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

Episode three - Lesson Learnt: Enhancing learning and managing emotions

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 three of a three-part series on Creating safety in M&M discussions. Lesson Learnt: Enhancing learning and managing difficult conversations David and Andrea explore key lessons learnt around managing difficult conversations reframing and inquiry techniques and to ensure everyone has a voice in the room even if some of the voices are controversial.

Key strategies are discussed around managing difficult conversations and emotions that may surface. This includes the importance of reframing any blaming and establishing shared agreements about how the meeting's going to run, what's acceptable behaviour, and what constitutes being respectful.

David: However, we do know that, in the past, people have felt that they are at risk in those meetings of being blamed or being scapegoated. And I know you've mentioned about the importance of psychological safety, but is there anything that you do that helps to mitigate against that happening?

Andrea: So, I think one of the big things is using that approach of contributing factors and actually reviewing the case and then saying actually this happened. This went well, this didn't go so well and let's look at these reasons why potentially it didn't go well. And then using that to start the conversation and that takes it away from blame because it brings it back to the systems. So, what about the systems improvement? And then we use the CEC M&M template for reporting, and everyone's used to seeing that. So, we have our action table at the beginning when we talk about what we've discussed in previous meetings and how we've actually actioned that and how it aligns with what we're doing in the quality improvement space. And research and education for example, and then at the end of each case, we recap and we say, OK, these were the things that were identified that we're going to put down as an action item and does anyone think that we need to put an incident in about this case or do we need to have it escalated? And we always have the clinical governance team at the meetings as well, so they can give us feedback and reflect with that lens on how they think the meeting went?

I think that for us has really helped because it's not about individuals and what they did or didn't do, but it's about the systems and the contributing factors and how we can actually do it differently the next time around. And that's how we model all of the meetings and then that's what's in the report. So, when we do the report it's not 'he said, she said' it's actually the synopsis of the case, taken straight out of the PowerPoint presentation. This was a summary of the discussion items. This was the one action that came out from this particular case and then we do that for the four cases and then we create the action table that then gets reflected in the next meeting.

David: I can see how that would be very helpful - that shift of perspective from the personal - the individual - to what's happening in the system really can take the heat out of some of

those conversations. However, one of the things that I think does concern people who are thinking about taking on the facilitation of a meeting like this, is the worry that there may be one or two individuals in the room who will not behave well, who will not follow the rules or whose language will not be appropriate. And I just wonder how you deal with those situations? For want of a better word, the sort of more difficult participants who perhaps have a particular bee in their bonnet about certain aspects of the process and maybe use the meeting as a way of venting some of their frustration. How do you deal with managing those types of personalities?

Andrea: I think that's a really good question, and it goes back to the principles we talked about at the beginning with facilitation and who are the facilitators. I feel very strongly that the people in the room that are facilitating have to be very senior clinicians. I don't think it's fair to put a junior (JMO or doctor) in a position where they are in with senior consultants who might not behave themselves, if you will, in the room. And then it's also taking and reframing what the person said and then exploring that a little bit. So, using those facilitation skills to say I hear you saying that this was concerning to you for these reasons So let's just talk about that a little bit more, or normalising it to the group. Has anybody else felt this way before and just taking it away again from the individual and actually generalising it a little bit? Or trying to normalise it for the group, but also acknowledging so in our last meeting, for example, we had attempted to use a different structure where we looked at a case and then used the Birmingham model of, you know, after you look at the case then you try and decide was this a case where the care that was given was good. Was it less than adequate?

And you use a ranking score and so we were trying this out in the second meeting and one of the consultants in the room said that he didn't like this as it made it sound like in the minutes you're going to basically say that the care was inadequate and that doesn't feel right to me and it felt like we could have that conversation, and so instead of just wow, that was bringing the heat a bit in the meeting, we just acknowledged it and then explored it a little bit and then used that to change the process. So I think that it's all about the facilitation and the way in which you can navigate those conversations: Reframing, exploring, you know the whole advocacy and inquiry techniques that you use with debriefing is really important, but not to shut people down. Because I think everyone needs to feel like they have a voice in the room, even if that voice is a bit controversial and so I think you need to take it away from that and generalise it or normalise it a bit more.

David: Yes, and I think that's very important where we have a phrase in the adaptive leadership model, which is about paying attention to the contrarian voices. So, you know, paying attention to all the voices, but sometimes it's so easy if a voice is so at odds with the general consensus. It's so easy to dismiss it and to characterise that contribution as being one which is designed to disrupt or that that person is being a bit of a maverick or a trouble troublemaker, and then we miss what it is that they're trying to tell us or trying to alert us to.

