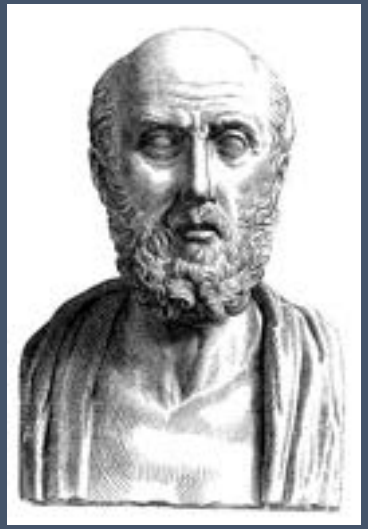
Morbidity and Mortality meetings

Effective or a waste of time and resources?

Thomas J Hugh MD FRACS
March 2023

"Life is short, art is long, opportunity fleeting, experience deceiving, and judgment difficult"

Aphorismi by Hippocrates



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RNSH Morbidity and Mortality meetings

Upper GI, Colorectal, Breast/Melanoma, Endocrine surgery

Is there a problem?

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Attendance at the M and M meeting 2022

Upper GI, Colorectal, Breast/Melanoma, Endocrine surgery

Consultants < 50% meeting attendance
- 12/20 (60%)

Consultants < 25% attendance
- 8/20 (40%)

- Trainees (Registrars and Fellows)
  - 50% attendance
- RMOs/interns/medical students
  - Almost never

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Ernest Amory Codman M.D.
(1869-1940)

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Ernest Amory Codman M.D.

Early advocate of the M and M meeting

Established the “End Results Hospital”

Site of the ‘Codman Hospital’, Boston

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Clinical audit versus M & M meeting?

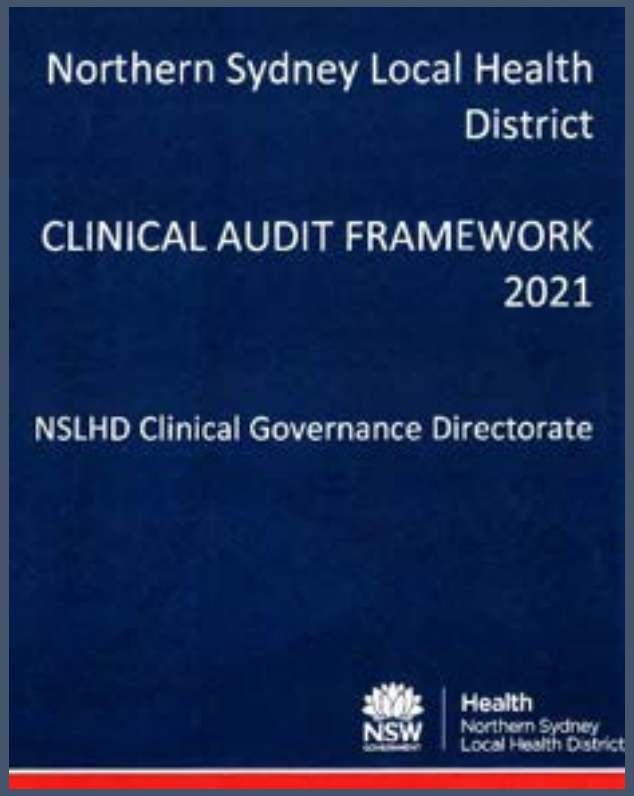
Clinical audit

- measures a clinical outcome or process against well-defined standards using the principles of EBM
- highlights discrepancies between actual practice and standard to identify changes needed to improve quality of care
- consists of a "quality audit cycle or loop"

Morbidity and Mortality meetings

- a forum where adverse outcomes are discussed
- potential to improve:
  - patient outcomes
  - quality of care
  - attitudes towards patient safety
- contribute to the education of clinical staff

Clinical audit



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ANZ Journal of Surgery

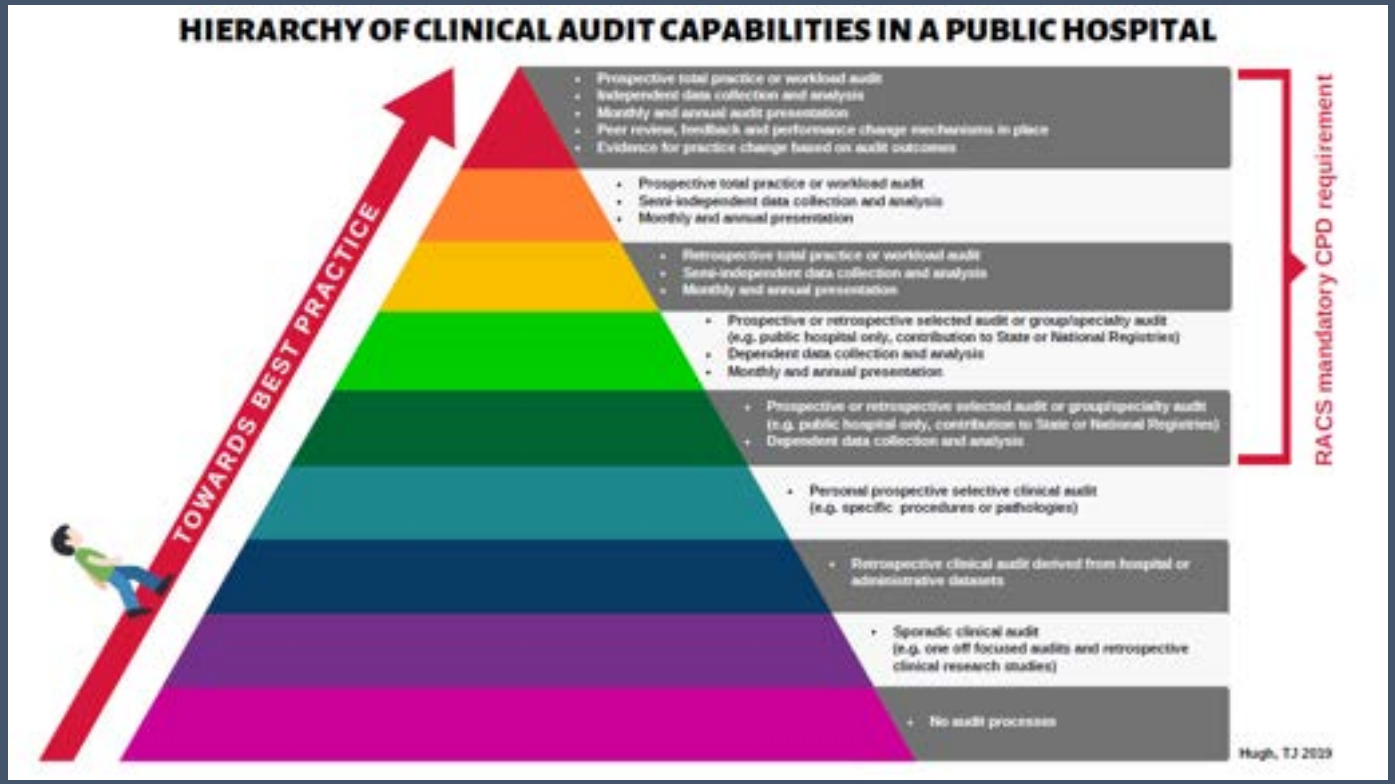
Royal Australasian College of Surgeons

PERSPECTIVE

Embedding a data culture in surgical practice: challenges and the need for a new approach

Maria Quilantang MBiostat, Thomas J. Hugh MD, FRACS

First published: 13 October 2020 | https://doi.org/10.1111/ans.16136



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What is an M & M meeting?

- Regular conference with a peer review discussion of issues that occurred during patient care where a complication or death occurred (negative outcomes)
- Enables learning from issues raised, by modifying judgment and clinical decision making
- Aims to prevent the repetition of these events, and thereby improve patient care
- Provide hospital administrators with an assurance that patients are not dying as a consequence of unsafe clinical practices!

Higginson et al BMJ Qual Safety 2012

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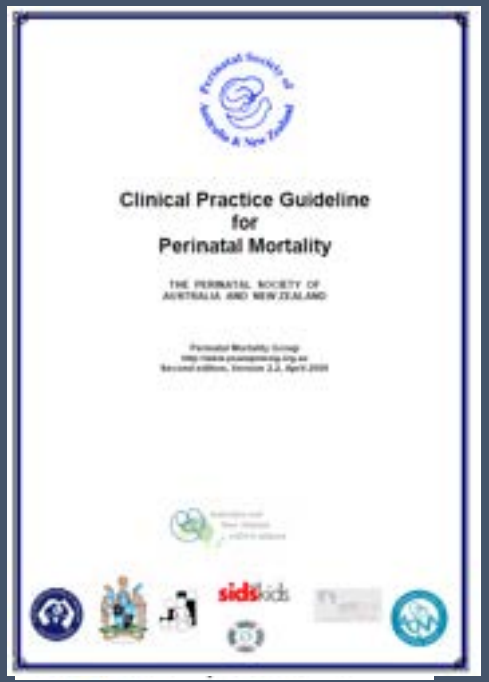
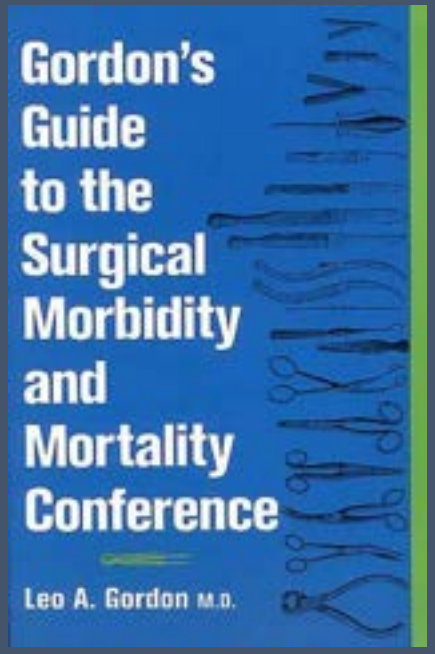
The Clinician's Toolkit
FOR IMPROVING PATIENT CARE
NSW HEALTH

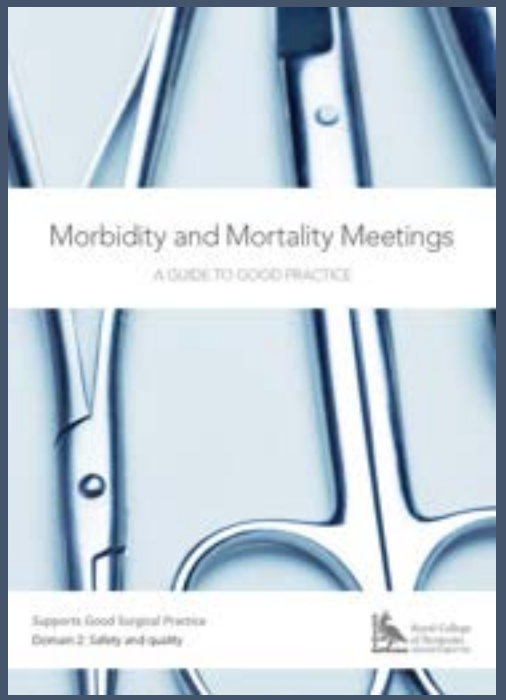

Recommended Guidelines for
Conducting and Reporting
Mortality and Morbidity / Clinical Review
Meetings
October 2016
CLINICAL
EXCELLENCE
COMMISSION

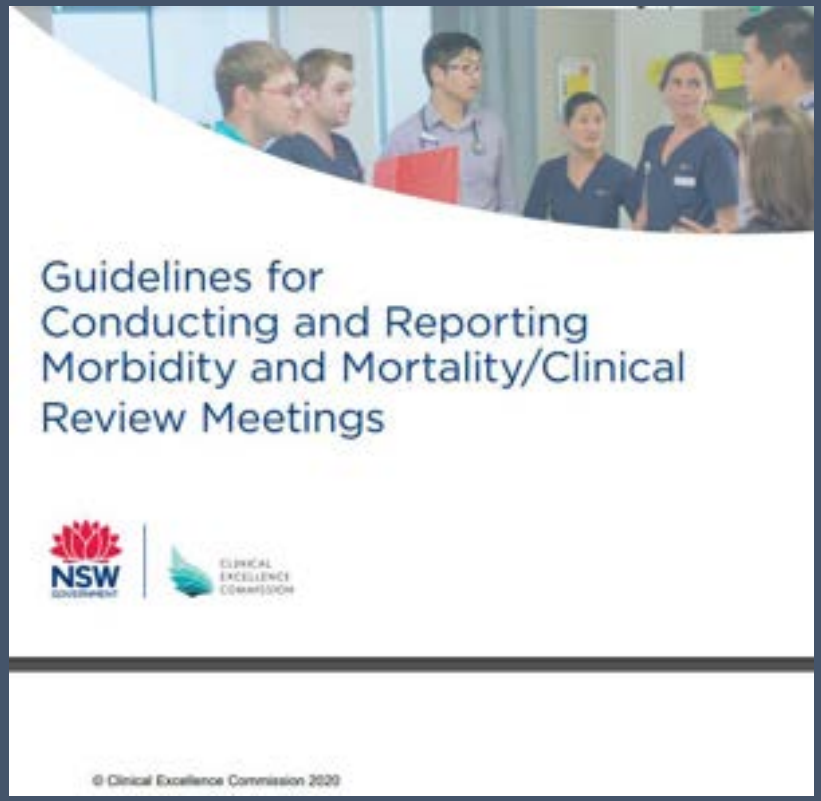

Royal Australasian College of Surgeons
Research, Audit and Academic Surgery


Clinical Practice Guideline
for
Perinatal Mortality
THE PERINATAL SOCIETY OF
AUSTRALIA AND NEW ZEALAND


Healthcare
Improvement
Scotland
Mortality and Morbidity
Reviews
Practice Guide – Working Version
NHS


Gordon's
Guide
to the
Surgical
Morbidity
and
Mortality
Conference
Leo A. Gordon M.D.


Morbidity and Mortality Meetings
A GUIDE TO GOOD PRACTICE
Supports Good Surgical Practice
Domain 2: Safety and quality



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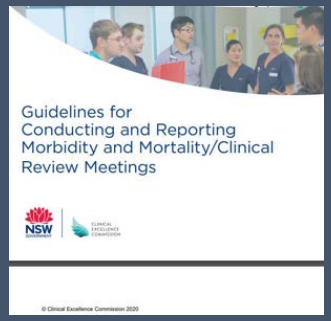

Purpose of M and M meetings

1. Review adverse clinical incidents and outcomes
2. Identify resilience in a complex system to enable positive outcomes in the face of challenges and uncertainty
3. Opportunity for clinical staff to engage in patient safety and quality improvement processes
4. Opportunity for education of all staff
5. Opportunity for senior staff to model appropriate professional behaviour

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Six core guiding principles in M and M meetings

Podcast

Guiding Principles of Morbidity and Mortality (M&M) meetings in action

Clinical Excellence Commission

https://podcasts.CEC Guiding principles of M and M meetings in action

Season one

- Episode one - Journey to a Restorative Just Culture (RJC)
- Episode two - Why is Restoring a Just Culture important?
- Episode three - Implementation of RJC
- Episode four - Insights from experiences implementing RJC

Season two

- Episode one - Facilitation standards in practice
- Episode two - Facilitation standards for psychological safety
- Episode three - Lesson learnt: Enhancing learning and managing difficult conversations

Season three

- Episode one - Right material: Choosing the right cases at the right time
- Episode two - M&M leadership: Choosing the right people
- Episode three - Safety Sciences and Human Factors in M&Ms
- Episode four – Vulnerability in leadership and MDT participation

Season four

- Episode one - Building understanding around error
- Episode two - War on error: Cognitive basis
- Episode three - Listen up for safety
- Episode four - Schism between quality and safety

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About the CEC · Keep patients safe · Review incidents · Improve quality · CEC Academy · Engage · Contact

Home ▸ Improve quality ▸ QIDS and QARS

Improve quality

- Quality Improvement Toolkits
- Teamwork, Culture and Person Centred Care
- QIDS and QARS
- National Safety and Quality Health Service Standards
- Clinical Leadership and Engagement
- Organisational Effectiveness
- Virtual care

QIDS and QARS

Quality Improvement Data System (QIDS)

The Quality Improvement Data System (QIDS) provides users at all levels of an organisation with a single point of access to information and tools for the purpose of improving the quality and safety of health service delivery. QIDS transforms data from several sources into a unified platform with standardised and customisable analytic and improvement tools. It enables users to translate raw data into insights such as current outcomes, trends over time, unwanted clinical variation, harm and outcome measures of improvement innovations.

QIDS can be accessed via NSW Health intranet, or internet for the Improvement Project module only. Local user access is managed by the Health Entity nominee and/or the Improvement Project Admin account holder.

Login to QIDS

QIDS training videos

The Clinical Excellence Commission (CEC) would like to acknowledge Northern Sydney Local Health District (NSLHD) in developing and producing the following QIDS training videos.

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M & M meetings

- Format
- Conduct
- Appropriate outcomes

Format

- A written charter (or terms of reference)
- An agenda distributed prior the meeting
- A regular schedule. Short and frequent, and timely
- Structured process for case identification (improve quality and consistency + ensure diverse selection)
- Highlight avoidable deaths and contributory factors
- Self-nomination of cases, including anonymously
- Multidisciplinary involvement, for staff that could benefit from the cases being presented

Conduct

- Should be more than peer review
- A structured case presentation format
- A focus on systems not individuals, or a central theme
- Confident facilitator who promotes openness and transparency
- A review of near-misses and close-calls
- A safe, blame-free environment

Appropriate outcomes

- Recommendations for individual/systems improvement made for each case
- A timeline and follow-up on recommendations for improvement
- A dedicated individual/group to implement recommendations for improvement
- Detailed records of M&M outcomes
- Integrate M&M meetings into the wider governance structures

Are we prepared to do this?
Should we do this?
If we don’t, what are the consequences?

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Are M & M meeting worthwhile?

- Prospectively collected data on surgical complications over 5 years from multiple New York hospitals (Antonacci et al 2009)
  - Mandatory M&M review process, surgeon 'report card' tool
  - 40 per cent reduction in gross mortality over 3 years
- Implementation of a structured M&M review process decreased anastomotic failure in colorectal surgery (Vogel et al 2011)
- May be a useful and effective tool for identifying areas for systems improvement
  - But only through changes to local practice protocols and guidelines and improved clinical practice
- May be a valuable education tool
  - Surveys consistently report that surgical and medical staff view structured M&M meetings to be valuable educational tools

A descriptive study of morbidity and mortality conferences and their conformity to medical incident analysis models: Results of the morbidity and mortality conference improvement study

Aboumatar et al. American Journal of Medical Quality. , 2007

- Wide variations in how M and M conferences are conducted
- No conformity to known models for analysing medical incidents
- 58% of department had a plan for assigning follow-up on recommendations BUT……
- Only 8% of departments had a standard approach for eliciting input from all providers
- Only 8% of departments had a structured tool to explore underlying system factors

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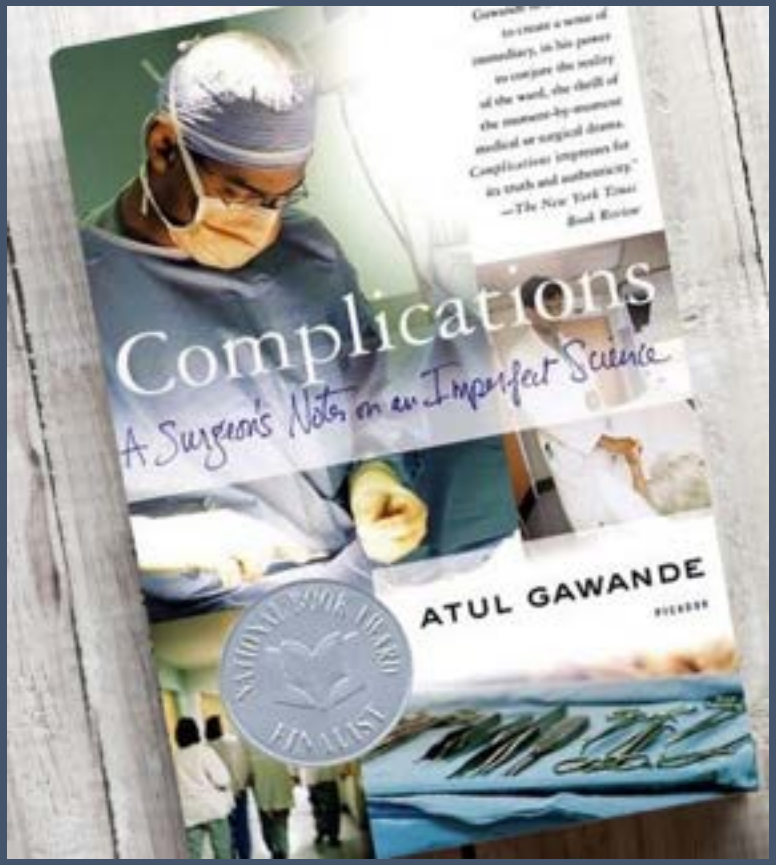

M&M meetings are *'a rather shabby approach to analysing error and improving performance in medicine'*

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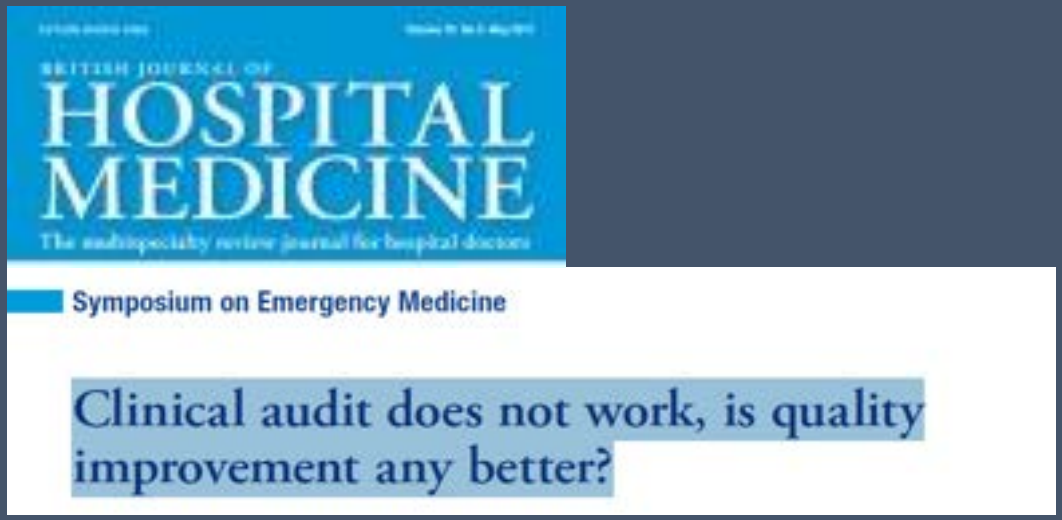

Boyle A, Keep J.
Br J Hosp Med (Lond). 2018 Sep 2;79(9):508-510.

- Clinical audit may be ineffective for improving care
- Quality improvement may offer a better way to improve care

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Barriers to an effective M and M meeting

1. Poor attendance
2. Not seen as core business
3. A lack of understanding around process – clinicians need training in quality improvement methods
4. Logistic issues – getting all relevant people in the room
5. Lack of faith about the process – negative perceptions
6. Heterogeneity in case selection, presentation and evaluation
7. Medico-legal concerns
8. Patient safety - how is this addressed and improved?

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Surgical M and M meetings at RNSH

What have we done in the past?

QaRNS program 1988-2007

- Dr Ross Wilson (Director, Quality Assurance RNSH)
- RNSH: first hospital to seek to measure its rate of adverse events
- A systematic clinical audit of the medical records of:
  - all patient deaths
  - unplanned transfers to ICU
  - unplanned returns to the operating room
- Medical records reviewed on a weekly basis by a Clinical Review Committee
  - representatives of senior management, nursing managers, ward nurses, junior doctors and consumers
- Monthly meetings run by Dr Wilson/Head of the Section

Joint Select Committee on the Royal North Shore Hospital

The Royal North Shore Hospital

Ordered to be printed 20 December 2007 according to Standing order 231

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- Dr Hoyle, the Director of Clinical Governance at NSCCAHS believes:
  - QaRNS is a ‘fantastic asset’ which he would ‘strongly recommend’ be utilised by the rest of the State
  - ‘Healthcare organisations should consider routinely using structured case note review on samples of medical records as part of quality improvements’

Recommendation 42

- NSW Health in conjunction with the CEC examine the use of systematic audits of medical records, such as QaRNS
- *While it would seem that valuable patient safety initiatives have been introduced to RNSH in recent years, the Committee heard from several clinicians who felt that the effectiveness of the patient safety program was compromised because the hospital did not ensure system improvements were implemented in response to healthcare incidents*

Surgical M and M meetings at RNSH

What do we do now?

