# PART THREE:
# MORBIDITY AND MORTALITY MEETING

## What are Morbidity and Mortality Meetings?

Morbidity and mortality (M&M) meeting are meetings held by clinicians to review adverse events (complications) that happened during the care of patients. The objectives of an M&M meeting are:

- To provide a safe venue for medical learning
- To identify areas of improvement of patient care
- To identify errors if any occurred
- To modify behaviour and judgment
- To identify systems issues that could affect patients' care negatively.
- To teach on quality improvement and medico legal issues
- To foster a climate of openness and discussion about medical errors

## Confidentiality and Privileged status

Properly run M&M meetings are non-punitive and focus on improving patient care rather than to threaten clinicians. Ideally, the meetings are held under "privileged status". In effect, this means that the proceedings of the meeting cannot be used in court. The aim is that clinicians can speak freely about a case, and do not need to be concerned about their openness being used against them in court. In many countries including Australia (Part VC, Health Insurance Act 1973) and the U.S. (O.C.G.A. § 31-7-130 et seq. and § 31-7-140 et seq.), M&M meetings can apply for privileged status to the federal government. Minutes cannot be accessed openly and will not be distributed.

Should an application for privileged status be rejected, many M&M meetings still go ahead but they chose not to have any minutes taken at the meetings. In that case, only action points are documented without naming individuals.

M&M conferences occur in regular intervals.

## Participants

- Chairperson
- All Faculty, trainees and medical students are expected to attend
- Anyone involved in the case with direct knowledge of the systems and events relevant to the discussion. This may include other physicians, nurses, pharmacists, therapists, lab personnel, and representatives of ancillary departments.

## Case Selection

- Inpatients or outpatients
- Any adverse outcome that might have been due to or worsened by error or system problems
- A “near-misses” event where there was an error or misstep in care delivery that did not but could have led to a poor patient outcome
- Any interesting and unique case that may provide a learning and inquiry opportunity

Typically, cases will be presented where an action is associated with an adverse event. However, it is equally important that cases also are included in which non-action is associated with harm to patients.

## Indicators that may be of assistance with case selection:

## Obstetrics Indicators

- Maternal Mortality within 30 days from delivery
- Unplanned readmissions within 30 days
- Maternal cardiopulmonary arrest
- Unplanned removal, injury or repair of organ during operative procedure
- Excessive maternal blood loss
- Excessive length of stay
- Eclampsia
- Unattended delivery
- Unplanned postpartum return to the operating theatre
- Caesarean delivery for uncertain foetal status
- Caesarean delivery for failure to progress
- Elective induction < 39 weeks gestation
- Neonatal Indicators
- Birth trauma
- Unexpected Intrauterine foetal demise &/or term stillborn

## Gynaecological Indicators

- Mortality within 30 days from surgical procedure
- Unplanned readmission within 30 days from surgical procedure
- Cardiopulmonary arrest
- Unplanned admission to intensive care unit
- Unplanned return to the operating room during the same admission
- Day-surgery patient admitted or retained for complication of surgery or anaesthesia
- Excessive blood loss
- Unplanned removal, injury or repair of organ during operative procedure
- Discrepancy between preoperative diagnosis and postoperative tissue report

- Removal of uterus weighing < 280 g for fibroids
- Removal of follicular cyst or corpus luteum of ovary
- Hysterectomy performed on woman younger than 30 years of age except for malignancy

## Ground Rules

- No finger-pointing – focus on systems of care rather than individual errors
- Confidentiality – avoid patient identifiers (no names, dates, record numbers) and do not discuss casually outside the conference
- Add the following statement to all documents: “Privileged & Confidential: Subject to Peer Review and Medical Review Protections under Federal Law”.

## Conference Format

- The presenter submits a presentation (powerpoint) of the case to the chairperson
- Chairperson will review the case in advance and is prepared for the topic
- Chairperson opens the M&M meeting and makes all participants aware of the confidential nature of the meeting
- Introduction of presenter
- Case presentation including overview of the case, timeline of events, how the patient care issue(s) caused potential or actual harm to the patient, family, or a healthcare professional (presentation should not exceed 10 minutes)
- Identify any evidenced-based literature that is applicable (provide copies to participants)
- Identify any professional standard’s body guidelines
- Chairperson will facilitate a discussion amongst the participants
- Name “Take Home Points”
- Recommend any clinical or system changes that should be considered to prevent this patient care issue from occurring in the future
- The entire discussion will not take longer than 15 to 30 minutes

## Root Cause Analysis

Root Cause Analysis is a technique used for very complex cases and that helps answer the question of why the problem occurred in the first place and seeks to identify the origin of a problem. It uses a specific set of steps, to find the primary cause of the problem, so that you can:

- Determine what happened.
- Determine why it happened.
- Figure out what to do to reduce the likelihood that it will happen again.

Often, there are three basic types of causes:

**Physical causes.** Tangible, material items failed in some way (for example, the foetal monitor stopped working).

**Human causes.** People did something wrong or did not doing something that was needed. Human causes typically lead to physical causes (for example, no one checked to be sure the maintenance was performed on the foetal monitor, which led to it failing).

**Organizational causes.** A system, process, or policy that people use to make decisions or do their work is faulty (for example, no one person was responsible for maintenance, and everyone assumed someone else had checked the foetal monitor).

A **Fishbone Diagram** can assist with the analysis of the root cause:

- Draw the diagram with a process arrow to the effect and draw a box around it.
- Decide what the major categories of the causes are (i.e., people, machines, measurement, materials, methods, environment, policies, etc.).
- Label categories important to your situation. Make it work for you.
- Brainstorm all possible causes and label each cause under the appropriate category.
- Analyse causes and eliminate trivial and/or frivolous ideas.
- Rank causes and circle the most likely ones for further consideration and study.
- Investigate the circled causes.

## Example of a Fishbone Diagram