MORBIDITY & MORTALITY MEETINGS

CUE CARD FOR PRESENTER

This is a guide for clinicians presenting a case. The aim is to support and add structure to case presentation, and, in particular, to draw attention to potential system factors that may have contributed to the adverse event.

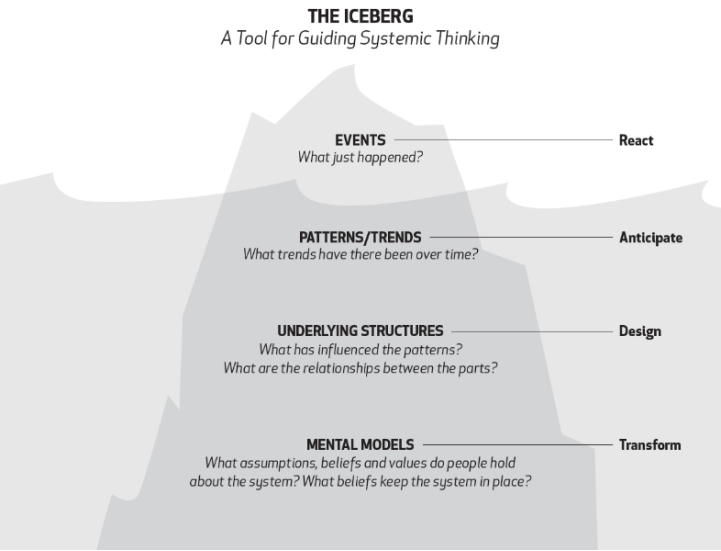

Image: A Systems Thinking Model: The Iceberg
Used with permission from Northwest Earth Institute, www.nwei.org/iceberg/

Introduction

Introduce yourself and your role and clinical expertise.

Situation and background

- Describe the patient, their medical history
- Pathology results and imaging
- Any procedures performed / medical care provided
- What happened – analysis of how it was recognised and managed

This document should 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.

Assessment (Discussion led by the Chair)

(Not all of the points below need to be discussed in every case)

Why did it occur? Consider System error/s:

- Access to services / diagnostics / provider
- Assessment factors
- Care planning
- Communication / documentation
- Environment
- End of life management
- Equipment
- Investigations
- Observations and Monitoring
- Policy and guidelines
- Resourcing
- Supervision/training/delegation
- Teamwork
- Transfer
- Workforce

Consider Human and Patient factors such as:

- Cognitive based errors (bias)
- Loss of situational awareness
- Co-morbidities

Recommendation (Learning and improvement)

- What did we learn from the case?
- What do we need to do to prevent this from occurring again?
- Who is responsible for actioning the recommendations?
- What system improvement can be implemented to minimise the risk and consequences of human error?

Morbidity & Mortality Meeting: Cue Card for Presenter.
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