Nursing M & M conference: Help in healing from a serious event

Your OR has had an adverse event. A debriefing has been held with those involved, and a root cause analysis has been performed. Systems issues have been identified, and process improvements are underway.

But how do you get the word out to other nurses and physicians that the same kind of event could happen to anyone—including them? How do you help drive the message home?

The perioperative nursing team at the University of Michigan (UM), Ann Arbor, has begun holding M & M, or morbidity and mortality, conferences for the nursing staff and has discovered the conferences are a powerful method for learning and healing.

For years, physicians have held M & M conferences as a structured forum for discussing cases in a nonthreatening environment. The purpose is to learn about system problems and how to prevent them in the future.

UM’s nursing M & M conferences not only have yielded process improvements but also have given staff who were involved in serious events a chance to share their stories and to heal.

“Nursing hasn’t typically done M & M conferences. As we talked about sentinel events, we realized there was an opportunity to do a QI/QA review in a nursing setting and discuss these events,” says Shawn Murphy, RN, BSN, MSM, CNOR, director of nursing for the OR/PACU and associate hospital administrator.

The idea developed from a journal club discussion of a 2006 article about nursing M & Ms in the American Journal of Critical Care, which outlined a template for M & M conferences. Bruce Angel, CRNFA, an RN first assistant who leads the club, suggested the idea to Murphy, and they decided to try it.

As of June 2010, UM has held 3 perioperative nursing M & M conferences, 2 of which have focused on serious events. The conferences are held during the OR’s weekly education hour on Thursday mornings and are attended by the perioperative nursing staff.

Plan carefully

The M & M conferences must be planned carefully and provide support for the staff who present the M & M cases, Murphy cautions.

“We focus on what happened, the systems issues, and what could have prevented the situation as soon as possible after the event,” notes Kathy Lanava, RN, BSN, CPHRM, a risk management specialist with a background in perioperative nursing who has helped guide the effort.

To introduce the M & M concept to the staff, Angel offered to lead the first
conference, which focused on a transvenous pacing miscommunication and some missing supplies. The case purposely was not as complex or emotionally intense as others that would come later.

Nurse managers met with the staff beforehand to explain what an M & M conference is. They noted that it is not punitive and does not involve the HR department or the union.

“We really stressed in this first meeting that this was nonjudgmental with a focus on systems issues,” Lanava says.

The first M & M

The first M & M conference started with a PowerPoint that explained the M & M concept and how the conference would be conducted.

Lanava says, “The point is to look at events that had occurred, learning opportunities, and how we could improve our systems. “It was also to say that we support you for sharing your experience so that someday we don’t have to walk in your shoes.”

Angel then presented the pacing case, describing what had happened and how the staff had handled it. He suggested reasons why the event occurred and possible solutions and opened the floor for discussion. One staff member offered a solution others hadn’t thought of, and Angel said he would work on it. At the next M & M conference, he was able to report that the solution had been implemented.

That continuity is important. “Bruce came back to discuss how he had followed up, the corrections he made, and the gaps that were closed,” Murphy says.

Focusing on a serious event

The second M & M conference was more intense, focusing on a wrong-site surgery that had involved an experienced team during an emergency.

So far, the M & Ms for serious events have followed the department’s review, which includes a debriefing, generally held within 24 hours of the event, and a sentinel event analysis led by the Office of Medical Affairs. For the debriefings, employee assistance personnel are available to provide staff support.

Again, the leadership team planned ahead for the nursing M & M, with a meeting to decide on the format and who would be present. They decided the case should be presented by a panel of the nurses and surgical technologists involved in the event. They considered asking the surgeon to participate but decided not to do so for this conference, though Murphy says all members of the perioperative team are welcome.

“We wanted the staff to talk about it from their perspective and to focus on the nursing issues,” Lanava says.

The leaders then met with the staff involved to see if they would be willing to participate.

“They all said yes because they didn’t want anyone else to experience what they had been through,” says Murphy.

A powerful gift

Murphy started the M & M conference by introducing the panel.

“All I could say was what a powerful gift this was for these individuals to tell their story. What an opportunity for them to share their experience, albeit difficult, to improve patient care,” she says.
The panel then shared their stories and talked about what they could have done differently. Tissues were available, and tears were shed both by the panel and the audience.

She says lessons learned focused on maintaining standardized work during emergent procedures because deviation from the standard work on all levels resulted in the wrong-site surgery.

In every M & M conference, Murphy says solutions, or countermeasures, are proposed by the presenters and staff. These are then recommended and tested as part of the OR’s improvement process, which has a heavy focus on Lean principles and understanding human factors.

“We are looking for gains every time on how we can create a safer practice and a better environment for our patients and our staff,” she says.

**Stories as a teaching tool**

The stories that come out in the M & M conferences have a powerful teaching effect, Lanava notes. With the stories, “the staff have an appreciation for why we are making a change. There is a reason behind it.”

Since then, two other nursing M & M conferences have been held on serious events in the OR.

The Risk Management Department supported and approved video recording of the M & Ms so they can be shared with staff who were not present.

“We felt that if a legal case were to come out of this, their stories would come out,” Lanava says. “So we felt recording and sharing this was far more important than any legal case.” But in the end, the video camera malfunctioned.

**Advice to consider**

Murphy, Lanava, and Angel offered advice for others who would like to consider holding nursing M & M conferences. Two key points:

- The organization must truly have a nonblaming culture.
- Staff who are involved in serious events must receive support.

The underpinning of a nonblaming culture is essential, Murphy emphasizes. At UM, all activities related to serious events are nonpejorative, including the debriefing and sentinel event analysis as well as the M & M conferences.

Support for the staff is equally important. “The staff is the second victim” of any serious event, Lanava observes.

Employee assistance personnel are on hand after serious events as well as to help staff who were involved in the event to prepare for the M & M conferences.

Other key advice: Seek support from the organization’s risk management experts. Make sure solutions brought forth in the M & M conferences are seriously considered as part of the department’s performance improvement process.

Now that UM has some experience with nursing M & M conferences, it seems “like a no-brainer that this is part of any nursing department or unit,” Angel comments.

Murphy adds, “Once you get your feet wet in the process, you say, ‘Why wouldn’t we do this? We have been missing an opportunity.’”
References

