# Record of learnings, recommendations & action monitoring report template

The M&M meeting record of learnings template is designed to be used as a written record of the meeting. Staff attendance should be recorded on this template. It will then serve as evidence of attendance for continuing professional development requirements.

An important aspect of the M&M meeting record of learnings is the action monitoring table, and documentation of any developed recommendations and actions from new cases discussed. Documenting these allows recommendations and actions to be tracked and reviewed to ensure their implementation has successfully occurred. It allows increased prioritisation for key risks, team collaboration, and promotes graded escalation as required to higher governance levels, including executive/board, where barriers to completion are identified.

The minimum requirements are:

* Meeting date, time, location
* Meeting attendees
* Action monitoring table
* Summary tables of mortality cases & cases chosen for further review/discussion
* Brief summary of each case discussed:
  + Anonymised for both patient and staff involved.
  + Summary of meeting discussion focusing on the systems factors that contributed to events rather than individual practice/performance.
  + Consensus summary of contributory factors (positive and negative) and lessons learned, including any recommended further reporting requirements and actions for improvement.
  + Proposed recommendations, actions, and assigned person(s) responsible for ensuring these are completed within the specified timeframe.
* Next meeting date, time, place

It is highly recommended that there is also some reporting of department-specific key performance indicators against local or national benchmarks (where available), as this helps to place cases and outcomes in the broader context of overall performance.

The record of learnings should be circulated following every M&M meeting, to all staff with a membership role (as defined in your department’s M&M ToR), and to any multi- or interdisciplinary staff involved in the patient care of reviewed cases. They should also be forwarded and saved centrally, via an established clinical governance process, to the organisation’s Quality department (or similar unit). This will improve organisational governance oversight, process support, and accountability.

# (*Insert unit*) M&M record of learnings report

## (insert month & year)

OFFICIAL

|  |  |
| --- | --- |
| Time and date |  |
| Location |  |
| Presenter |  |
| Attendees |  |
| Apologies |  |

## Action monitoring

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Recommendation | Outstanding Actions | Barriers to completion | Person responsible\* | Timeframe/ due date |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

\*This person is responsible for implementing recommendations, and feeding any actions required both UP to higher governance levels, and reporting back DOWN to the departmental level.

## Unit Key Performance Indicator (KPI) monitoring

(Delete this box prior to using)

Insert chart/table with relevant unit statistics

i.e. Unplanned return to theatres, surgical complications, access block, left without being seen, 72-hour representations

Benchmark this against similar health services where possible

## Mortality Review

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date | Age | M/F | Cause of death | Death classification\* | Referred to Donate Life | CoronersY/N |
|  | 86 | M | Out of hospital cardiac arrest | 1b | Y | N |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

\* 1a. Anticipated/Expected death e.g. disease progression,

1b. Death post out of hospital cardiac/respiratory arrest,

2. Not unexpected death, occurred despite known preventative measures taken in an adequate and timely fashion

3. Unexpected death not reasonably preventable with clinical intervention

4. Unexpected death unrelated to illness progression, different from expected outcome, preventable and steps not

taken to prevent it

5. Unexpected death resulting from medical intervention

## Morbidity & Mortality Review

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Case | MRN | Incident report no. | Incident date | Type | Brief description of event |
| 1 |  | Insert VHIMS/ SIRS # |  | Morbidity | e.g. medication error delayed recognition of ….., iatrogenic injury to ….. etc. |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |

Case 1: e.g. Medication Error (delete this text before distributing this document)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Summary | Paragraph description of course of events. Stick to facts only here.  Delete this text before distributing this document | | | |
| Systems lessons learned:  Factors that did not go well | Use systems-focused case analysis tool to identify systems factors (positive and negative)  e.g. access block, staff skill mix/shortage  Delete this instruction text before distributing this document | | | |
| Systems lessons learned:  Factors that did go well | Use systems-focused case analysis tool to identify systems factors (positive and negative)  e.g. deterioration recognised in a timely manner, good use of available policies/algorithms  Delete this instruction text before distributing this document | | | |
| Discussion points: |  | | | |
| Mortality case | Death classification:  1a. Anticipated/Expected death e.g. disease progression  1b. Death post out of hospital cardiac/respiratory arrest  2. Not unexpected death, occurred despite known preventative measures taken  in an adequate and timely fashion  3. Unexpected death not reasonably preventable with clinical intervention  4. Unexpected death unrelated to illness progression, different from expected  outcome, preventable and steps not taken to prevent it  5. Unexpected death resulting from medical intervention | | | |
| Coroners Y  N | Office Chief Psychiatrist Y  N | | |
| Morbidity/ Mortality case | ISR classification  1  2  3  4  N/A  SIRS Classification  1  2 | VHIMS/ SIRS (aged care) completed:  Y  N  VHIMS/ SIRs ID: | | If no - person responsible for completion: |
| Meets Sentinel event criteria:  Y  N | Date reported:  By whom: | | |
| Meets SDC (SAPSE) criteria:  Y  N | Date reported:  By whom: | | |
| Open disclosure required:  Y  N | Date performed:  By whom: | | |
| Recommendation/ Action | Delete or add ‘Item’ and ‘Action/Person responsible/Deadline’ rows as required.  Delete this instruction text before distributing this document | | | |
| Person responsible |  | | **Deadline** |  |
| Recommendation/ Action |  | | | |
| Person responsible |  | | **Deadline** |  |

Case 2:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Summary |  | | | |
| Systems lessons learned:  Factors that did not go well |  | | | |
| Systems lessons learned:  Factors that did go well |  | | | |
| Discussion points: |  | | | |
| Mortality case | Death classification:  1a. Anticipated/Expected death e.g. disease progression  1b. Death post out of hospital cardiac/respiratory arrest  2. Not unexpected death, occurred despite known preventative measures taken  in an adequate and timely fashion  3. Unexpected death not reasonably preventable with clinical intervention  4. Unexpected death unrelated to illness progression, different from expected  outcome, preventable and steps not taken to prevent it  5. Unexpected death resulting from medical intervention | | | |
| Coroners Y  N | Office Chief Psychiatrist Y  N | | |
| Morbidity/Mortality case | ISR classification  1  2  3  4  N/A | VHIMS/ SIRS (aged care) completed:  Y  N  VHIMS/ SIRs ID: | | If no – person responsible for completion: |
| Meets Sentinel event criteria:  Y  N | Date reported:  By whom: | | |
| Meets SDC (SAPSE) criteria:  Y  N | Date reported:  By whom: | | |
| Open disclosure required:  Y  N | Date performed:  By whom: | | |
| Recommendation/ Action |  | | | |
| Person responsible |  | | **Deadline** |  |
| Recommendation/ Action |  | | | |
| Person responsible |  | | **Deadline** |  |

# (insert month & year) Recommendation/Action Summary

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Recommendation | Action Required | Person responsible | Timeframe for completion | Theme |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |