The morbidity and mortality (M&M) conference is a traditional forum that provides clinicians with an opportunity to discuss errors and adverse events. Most are discipline specific.

When a mortality or significant morbidity occurs in the OR, however, it is rarely owned by a single discipline. Multiple disciplines take care of the same patient at the same time and from very different vantage points.

Because of this, perioperative services at Vanderbilt University Medical Center (VUMC), Nashville, Tennessee, replaced its M&M conference with a multidisciplinary M&MI review that focuses on safety, quality, and the value of the team in the care and management of patients.

“We added the ‘I,’” says David Wyatt, MA, MPH, BSN, RN, CNOR, administrative director of perioperative services, “because ‘I’ means improvement to us.”

The goal is to not just have a discussion of mortality and morbidity but to pull from that any kind of improvement that needs to be made, Wyatt told OR Manager.

Flow chart helps selecting cases
A small group that includes Wyatt and other surgical and anesthesia quality officers selects cases to present at the multidisciplinary M&MI conferences from options given to them by the quality and risk management departments. This group also invites the speakers who will present the cases.

“We pick the cases we feel represent what we most want to have a discussion about from a multidisciplinary standpoint,” says Wyatt.

To ensure the cases are indeed related to system issues and not individual errors, the quality and risk management departments use a flow chart adapted for VUMC from the UK National Health Service, National Patient Safety Agency, Incident Decision Tree (sidebar, p 18).

“It helps us weed out the issues that are about an individual’s practice rather than a system issue,” says Wyatt. “It also helps find system problems that appear to be discipline specific but aren’t.”

For example, he says, they have reviewed cases they thought were discipline specific, but when they looked further, the problem was that the providers weren’t communicating with anyone, and that caused the morbidity. “That’s a system issue that needs to be discussed,” he says.

Mechanism for communication
The M&MI forum provides a mechanism for communication between surgical specialties—known as pods at VUMC.

The pods have become a great tool for managing competencies for each service, but they can also be a problem, says Wyatt. “They start to function like their own hospital and their own world.”

This structure can make it difficult to communicate an issue that is more system-
The flow chart used to choose cases to present at the quarterly perioperative multidisciplinary M&MI conferences at Vanderbilt University Medical Center, Nashville, Tennessee, consists of four tests.

**Deliberate harm test**
Ask: Were the actions as intended? If the answer is Yes, and the person intended to do the action and intended to harm the patient, the flow chart leads down to bad intent.

If adverse consequences were not intended, which is most of the time, the chart leads to the next test. (Not a case for M&MI review.)

**Physical/mental health test**
Ask: Does there appear to be evidence of ill health or substance abuse? If Yes, ask: Does this individual have a known medical condition? Answers of either Yes or No lead to the next test. (Not a case for M&MI review.)

**Foresight test**
This test helps to understand the application of policies and procedures. Ask: Did the individual depart from agreed protocols or safe procedures? If Yes, ask: Were the protocols and safe procedures available, workable, intelligible, correct, and in routine use? If Yes, ask: Is there evidence that the individual took an unacceptable risk? If No, go to the next test. (Not a case for M&MI review.)

**Substitution test**
Ask: Would another individual coming from the same professional group and possessing comparable qualifications and experience, behave in the same way in similar circumstances?

This test, says David Wyatt, MA, MPH, BSN, RN, CNOR, administrative director of perioperative services, is the most meaningful for him. “I ask myself, if I pull that person out, and put a comparable professional in, would the same thing possibly happen?” If the answer is No, then it’s about individual related issues.

If the answer is Yes, it’s an issue that is system related and needs to be reviewed from a multidisciplinary standpoint. (A case for M&MI review.)
atic and not specific to one service, he says.

VUMC, the only level I trauma center in middle Tennessee, has 53 adult onsite ORs that are in seven primary procedural locations and 15 ORs in three freestanding community ambulatory centers. Last year, more than 35,000 procedures were performed onsite. This does not include pediatric procedures, which also are substantial.

OR team members consist of 350 surgeons, fellows, and residents; 300 anesthesiology faculty and staff; and more than 800 nurses and surgical, clinical, and anesthesia technologists.

Because of the number of professionals caring for patients in such a large setting, not everyone will know the important issues or understand them, even if they know, says Wyatt. “The M&MI conference gives us a way to reach everyone and communicate the important issues.”

Need to speak up

M&MI conferences are held quarterly, and about 800 people attend, including surgeons, residents, medical students, anesthesiologists, nurse anesthetists, nursing leaders, nursing staff, surgical technologists, and perfusionists. “This makes for a robust discussion,” says Wyatt.

The conference is held from 6:30 am to 8 am on the first Friday of the quarter. No cases are scheduled during this time.

Despite the robust discussion, however, Wyatt says he finds it troubling that very few nurses speak up. “When a case is presented, a lot of our surgeon and anesthesia colleagues will discuss and ask questions about why this occurred and give suggestions about what we could do better, but very few times do we have nurses who speak up,” he says.

Because of this reluctance, Wyatt has made it his job as the leader of the clinical nursing staff to speak up if there is something that needs to be addressed from a nursing standpoint.

The nursing profession has failed nurses, says Wyatt, in that they are not taught to review morbidities and mortalities, and they are not taught how to deal with adverse events and outcomes the way physicians are.

Attending M&M conferences throughout medical school and residency offers physicians a significant benefit because it gives them a critical view of an incident so they will know how to prevent it in the future, he says.

Nursing M&M

To encourage nurses to add their voices to the M&MI conferences, Wyatt started a quarterly M&M conference for perioperative nursing staff.

The discussions focus on issues that are part of nursing practice, such as integrity of the sterile field, counts, and retained surgical items. Occasionally, specific cases also are discussed. The OR directors, quality consultants, risk managers, and Wyatt select these cases to review.

The nursing M&M conference is a mechanism for dispersing information about an event or near miss, as well as the patient and staff involved, Rachael Poff, RN, CNOR, told OR Manager.

When an event or near miss happens, a root cause analysis is performed and then all involved discuss the cause and how to prevent it from happening again. But a lot of times that discussion hasn’t been shared with the rest of the nurses, says Poff, orthopedic nurse manager at VUMC.

“Bringing this information to all the staff at the nursing M&M takes away the
secrecy about incidents,” she says. “It may have happened in someone else’s room today, but it could very well happen in your room tomorrow.”

When there was a lot of concern about the risk for retained surgical items, discussion at the nursing M&M conference helped the staff understand the role played by nursing practice in this risk and what the improvement process steps were going to be, says Poff.

“We made sure everyone got the same message from what we identified in the root cause analysis and what processes were being changed.”

This forum gives all nurses an opportunity to understand an issue and how the process can be improved, says Poff.

Nursing M&M conferences are a valued opportunity to engage staff in exploring adverse events and to promote transparency and a nonpunitive culture. ✤

—Judith M. Mathias, MA, RN

References


