

Morbidity & Mortality Rounds

A Quick Reference Guide

P. Benassi, L. MacGillvray, I. Silver, S. Sockalingam



This guide is intended to highlight key aspects of M&M Rounds to be considered when developing local program initiatives.

Setting Objectives and Group Norms

Why organize M&M Rounds (MMR)? M&M Rounds can be powerful opportunities for learning and reflection with the goal of improving patient care. Having clear objectives and goals for conducting MMR will help with achieving the intended outcomes of these rounds. ¹

- Will it be focused on medical knowledge, system-based thinking, quality improvement or a combination of these?
- Who is the potential target? E.g. physicians, allied health, trainees, etc.

How to set-up a Safety Culture? One component of any health care "system" is its culture, defined as the shared ways of thinking, acting, and interacting among a group of individuals. This can be articulated during MMR, for example, "Create a learning environment where experiences are shared in order to explore how care is delivered within a system of care". For a review of individual and group best practices associated with a learning culture, see article by Hoff et al. (2005): <http://www.ncbi.nlm.nih.gov/books/NBK20470>

Case Selection

What makes a good case? Depending on the objectives of the MMR, one might choose to explore any case with an adverse outcome, or select ones that are preventable and highlight specific learning objectives (e.g. system issues). In either scenario, it will be helpful to develop an operational definition for "adverse outcome". A good resource is A.H.Q.R. Glossary:

https://www.psoppc.org/c/document_library/get_file?uuid=4a938a4c-5828-4e4d-b6bc-b5832d4fbf9a&groupId=10218

Where to look for cases? Cases can be found from multiple sources including incident reports, divisional departments, program directors, and individual care providers (e.g. nurses, physicians, residents, pharmacist, etc.).

How much information is needed around a case? When investigating a case for MMR it is helpful to utilize different sources of information in order to conduct a comprehensive case analysis (e.g. medical record, interviewing individuals directly involved, etc.)¹

Presentation

Who to invite? Since medical errors occur within a system, reviews are best done through inter-professional conferences.¹

How to discuss the case? Review cases using a standardized format that allows time for case description, systematic analysis and time for group discussion. It is helpful to have at least one assigned facilitator who orients participants to the goals and norms of MMR, manages time, facilitates discussion, and summarizes lessons learned. For issues pertaining to QCIPA legislation, please refer to the QCIPA Guide: <http://www.psychiatry.utoronto.ca>

What has been shown to not be helpful in MMR? Impeding factors have included non-standardized presentations, inadequate discussion time, degeneration into a lecture, lack of clearly stated objectives or lessons learned¹

Case Analysis

How to review cases? To encourage comprehensive, system-level case review it's helpful to utilize theories based on Root Cause Analysis (RCA). RCA involves asking the questions (See Table 1):

- What happened?
- How did it happen?
- Why did it happen? Consider Individual, Task, Team and Organizational Factors

What tools can be used? There are a variety of tools that prompt reflection on the different contributory factors or conditions in which error may occur.⁴ These include 5 Whys, Fishbone Diagrams, Mind Maps, and Process Maps (see Table 2 & Figure 1)

Follow-Up

How can MMR bridge education and quality improvement? MMR can help identify care issues that are amenable to change and improvement. It is helpful to summarize lesson learned and possible change ideas from the session.¹

How to strengthen MMR ability for change? Role of formalized and dynamic pathways for knowledge translation from MMR to a Quality of Care Committee or other Department Administration is vital to support quality improvement initiatives being implemented¹

Measuring Outcomes

How to know if MMR are working? Plan to assess a variety of outcome measures to evaluate if the MMR is achieving the objective and goals of the activity. These could include self-reports of learning and competence to actual patient outcomes (e.g. changes to system leading to improved care outcomes)



References

1. Benassi, P., MacGillivray, L., Silver, I., & Sockalingam, S. (2015) Understanding the Role of Morbidity and Mortality Rounds in Psychiatry: A Systematic Review of Implementation and Educational Outcomes.
2. Hoff, T.J., Pohl, H., & Bartfield, J. Implementing Safety Cultures in Medicine: What We Learn by Watching Physicians. In: Henriksen K, Battles JB, Marks ES, et al., editors. Advances in Patient Safety: From Research to Implementation (Volume 1: Research Findings). Rockville (MD): Agency for Healthcare Research and Quality (US); 2005 Feb. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK20470/>
3. Agency for Healthcare Research and Quality. (March 2010). Glossary: AHRQ Common Formats Version 1.1. Retrieved from the web October 13, 2015 from: http://www.psoppc.org/c/document_library/get_file?uuid=4a938a4c-5828-4e4d-b6bc-b5832d4fbf9a&groupId=10218
4. Root Cause Analysis: Tracing a Problem to its Origins. Mind Tools. Retrieved from the web October 10, 2015 from: https://www.mindtools.com/pages/article/newTMC_80.htm

Appendix

Table 1. Contributing Clinical Factors

Framework of Factors Influencing Clinical Practice & Contributing to Adverse Events		
Framework	Contributory Factors	Examples of Problems that Contribute to Errors
Institutional	Regulatory Context Medico-legal Environment	Insufficient priority given by regulators to safety issues; legal pressures against open discussion, preventing the opportunity to learn from adverse events
Organization and Management	Financial Resources & Constraints Policy Standards and Goals Safety Culture and Priorities	Lack of awareness of safety issues on the part of senior management; policies leading to inadequate staffing levels
Work Environment	Staffing levels and mix of skills Patterns in workload and shift Design, availability, and maintenance of equipment Administrative and managerial support	Heavy workloads, leading to fatigue; limited access to essential equipment; inadequate administrative support, leading to reduce time with patients
Team	Verbal Communication Written Communication Supervision and willingness to seek help Team Leadership	Poor supervision of junior staff; poor communication among different professions; unwillingness of junior staff to seek assistance
Individual Staff Member	Knowledge and skills Motivation and attitude Physical and mental health	Lack of knowledge or experience; long-term fatigue and stress
Task	Availability and use of protocols Availability and accuracy of test results	Unavailability of test results or delay in obtaining them; lack of clear protocols and guidelines
Patient	Complexity and seriousness of condition Language and communication Personality and social factors	Distress; language barriers between patients and caregivers; acuity

Table 2. System Audit Tools

System Audit Tools		
<p>Fishbone Diagram</p> <p>A cause-and-effect diagram where the “head” of the fish represents the adverse outcome or systems problems and the “bones” represent contributing factors</p>	<p>Mind Map</p> <p>A diagram representing relationships between a systems problem and its root causes. The adverse outcome or problems is typically depicted in the center with contributing factors branching outwards to multiple levels.</p>	<p>Flow/System Map</p> <p>A diagram depicting the stepwise sequence of elements in a system; similar to a flow chart. Often used to identify unnecessary or redundant steps in a process</p>

Figure 1. Example of Fishbone Diagram

