Recommended Guidelines for Conducting and Reporting Mortality and Morbidity / Clinical Review Meetings

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1.1	Document review	Dr Maree Bellamy	2012
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1. Introduction

Effectively run clinical audit and peer review processes, incorporating analysis of mortality and morbidity (M&M), contribute to improved patient safety. This guide aims to provide practical advice to clinical departments on establishing and running M&M/clinical review meetings. It is recognised that different departments will have different requirements and aims in relation to M&M/clinical review meetings.

Some services may choose to apply another title to their M&M/clinical review meeting, such as case review however the purpose, outcomes, principles and documentation are the same.

2. Purpose and Scope

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

3. Related Legislation, NSW Health Circulars, Area Policies, Other Documents

These guidelines draw upon a number of NSW Health documents:

- Clinical Excellence Commission, 2016. Clinician's Guide to Quality & Safety
- NSW Health Incident Management Policy PD2014_004
- NSW Health Complaint or Concern about a Clinician PD2006-007
- NSW Health Patient Safety & Clinical Quality Program PD2005-608
- National Safety and Quality Health Service (NSQHS) Standard 1 Governance and Quality in Health Service Organisations

4. Principles

Although M&M/clinical 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, it is important to recognise that M&M/clinical review meetings also form an important part of the institutional and state-wide opportunity for system improvement. If issues are recognised at an M&M/clinical review meeting that may have lessons for other Departments or other institutions, these should be reported promptly at the Patient Safety and Quality forum, or to the Director of Medical Services (DMS) in more urgent circumstances.

All clinical departments are expected to adhere to the following principles:

- M&M/clinical review meetings should be held on a regular, scheduled basis.
- Meetings should be multidisciplinary, including clinicians from nursing, medical and allied health.
- Meetings should be 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.

- The focus of these meetings should be on the systems and processes of care and not on individual performance.
- Recommendations arising from individual cases should focus on 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.
- Actions to implement the recommendations should be initiated and it is the responsibility of the Chair of the meeting to oversee progress in their implementation.
- Outcomes and decisions of these meetings should be documented in a brief meeting report.

5. Meeting Guidelines

5.1 Responsibility

- Participation in morbidity and mortality 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 appropriate Facility Manager and the Facility Patient Safety and Quality Committee.

5.2 Organisation and Conduct

- Meetings should be held on a regular basis. The expectation is that this will be at least monthly, unless specified otherwise by the appropriate Network Director / Facility Manager.
- 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 should be developed and a copy given to all committee members. TOR are to be updated annually (an example is attached in Appendix A)
- 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 there should be a designated person to take notes of key findings 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. Where serious concerns arise regarding a pattern of performance of an individual, the Chairperson should raise the matter confidentially and independently of the M&M process, with the Clinical Department Head with escalation to DMS as appropriate. In addition, the Director of Clinical Governance should be notified in accordance with the "Complaint or Concern about a Clinician" policy directive (PD2006-007)

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

- Review of previous minutes/meeting report
- Review of progress of outstanding recommendations/actions
- Review of deaths
- Review of serious adverse events
- Review of IMS incidents (particularly those with principle Incident type of Clinical Management)
- Review of complaints
- Review of cases requiring open disclosure

5.3 Review of Deaths

- Death review must include all deaths in which the death was caused by or associated with a health care intervention, rather than a result of the natural course of the illness. This does not preclude reviewing the quality of end of life management of expected deaths. At minimum, these cases should be itemised and the opportunity to discuss any case should exist. Depending on volume, the chair may wish to highlight specific cases for presentation or more detailed discussion.
- A common practice is for a nominated clinician to 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, and not on the individuals who provided the care. 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

5.3.1 SAC 1 Deaths identified in M&M/clinical review meetings

The Area Health Service has a legislative responsibility to report SAC 1 deaths through the Incident Information Management System (IMS) 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) must be conducted into all SAC 1 deaths.

- SAC 1 deaths are usually identified close to the time of death, entered into IMS 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/clinical review meeting. This does not preclude discussion by the M&M/clinical review meeting.

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 IMS and Clinical Governance should be notified as soon as possible.

5.4 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/clinical review meeting Chair should write to that particular Department's Head of Department informing them of concern and suggest they review the care provided.

5.5 End of life Management

In each M&M/clinical review or Case Conference, for each death, while team members consider the circumstances of the death itself they should include a review of the patients last days of life management. This should 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?

5.6 Delegation and Supervision of Clinical Care

Safe clinical care requires care was 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/clinical 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?

5.7 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. (Appendix D - Cognitive Autopsy Guide)

5.8 Reporting

A brief meeting report should be compiled after each meeting, which identifies 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.

- The report should be distributed within the Department
- A quarterly report must be submitted to the Network Director / Facility Manager, the Network / Facility Patient Safety and Quality Committee (A suggested reporting format is provided: Appendix C).
- Where actions recommended by the M&M meeting cannot be implemented, this must be specifically highlighted to the Network Director / Facility Manager and the relevant Facility or Network Management.

5.9 Review of Other Quality and Patient Safety Matters

M&M/clinical review meetings provide a valuable opportunity for departments to review the quality of the care that is being provided and to identify any opportunities for improvement. A key means by which such opportunities can be identified is by reviewing:

- Other serious adverse events (other than deaths)
- Clinical indicators which reflect performance
- Review of IMS incidents (particularly those with principle Incident type of Clinical Management)
- Review of complaints
- Review of cases requiring open disclosure
- Review of Risk Register

It is particularly valuable for departments to identify recommendations arising from such reviews and ensure that actions occur in relation to these recommendations.

6. Qualified Privilege

M&M/clinical 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/clinical 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

SWAHS – Guidelines - Conduct of Morbidity and Mortality meetings

Appendix A: M&M/clinical review meeting Terms of Reference

Purpose

To contribute to improved clinical quality and patient safety through:

- Critical analysis by a multidisciplinary group of clinicians of the circumstances surrounding the outcomes of care. These outcomes will include selected deaths, serious morbidity and significant aspects of regular clinical practice.
- Making recommendations which focus on measures that can prevent similar incidents or adverse outcomes, or for improving the processes of care provided to this group of patients. Recommendations will avoid apportioning blame to individuals.
- Initiating action on these recommendations and overseeing the progress of these actions.
- Ensuring progress on these actions is made known to the Network/Facility patient Safety and Quality Committee

In particular the committee will review or provide the opportunity to review:

- All deaths associated with a health care intervention and which are not an expected manifestation of the disease process
- Individual or aggregate data regarding adverse outcomes or clinical events which are agreed by the committee as providing useful insight into the quality of care provided
- Statistical indicators of the departments performance against agreed benchmarks
- IMS clinical incidents
- Patient complaints received by the department
- Open Disclosure cases involving major adverse events

The committee will consider whether any issue raised needs to be recorded and maintained on a Network /Facility or Departmental Risk Register

Membership

- All senior medical staff appointed to the Department
- All junior medical staff appointed or allocated on rotation to the Department
- All CNCs, CNSs or CNEs related to the Department's activity
- Nursing staff associated with the Departments dedicated wards
- Allied health staff dedicated to the Department's activity
- Clinicians from other Departments with which there is frequent interaction

Modus Operandi

- The meeting will occur monthly.
- The schedule of meetings will be published well in advance.
- The meeting will elect a Chairman. This election will be ratified by the Department Head.
- The office of chair will be reviewed annually but may be extended.
- An agenda will be circulated in advance of the meeting.

- Actions notes will be kept and circulated to members after the meeting.
- The chair will conduct the meeting so as to ensure that it focuses on health care service improvement and not on individual blame

Reporting Lines

The committee reports directly to the Network Director / Facility Manager and will submit minutes to the Network/Facility Patient Safety and Quality Committee, and relevant Network/Facility managers.

Appendix B: Morbidity and Mortality Meeting Report

Department:_____

Network/Facility: _____

Date:_____ Time:_____ to _____ hours

Venue:_____

Attendees (name & designation)

_____
_____
_____

1. Actions from Previous Meeting:

Action	Outcome to Date	Person Responsible	Keep on Agenda?

2. Case Reviews
(Listing of specific cases reviewed by MRN – unless covered under item 4)

3. Recommendations and Actions from this month's Case Reviews:

Recommendation	Action Required	Person Responsible	Timeframe

4. Referrals

(Includes the cases to be referred to other departments and bodies external to the committee)

SAC 1 Referrals (any case determined to be SAC 1 & not previously assessed as such – identify by MRN or IMS id)

Specific Issues - (any issue which needs to be highlighted to the Network/Facility Patient Safety and Quality Committee)

Additions to Risk Register

5. Attachments *(attach any list of de-identified cases presented to the committee for review)*

Distribution of M&M/clinical review Meeting Report

1. Copy to all Department members
2. Quarterly summary report of outcomes to Network Director/Facility Manager for inclusion on Network/Facility Patient Safety Quality Committee Agenda

Name of doctor completing:

