Child mortality review meetings

Introduction

Clinical mortality review meetings are very useful for quality improvement in hospitals, and for identifying public health priorities in the community. If conducted appropriately audit meetings help identify patterns of morbidity and mortality; health service weaknesses and strengths; they can suggest appropriate interventions to prevent avoidable deaths, and the process of ongoing audit can assess their effects. Audit should not be a complicated exercise. Where time is short having a structured weekly meeting where there is honest, open and confidential discussion about the deaths and ways to improve practice can be very effective. This can be a great support to nursing and junior staff. In some hospitals it is relatively easy to identify problems, and even to propose solutions, but making sustained changes to clinical practice will be more challenging. If interventions are proposed that cannot be implemented this can be demoralizing. It is important therefore to focus on feasible interventions and have some true successes, to give staff confidence in the audit process. Individuals need to be given the responsibility for making changes, and to report back to the audit meeting as the process occurs.

General principles of holding an audit meeting

- Hold regular meetings: sustainability is more likely if there is a commitment by staff to be present at a regular time every week.
- As time is often limited it is better to audit a few deaths in detail and come up with good resolutions for improvement, rather than all deaths superficially.
- Confidentiality: encourage open discussion inside the meeting, but no discussion of specific cases outside.
- Attendance should be voluntary but strongly encourage all staff to attend. Audits should involve all clinical staff; nurses, doctors, registrars, residents, allied health staff. Effective audit meetings require active and voluntary participation of staff.
- Be non-blameful and non-threatening, and welcoming to all staff.
- The team leader should be open about declaring his/her own failings: we all make mistakes, and we should be able to learn from them. Admitting where we could do better can put junior staff at ease and make people more open to communicate.
- Audit meetings should have a strong educational function; take the opportunity to use case examples to teach on subjects that are relevant to improving quality of care.
- Use a team approach to identifying and solving problems: get a wide spectrum of views on the cause and prevention of adverse events.
- Be respectful and acknowledge all health workers' efforts. Try to understand how others are feeling, especially if they have been caring for a child who has died.
- Move from specific cases to general issues.
- Look for common patterns of avoidable events; don't just react to a single rare mistake or event.
- Do not single out individuals for blame. The team leader should emphasize how 'we' could do things better, or where systems can be improved.

- Consider the entire health system when trying to understand avoidable factors in deaths, not just referral-level hospital care, but what changes might be needed in health centres, or preventative health care, or referral services, or education in the community.
- During each audit meeting comment specifically on 'things that went right'. Complement health workers on their successes.
- Emphasize the *survival rate*: if the mortality rate was 5%, then *95% of children admitted survived* to discharge.
- Suggest feasible and affordable changes in clinical practice, rather than repeatedly identifying problems that cannot be remedied because of external or financial constraints. 'Do what is doable' and monitor to see if quality of care improves.
- Have clear resolutions about action items and who will do them, and timelines.
- Review all previous weeks' audit resolutions and follow up to determine if these were carried out.
- Acknowledging the cleanliness of the ward can be a boost to the morale of ancillary and cleaning staff; they too need to be acknowledged for their vital role in good patient outcomes.
- Have a focus on things that are not directly related to deaths, but improve quality, including having a child friendly environment.

Forms for child mortality auditing and review meetings

01 The Death registrar form is held in the ward, and the names of children who died are recorded. This is so that at the designated time in the week that the audit meeting is going to be held, you will have a list of the cases for discussion. This form is taken to the meeting to ensure that all cases are discussed.

02 The Child Mortality Reporting Form is the main form used at the weekly audit meeting to record information about the case. It is best if the person who is coordinating the meeting fill some of the demographic information in before the meeting, so the meeting can focus on discussing the story, and determining if there are any avoidable factors, and what action needs to be taken.

03 The Cause of death codes is a list of standardised diagnoses. These are common in PNG, and all are included in the PHR. This is in an effort to assign an accurate and standardised cause(s) of death.

04 The Action plan summary form is a summary each week of the meetings resolutions, which should be reviewed at the next and subsequent meetings to determine if the required action was taken. Over time, by filling out this form and reviewing all outstanding actions, it should be possible to determine if progress is being made.

Prioritising cases to review

When there is limited time it is important to *review deaths from which the most lessons can be learnt.* Although all deaths can teach us something, in very busy wards we may need to

prioritise. As time is often limited in audit meetings it is better to audit and discuss one or two cases in depth and come up with good resolutions for improvement, rather than a large number of cases superficially.

Some criteria for selecting cases to review in detail include:

- The death was unexpected
- The death occurred after complications
- The death occurred after surgery or a procedure
- The death occurred in the first 24 hours of hospitalisation
- Staff or family have raised concerns about the death
- There is uncertainty about the events leading up to the death
- The case was complicated and required many decisions
- Sometimes it can be useful to review a cluster of several similar deaths
- The case illustrates a possible deficit in case management, or health care provision

Sometimes audit meetings spend a lot of time discussing the presentation of the case or the diagnosis. Ideally most of the audit meeting should be spent discussing the lessons learned and the changes that may prevent deaths or adverse outcomes in the future, and how to implement them.