Review of Morbidity and Mortality (M&M) Meetings in the Southern Health and Social Care Trust

How can these lead to Quality Improvement?

Dr Lauren Megahey
ST4 in Psychiatry of Old Age
ADEPT Clinical Leadership Fellow
Review of Morbidity and Mortality (M&M) Meetings in the Southern Trust

**Background:**
- Project initially developed by Dr John Simpson and Stephen Wallace.
- Numerous high profile reports have highlighted the importance of patient safety.

**Aims:**
- Develop a robust system, across all specialties, for discussing patient care, highlighting areas for improvement and sharing learning points.
- Promote open discussion, without fear of blame.
- Learn from complications and errors, prevent repetition of errors, and promote patient safety.

**Project Summary:**
- Format and structure of existing meetings were reviewed.
- 15 interventions were identified to improve and strengthen existing M&M processes.
15 Interventions:

1. Standardised calendar of meetings
2. Clarification of sub-specialty input
3. Multidisciplinary team input
4. Inclusion of ‘patient safety inputs’
5. Standardisation of agendas and outputs
6. Development of ‘lessons learned’ shared learning
7. Clarification of links to existing governance structures
8. Ensure relevance of CHKS mortality reporting
9. Development of specialty driven trigger lists
10. Identification of cases to discuss
11. Review of screening templates
12. Define role of M&M Chair
13. Mechanism to support individual reflection of practice
14. Development of individual score cards
15. Define role of M&M Monitoring Group
Project Progress:

- Many of the interventions have been implemented
- ‘Fine tuning’ and addressing challenges
- Emphasis is on clinical engagement
- Culture transformation is gradually happening
- Focusing on sharing learning – leading to other projects
Ways to share learning – some examples

• **Southern Trust:**
  ✓ Learning letters
  ✓ Review of SAIs 2011 – 2015, classification into categories for trend analysis and to target interventions

• **Collaborations with other Trusts:**
  ✓ Met with Belfast Trust Outcome Review Group
  ✓ Considering ‘lesson of the week’ (as done in Western and Belfast Trusts)

• **Regional:**
  ✓ RQIA Review of Learning from SAIs in Northern Ireland
  ✓ Involvement with Regional Mortality & Morbidity Review System
  ✓ Writing regional guidance re. the M&M processes in N. Ireland
  ✓ Considering other options e.g. online resources

• **Further afield:**
  ✓ International Forum on Quality & Safety in Healthcare
Development of Northern Ireland Regional Guidance for the Mortality and Morbidity (M&M) Process:

✓ Written as part of my ‘ADEPT Clinical Leadership Fellow’ post.

✓ Many individuals, across all disciplines and specialties, gave valuable input and advice.

✓ Content agreed with all 5 Health and Social Care Trusts in Northern Ireland.

✓ Developed in conjunction with the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland.

Author(s): Dr Lauren Megahey, ST4 in Psychiatry of Old Age and ‘ADEPT Clinical Leadership Fellow.’
Dr Julian R Johnston, Medical Adviser, Death Certification Policy and Legislation Unit, DHSSPS.
Sharon Wright, Death Certification Policy and Legislation Branch, DHSSPS.
Mr David Best, Head of Death Certification Policy and Legislation Branch, DHSSPS.
Mr Stephen Wallace, Project Manager, Southern Health and Social Care Trust.
Many others contributed to this document, including, but not limited to: Dr Richard Wright, Dr John Simpson, Dr Aidan Cullen, Dr John Harty, Mr. Lloyd McKie, Dr Alan McKinney, Dr William Donaldson and Dr David Hill.

Ownership: The Medical Director in each Health and Social Care Trust will be given ownership of this document.

Each Health and Social Care Trust can add their own logo, but the aim is for one system to apply across all Trusts.

Any local variations can be added as an appendix.

Approval by: Insert name of Trust committee / group responsible for approval
Approval date:
Operational Date: Insert date on which policy issued
Next Review: Insert next review date
Version No. Supercedes

Key Words: Mortality, Morbidity, M&M lead, M&M meeting

Links to other policies

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Author</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/12/2015</td>
<td>0.1</td>
<td>Lauren Megahey</td>
<td>Initial Draft</td>
</tr>
<tr>
<td>05/01/2016</td>
<td>0.2</td>
<td>JR Johnston</td>
<td>Into Regional template</td>
</tr>
<tr>
<td>11/01/2016</td>
<td>0.3</td>
<td>Lauren Megahey</td>
<td>Redrafted</td>
</tr>
<tr>
<td>29/02/2016</td>
<td>0.4</td>
<td>Lauren Megahey</td>
<td>Redrafted</td>
</tr>
<tr>
<td>22/03/2016</td>
<td>0.5</td>
<td>Lauren Megahey</td>
<td>Minor changes following regional consultation</td>
</tr>
</tbody>
</table>
## Contents:

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>INTRODUCTION / PURPOSE OF POLICY</td>
<td>3</td>
</tr>
<tr>
<td>1.1</td>
<td>Background</td>
<td>3</td>
</tr>
<tr>
<td>1.2</td>
<td>Purpose</td>
<td>3</td>
</tr>
<tr>
<td>2.0</td>
<td>DEFINITIONS / SCOPE OF THE POLICY</td>
<td>3</td>
</tr>
<tr>
<td>3.0</td>
<td>ROLES / RESPONSIBILITIES</td>
<td>4</td>
</tr>
<tr>
<td>3.1</td>
<td>M&amp;M Leads / Chairs</td>
<td>4</td>
</tr>
<tr>
<td>3.2</td>
<td>Attendees</td>
<td>6</td>
</tr>
<tr>
<td>3.3</td>
<td>Governance, Appraisal and Revalidation</td>
<td>10</td>
</tr>
<tr>
<td>3.4</td>
<td>M&amp;M Review Groups</td>
<td>11</td>
</tr>
<tr>
<td>4.0</td>
<td>KEY POLICY PRINCIPLES</td>
<td>12</td>
</tr>
<tr>
<td>4.1</td>
<td>M&amp;M Leads</td>
<td>12</td>
</tr>
<tr>
<td>4.2</td>
<td>M&amp;M Meetings</td>
<td>12</td>
</tr>
<tr>
<td>4.3</td>
<td>How to set up an M&amp;M Meeting</td>
<td>13</td>
</tr>
<tr>
<td>4.4</td>
<td>Ground rules</td>
<td>13</td>
</tr>
<tr>
<td>4.5</td>
<td>Suggested calendar of dates</td>
<td>14</td>
</tr>
<tr>
<td>4.6</td>
<td>Structure of meetings</td>
<td>15</td>
</tr>
<tr>
<td>4.7</td>
<td>Inputs and outcomes of meetings</td>
<td>16</td>
</tr>
<tr>
<td>4.8</td>
<td>Specialty input</td>
<td>17</td>
</tr>
<tr>
<td>4.9</td>
<td>Membership of meetings</td>
<td>18</td>
</tr>
<tr>
<td>4.10</td>
<td>Selecting cases for detailed discussion</td>
<td>19</td>
</tr>
<tr>
<td>4.11</td>
<td>How to present cases (SBAR)</td>
<td>20</td>
</tr>
<tr>
<td>4.12</td>
<td>Admin support</td>
<td>22</td>
</tr>
<tr>
<td>4.13</td>
<td>Shared learning</td>
<td>23</td>
</tr>
<tr>
<td>4.14</td>
<td>Assurance</td>
<td>25</td>
</tr>
<tr>
<td>5.0</td>
<td>IMPLEMENTATION OF POLICY</td>
<td>26</td>
</tr>
<tr>
<td>5.1</td>
<td>Dissemination</td>
<td>26</td>
</tr>
<tr>
<td>5.2</td>
<td>Resources</td>
<td>26</td>
</tr>
<tr>
<td>5.3</td>
<td>Exceptions</td>
<td>26</td>
</tr>
<tr>
<td>6.0</td>
<td>MONITORING</td>
<td>26</td>
</tr>
<tr>
<td>7.0</td>
<td>EVIDENCE BASE / REFERENCES</td>
<td>27</td>
</tr>
<tr>
<td>8.0</td>
<td>CONSULTATION PROCESS</td>
<td>28</td>
</tr>
<tr>
<td>9.0</td>
<td>APPENDICES:</td>
<td>29</td>
</tr>
<tr>
<td>9.1</td>
<td>Appendix One: Historical background and evidence for M&amp;M Meetings</td>
<td>29</td>
</tr>
<tr>
<td>9.2</td>
<td>Appendix Two: Opportunities for further development</td>
<td>31</td>
</tr>
<tr>
<td>9.3</td>
<td>Appendix Three: Regional Morbidity and Mortality Review System</td>
<td>32</td>
</tr>
<tr>
<td>9.4</td>
<td>Appendix Four: Child Death Notification Processes</td>
<td>32</td>
</tr>
<tr>
<td>10.0</td>
<td>ACKNOWLEDGEMENTS</td>
<td>33</td>
</tr>
<tr>
<td>11.0</td>
<td>EQUALITY STATEMENT</td>
<td>34</td>
</tr>
</tbody>
</table>
The Future:

