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

Episode two - Facilitation for psychological safety

Debbie: I'm Debbie Draybi from the Clinical Excellence Commission and I am pleased you can join us for this three-part podcast series with Dr Andrea Christoff and David Sweeney. This podcast is part two of a part series on Creating safety in M&M discussions. In this segment Facilitation for psychological safety David will explore with Andrea how facilitation enable psychological safety in M&M meetings including developing transparency and openness of what will be discussed and ensuring clinicians know what to expect before coming to a meeting. Andrea highlights examples of the importance of relationships and trust and fostering a culture of speaking up for safety within teams.

David: Through a process of looking at the research and the evidence base across the world, we've come up with these eight standards which really focus in on eight areas of practice in facilitation. But a lot of those areas of practice or facilitation could also be transposed to the way in which people exercise leadership. So, first of all, we're thinking about purpose and the importance of starting with purpose. Any leadership activity or any of our facilitation activity has to start with purpose. We also have to create the right environment, the right container for good work to happen in and that requires psychological safety. It also requires the creation of effective relationships across disciplines and across subject matters, and the application of highly effective leadership and facilitation skills in the moment. And that requires us to consider multiple perspectives. So the different stakeholder perspectives who need to be brought together, in order for good facilitation to take place, we need to understand their position, their interests, and their concerns in order to be able to work alongside those stakeholders and create the right environment for facilitation to take place.

Andrea: And I think one of the other keys to that is not only having the people in the room, but actually having the structure around what they're coming into the room for. This means sending out the cases in advance and letting them reflect on it and even catching up with them prior to the meeting to have a conversation. When I review the cases for morbidity, for example, I'm not necessarily the clinician that was involved, but if I was involved, I don't actually do the facilitation because I think I create inherent bias into the review. If I was the doctor that was the core person during the patient's stay in the intensive care unit, I'd get someone else to review it because I think that's really key. We don't know when we look at something retrospectively that we may actually apply that retrospective review bias to that case, and I think it's really important having the people in the room that can actually speak to what happened in the moment.

David: So that's an interesting issue that you raised there, which is that you have a particular position in relation to the morbidity and mortality meeting. You're the Chair of that meeting/committee but there are times when you pass over the facilitation of the conversation, and you delegate the facilitation of the conversation to someone else and I know that in other circumstances there is some concern about doing that because people who are Chairs of meetings feel like they may lose their control or their authority/ credibility in the meeting if they hand it over to someone else. But I think what you're telling me is that actually that isn't what happens in practice?

Andrea: Yes, so I think it depends on who's in the room and what the trust level is of people that are coming to the meeting. We've been doing the meetings in the paediatric ICU for the last 18-months and doing them in this structured way. But I think initially when we started it wasn't like that and people didn't really know what they were walking into. But we do have a core group of people that can facilitate that have learned the skills and we can count on them to be in the room to do that. We used to start by sharing and facilitating the meetings and now what we do is we just have this core group of people that we rotate around so that it's not dependent on one person as well. You do get a different variety and variation because everyone has a different style. So, we talked about me using radical candour and someone else might explore the same case, but in a slightly different way to engage people in the room. So, I actually think it's good to have variation as long as you're continuing to maintain a safe space.

David: Yes. You've mentioned a couple of things in your remarks: You focus very much on the structure and the importance of having a highly effective structure, and one that people know. So, people understand what the structure is before they arrive, so they know what they're walking into. But you also have mentioned quite a few times the importance of safety and trust for the participants in the meeting. So that's a very important standard in our model in how you create that psychological safety, but I wonder whether you could say something about how you do that?

Andrea: Yes, so I think it's taken a long time and again it comes down to culture and it's not just about the meeting itself, but it's about the relationships that you have outside the meeting and how you conduct yourself within your clinical space. We work really hard to not only meet up with people that are involved in the cases and do the reflection and get their perspective, but also just developing those relationships between departments and within your own team locally - within the intensive care unit - to actually help foster that culture. I actually don't think that you can expect people to come into a room for an M&M meeting and talk very openly and transparently with trust and respect if you're not actually doing it outside of the room.