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Audit of M and M activities in the RNSH DoSA

DoSA Department	M and M meetings	Formal process for selecting and discussing cases
A	No	N/A
B	Monthly	No
C	Every 2 - 3 months	No
D	Monthly	No
E	Monthly	No
F	Monthly	No
G	5 meetings per year	No
H	Quarterly	No
I	Monthly	No
J	Monthly	No
K	Unknown	Unknown
L	Sporadic quarterly	No
M	Monthly	No
N	Monthly	No
O	Unknown	Unknown
P	Weekly	No

Audit of M and M activities in the RNSH DoSA

DoSA Department	M and M meetings	Formal process for selecting and discussing cases
A	No	N/A
B	Monthly	No
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G	5 meetings per year	No
H	Quarterly	No
I	Monthly	No
J	Monthly	No
K	Unknown	Unknown
L	Sporadic quarterly	No
M	Monthly	No
N	Monthly	No
O	Unknown	Unknown
P	Weekly	No

Audit of M and M activities in the RNSH DoSA

The key points

1. A lot of clinical audit and M and M activity is happening (including Total Practice audit)
2. No structure around how clinical audits or M and M meetings are conducted
3. No department is doing routine independent or automated data collection
4. Some departments are doing almost nothing
5. There are sensitivities within some departments about the purpose of these processes

Health
NSW Northern Sydney Local Health District

NSRHS Quarterly Morbidity & Mortality Summary Report

..... Department / Service

..... (Insert dates for period under study)

General Morbidity & Mortality Information			
		Of the cases reviewed what were the:	
Number of cases reviewed:	_____	Number of medication incidents:	___
Number of cases unresolved:	_____	Number of infection control incidents	___
Number of 'rapid' death reviews:	_____	Number of communication incidents	___
Number of Coroner's reports:	_____	Number of blood & blood products incidents	___

Summary Of Key Issues Identified From Morbidity & Mortality Reviews
•

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RNSH Morbidity and Mortality meetings

Upper GI, Colorectal, Breast/Melanoma, Endocrine surgery

How robust is our M and M meeting?

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Systematic review of the function of M and M meetings

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Enabling characteristic	Bronze	Silver	Gold
Format			
Structured case identification	✓	✓	✓
Consistent, structured meeting format	✓	✓	✓
Regular meeting occurrence and duration	✓	✓	✓
Written terms of reference	✓	✓	✓
Prior dissemination of meeting agenda and cases to be presented	–	✓	✓
Inter-profession and multidisciplinary involvement	–	✓	✓
Appointment of specific M&M meeting personnel to manage administration and completeness of data	–	✓	✓
Self-nomination of cases	–	–	✓
Conduct			
Consistent, structured case presentation	✓	✓	✓
Safe, blame-free environment	✓	✓	✓
Systems focus	✓	✓	✓
Review of close-calls as well as formal M&M cases	–	–	✓
Outcomes			
Assigning a timeline (where necessary) to recommendations for improvement	✓	✓	✓
Assigning an individual/group to carry out recommendations for improvement	–	✓	✓
Detailed record keeping	–	✓	✓
Audit of M&M meeting procedures	–	–	✓
Follow-up on implementation of recommendations for improvement	–	–	✓
Ensuring recommendations for individual/systems improvement are made for each case			

Attainable standards for effectively run M&M meetings. *Vreugdenburg et al ANZJS 2018*

Enabling characteristic	Wooden spoon RNSH	Bronze	Silver	Gold
Format				
Structured case identification	X	✓	✓	✓
Consistent, structured meeting format	X	✓	✓	✓
Regular meeting occurrence and duration	✓	✓	✓	✓
Written terms of reference	X	✓	✓	✓
Prior dissemination of meeting agenda and cases to be presented	X	–	✓	✓
Inter-profession and multidisciplinary involvement	X	–	✓	✓
Appointment of specific M&M meeting personnel to manage administration and completeness of data	X	–	✓	✓
Self-nomination of cases	X	–	–	✓
Conduct				
Consistent, structured case presentation	X	✓	✓	✓
Safe, blame-free environment	X	✓	✓	✓
Systems focus	X	✓	✓	✓
Review of close-calls as well as formal M&M cases	X	–	–	✓
Outcomes				
Assigning a timeline (where necessary) to recommendations for improvement	X	✓	✓	✓
Assigning an individual/group to carry out recommendations for improvement		–	✓	✓
Detailed record keeping		–	✓	✓
Audit of M&M meeting procedures		–	–	✓
Follow-up on implementation of recommendations for improvement	X	–	–	✓
Ensuring recommendations for individual/systems improvement are made for each case	X			

Attainable standards for effectively run M&M meetings. Vreugdenburg et al ANZJS 2018

3. A Meeting Framework
Systematic agenda setting with support from clinical analytics

Minimum Standard	Gold Standard
Consistent, structured meeting format and agenda informed by key triggers and criteria developed for each meeting	Structured meeting format which reflects relevant issues in the clinical context and triangulated with other data sets
Key identifiable triggers and criteria include: • Complex presentations with multiple risk factors with positive outcomes • Clinical indicators which reflect performance • Adverse events (including serious morbidity) • Selected deaths and sentinel event • Patient Safety Incidents notified in IIMS & ims+ (e.g. Incident type Clinical Management) • Consumer or family/ carer feedback • Cases requiring Open Disclosure • Themes from Risk Register (at least annually)	Identifiable triggers and criteria to emphasise positive outcomes to enhance learning from what is done well
Access to automated processes that identify relevant themes and triggers that support a systematic case selection including: • Quality Improvement Data System (QIDS) • National Surgical Quality Improvement Program (NSQIP) • CEC Death Review database • Consumer or family/ carer feedback	Incorporation of objective analysis using available data, to place cases and outcomes within the broader context of overall performance and to reduce the impact of cognitive biases inherent in retrospective case consideration and discussion. Such analysis may include: • A literature review of available evidence • Statistical indicators of performance against agreed benchmarks, taking into account case-mix and local factors
Emphasis on themes identified rather than specifics of individual cases: looking for patterns across outcomes that can be translated into learning opportunities rather than for causes of individual outcomes	Establishing relationships with identified clinical analytics experts in local settings to enable access to meaningful and relevant data to enhance systematic processes
Reference to best practice, peer reviewed clinical guidelines, standards	Focused systematic or narrative reviews of the clinical literature and the evidence base for best practice, including the patient safety literature

