Beneficial partnership yielding value

The relationship between TASM and DoH has enabled many initiatives to be developed

The Tasmanian Audit of Surgical Mortality (TASM) was established in 2004. The governance arrangements for TASM fall under a committee of the Royal Australasian College of Surgeons (RACS), with members comprising of RACS Fellows and Fellows of the Australian and New Zealand College of Anaesthetists. A project manager from the Hobart RACS office oversees the audit.

RACS entered administrative arrangements from the inception of the audit with the Department of Health (DoH), Tasmania. In return for financial support to TASM, the project manager sits on the Clinical Governance and Quality and Patient Safety Service team within Clinical Governance, Clinical Quality Regulation and Accreditation.

The relationship between TASM and DoH has enabled many initiatives to be developed that have enhanced the value of TASM reporting within the Tasmanian public hospital setting. A recent example is the Tasmanian public health system prescribing the Safety Reporting and Learning System (SRLS) as its default incident recording and management system. The mortality module of the SRLS was implemented in February 2020 and was a ground-breaking project. It replaced manual forms with automated electronic notification of death certificates to Births, Deaths and Marriages—the same process applies lodging a 'death report to coroner' to the Magistrate's Court of Tasmania Coronial Division. Note that, for the purposes of TASM, the SRLS captures all deaths, including deaths that form part of the audit.

Manual completion of death certificates was subject to many potential sources of error and delay—reflecting poorly on doctors and the health service. At times, this had an impact on grieving families due to delays, lost forms or incorrect information.

Electronic reporting of all deaths via an online platform has delivered process improvements and better outcomes for varied stakeholder groups, including reporting doctors, patient families, hospital executives, patient safety staff, and the Patient Administration System (PAS) team. More recently, this included clinicians in general practice. An enhancement was made in July 2021 whereby a general practitioner (GP) is automatically notified of their patient's death during an episode of care, affording the listed GP awareness and oversight of their patient's journey in real time.

This project has been a resounding success as evidenced by post-evaluation surveys. These indicate that the system is easy to use and a vast improvement, with electronic forcing functions for reporters, mandatory fields, and detailed integrity checks in place before forms are distributed.

The system can boast of 100 per cent legibility, fewer amendments and much more timely distribution of both death certificates and coroners' reports.

'The death of the paper death certificate' has been presented at local forums and was accepted as a poster presentation at the International Forum on Quality and Safety in Healthcare in 2021. A working group is currently leading improvements for use of the mortality module to include coroners' findings. This will help 'close the loop' by streamlining their management in one state-wide electronic location, documenting coroners' recommendations and evidence of actions taken and, most importantly, sharing learnings across the state.