Even just debriefing events as they happen on the floor and being able to be open and honest in those moments is really important. I don't necessarily know that we're there yet, but it's a work in progress. I see that happening in parallel. So, as you develop the speaking up for safety culture within the intensive care unit, for example, that will translate into the meetings in which we're talking about some of these challenging cases and the safety that people feel in the room.

David: Yes, so when you're talking about developing the right sort of culture for those meetings, what you're saying is that that doesn't happen in isolation. That there's a broader cultural issue about how the team works and how people communicate and talk about issues as they arise on the floor, which gets translated into the meeting or is supported by the way in which the meeting is conducted. The other thing you mentioned was the importance of the sorts of conversations that you have with people outside of the M&M meeting itself and how that can then feed into more productive/effective relationships in the meetings.

Andrea: Yes and I also think within the meeting - when we reflect back on the structure - it's actually having the opening so that people know we're going to talk about the basic assumption and setting the scene for why we're here: talking a little bit about the safety science and then going into the cases and doing a synopsis review of the case and the timeline and then bringing it back to contributing factors and systems issues. So people actually know that you're going to see a little box up on the screen that has the different contributing factors that might have led to an adverse event - if this was an adverse event, for example - and it's interesting when you get people into the room that have never seen the little box before. When we first started doing this you would actually see a tick for the contributing factors - if it was a staffing or equipment issue or a medication error - and we had some visiting teams come in and actually see the box up with the tick which they found quite confronting showing they did something wrong because the box was ticked for their case.

So, we modified the process and we went back and said let's actually let the group decide what the contributing factors were, based on the discussion. Then we'd come up with the issues and then some recommendations based on that and we'd use that to help facilitate the conversation. So, we've actually overtime modified what we're doing based on feedback in the room. To me that means that people could say that that didn't feel okay for me/ that felt very uncomfortable. Could we look at doing it a different way? And then we'd modify what we were doing.

David: Yes, so that's an interesting point you raised there, which is about the importance of reflection. So, M&M meetings themselves are a reflective practice in terms of looking at what's happened in various clinical situations. But what you're also saying is that it may be important to also apply a reflective lens to the meeting itself so that the meeting itself becomes a place where people can speak up and say whether they felt uncomfortable at certain points, or they felt that a particular issue was glossed over or not handled well. You're creating an environment in which people are able to speak up in the room, not just about the case, but also about the way in which the case is being spoken about.

Andrea: Yes. So it's about the process and I think when we go back to facilitation, one of the things that we thought was really important was the group of facilitators and planners for the meeting meet in advance to go through the cases and actually talk about what we think the themes are that are going to potentially come out as discussion points so that we can actually discuss it amongst ourselves about what we think and how we would facilitate that. Then after the meeting we'd meet again a day or two later when we're reading the minutes to then reflect on how the session went. So how did you think that went, and do you think people felt okay? At the moment we don't have a structured way of evaluating. So, when you look at your eight principles of facilitation and we do an evaluation form at the end, but we don't specifically talk about psychological safety and structure. And so that's something that we're trying to build on and create as the next phase. Moving forward, how do we actually evaluate that these sessions are effective?

David: Yes, and I can see that the structure that you're talking about is one on which extends beyond the meeting itself. So, you're talking about the way in which you plan for the meeting to take place, the way in which you then reflect on and review how the meeting went. So, it's not simply a case of some very bare minutes about who said what. There's also a process for you to reflect on how did we do? Did we get to the really important areas there? Were we focused on the right things? Did we achieve what we were trying to achieve? So that process of seeing the meeting not just as being the time that you spend together, but also the preparation time, the engagement with key stakeholders outside of the meetings, and then that reflective process following the meeting so that you're constantly thinking about ways in which the meeting itself can be improved.

Andrea: Yes, and I think an example of that was last month where we held a meeting and there was a lot of conversation around the CEC and the new guidelines around M&Ms and some people weren't familiar with it. We talked about an RCA and how the language around RCAs is now changing and so we had a whole conversation around that and so, as part of the minutes, we then sent the link around. So, we sent the link to the CEC website for the M&M or if in a different context we'd send an article that relates to Safety II. So that people actually don't just have the minutes, but they have that follow-on of the conversation that was generated and what that means is that they can then learn a little bit as well in the process about safety improvement, methodology and things like that.

David: Yes, yes, that's fantastic.

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.