Print_____ Signature _____Designation _____ Date____/___/ ____

Appendix C: Quarterly Morbidity and Mortality Summary Report

For: _____department/service

Date from: _____ / _____ / _____ to : _____ / _____ / _____

GENERAL MORBIDITY & MORTALITY INFORMATION			
What were the number of:			
Cases reviewed:	_____	Medication incidents:	_____
Cases unresolved:	_____	Infection control incidents:	_____
Communication incidents:	_____	Cases referred to other departments	_____
Coroner's reports:	_____	Delegation/Supervision incidents:	_____

Summary of Key Issues Identified from Morbidity & Mortality Reviews

Outstanding Issues from other Departments

Outstanding Issues to other Departments

Recommendations to Clinical Review Committee for Clinical Practice Changes

Actions from Previous CRC Recommendations

Morbidity & Mortality Case Presentation Summary

Name of doctor completing report:

Print_____ Signature _____Designation _____ Date____/___/ ____

Appendix D: Cognitive Autopsy Guideline

Benefits

Performing a cognitive autopsy following the recognition of diagnostic error is a self-reflection exercise that provides meaningful and realistic feedback. 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.

Sharing the information learned from a cognitive autopsy and generating discussion with team members in forums such as morbidity and mortality meetings promotes a team approach to the key learning in order to improve recognition of the cognitive factors involved in the decision making process and encourage recognition and discussion of the system factors that may have contributed.

When

A cognitive autopsy is often performed as an individual process and should be conducted as soon as possible after a diagnostic error has been realised. 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. The principles can also be used as part of team discussion to identify and prevent future diagnostic errors.

Cognitive Autopsy Guidelines

1. Conduct as soon as possible after event
2. Avoid discussion with others
3. Be well-rested and have an adequate amount of sleep
4. Find a secluded place, free of interruptions with enough time to consider the events in detail
5. Start with the beginning of the day or shift and work through towards the event
6. Consider the event in detail keeping an open mind about events, thoughts and feelings
7. Pay close attention to ambient conditions
8. Write down everything, however trivial
9. Discuss with others and record their comments and observations
10. Consider the cognitive biases involved and their respective impacts

Action

The opportunity to discuss the outcomes of a cognitive autopsy during morbidity and mortality (M&M) meetings is one that should not be missed. This is an important aspect of learning and developing as a team to prevent the same mistakes from recurring in the future. These meetings need to be structured in a way that enables and promotes discussion and analysis of the thinking processes in a non-judgemental manner for this to be an effective, open and honest discussion that leads to the identification of system solutions.

References:

Croskerry, P, Singhal, G and Mamede, S. 2013. *Cognitive debiasing 1: origins of bias and theory of debiasing*: Published online first, BMJ Quality and Safety, Vol. 0, pp. 1-7.

Croskerry, P. 2003. *The importance of cognitive errors in diagnosis and strategies to minimize them.* Acad med; 78: 775-80.

Croskerry, P. 2002. *Achieving quality in clinical decision making: cognitive strategies and detection of bias. Acad Emerg Med; 9(11): 1184-204*

Considerations during a Cognitive Autopsy

Cognitive Autopsy Steps	Considerations and Rationale
1. Conduct as soon as possible	• The recall of information deteriorates rapidly over time. • As it is important to reflect on every possible aspect of the situation a detailed reflection as soon as possible allows the best opportunity for learning from the event.
2. Avoid discussion with others initially	• Discussing the situation with others before reflecting individually creates the potential to distort perceptions and recollections
3. Work through the day from the beginning of the shift through to the event	• Write down a detailed account of the shift providing as much objective detail as possible is required. • Develop a timeline that outlines key points or events throughout the day that could have contributed to an error. • Use the timeline to identify the critical decision points for the case under review • Reflect on the decision points to identify key cues and decision goals (Be aware of hindsight bias)
4. Consider the event in detail keeping an open mind about events, thoughts and feelings	While reflecting on the event consider the following stages of decision making: *Plan* • Do I feel comfortable with my judgement? • Was the patient comfortable with my judgement? *Reflect* • Does it make clinical sense? • Did I put enough effort thinking about the case? • Did I have biases when thinking about the case? *Manage* • Do I need more information or skills to manage this case better?
5. Consider the ambient conditions	• Was it a busy shift, lots of pages, other clinical priorities to manage? • What else was going on around me such as new procedures, organisational changes, different environment or different colleagues? • Were there other things on my mind that day such as a conflict at home or an unwell family member?
6. Consider the cognitive biases involved and their respective impacts on the decision making process in this case	Common biases related to diagnosis and clinical decision making include: • Anchoring • Framing • Availability • Confirmation • Overconfidence • Attribution error

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