| **ACTION PLAN SUMMARY FORM** |  |
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| **Name of Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Province\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of mortality audit meeting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Review action at follow-up M&M meeting** |
| **Finding to be improved** | **Action to be taken**  | **Level where action is required**  | **Deadline**  | **Person responsible for making change**  | **What action was taken and what is the outcome?**  |
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| Name: Signature: |