Systems –Based Practice:

Patient-Safety:

Using the table below, review one of your inpatients that had an unexpected outcome or complication (may be procedural related).

MORBIDITY/ MORTALITY REVIEW WORKSHEET

DMC/WSU SINAI-GRACE HOSPITAL EMERGENCY MEDICINE

RESIDENCY PROGRAM

Month Event Occurred:

Day of the Week Event Occurred:

Site Event Occurred At: SGH HV-SH CHM

Patient Last 4 digits of Medical Record/FIN#:

Date of Admission: **Date of Event (Expiration or Adverse Event):**

Admission Diagnosis: **Diagnosis following event or expiration:**

Chart Review Questions:

Please answer: Yes No Not Sure Elaborate as needed

1) Was the patient admitted? If so, to what service??
2) Did the event (adverse event or death) occur within 48 hours of admission?
3) Was there an MICU consult placed in the ED? Was the patient accepted to the MICU from the ED?

4) What adverse event did the patient have potentially as a result of the error?
5) Was the patient's death a direct result of presenting illness?
6) Was the patient's death related to an unexpected complication?
7) Was the standard of care demonstrated by the provider(s)?
8) Was death preventable?
9) Was death due to an adverse event?
10) If death was due to an adverse event, (check all that apply) :

- Delay in diagnosis
- Premature closure of possible diagnosis
- Error in interpretation of data/diagnostic studies
- Procedural error
- Delay in action/intervention
- Medication error (How so? Dose? Drug interaction? Inadequate monitoring?) Was Pharmacist involved in the care?

11) If error or adverse event, was there any documentation of disclosure (Was patient or family informed? If so, how? If not, why?)

12) Was an autopsy requested?

13) Was an autopsy performed?

14) What did you learn from the experience that will help prevent a similar error from occurring in the future?

Comments:

Recommendations:

System Solution: