holds non-practising registration under the Health Practitioner Regulation National Law in a health profession.

APPENDIX 2: Queensland Perioperative Periprocedural Anaesthetic Mortality Review Committee Flow Chart

QPPAMRC - Standardised Mortality Review Flow Chart

The purpose of the committee is to collect and analyse clinical information regarding perioperative and periprocedural anaesthetic mortality in Queensland to identify statewide and facility specific trends; make recommendations and assist with the adoption of standards and indicators to improve the safety and quality of anaesthetic and perioperative care.

This standardised process has been developed to align with existing mortality review processes (via EDMS / Clinical Governance Department / Mortality Review Officers) and minimise duplication of reporting and review as much as possible. This process applies to all patients who die within 30 days of having a procedure involving anaesthesia and / or sedation using anaesthetic drugs*.



*ketamine, propofol, thiopentone, fentanyl, midazolam rocuronium, suxamethonium (not an exhaustive list).

**patient details and DRG codes required

APPENDIX 3: Queensland Perioperative Periprocedural Anaesthetic Mortality Review Committee Annual Self-Assessment

The Committee is to undertake an annual self-assessment of its performance against the Terms of Reference and work plan.

The self-assessment is to cover the following, as a minimum:

- Has the Committee achieved the objectives of the work plan?
- Has the Committee adequately discharged its responsibility under its approved Terms of Reference?
- How effective has the Committee been in meeting the Committee's identified purpose and functions?
- Do the Committee Terms of Reference remain relevant? If not, why not, and what changes are required?
- Does the Committee meet and report with sufficient frequency to discharge its delegated responsibility?
- Does the Committee possess an appropriate mix of skills and knowledge?
- Are quorums achieved at all meetings?
- Is the attendance of individual the Committee members satisfactory (i.e. >75%)?
- Are matters requiring the Committee deliberation submitted in writing and adequately explained?
- Are agendas and meeting papers circulated in sufficient time to allow proper consideration by the Committee members prior to meetings?
- Is the Committee able to obtain all the information it requires?
- Are resolutions of the Committee documented and communicated to appropriate bodies in a timely manner?
- Are minutes and meeting papers appropriately documented and stored?
- Are the Committee's endorsed recommendations regularly reviewed and followed up to ensure the required action has been taken?

APPENDIX 3: Confidentiality Agreement



CONFIDENTIALITY FORM

To be signed by all members of an approved Quality Assurance Committee pursuant to p6, s84 of the *Hospital and Health Boards Act 2011*. The *Hospital and Health Boards Act 2011*, Part 6 and Part 7 replace the disclosure of information and confidentiality provisions in the repealed *Health Services Act 1991*.

I (*print name*)member of the (*print name of committee*)..... quality assurance committee declared pursuant to s84 *Hospital and Health Boards Act 2011* undertake to protect the confidentiality of all personal and medical information that I collect, see or handle in the course of my membership of the above mentioned committee.

Further, I hereby declare that I have not been the subject of any misconduct proceedings including breaches of confidentiality.

Signature:.....

Date:.....

Name of Witness:.....

Signature:.....

Date:.....

Completed forms must be retained as part of the documentation of the approved Quality Assurance Committee to which the form refers.