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Cases across the Continuum of Care: Improving Outcomes through the Recognition and Prevention of the Unexpected

Jamie Dyson, PT, DPT

Objectives

- Define the importance of performing morbidity and mortality presentations in acute care physical therapy.
- Explain the clinical reasoning of least two cases with unexpected or unintended outcomes with colleagues to improve patient outcomes.
- List at least three suggestions for future management of cases with unexpected or unintended outcomes.
- Describe at least three strategies to successfully implement morbidity and mortality presentation in your own practice.

Why???

- Improve outcomes and reduce errors
- Inform practice, research, and education
- Quality assurance
- Provide an avenue for coping and emotional support

"No one who cannot rejoice in the discovery of his own mistakes deserves to be called a scholar."

- A structured hospital-wide MM&I conference is an effective means of engaging physicians, nurses, and key administrative leaders in the discussion of adverse events.
- The identification of potential system failures and the creation of workgroups to address specific systems-based problems can promote initiatives to improve patient care and safety.

Deis et al

MM&I conference outline

	Time allotted	Participants
• Opening: Reminder of systems-based approach and confidentiality	5 min	Leader
• Review of task force progress from prior conferences	10 min	MMI task force
• Case presentation (timeline format)	10 min	Resident leaders
•Brief literature review relevant to case in question	5 min	Resident leaders
• Identification of key issues leading to undesired outcome	25 min	All participants
• Identification of workgroups to address the key issues	10 min	MMI task force
• Reminder of confidentiality	5 min	Leader
• Evaluation of conference	5 min	Leader

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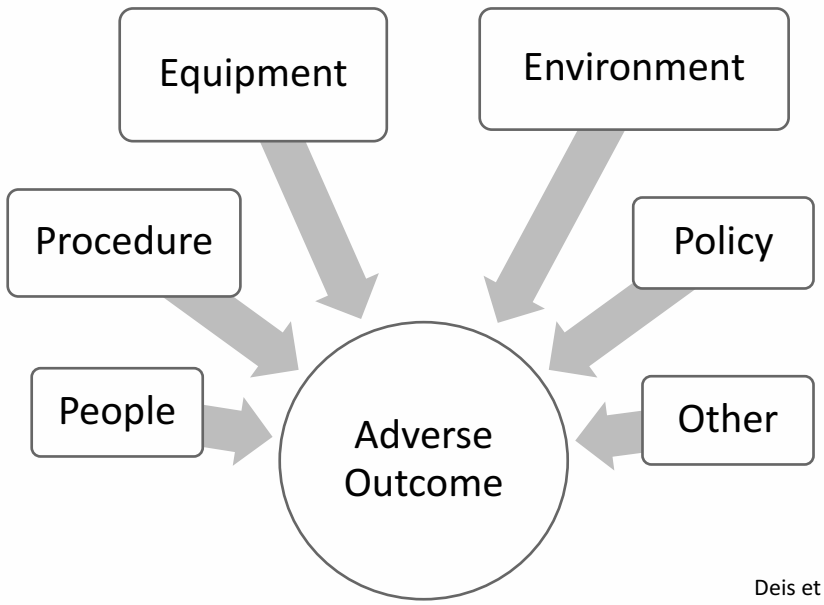

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Factors contributing to adverse outcome

Factor	% Cases
Communication: e.g., inadequate handoffs; incomplete clinical information	64
Coordination of care: e.g., involving multiple services and/or care sites	36
Volume of activity/workload: e.g., increased clinical volume and/or perception of workload	18
Escalation of care: e.g., delay or failure to involve more senior physician or nurse	14
Recognition of change in clinical status: e.g., delay or failure to recognize changing clinical signs and/or symptoms	14

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Life is short, art is long, opportunity fleeting, experience deceiving, and judgment difficult.

—HIPPOCRATES

Factors that contributed to an incident and were the target of an improvement initiative decided during morbidity and mortality conferences

Factors	Number	Percent
Staff	111	39.4
Organizational/ environmental	91	32.3
Other	36	12.8
Agent/equipment	24	8.5
Patient	20	7.1

François et al.

Perceived Benefits

Lecoanet et al

Initial Education	37%
Continuing Education	42.4%
Improvement Of Quality Of Care	61.9%
Improvement Of Patient Safety	63.2%
Standardization Of Medical Practices	45.2%
Application Of Clinical Guidelines	37.2%
Improvement Of Functioning In The Unit	47.7%
Improvement Of Teamwork	33%
Improvement Of Relations Between Medical And Paramedical Teams	22.8%
Improvement Of Safety Culture	35.9%

Survey of Internal Medicine MDs

- 76 percent did not discuss their “most significant medical mistake in the last year” with the patient who suffered from the mistake or the patient’s family
- 50 percent discussed the case with the supervising attending physician
- These mistakes were significant enough to engender responses of remorse, anger, guilt, and inadequacy

Vincent Liu, MD

Goals of M and M session

- Identify events resulting in adverse patient outcomes
- Foster discussion of adverse events
- Identify and disseminate information and insights about patient care that are drawn from experience
- Reinforce accountability for providing high-quality care
- Create a forum in which physicians acknowledge and address reasons for mistakes.
- Prevent the repetition of error

Orlander et al
Bernstein

Learning Aims

- Improving presentation skills
- Developing skills for reflection
- Understanding root cause analysis techniques
- Recognizing adverse events and possible contributing factors
- Recognizing that most medical errors are due to 'system' problems, rather than individuals, and the importance of improving systems to improve patient safety
- Improving communication skills
- Developing a 'safety culture'—encouraging the reporting of 'adverse events' and 'near-misses' for organizational learning.
- Understanding the importance of being honest and transparent
- Stimulating ideas for quality improvement projects to improve quality of care

George

Ground Rules

"A person who never made a mistake never tried anything new."

Ground Rules

- Patient care can be difficult.
- Supportive learning environment
- Find your unexpected
- **Discussion & questions**
- Variation in treatment depending on goals participants/ evidence
- Errors are inevitable, but they give us a tool to improve our skill as providers.
- The goal is not to criticize, but to profit by sharing and examining our experience.

Orlander et al

Case 1

Acute Care

Case 2

Outpatient Orthopedics

Case 3

Acute Care

Implementation

Suggestions

- Create environment
- Start and set the example
- Quality assurance
- Template
- Combined efforts
- CEU's

Barriers

- Resistant admittance
- Access & interpretation of literature
- Risk
- Time
  - Presenter
  - Schedule

"Insanity: doing the same thing over and over again and expecting different results."

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"Education is what remains after one has forgotten what one has learned in school."

Mistakes & Pursuing Questions…

http://www.ted.com/talks/brian_goldman_doctors_make_mistakes_can_we_talk_about_that

http://www.ted.com/talks/stuart_firestein_the_pursuit_of_ignorance

Discussion…

“When you are courting a nice girl an hour seems like a second. When you sit on a red-hot cinder a second seems like an hour. That’s relativity." ------ IT DEPENDS!