Creating safety in M&M discussions with Andrea Christoff & David Sweeney

Episode one - Facilitation standards in practice

Debbie: I'm Debbie Draybi from the Clinical Excellence Commission welcome to Podcast Series one of the Guiding principles of effective Morbidity and Mortality in action. This series is on Creating safety in M&M discussions and is a three-part series around the themes of facilitation, psychological safety and lessons learnt from experience of supporting the leadership in M&Ms.

Debbie: Today I have joining me two leaders in this field around facilitation and Morbidity and Mortality meetings: I have David Sweeney from HETI who's the director in Leadership and Dr Andrea Christoff, who's the Medical Co-Director at the Children's Hospital at Westmead.

Debbie: Thank you David and Andrea for joining us today and they will be sharing their insight and experience into facilitation. David will talk specifically around HETI's facilitation standards and will explore with Andrea her experiences around facilitation in supporting and enhancing leadership in M&Ms. David comes with significant experience in leadership and facilitation. He's a Capability and Capacity facilitator and has a strong background in leadership in the public sector, both in the UK and also in Australia.

Dr Andrea Christoff trained in Paediatrics in the United States and has completed her Fellowship training in Emergency Medicine, and Intensive Care at the Children's Hospital at Westmead. Andrea has a strong interest in safety and quality in healthcare and will today talk to us about her experiences in leading M&Ms and supporting conversations around improvement in M&Ms. Without further delay, I'd like to hand over to David and Andrea who will have a conversation about their experiences around facilitation in M&Ms. So, thank you both for joining us here.

David: So, by way of introduction, I thought I'd start by saying something about the work that we've been doing in the leadership team at HETI, looking at this issue of facilitation because, for us, there is a very strong and powerful link between the targeted use of facilitation and the exercise of leadership. And I think that this topic that we're talking about today, which is M&M meetings, is a really great example of where highly effective facilitation can really make an important difference. So, I wanted to start, Andrea, by asking you something about how the area of M&M meetings first came to your attention and why you thought this might be a good opportunity for bringing in some stronger facilitation skills.

Andrea: Thank you, David. So, the background for me, I think, started with me doing a lot of education-based simulation and debriefing. I've had some advanced training in debriefing processes and when I first moved to Australia, I was attending both morbidity meetings and mortality meetings across different departments. I guess the thing that stood out to me was that they were very siloed conversations that weren't including all the disciplines, for example in the meeting, and so for me it was a goal to bring multi-disciplinary M&Ms to my department so that we could then try to explore what's happened with events - what went well, what could be improved - and look at it from a very structured systems improvement perspective. So I think the debriefing background in simulation has actually engaged me into the process of facilitating in the M&M's and developing that structure.

David: Yes, and what was it when you first started attending M&M meetings that you noticed about the way those meetings were being conducted that you thought that there's an opportunity here to do something different?

Andrea: So in one of the first meetings that I attended there was a case that was presented around the death of a child and there were some discrepancies between the management strategy for the patient and it was very clear that there were some mistakes that had been made and I just felt as though the conversation was very circular and we weren't really getting to the point of it. And when I just used my radical candour to say, well, it looks to me like there was an error in what happened, I immediately got shut down by both the medical staff and the nursing staff in the room because it was a no-go space in which they didn't want to talk about that. And so, there wasn't a structured safe way that we could explore the events that happened around the death of this child that we could learn from. And so, for me, that was the nidus, if you will, for wanting to develop a space where we could actually explore, in a meaningful way, that was safe for staff to actually talk about.

David: So I really like your phrase 'radical candour' because I think people often think that, in order to talk about some of those taboo areas, it requires enormous bravery and courage and, in fact, the only way to do it is to end up getting people off side or being very confrontational. But I get the sense from what you're describing there is that you've been applying some tools to surface some of these difficult subject areas in a way which keeps people in the room - if you like – and keeps people still engaged with the content.

Andrea: Yes, I think it's about the way they want you to frame it and so on the back of going to some of these earlier meetings and, using the structure of the CEC guidelines for the M&Ms, we've actually developed a very structured way in which we approach every meeting. We open it up and try and provide some safety science and talk about some themes in anticipation of the cases. We relate that to actual data of what we know what's happened in the intensive care unit. For example, over the last couple of months looking at how we are benchmarking against other centres and other departments, contextualises it a bit in that sense. And then we move into talking about the cases and using that very straightforward approach, recognising that things went well, but then also being just direct about what didn't go well and actually having a conversation about it and then trying to bring people into that space to talk about it, which is not easy, particularly if you don't have everyone in the room. So I guess that was one of the other things that I struggled with when I first started going to these meetings several years ago was that it was just within one department, and so it's really difficult to talk about a case openly and transparently if you don't have everybody in the room. So, for example, if a patient transverses through the emergency department to the intensive care unit to the operating theatre to the ward and then goes home, that patient has travelled through potentially multiple teams.

