MACOMB COUNTY COMMUNITY MENTAL HEALTH
PROVIDER MORTALITY REVIEW

(To be completed by clinically responsible Provider Mortality Review Team)

VENDOR ORGANIZATION NAME: _____

Vendor #_____

Provider #_____

PROVIDER NAME: _____

Consumer Information:

Consumer: _____ Clinical Record # _____

Event Description: [Describe the details of the death and the service that was impacted.]

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_____

_____

Documents Reviewed: [List all documents reviewed, i.e.: clinical record, treatment plan, BTP, autopsy report]

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_____

Summary of Findings: [What steps in the existing process failed? What human error was involved? How did staff respond and was it appropriate? Were there any unexpected issues in the time leading up to the incident?]

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Identified Areas for Improvement: [Are there any processes that can be improved? Are there any knowledge gaps that were identified during this investigation?]

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_____

Plan of Action / Recommendations: [Include staff that will be involved in action plan and the date by which all actions will be completed.]

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_____

Review Team Members: _____

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_____

Send to: MCCMH Office of the Chief Medical Officer
19800 Hall Road
Clinton Township, MI 48038