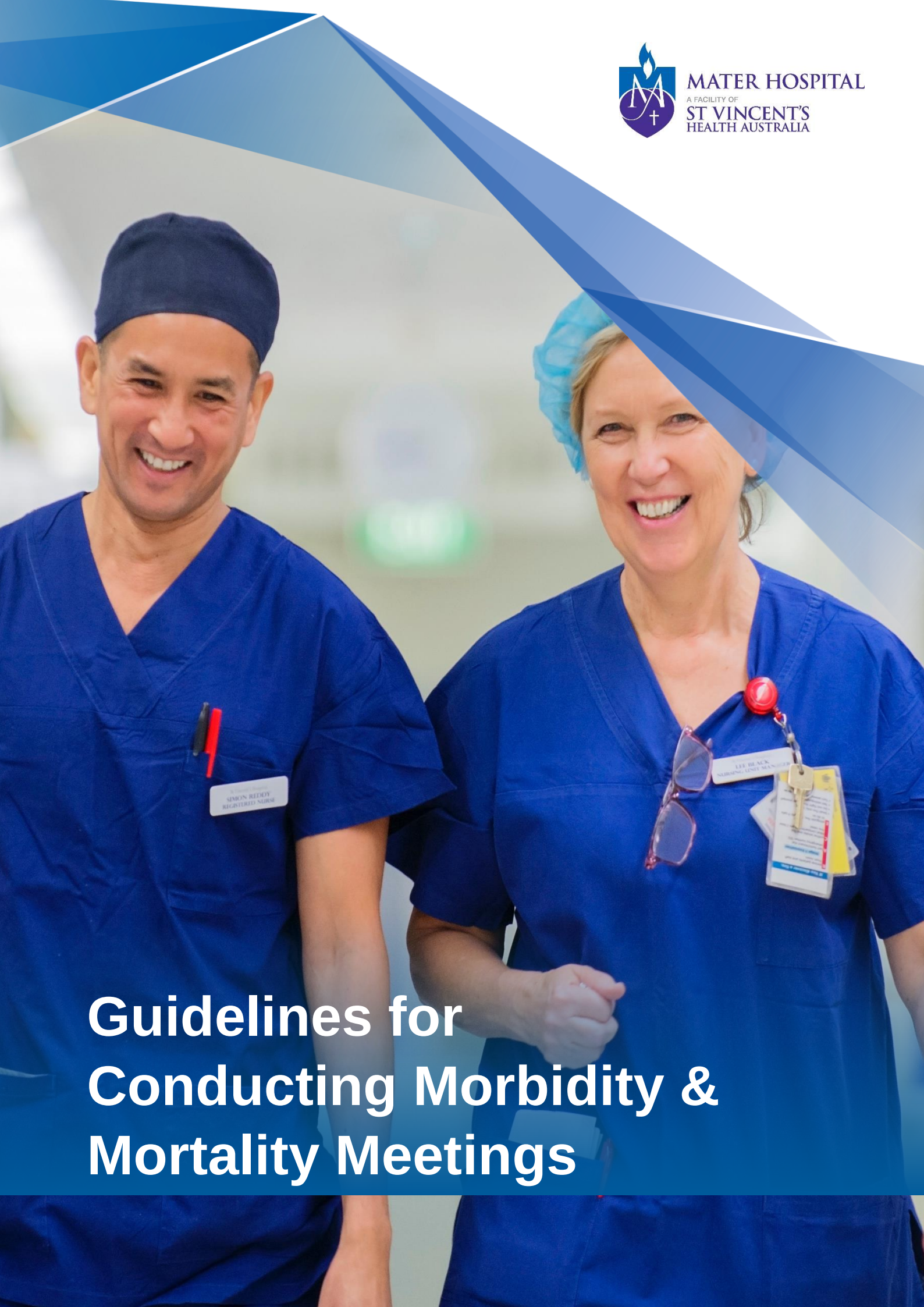
MATER HOSPITAL
A FACILITY OF
ST VINCENT'S
HEALTH AUSTRALIA



Guidelines for Conducting Morbidity & Mortality Meetings

1. Introduction

The Mater's commitment to patient safety and quality of care encompasses a duty to ensure that governance processes are in place to review and learn from adverse events that occur.

Effective clinical audit and peer review processes, including Mortality and Morbidity (M&M) meetings, improve patient safety.

