| **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: | | | | | |