Criticisms about the current meeting

- No clear and agreed reasons for having M and M meetings
- No guidelines for how to conduct the meeting
- Discussions of cases often not pursued in depth
- Lack of reference to, or perceived biased interpretation of the literature
- Environment not conducive to open discussion
- Presentations often do not provide lessons or insights for trainees or the hospital
- Poor attendance by trainees/RMO's/medical students

AIMS for future M and M meetings

- Develop a meeting environment conducive to open discussion without a sense of persecution
- Underpin discussions with accepted surgical principles especially in the case of complex, high-risk surgery
- For all members of all departments to feel the meeting is worthwhile
- To increase the attendance by:
  - improving structure of the meeting
  - Improving the quality of the discussions

PROPOSALS for future M and M meetings

- Define the reason for having the meeting, agree on attendance and participation
- Get upfront consultant agreement that there should be an atmosphere of appropriate **scrutiny** but with the ability for all discussants to comfortably contribute to the discussion (including junior staff)
- Introduce the concept of different ERRORS in routine discussion
  - All consultants accept error concepts as a way of learning and making change for future patients e.g.:
    - **No error** occurred
    - A **judgement error** occurred (selection for op, decision regarding re-intervention)
    - A **technical error** occurred
    - A **system error** occurred
  - Identify and rectify any identified **system** errors

Suggested specific actions

- Each subspecialty group to draw up a list of :
  - what is considered “standard” versus “non-standard” surgical care for each pathology
  - what is considered an “ideal” or “textbook” outcome versus a “non-textbook” outcome (e.g. operative time, LOS, complications, resection margin status etc.) for each of these pathologies
- Determine agreed upfront criteria for selecting cases for the meeting
  - independent of the treating consultant
- Suggested criteria for selecting cases for discussion
  - Any peri-operative death
  - Any unexpected death or major morbidity during a non-operative admission
  - Any major unexpected outcome during the post-operative hospital admission
  - Any unusual minor morbidity (eg. deep infection, thrombo-embolism, anaphylaxis etc.)
  - Patients should be bought back for repeat discussion/mention at the meeting if they continue to have a prolonged admission or are re-admitted within 90 days of their operation
  - Any other minor morbidity that the group wishes to flag or that is a KPI for either the department or the hospital

Suggested methods of discussion

- Chairperson to use standardised (and upfront agreed) questions to analyse the selected cases (attempt to diffuse bias, sense of persecution)
- Expectation that the individual (consultant or trainee) responding or presenting will justify responses with reference to common practice and the literature
- Chairperson will direct the discussion at his/her discretion
  - Issues of contention will be addressed by:
    - Documenting that there was a difference of opinion
    - The individual involved in the care (consultant or trainee) will make a short presentation at the next unit meeting to clarify the contentious issues
    - Another individual in the same sub-specialty will comment on the lack of bias in the overview
- Record the minutes of the meeting and consider presenting these on a regular basis to the Clinical Head of the DoSA or the RNSH Clinical Governance unit
- Consider inviting peer review consultants from outside RNSH to participate in the M and M meeting

Suggested standardised questions to be asked

- Was the presentation unusual?
- Was the case discussed at a multi-disciplinary meeting and what was the consensus and why?
- Was the indication for surgery appropriate?
- Was the timing of surgery appropriate?
- Was there appropriate work-up for the patient?
- Was the patient prepared for potential problems?
- What are the risks and benefits of the operation versus the alternative options?
- What was the consensus of any MDT meeting discussions
- What are your previous results with similar cases in the unit?
- Is this approach considered standard by national and international standards?
- Where there any technical problems during the procedure?
- Was there a variation on the accepted technical approach?
- Was the appropriate post op documentation and care given?
- Were post operative complications recognised in a timely fashion?
- Were complications and management options entertained?
- Was there a problem with decision making regarding post operative complications?
- Was there adequate co-ordination of care between the trainee and consultant, or between two consultants?
- Were the relatives fully informed of the patient's likely prognosis and then post-operatively their progress?
- Was an autopsy discussed?
- What lessons were learnt from the complication? What can be done to prevent this occurring again?

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.

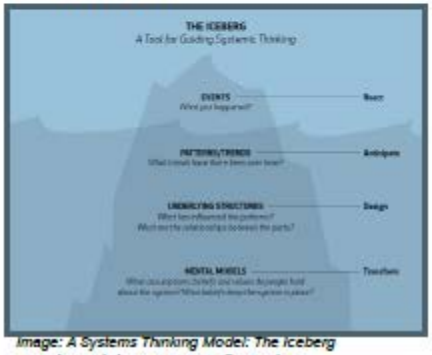

Image: A Systems Thinking Model: The Iceberg
Used with permission from Northwest Earth Institute, www.nwei.org/iceberg/

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.
Released February 2016. © Clinical Excellence Commission. SHPN (CEC) 160061

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Morbidity and mortality conferences in general surgery: a narrative systematic review Slater et al Can J Surg 2020

MMC problems and recommended interventions

Problem	Recommendation
How to improve education value of MMC	• Enforce a time limit < 15–20 min • Standardize presentations with a PowerPoint template or SBAR format • Dedicated moderator to facilitate discussion • Target discussion questions to specific audience members or use an audience response system • Assign all unanswered questions as a research question to learners to be reported at the next MMC
How to improve error analysis	• Focused discussion on causative factors • Taxonomic error analysis
How to better represent morbidity and mortality with case selection	• Use an electronic database (e.g., NSQIP) to identify cases for presentation • Dedicated moderator to select cases for presentation
How to improve MMC attendance	• Teleconferencing for geographically separated centres • Plan MMCs in the morning before operating hours
How to improve continuity and dissemination of MMC content	• Create and circulate newsletters that highlight salient points of each MMC • Distribute surgeon report cards that detail quality-dependent factors that may have contributed to adverse events

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Do I have to attend M and M meetings?

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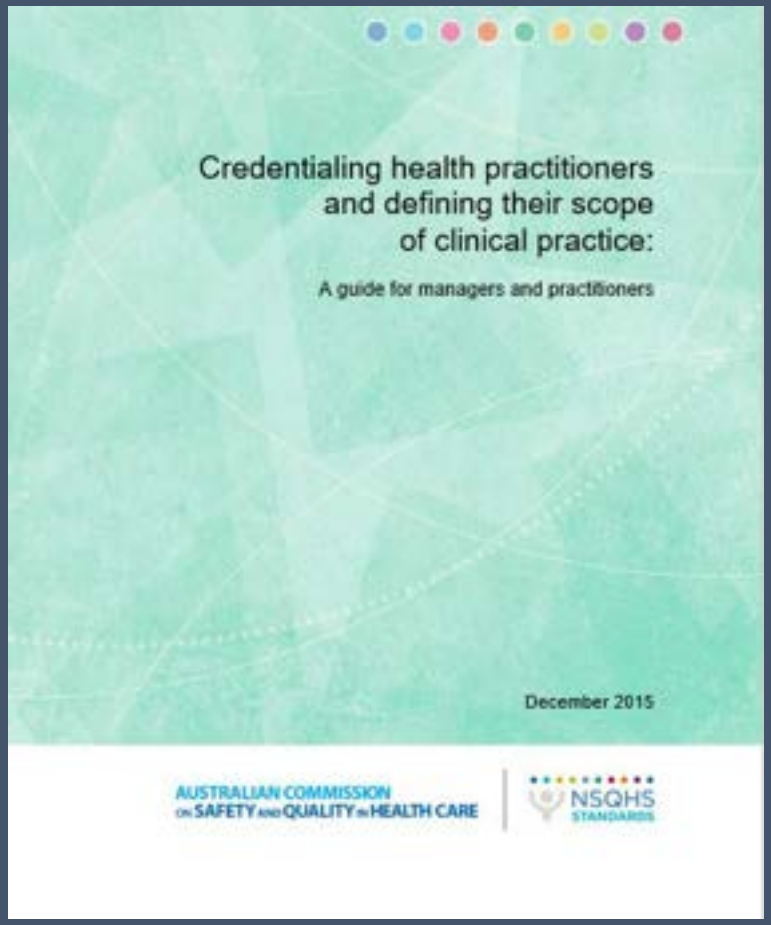
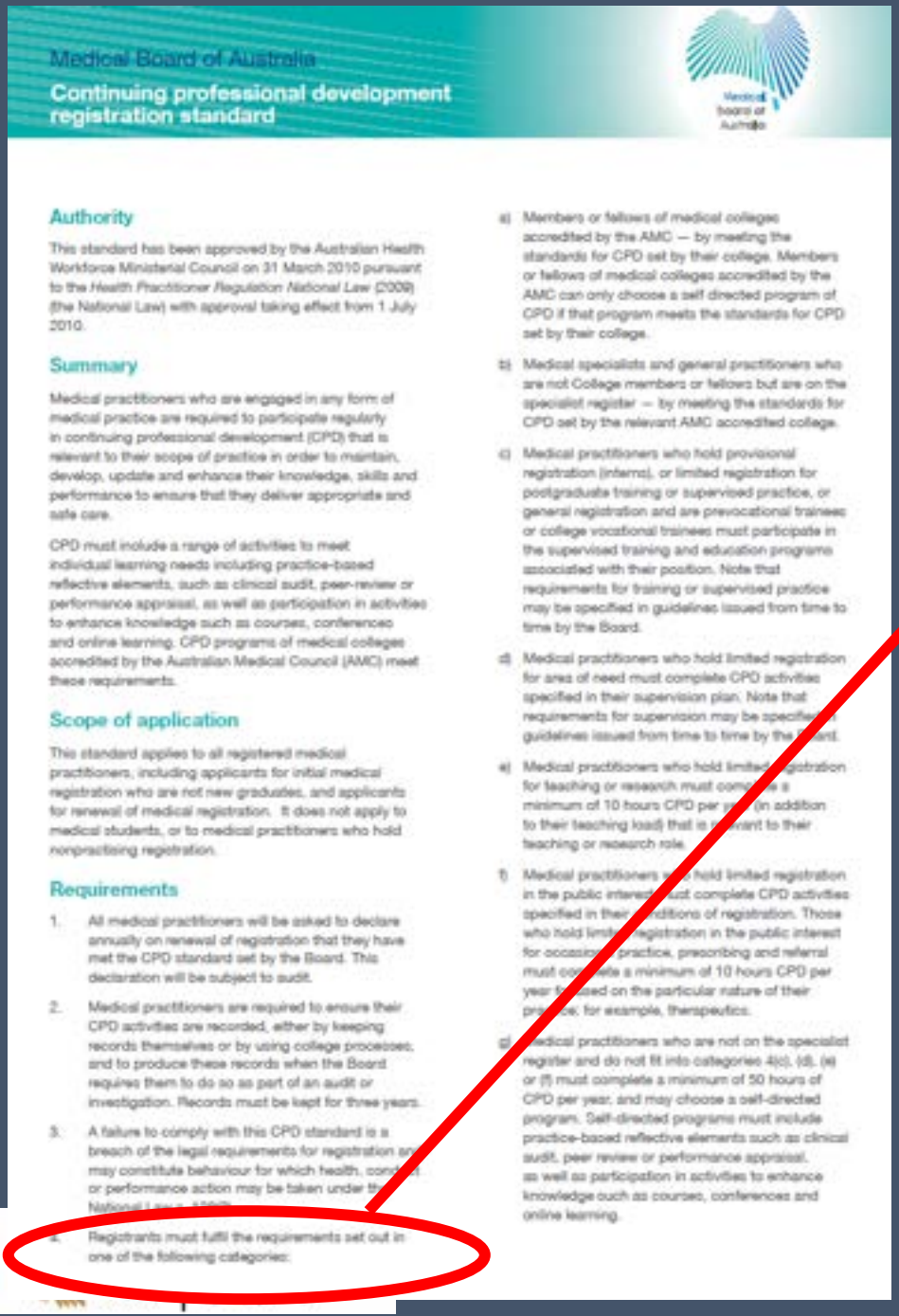


3.2	Scope or practice requiring specific credentialing	Participation in quality and safety activities, including morbidity, mortality, and clinical incident reviews



Medical Board of Australia

Continuing professional development registration standard

Authority

This standard has been approved by the Australian Health Workforce Ministerial Council on 31 March 2010 pursuant to the *Health Practitioner Regulation National Law (2009)* (the National Law) with approval taking effect from 1 July 2010.

Summary

Medical practitioners who are engaged in any form of medical practice are required to participate regularly in continuing professional development (CPD) that is relevant to their scope of practice in order to maintain, develop, update and enhance their knowledge, skills and performance to ensure that they deliver appropriate and safe care.

