Mortality and Morbidity Meetings

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We are all in this together

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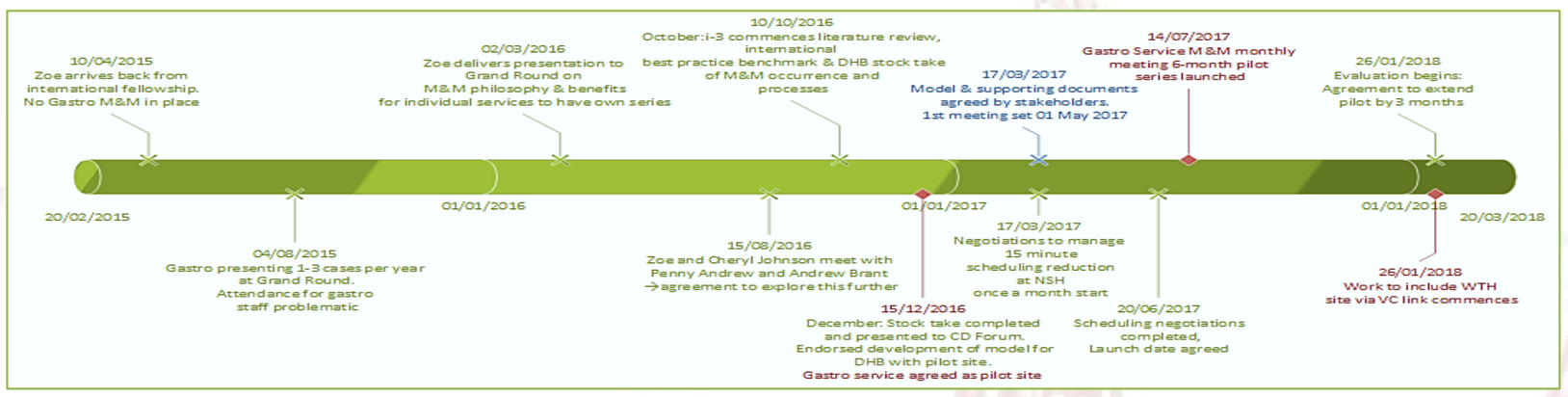
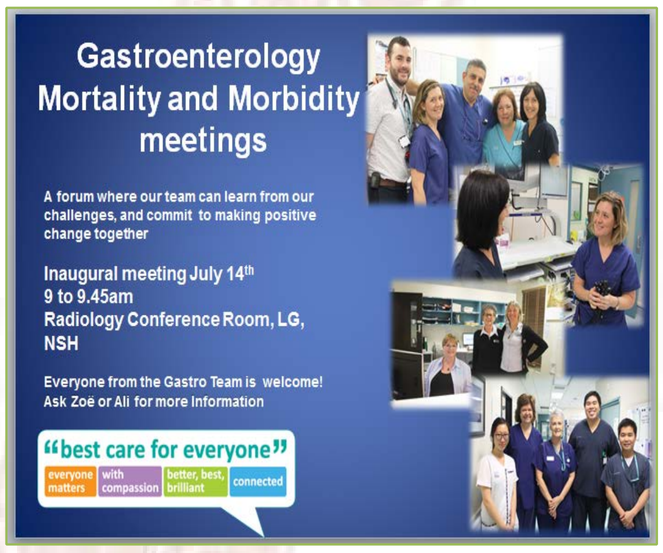
Since the 1900's, Mortality and Morbidity meetings (M&M's) have enabled learning from adverse incidents, and have evolved into a dedicated, trackable and safe forum for multidisciplinary learning. A 2017 DHB-wide stock take highlighted variations in practice, process and outcomes with no single service meeting international recommended standards. This project set out to develop a single service model through the Department of Gastroenterology at North Shore Hospital (NSH) that would meet expectations and improve the culture of transparency, and evolve team culture towards cohesion, tolerance and understanding. The ultimate goal is to improve the patient experience for those cared for in an enhanced environment and culture.

Our aims: To set up M&Ms to enhance the quality of clinical care, patient safety and patient experience. To support the growth of an inclusive team culture with an open and transparent learning process in a no-blame environment.

How did we do it? From concept to reality





Our outcomes – what have we learnt and delivered?

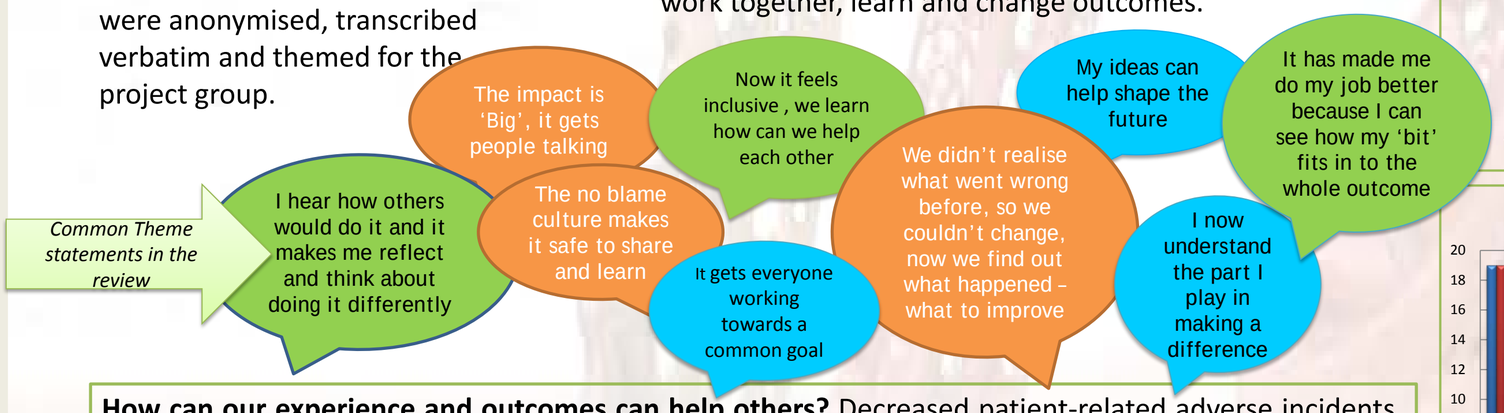
Our belief: If staff (as individuals and as a team) understood the impact of applying their presence, knowledge and skill on patient experiences and outcomes, then over time the department would be a safer and happier place to be a patient, and for staff to work in.

At the end of the six-month pilot a staff experience review was undertaken. A random sample of 30 staff from all disciplines and levels were invited to talk about their perception of the new process, the experience of being part of the change, their interpretation of benefits and outcomes, and recommendations for the next steps. 17/30 participated by meeting 1:1 with the i³ social researcher. Answers were anonymised, transcribed verbatim and themed for the project group.

Results of Experience Survey:

- 42% attended regularly
- 62% felt encouraged to present in front of their peers
- 83% Felt freedom to voice their thoughts on a case, including preventative actions for the future
- 92 % believe this model and process would help other departments grow
- 66% state that M&M meetings have had a positive impact on their job and the working environment department

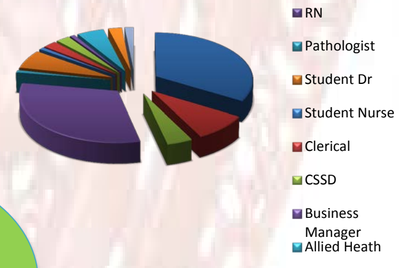
When asked, staff believed the purpose of the M&M was to improve safety and quality, improve the way we work together, learn and change outcomes.



Measuring results

Staff feedback shaped the format, style and feel of the M&M from the first meeting. Using a PDSA approach, feedback from every meeting was evaluated with changes to improve the document for users, participant experience, meeting flow or outcomes process were made to improve the meeting and staff engagement.

