Episode one - Right Material - Choosing the right cases at the right time

Debbie Draybi: I'm Debbie Draybi from the Clinical Excellence Commission and am pleased you can join us for this four-part podcast series with Dr Clare Skinner and Dr Dane Chalkley. This podcast is part one of a four-part series on M&M leadership and case selection Right Material and Right people. In this segment Right material: Clare and Dane talk about the importance of choosing the right cases and ensuring you have the right people engaged in the meeting.

Clare describes the importance of empathy and her determination that no one would ever have a surprise in the M&M by ensuring that clinicians are clear on what cases are discussed. Dane emphasises that making the meeting psychologically safe is about choosing the 'right case for the right person' and thinking carefully of the timing of case selection as this will impact on the capacity to learn.

Clare and Dane talk about their experiences with the safety sciences and Human Factors to enable safe discussions from a systems perspective. This includes identifying cases that include positive learning experiences.

Debbie: Thank you both for being here and I'm looking forward to having a conversation with you today around your experiences with M&M, particularly in the context of when we look at our M&M guidelines. We've established the guiding principles around effective M&Ms and that is guided by the literature but also from the experience of clinicians like yourselves who have led the way and presented some fantastic examples at our forum that we had a couple of years ago. As a starting point, we really want to focus and emphasise the importance of psychological safety. You both have a lot to do with culture and culture in the workplace and wellbeing of staff, and I'm really wondering from your experiences what are some of the things that have worked and that you think would really support clinicians who are leading M&Ms in making that space a safe space for clinicians.

Dr Clare Skinner: I think the main thing when you're leading a meeting like an M&M meeting is to do it with empathy. So, I think we've all experienced that sensation of sitting in an M&M meeting and hearing the start of a case and thinking 'Oh my goodness, is that the person I saw?' and then instantly your body goes to jelly, you stop thinking properly, you're terrified. And for me, as a director of an emergency department for several years, and as someone who led the M&M in that emergency department, I was absolutely determined that no one would ever have a surprise in the M&M meeting. That was really important to me to choose the cases that we talked about really carefully. So, only choose the cases where you're actually going to learn from them, not where you're just going to embarrass or shame someone.

Shame is a negative motivator. And then the other thing was to make sure that that person's voice was included. So, if you're going to review a case and present it in the M&M, make sure that person knows, and they are actively involved in reviewing the case and you hear their side of the story because it's very easy sitting in an M&M meeting to pick someone's decision making to bits and forget the context in which they did that. Everyone who works in Healthcare is motivated by wanting to look after patients and provide good care. They make decisions for a reason. I think you've got to assume that people are well motivated, intelligent and trying to do a good job. And so, you owe them the respect of including them

in your decision making about the M&M and being empathetic to how that process is going to feel for them at all times.

Dr Dane Chalkley: I think you have to look at what your intention of an M&M meeting is and what the actual purpose is, what the outcome is. And I think most people would assume that an M&M meeting is mostly actually about interprofessional learning than it is about changing outcomes for patients. The evidence for that is relatively scanty. There's definitely some evidence behind improving systems. But most M&Ms, by definition of their title, are focussed on negative outcomes over a Safety I approach which is the retrospective analysis of error.

You cannot retrospectively analyse error in a complex socio-technological system like a hospital with your retrospective scope and come to a conclusion that this is the issue. So therefore, you have to work out what am I hoping to achieve from this meeting, and the number one thing is - and it's beautiful to see it on the guidelines from the CEC - the safety of the people who are actually at the meeting. And that's the absolute imperative and that should be the first thing and the main thing that people consider when running a meeting.

So that goes directly back to what Clare was saying and anonymity is very important. Choosing the right case for the right person is important so there's a learning from that case rather than just airing dirty laundry, which is what some M&Ms can be like historically. It's really important to make sure that the safety - the psychological safety of everyone in the room - is preserved. That means that people should volunteer or should be willing and able to contribute if they want to or be willing and able to not be there, should they want too as well.

Clare: You don't learn if you're feeling ashamed and you don't learn if you're feeling frightened.

Dane: The term *second victim* was coined 20 years ago, and it's gone through some periods of, you know, not being popular and then being less popular and now we have *third victims,* but it was part of the terminology. The whole point is that, as Claire said, you have to assume that everyone in the room went into becoming a health care professional to look after patients and anything that you're looking at in an M&M - which is a retrospective look at error - has to be done with absolute emotional intelligence and delicacy to protect the psychological safety of a group of people who are there to look after patients. I think part of what you're alluding to, I think, is actually case selection. You have to work out if I'm going to cause any harm from talking about this case? And are there any other learning points and I wouldn't choose a case unless there were some positive learning points, even if it was a very hard case.

With the death of a child, for example, there can be some really good, positive learning points about how things went well despite the difficulties, but you also have to think that we don't just want this to be a debrief, we want this to be something that is useful and positive. And ultimately, despite the sadness and the emotions behind the case, is something that everyone can learn from in a safe way.

Clare: And that's a really key point you've raised too, Dane, which is that you can have a bad

outcome, but things can be done well. And that's something we don't acknowledge enough, and particularly with things like mandatory referral to RCA SAC 1s. For example, there can be a SAC 1 one that was a bad outcome, but things were still done very well, and people can feel very vulnerable when that's investigated in a way which assumes that they did something wrong.

Debbie: And that's the challenge when often the focus is on the outcome rather than the things that were done.