So in order to actually talk about that case - whether it's a morbidity case or mortality case or a combination of both - I feel like you need to have all the players in the room to have a very robust, rich conversation because you can't make assumptions about what other teams

were thinking when they developed the management strategy for the patient. I think we always go back to the basic principle that everybody comes to work to do the best that they can for the patients and that the decisions that were made in the moment were made for a reason. And we need to be able to explore that with the people that were involved.

David: Well, I think that's a very interesting point that you touch on there, which is very relevant to good facilitation practice, which is taking that position which attributes reasonableness to other people and their position and their actions in the time, but also what they have to say about it afterwards that starting from a position where you take seriously those different contributions, that you delay judgment about whether that was the right thing to do, or that it could have been done better until the full picture is explored. Of course, the point you make about having everybody there is going to be very important in constructing that picture, because otherwise, if certain individuals or certain parts of the system are not there, then you're going to make those assumptions, aren't you?

You're going to say, well, we assume that those people were behaving in this way or took those decisions. But their voice is not part of the conversation. So, the point you make about making sure that everybody contributes to those reflective discussions seems to me to be incredibly important. What, though, has been the most difficult thing - in terms of the changes that you made - or the ways in which you've restructured the meetings, or re-designed the meetings - what have been the points where you've encountered most resistance, or where it's been most difficult to engage people in a different way of holding these types of meetings?

Andrea: So, I think before we started doing morbidity meetings, we only did mortality, so we were only talking about the death and the process of end of life in the intensive care unit. So, 18 months ago we introduced morbidity and talked about themes. We thought that that was really important to actually theme the cases. For example, like failed extubations or readmissions to the intensive care unit. And then we'd use a case that was around that and I think at the beginning it was kind of shifting from just talking about mortality and what happened around the death of this child to actually taking a deeper dive into a morbidity case and looking at contributing factors. So, there was a bit of resistance to use the systematic approach, but we've gotten over that over the last year and people have embraced it. I guess the challenging thing for me is we get quite a lot of feedback that we haven't gone into the case in enough detail and we haven't got around to talking about the issues enough. And when you have that time pressure of an hour to 90 minutes to go through themes, talk about safety science, do a bit of morbidity, do a bit of mortality, how do you find that balance?

As far as buy-in goes, we have a really good group of clinicians, where both medical, nursing and allied health are very keen to come. It's one of our most attended meetings. With some of them being zoom meetings - because of COVID - we have 45 to 50 people just coming to our local M&Ms. We circulate the minutes to everyone that's attended. So as far as barriers are concerned, I think we're still probably not there with the psychological safety and actually really getting into some of the issues and speaking about them in an open and

transparent way, and I think that that's just going to take time and again is linked to the culture outside of the meetings. It's just a process that we're working on, and that's probably the biggest barrier for us.

David: Yes, and the other thing that you mentioned, when you were talking about stakeholders, was bringing in people all along the patient's pathway. Do you find that bringing in, I suppose, people who are not directly connected to your unit but have had some involvement in caring for that patient along the journey is challenging? Bringing in these external parties to your unit, does that get in the way of people being open and honest about what's happened?

Andrea: I think again it goes back to the functional relationships and in intensive care we're very integrated with all the other teams because the patients are in ICU and they've got multiple teams coming in and out. So again, it's that relationship outside of the meeting and then that reflection before the meeting. So, for a case, for example, that involved an oncology patient, we'd meet with the oncology team to say we're going to present this case. These were themes that came up for us, and we just wanted to give you some time to reflect before we have the meeting, so no one's really dumped on. unprepared for this session. Again, I think because our relationships with those outside teams are so integral, there is that mutual respect in the room. Sometimes not, and we recognise that, and you can tell when there's a shift in the meeting and it's very superficial. People aren't really talking about the issues, and someone doesn't feel safe to bring it up or say what they think, and to me, that's a fail. That's a meeting where we could have prepared in a different way or we need to actually reflect on why that happened in the way that it did. So yes, it's a work in progress.

David: It sounds like one of your guiding principles for the way in which the meeting gets conducted is that this is a learning space and some of the other ideas that you've mentioned about sending people articles or sending people links to new guidelines that what you're creating there is a space for which people can get a benefit even if they weren't directly involved in the case themselves. There is always a learning opportunity for people, and I suppose it seems to me that that should be the primary purpose of those meetings.

Debbie: Thank you for listening to this podcast with Dr Andrea Christoff and David Sweeney on Creating safety in M&M discussions I hope you enjoyed it. Please note this is one of a three-part series and I hope you listen to the other two segments as Andrea and David continue the conversation on the power of effective facilitation to enable psychological safety in M&M meetings. Listen in as David and Andrea discuss their insight and lessons learnt from experience of supporting the leadership in M&Ms.

Debbie: I'm Debbie Draybi from the Clinical Excellence Commission and am pleased you can join us in this conversation with senior leaders on Guiding principles of effective Morbidity and Mortality in action. This podcast series aims to explore the experiences and insight from leading M&M meeting. Look out for more podcasts as we continue this conversation and clinicians share their journey and learning. I hope you find it useful and if you would like to contribute to this conversation please contact me.