Recent reports regarding clinical governance have placed specific focus on robust processes for conducting mortality and morbidity reviews as well as the use of benchmarked data to examine patterns of care and patient outcomes[1,2].

M&M processes are a key quality and safety requirement of clinical governance for the Mater hospital, and is in accordance with the Australian Commission for Safety and Quality in Health Care National Safety and Quality in Health Service Standards (2018).

2. Purpose and Scope

This document describes a comprehensive list of functions for M&M review meetings, and individual departments will need to decide how to apply these most effectively in their circumstances.

3. Related Legislation, NSW Health Policies, Other Documents

These guidelines draw upon a number of important documents:

- Clinical Excellence Commission, 2016. Clinician's Guide to Quality & Safety
- SVHA, 2017. Clinical Quality & Safety Guidelines
- SVHA, 2016. Clinical Quality & Safety Policy
- NSW Health Incident Management Policy PD2014_004
- NSW Health Complaint or Concern about a Clinician PD2018_032
- National Safety and Quality Health Service (NSQHS) Standard 1 - Clinical Governance

4. Principles

M&M review meetings have the very important function of providing education and an opportunity for reflection that may result in individual clinicians resolving to adopt different approaches with the next similar patient; importantly M&M review meetings also form part of the institutional and state-wide opportunity for system improvement.

If the M&M review meeting yields lessons for other Departments or other institutions, these should be reported promptly at the Patient Care Review Committee, or to the Director of Medical Services (DMS) in more urgent circumstances.

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[1] Duckett et al, *Targeting Zero*, *Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*, 2016. Department of Health and Human Services Victoria. Melbourne. p. 44

[2] Currow et al, *Off-protocol prescribing of chemotherapy for head and neck patients Final Report*, 2016. NSW Health. Sydney. p. 36

All M&M review meetings should be:

- Multidisciplinary, including clinicians from nursing, medical and allied health.
- Used to critically analyse the circumstances surrounding outcomes of care. These outcomes should include selected deaths, serious morbidity and significant aspects of regular clinical practice
- Focused on the systems and processes of care and not on individual performance.
- Focused on recommending measures that can prevent similar outcomes or adverse incidents, or that will improve the processes of care provided to this group of patients. These recommendations should not apportion blame to individuals.
- Mechanisms for overseeing and monitoring progress of these recommendations.
- Clearly documented in the minutes

5. Meeting Guidelines

5.1 Responsibility

- Participation in M&M meetings should be considered a 'core' activity for all clinicians. The responsibility for ensuring this occurs resides with the duly appointed clinical department head.
- Oversight of this activity will occur through the Executive team.
- **All Accredited Medical Practitioners are required to ensure that they are allocated membership under a specialty M&M Meeting as part of the requirement for compliance with SVHA By-Law**
- A continuous record of attendance of each member is to be kept and used in the annual evaluation of M&M Meetings

5.2 Organisation and Conduct

- Meetings should be held on a regular basis. The expectation is that this will be at least twice yearly, unless specified otherwise by the Chief Executive Officer/Director of Medical Services.
- The meetings should be scheduled well in advance, (i.e. 6-12 months) with a set day, time and venue to maximise the clinicians' availability to attend. A reminder should be advertised in the clinical area at least one week in advance of each meeting.
- Terms of Reference (TOR) should be developed and provided to all committee members. TOR are to be updated second yearly.
- All levels of staff involved in the care of these patients should be involved. They should be multi-disciplinary so that clinicians from all of the relevant specialties and professional backgrounds (i.e. medical, nursing, allied health) can attend. In determining membership, consideration should be given to clinicians from related specialties with whom the department frequently interacts.
- A person should be elected as the Chairperson, and a designated person should take notes of key findings and discussions at each meeting, which will assist in the compilation of a Meeting Report (Appendix B).
- The Chairperson, who should be a senior and respected member of the Department, will have the role of initiating discussion and ensuring that every opportunity is taken to identify and document actions for improvement. The Chairperson may be different to the person presenting individual cases.

- The Chairperson is responsible for creating an atmosphere that is conducive to open discussion and should ensure all members have an opportunity to contribute.
- **The Chairperson is responsible in ensuring that discussions are used for educational purposes and not for apportioning blame to individuals.**
- **The M&M is not qualified to sit in judgement of individual performance.** If concerns arise in that regard, the matter should be referred to the hospital executive team via the Director of Medical Services/Chief Executive Officer as appropriate.

A standing agenda should be developed which should incorporate the following elements:

- Previous minutes/meeting report
- Progress of outstanding recommendations/actions
- Deaths
- Serious adverse events
- RiskMan incidents (particularly those with principle Incident type of Clinical Management)
- Complaints
- Cases requiring open disclosure
- Relevant trended and benchmarked Clinical indicator data

5.3 M&M Meeting Requirements

Format	Conduct	Outcomes
M&M Chair appointed, written terms of reference in place, and meetings occur on a regular and scheduled basis, with a consistent structure and format	Review of selected Mortality and Morbidity cases, significant aspects of regular clinical practice, benchmarked/ trended data and near misses	Meeting minutes sent to attendees, Medical Director, Clinical Review Committee (CRC)
Good attendance and participation at meetings, acknowledged as a core activity for all doctors	Consistent, structured and de-identified case presentation	Minutes contain agreed outcomes/ recommendations and actions
Process for choosing the cases to be presented completed in advance and presenters contacted, and agenda sent out prior to meeting	Systems-focus discussion, with recommendations focused on measures that can prevent similar outcomes/ incidents and improve care	Follow up re implementation of recommendations / actions from previous meetings occurs at M&M and CRC
Inter-profession and multidisciplinary involvement	Open discussion, in a safe blame free environment with an opportunity for learning	Outstanding Actions/ recommendations requiring escalation are escalated to Medical Director / CEO
Secure storage of case presentations, agenda and minutes		
Meets College CPD requirements for attendees		

5.4 Review of Deaths by the M&M committee

- Death review must include all deaths in which the death was caused by or associated with a health care intervention. This does not preclude reviewing the quality of end of life management of expected deaths. Depending on volume, the chair may wish to highlight specific cases for presentation or more detailed discussion.
- A nominated clinician may review all deaths prior to the meeting and, in conjunction with the chair, decide which cases will benefit from detailed presentation and discussion. Where this happens, the opportunity must still exist for clinicians to raise concerns about any other deaths that have not been presented in detail.
- Some deaths must be reported to external bodies (e.g. Coroner, SCIDUA, CHASM, Peri-natal Mortality committee). The fact that an external report has occurred should not be a reason for dispensing with local review.
- When presenting information about death or adverse events, either in detailed or summarised tabular format, the information should be de-identified (that is, patients should not be referred to by name)
- Where cases are identified for presentation, clinicians from outside the department who played a significant role in the patients care should be invited to attend.
- Focus should be placed on identifying the issues related to any processes or systems of care that contributed to the death. Primary questions to consider for each case are:
    - *What happened?*
    - *If there was a breach of a standard of care or an error, why did it happen?*
    - *What can be done to prevent a recurrence*?
- Discussions should focus on measures that can be recommended or implemented to prevent a similar incident or adverse outcome.
- If issues that are raised represent substantial risks to the Department's ability to deliver its service, or to provide safe care, they should be referred to the Network / Facility Patient Safety and Quality Committee for inclusion on the Network / Facility Risk Register. The Department must consider and document actions that can be taken to manage or minimize the risk

5.4.1 SAC 1 Deaths identified in M&M review meetings

The healthcare facility has a legislative responsibility to report SAC 1 deaths through the Incident Information Management System (RiskMan) by means of a Reportable Incident Brief (RIB) to the Department of Health. These are deaths associated with health care intervention in which it is though that an error; a breach of an accepted standard of care or a systems failure contributed to the cause of death.

A Root Cause Analysis (RCA) should be conducted into all SAC 1 deaths.

SAC 1 deaths are usually identified close to the time of death, entered into RiskMan and an RCA initiated by the Clinical Governance Unit. Typically, an RCA will be underway by the time the case is being considered at an M&M review meeting. Discussion should be delayed until the next meeting after the findings of the RCA are known.

The death should stay on the agenda until the meeting has had the opportunity to review the outcome and recommendations of the RCA.

In the event that a death, which has not been previously identified as a SAC 1, is reviewed, and the meeting concludes that it satisfies the criteria for SAC 1, the death should be entered into RiskMan and the Quality & Risk team should be notified as soon as possible.

5.5 Referral to other Departments

In some cases the review of the patients care and management may identify care that is delivered by another team/service that is seen to have affected the patient's outcome. In this case the M&M review meeting Chair should write to that particular Department's Head of Department informing them of concern and suggest they review the care provided.