Distribution of staff disciplines during the pilot programme

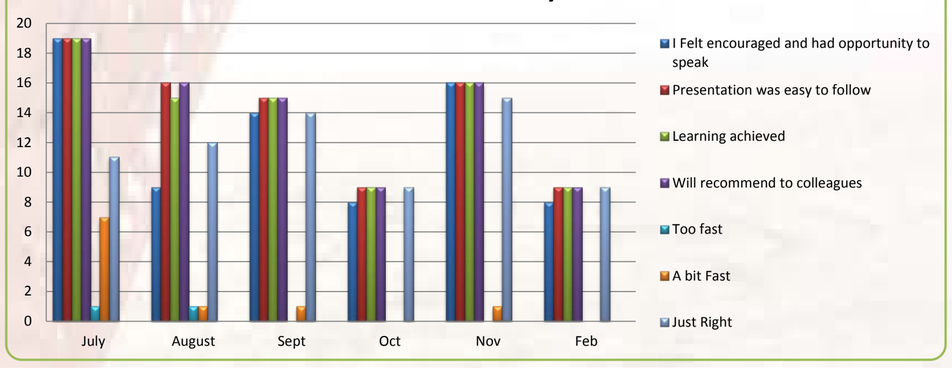


Average number of staff attending = 22

Examples of rapid cycle change and testing

Stakeholders told us …	Action we took before next meeting . . .
1. Inconsistent time spent on cases	1. Chair worked with presenters on content, Case Preparation Tool & time allocation
2. Hard to hear at times	2. Position presenter in different place, configure room to suit us, reinforced the business rules of 1 voice at a time
3. Invite other department staff relevant to case	3. Invited them, agree attendance when cases relevant to their actions occur
4. Meeting reminder out earlier	4. Regular electronic invite set up

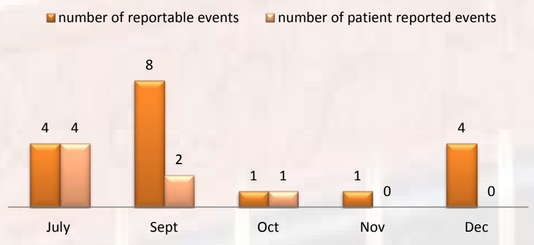
How I felt about today's M&M



How can our experience and outcomes can help others? Decreased patient-related adverse incidents reported for NSH Gastroenterology points to a trend of improved care. 6x more cases can be presented per annum compared to the previous system. There is active work on patient outcomes and system changes under review, monitoring and reporting with cycles of change. We believe we have developed, tested and evaluated a model that meets international best practice recommendations, is easy to implement and use, and produces a positive contribution towards improving outcomes and experiences for patients and staff.

The impact on adverse incidence

Gastroenterology Incident Reporting July - December 2017

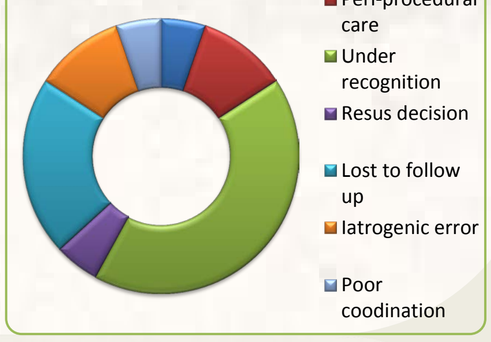


Tools in the 'M&M Toolkit' delivering a ready-to-go package for other services to use

Case presentation outcomes

- 18 cases reviewed in 6 months (previously 2 – 3 per annum)
- 5 deaths, 10 harm, 3 near-miss
- Broad range of case-types
- 38 recommendations generated
- 17 actions agreed from recommendations : 5% completed, 71% partially completed, 24% not yet started
- 59% of actions do not involve direct expenditure e.g. improve communication & care pathways

M&M agreement on outcome by type



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