And it might actually be very important and what you're suggesting is that taking those contributions and acknowledging them, unpacking them a bit more, allowing them to be

vented and explored without you know, immediately dismissing them, may be a way of not just getting the learning out of that contribution, but also a way of perhaps taking some of the sting/some of the heat out of the way in which it's been developed, because you're so obviously engaging with it, so obviously acknowledging that there might be something that's worth considering.

Andrea: Yes I think it's about validating, and that's what brings people to the meeting and they like to come because they know that they can give their opinion, even if that might not be the same opinion of everybody else in the room, and everyone has a fair go and the ability to speak their mind in a respectful way. You know, if it's disrespectful, then that behaviour needs to be called out. And that's not okay because that doesn't make anybody feel safe in the room. This whole *above the line* and *below the line* behaviour, we need to be able to call it out in meetings. And sometimes people aren't so good at doing that. And that to me is the most challenging thing when people make an offhanded comment that is perceived as being critical or blaming to other people. And then all of a sudden you can see in the room that everyone kind of just shuts down. And then the facilitator actually tries to take whatever that statement was and reframe it and unpack it a little bit more for the rest of the team, so that the whole meeting doesn't get derailed which I think is a big challenge.

David: Yes, it is. And the other thing it makes me think about is that, in order for that environment to work, you have to have some shared agreements about how the meeting's going to run, what's acceptable behaviour, what constitutes being respectful, what is, you know, helpful communication. So those are things which obviously you've thought about as a meeting. I'm just wondering if somebody new comes to that meeting, that hasn't been before, how would they know that those were the rules, if you like, the terms of engagement in a meeting of that kind?

Andrea: So, at the beginning when we talk about the basic assumption, we set the ground rules for the meeting, so this is not about blame but this is to review the cases using a very systematic approach to look at systems factors and improvement opportunities and that you know we will get into the cases and everybody has a voice and we encourage people to speak up, but it's not going to be a blame session and we pretty much say that at the beginning,

David: Yes, so you rehearse that every time, almost as a reminder for people.

Andrea: So, if someone does do that then we can remind them when we spoke at the beginning that it's not about blame. We actually need to get into the issues a little bit more and talking about them is really important and I know that this topic is a little bit sensitive. And this case has impacted on a lot of the clinicians that were involved, so let's talk about that.

David: That's interesting, and the other thing that it makes me think about is how, in meetings of this kind, people's feelings are or can be very close to the surface, but there's

often a bit of worry about talking about feelings in case people get upset or distressed, those sorts of things. So, I wonder how do you manage that? You know you spoke about moving it from the personal to the systemic, but if there are obvious feelings that people have about the subject matter, how do you manage to have a conversation about that that doesn't become overly distressing?

Andrea: Yes, I think there are some things that need to be parked and they would probably need a different forum to discuss them. So, in addition to the M&M meetings that we have, whenever there's a cardiac arrest on the unit or the traumatic death of a child, we do a debrief and reflection. So, we do a *hot debrief* as well as a *cold debrief* which again have lessons learned and had psychological support for the people that are there. So, these are facilitated by a clinician and a social worker and again we have rules of engagement for that. So if we feel as though something is very emotional or is bringing the heat for whatever reason, and it's a very emotionally provoking case, then I would probably suggest in that situation that we park those emotions and we discuss them in one of those reflection forums and invite people to come to that and be supported.

If someone leaves the room during a case discussion, then we say that we will always go after them to check on their wellbeing and then again provide them some resources if this has just been all too overwhelming for them to actually be in the room while the case is being discussed. So, I do think there's a fine line between using a systematic approach in an M&M meeting and actually having a debrief about a critical incident, and sometimes they get blended together because the critical incident is now the topic of the M&M. But what we like to try and do in having an M&M meeting is we would always have that facilitated reflection session about a critical incident.

So, if there was a death of a child, we'd have an arrest debrief, we'd have a team reflection session, we'd have lessons learned from that. It might be an RCA which we would then discuss the recommendations as part of the M&M meeting and then go into the details of the case. So, I feel like doing all of those things in combination try to help mitigate some of the issues around being really distressed and emotive in a meeting, but it doesn't mean to say that it doesn't happen. So, I think we need to recognise when it's happening and support the person that's really distressed, but then also take it into a separate forum for discussion where they can be supported in a different way outside of the M&M. But I think the pre-meeting really helps because if you meet with the key players for the case and you know that it's really going to be an emotive case to discuss by pre-meeting with the individuals, you actually have that opportunity to do that reflection with them so that they know and they can talk through it before they then come to the M&M meeting.

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.