5.6 End of life Management

In each M&M review, for each death, while team members consider the circumstances of the death itself they should include a review of the management of his or her last days of life. Questions to be addressed include:

- *Was there an opportunity to commence end of life discussions earlier with the patient, for example, was the patient hospitalised more than 3 times in the 12 months prior to dying?*
- *Did the patient have a clinical review call or rapid response in the 24 hours prior to dying?*
- *Could the treating team have identified that the patient was at risk of dying during the episode of care despite treatment?*
- *If appropriate, was there an opportunity for the treating team to commence earlier end of life management planning that included identifying the patient's wishes?*

5.7 Delegation and Supervision of Clinical Care

Safe clinical care requires care should be provided either directly by experienced, skilled staff, or by inexperienced staff under a level of supervision that is appropriate for the patient's illness and circumstances, and for the level of competence of the staff member performing care. When required, escalation of care to other clinicians should be timely and responded to appropriately.

In each M&M review or Case Conference, for each death and severe adverse events, team members should consider if:

- Clinical care was delegated appropriately
- Supervision of clinical staff was provided when necessary
- Supervision provided by clinicians at the point of care was appropriate for the level of expertise of the clinicians involved
- Supervision was structured to allow clinicians to be trained without compromising patient care
- Were any escalation opportunities missed?

5.8 Diagnostic Error

Diagnostic error refers to a diagnosis that is missed, incorrect or delayed as detected by subsequent definitive information. They range in severity from near misses, with little or no impact on overall

patient outcomes, to serious incidents with significant adverse outcomes for patients. The absence of an accurate diagnosis may lead to delays in initiating the optimal treatment and subsequently increased length of stay and poorer patient outcomes. The opportunity to discuss diagnostic error in the M&M meeting provides an important aspect of learning and developing as a team to prevent the same mistakes from recurring in the future. A Cognitive Autopsy is a self-reflection exercise that provides meaningful and realistic feedback following the recognition of diagnostic error. The self-reflection process encourages reflective learning, the development of insight and a change in clinical cognition that reduces the likelihood of the error being repeated.

5.9 Reporting

A list of trigger questions are provided in Appendix A to be considered for each death considered in an M&M meeting.

Each case reviewed at the M&M Meeting should be considered and reported using the standardised reporting form.

Meeting minutes should be compiled after each meeting, which identify cases discussed (identified either by MRN or by initials and date of death) and the actions that must be taken as a result of the review. If there are no recommendations for action this should be recorded and all action items should be placed on the agenda for the next meeting.

- All meetings must be minuted in accordance with the approved standardised format.
- The minutes should be distributed within the Department
- Where actions recommended by the M&M meeting cannot be implemented, this must be specifically highlighted to the Chief Executive Officer and the relevant Management team.

Minutes from the M&M committee meeting should be sent to the Quality & Risk Manager to be tabled at the Patient Care Review Committee which meets every quarter.

6. Qualified Privilege

M&M review meetings have no special legal privilege. Although the Health Administration Act allows the minister to nominate approved quality assurance committees, which attract qualified privilege, approval is rarely sought or granted for individual departmental M&M review committees. Therefore, minutes of meetings should be written from the assumption that they could potentially become public documents. This means writing the minutes in a style which avoids statements of blame and concentrates on the actions arising from the deliberations.

7. References and Links

CEC, 2016. Recommended Guidelines for Conducting & Reporting Mortality & Morbidity /Clinical Review Meetings

SVHA, 2017. Clinical Quality & Safety Guidelines

Appendix A

Date of Review: Speciality:

URN:

Date of Admission: Date of Discharge:

Admission Diagnosis:

Trigger Questions **(These questions should be considered in discussion of case)**	**Trigger question considered (Y/N/NA)**	**Comments**
Was there a delay in diagnosis/assessment?		
Was there issue with misdiagnosis?		
Was there a delay in initiating treatment or recognising deterioration?		
Was there deterioration in the patient that was recognised and responded to in a timely manner?		
Were there communication issues or incorrect/misinterpretation of information?		
Did the care/ management deviate from the Policy/Best Practice Guidelines?		
Was there a complication due to treatment/procedure/operation?		
Was there a medication error?		
Was there a misuse or malfunction of equipment?		
Was there a delay in accessing appropriate resources/assistance to treat the patient?		
Were the appropriately skilled staff available?		
Was open disclosure conducted after the event?		