Dane: Yes, I think you're absolutely right Debbie. So, if the switch that gets flicked to start the RCA processes is a negative outcome, then almost by default the approach and the feeling within that investigation is negative. Where was the error in this? Where was the error? There may not be error here and very often there isn't error. So, at that point you have to say, 'well is this the right case for my M&M?' Is it useful? I personally wouldn't put any case that was an RCA or a clinical incident review into an M&M unless it's absolutely finished, done and dusted and this isn't for everyone to give their opinion about where things should have been done better, it's more about to learn, as Clare said, from the Human Factors.

Clare: Case selection is really important though. I'm like you, I find it really difficult when I'm told that this must go in your M&M and so I have to admit I've got several different ways of presenting a case in the M&M and one is almost like doing a hypothetical where I let the case unfold and let people talk about what they would have done. But the other is where I literally just rattle off the story where I don't want that degree of input into it, and there's some cases I present in the M&M where we're just really going through the motions, and that's probably not very politically correct to acknowledge here, but I think that's actually about protection of who was involved. So sometimes I speak to hypothetical cases and when the people in the room make the same decisions as the clinician who was involved, that's almost cathartic for the parties involved.

That journey of discovery with your colleagues and reflection that this isn't me. The system was setting me up to fail you. That's cathartic, yeah, but there are times where you just want to tell the story where there is a learning, but you can just tell it from the story. You don't need to actually deep dive and it's also important to work out how much time you give each case as well, like everything isn't equal. You know I go to other teams' M&Ms and I've watched other people present the M&Ms in emergency departments and where everything is given, you know, 10 slides, that's not there. You know, for me, there is a one slide case, and there's a 10-slide case. And you have to really choose which one is which. Sometimes you want the Socratic reasoning before you're going through everything in detail and other times you literally just need to go through the motions of telling the story.

Dane: I quite like using a similar reference of Claire's of the clinical hand grenade where you take people on this beautiful path, knowing full well that they're going to make exactly the same errors that the clinician did if you're talking about a Safety I case where there is an error, letting people go and then they learn by realising that the clinicians didn't quite get it right. They got so much of it right in the lead-up and then it just fell apart because it wasn't as apparent as people thought it would be with the retrospective scope. So, I think that I love that.

Clare: So, I've got a question for you Dane which is how live are your cases? Do you do stuff as it happens, or do you wait a little while and let it percolate through the system? Do you have a take on that?

Dane: In terms of when things have just happened? I would never present a Safety I case since it is absolutely finalised, done and in stone. I think to do so is dangerous potentially, and if it's still raw. So, the first thing that happens when you're on an RCA panel - and I tried to be on every RCA panel for the emergency department because I just want to try and ensure that the people who have been interviewed are protected - and your first reaction when you are phoned or contacted to be interviewed for an RCA is 'what have I done? Is this the end of my career? Who did I hurt? Was it me? Whose fault was it?' You can't take that stuff into a meeting.

It has to be resolved, the findings have to be in to come to some sort of conclusion, and the person who is involved has the right to choose whether or not they want to even be there, whether or not they want to present, but they have to have received some sort of resolution. And debriefing and counselling for people who are involved in these is incredibly important. And I'll go back to the term *second victim*. Again, it's not a term that's particularly in use at the moment. It goes through phases, but it is the principle behind protecting the people who could get hurt by virtue of their error is incredibly important and to bring it into a meeting like that without really stringent safety is so important to me.

Clare: I agree, you let the difficult stuff settle for a while.

Dane: Yes, this isn't a counselling session.

Clare: That's been really hard actually, with the time limited RCAs as often there's a pressure on you to get something presented in your M&M from the point of signing off the RCA. And it actually needs to settle because otherwise it will just be harmful.

Dane: Yes, or just give it a one line that really doesn't allude to very much. But that's the thing because it's our responsibility as the Chair just to say, I know my team, I know who is there and I understand the core principles of what I'm hoping to achieve from this. Is this suitable for that environment irrespective of whether it's been mandated that I tell you about it? In what detail I share it is up to me. And that's matched to the people who are going to hear it.

Clare: The reality is, if you're the Chair of the M&M, you're talking to everyone who's involved in these cases all the time. The M&M is literally the tip of the iceberg in terms of what is going on with the quality in the department. The vast majority of quality in the department is conversations and counselling and debriefing a whole bunch of other stuff, so I think that's something I find a little bit strange as well is the notion if it's not in the M&M, you haven't taken it seriously. Often with the biggest cases/ the biggest problems that I've taken very seriously, I find they only make it very superficially into the M&M. Yes, the real talking is happening in a much more safe space.

Dane: Yes - again safe. It's got to be safe.

Debbie: The M&M spaces. What's really critical is the readiness of the group and the timing is crucial. Being very careful around where the particular incident is at in the system and whether the individuals that are involved are really ready to talk about it and be involved in some learning.

Dane: Yes, and if you consider how much learning people are going to get, how much improvement, whether or not that translates to improved patient outcomes, then you've got that on one side of the seesaw and one side of the fulcrum, and the balance. Then you have to think about the individuals involved and they contribute the most to your decision-making strategy, I think.

Debbie: Thank you for listening to this podcast with M&M leadership and case selection Right Material and Right people: I really hope you enjoyed it. Please note this is one of a four-part series and I hope you listen to the other three segments as I continue this conversation with Dane and Clare explore around choosing the right cases.

Dane and Clare talk about the importance of leadership in M&Ms, they also talk about their experiences of safety sciences and the importance of Human Factors. We explore multidisciplinary participation and it's a real opportunity to listen in and really hear the level of vulnerability and experiences that Dane and Clare talk about as they explore their M&M leadership. Listen in as Clare and Dane discuss their insights and lessons learnt that they have had along the way in supporting 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 with clinicians as they share their journey and learning. I hope you find it useful and if you would like to contribute to this conversation please contact me.