• Aim for continued improvement of shared learning to further improve patient safety, e.g.
  - development of internet learning site
  - considering ‘lesson of the week’

• Improve multidisciplinary input into meetings

• Have clear requirements re. M&M participation for appraisal and revalidation
How can M&M Meetings Lead to Quality Improvement?

Berwick Report, 2013:

‘the most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.’
How can M&M Meetings Lead to Quality Improvement?

• M&M meetings are ‘a routine forum for the open examination of adverse events, complications and errors which have led to illness or death of a patient, and which are reviewed in order to learn from these events so as to improve the management and quality of care.’

  (Travaglia and Debono, 2009.)

• Studies show that approximately 10% of patients admitted to hospital suffer an adverse event.

  (Vincent et al, 2004.)

• Specialty-based M&M meetings enable robust discussion and peer challenge.
If physicians do not attend M&M meetings, ‘they fail to educate themselves and others, while also imparting the message to their staff and patients that they simply do not care or do not assume responsibility for what has occurred.’

Epstein, 2012
How can M&M Meetings Lead to Quality Improvement?

• Learning should be shared, in order to prevent unnecessary repetition of errors, and to optimise patient care.

• Learning needs to be simple, relevant, and not just a tick-box exercise.

• Frontline staff can work together with governance teams to develop solutions to issues that arise.

• As well as a platform for review, M&M meetings also have a valuable role in medical education.

• It is important to highlight areas of good practice, from which others could learn.
A 2009 review of the literature around M&M meetings found evidence to support key strategies to contribute to quality improvement and learning processes.

These include:
- commitment from senior staff
- a safe and supportive environment
- consistency in organisation
- an inclusive approach
- a structured process
- detailed feedback and follow-up.

(Travaglia and Debono, 2009.)
In practical terms...

- Identify areas of good and poor practice via M&M discussions
- Discuss possible quality improvement projects as a team
- Feed back findings at M&M meetings
Suggestions for the future

• Possibly identify a Quality Improvement Lead for each specialty?

• Dedicate a section of each M&M meeting to Quality Improvement?
Questions?
References


• Epstein NE. Morbidity and mortality conferences: Their educational role and why we should be there. Surgical Neurology International, Nov 2012; 3: S377-88


• Vincent C, Moorthy K, Sarker SK, Chang A, Darzi A. Systems approaches to surgical quality and safety: from concept to measurement. Annals of Surgery 2004; 239 (4); 475-482