CPD must include a range of activities to meet individual learning needs including practice-based reflective elements, such as clinical audit, peer review or performance appraisal, as well as participation in activities to enhance knowledge such as courses, conferences and online learning. CPD programs of medical colleges accredited by the Australian Medical Council (AMC) meet these requirements.

Scope of application

This standard applies to all registered medical practitioners, including applicants for initial medical registration who are not new graduates, and applicants for renewal of medical registration. It does not apply to medical students, or to medical practitioners who hold nonpractising registration.

Requirements

1. All medical practitioners will be asked to declare annually on renewal of registration that they have met the CPD standard set by the Board. This declaration will be subject to audit.
2. Medical practitioners are required to ensure their CPD activities are recorded, either by keeping records themselves or by using college processes, and to produce these records when the Board requires them to do so as part of an audit or investigation. Records must be kept for three years.
3. A failure to comply with this CPD standard is a breach of the legal requirements for registration and may constitute behaviour for which health, conduct or performance action may be taken under the National Law or AHPRA
4. Registrants must fulfil the requirements set out in one of the following categories:

a) Members or fellows of medical colleges accredited by the AMC — by meeting the standards for CPD set by their college. Members or fellows of medical colleges accredited by the AMC can only choose a self directed program of CPD if that program meets the standards for CPD set by their college.

b) Medical specialists and general practitioners who are not College members or fellows but are on the specialist register — by meeting the standards for CPD set by the relevant AMC accredited college.

c) Medical practitioners who hold provisional registration (interns), or limited registration for postgraduate training or supervised practice, or general registration and are prevocational trainees or college vocational trainees must participate in the supervised training and education programs associated with their position. Note that requirements for training or supervised practice may be specified in guidelines issued from time to time by the Board.

d) Medical practitioners who hold limited registration for area of need must complete CPD activities specified in their supervision plan. Note that requirements for supervision may be specified in guidelines issued from time to time by the Board.

e) Medical practitioners who hold limited registration for teaching or research must complete a minimum of 10 hours CPD per year (in addition to their teaching load) that is relevant to their teaching or research role.

f) Medical practitioners who hold limited registration in the public interest must complete CPD activities specified in their conditions of registration. Those who hold limited registration in the public interest for occasional practice, prescribing and referral must complete a minimum of 10 hours CPD per year focused on the particular nature of their practice, for example, therapeutics.

g) Medical practitioners who are not on the specialist register and do not fit into categories 4(c), (d), (e) or (f) must complete a minimum of 50 hours of CPD per year, and may choose a self-directed program. Self-directed programs must include practice-based reflective elements such as clinical audit, peer review or performance appraisal, as well as participation in activities to enhance knowledge such as courses, conferences and online learning.

Requirements……

4. Registrants must fulfil the requirements set out in the following categories:

a) Members or fellows of medical colleges accredited by the AMC by meeting the standards for CPD set by their college.

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REGISTRATION STANDARD: CONTINUING PROFESSIONAL DEVELOPMENT

What happens if I don't meet this standard?

The National Law establishes possible consequences if you don't meet this standard, including that:

- the Board can impose a condition or conditions on your registration or can refuse your application for registration or renewal of registration, if you don't meet a requirement in an approved registration standard for the profession (sections 82, 83 and 112 of the National Law)
- a failure to undertake the CPD required by this standard is not an offence but may be behaviour for which health, conduct or performance action may be taken by the Board (section 128 of the National Law), and
- registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct for health professionals (section 41 of the National Law).

More information

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Clinical Excellence Commission. 2016. Guidelines for conducting and reporting Mortality & Morbidity / Clinical Review meetings

All clinical departments are expected to adhere to the following principles:

- M & M/clinical review meetings should be held on a regular, scheduled basis
- Should be multidisciplinary, including clinicians from nursing, medical and allied health

Continuing Professional Development Guide

Service
Integrity
Respect
Compassion
Collaboration

SURGICAL AUDIT AND PEER REVIEW

- Undertake a peer reviewed Surgical Audit and participate in ANZASM where available

CLINICAL GOVERNANCE & QUALITY IMPROVEMENT

- Hospital or clinical meetings that focus on improvements in clinical care
- Meetings reviewing adverse events and instituting action to remedy systemic faults

COMPLIANCE

- Non-compliance with CPD is regarded as a breach of the Code of Conduct and will trigger a response as outlined in the College's Sanctions Policy
- All Fellows should be aware that the ultimate sanction under this policy is loss of Fellowship including notification to the appropriate registration authority

NSW Patient Safety and Clinical Quality Program

Policy Directive

NSW GOVERNMENT

Patient Safety and Clinical Quality Program

Summary	The Patient Safety and Clinical Quality Program provides a framework for significant improvements to clinical quality in our public health system.
Document type	Policy Directive
Document number	PD2005_608
Publication date	26 July 2005
Author branch	Clinical Excellence Commission
Branch contact	02 9269 5500
Review date	01 December 2020

"……. each Local Health District to have a system in place for conducting a timely review of the medical record of all patients who have died whilst receiving care within its facilities"

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CHASM
Collaborating Hospitals Audit of Surgical Mortality

COLLABORATING HOSPITALS' AUDIT OF SURGICAL MORTALITY (CHASM)

PROGRAM REPORT FOR

SYDNEY LOCAL HEALTH DISTRICT

2014

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Commonwealth Qualified Privilege Protection

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Commonwealth Qualified Privilege Protection

- Quality assurance activities in Australia (including M and M meetings) receive Commonwealth Qualified Privilege Protection – that means discussions related to sensitive clinical issues cannot be used against a clinician in a court of law
- Clinicians who do not attend regular M and M meetings may be in breach of their local Hospital's quality assurance requirements and the RACS CPD requirements
- By non-participation clinicians may negate the Qualified Privilege Protection provisions. Theoretically, case notes and discussions from the M and M meetings could be subpoenaed

Conclusions

- Don’t avoid M & M meetings – prioritise this activity
- Learn to value M & M meetings and contribute to making them more effective
  - It is not just about your patient or your department
  - Make a contribution to education and patient safety in the hospital
- Demand hospital administrations/clinical governance units provide specific funding to support robust M & M activities (e.g. secretarial, organisational support, communication etc.)

Morbidity and Mortality meetings

Effective or a waste of time and resources?

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