MORBIDITY & MORTALITY MEETING

CHECKLIST FOR CHAIR

Guiding Principles

Create a safe, open, and respectful atmosphere for open discussion and learning, allowing all members to contribute. Reiterate confidentiality i.e. avoid patient identifiers and do not discuss details outside the meeting.

The focus on the meeting should be on systems of care rather than individual errors i.e. what happened, why and what can be done to prevent a reoccurrence.

Encourage discussion and ensure that every opportunity is taken to identify and document actions for improvement. Actions from the recommendations must also be allocated to individual/s responsible for implementation.

It is recommended that individuals directly involved in a case do not present to ensure objectivity is maintained. It is, however, important for the clinician/s involved to attend to provide clarity and insight as required.

Where concerns arise regarding a pattern of performance of an individual clinician, that matter should be raised confidentially and independently of the Morbidity & Mortality (M&M) process. The case presentation should be ceased at this point.

Terms of Reference

- Chair to be elected/ appointed, and then reviewed at least every two years
- Include reporting lines/escalation policy for quality and safety issues within the Local Health District (LHD). Refer to CEC M&M Terms of Reference

Meeting

- Send an open invitation to all clinical staff attached to the department/ward and to clinicians involved in the cases presented.
- Schedule and publish regular meeting dates in advance at a time to suit clinicians (i.e. monthly). Inform attendees of the expectation of attendance, and of communicating outcomes to colleagues.
- Prepare and circulate the agenda and meeting papers including a brief description of each de-identified case prior to the meeting.

To be read in conjunction with the CEC's Recommended Guidelines for Conducting and Reporting Mortality and Morbidity / Clinical Review Meetings

The CEC acknowledge the input from the NSW Paediatric Safety & Quality Network in the development of this resource

Case Suggestions

Essential
SAC1 incidents; RCAs; Deaths; Coroners Case; SAC 2 incidents; London Protocols[1]; Case reviews
Additional
Deteriorating patients/near misses; REACH activation; transfers to or from higher care services; IIMS summary and trends/themes (e.g. medication errors); cases identified by nurse unit manager or medical lead for the department/ward; referrals from other M&M Committees; End of Life management concerns

Other potential sources of data for identifying cases may include:

- Coroners Reports
- Death Review Database
- Complaints manager

Reporting

This may include the following:

- Distribute minutes, including delegation of actions and recommendations - see your Local Health District, Clinical Governance Unit (CGU) guidelines for safety and quality reporting (Director of Medical Services/Patient Safety and Quality Committee)
- Refer cases reclassified as SAC 1 to CGU
- Notification of incidents through IIMS for any case not already reported
- Escalate any system factor issues identified to local managers/CGU
- Escalate cases to other committees (CHASM[2]/ SCIDUA[3]/CGU)
- Update the Risk Register as required
- Ensure close loop communication occurs with clinicians/departments/services/ external sites involved in the case as delegated by the chair

[1] London Protocol (LP) – A LP is a detailed review of serious incident that does not meet the requirements for an RCA. This process is not privileged, but similarity to the RCA involved identifying root causes, system issues and recommendations. The team is appointed by the CGU and usually led by a CGY staff member.
[2] CHASM – Collaborating Hospitals Audit of Surgical Mortality
[3] SCUDIA – Special Committee Investigating Deaths Under Anaesthesia

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