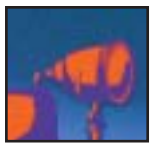

Perspective

Multi-Professional Mortality Review: Supporting a Culture of Teamwork in the Absence of Error Finding and Blame-Placing

Kristine Jarvi, Roxana Sultan, Ainsley Lee, Frank Lussing and Rama Bhat

ABSTRACT

Commitment to patient safety must be a priority of every healthcare institution. York Central Hospital has implemented a quality initiative to address multi-professional issues that result from a significant sentinel event where there is a notion of perceived wrongdoing due to an adverse and/or unexpected outcome – the Multi-Professional Mortality Review process. Unlike the traditional approach to professional review in healthcare, which results in a culture of error finding and blame-placing, this process acknowledges the fact that human errors can occur, reaffirms what is working well and ensures that steps are taken to mitigate the effects of the sentinel event under consideration. The review panel consists of healthcare professionals who have been involved in the case. The panel reviews the case and makes recommendations to senior clinical committees and hospital administration. The multi-professional review process has been met with a positive response at York Central Hospital and, to date, has served as a driving force behind the implementation of a number of systemic and professional changes.

Introduction

Commitment to patient safety must be a priority of any healthcare institution. Quality initiatives centred around ensuring maximal safety for patients can focus on a number of different aspects of patient care. An example is York Central Hospital's Multi-Professional Mortality Review (MPMR) process established in 1999. The process requires a multidisciplinary team to conduct a qualitative audit of a significant sentinel event where there is a notion of perceived wrongdoing due to an adverse and/or unexpected outcome.

The traditional approach to professional review within the healthcare industry has taken place within a culture of error finding and blame-placing (Reinersten 2000). Furthermore, when the focus of review is limited to individual performance, it is often difficult to examine the broader context within which the outcome took place. Without this expanded outlook, systemic issues may not come to light and the desired impact on patient safety may fail to occur. The MPMR process

fosters an inclusive and participatory approach to review, which leads to a more comprehensive analysis. By encouraging reflection and discussion, practical solutions come to light as a result of such an integrated review in addition to reaffirming what has worked well within the system.

Broadening the review process facilitates access to information about the action and event surrounding the case under consideration. Consequently, by breaking down the barriers to communication and disclosure, the process shifts from a "conspiracy" of silence and secrecy to a forum for collaborative information sharing and problem solving. This framework provides a more affirming approach to addressing issues and helps build an infrastructure of trust, thereby promoting honesty and disclosure. The process acknowledges the fact that human errors can and do occur, but ensures that steps are taken cooperatively to minimize their frequency. The incorporation of non-punitive reporting mechanisms also helps to identify areas in which change is needed and further encourages open dialogue.

Rather than simply taking on the reactionary approach, the MPMR process seeks to reaffirm what is working well, prevent future errors from occurring, and ameliorate the effects of the sentinel event under consideration. The process can therefore promote the design and implementation of new systems of care.

Purpose of the Review

One of the purposes of an MPMR is to conduct a focused review of the management of a particular case in light of the sentinel event that arose from it. By examining the case and uncovering information about the handling of the case, the review process reconstructs the events that led up to the final outcome. The review process also facilitates the formulation of recommendations regarding future practices and procedures. By drawing attention to the areas in which errors may have occurred, the review process promotes active change management and quality initiatives.

Another purpose of the review is to reaffirm existing practices and procedures in areas where no need for change can be identified. Procedures can be held to rigorous standards of review before being accepted as qualifying for reaffirmation. This aspect of the review provides a positive perspective to the process as a whole, commending certain practices while simultaneously seeking to alter others. Finally, the process reinforces a commitment to continued quality improvement. Any performance issues that may arise as a result of the review are dealt with by respective professional performance management processes.

Methods

At York Central Hospital, cases must meet specific criteria in order to qualify for a MPMR. Based on the criteria, there are generally two situations when a MPMR is completed:

1. Request from a department or program resulting from a mortality chart review, or
2. Validated complaint received by the Chief of Staff or the Chief of Nursing/Professional Practice Leader.

In all cases, when a patient expires within the facility and the patient is not a palliative patient admitted with a "do not resuscitate" (DNR) order, a departmental mortality chart review occurs automatically. At this stage, individual departments or programs within the hospital may conduct multi-professional review as per their own policy. If no multi-professional issues or concerns are identified at the departmental or program review level and no additional requests for a multi-professional chart review are received, then the case does not proceed to a MPMR.

However, in situations where multi-professional issues or concerns are identified at the departmental review, or a complaint has been received by the Chief of Staff or the Chief of Nursing/Professional Practice Leader, the MPMR process is initiated. The first step is initiated when the Chief of a Department, Chief of Nursing/Professional Practice Leader or Program Director notifies the Chief of Staff of the request, stating the reasons for the review. The Chief of Staff will review the request, and if appropriate, will convene a MPMR. At this point, those people involved in the case are informed that the chart is under review.

Panel selection begins with the Program Director and Chief of the Department or delegate of the relevant program/department reviewing the patient's chart and all notes written by the professionals who were involved in the care of the patient. The Program Director and Chief of the relevant department select individuals who have been involved in the case and invite them to participate in the review process. In certain circumstances (direct involvement in care of patient, complicated procedures, etc.), Educators, Patient Care Coordinators, and Administrative Coordinators are invited to participate. The Chair/Facilitator of the review is chosen by the Chair of the Professional Advisory Committee and the Chair of Medical Advisory Committee. The Professional Advisory Committee is a multidisciplinary advisory body that provides a forum for the discussion of regulatory body and professional issues as well as establishing credentialling processes to ensure all professionals in the organization meet legislated and organizational standards.

The professionals assigned to the Multi-Professional Mortality Review are required to review the chart and prepare themselves for the review. In most cases, individual professional groups meet prior to the formal MPMR to prepare and discuss the case. For example, nursing, pharmacy and RT may meet to review significant issues or elements of the case. These preparation reviews are facilitated by the Chief Nursing

Officer, Program Director and/or Administrative Coordinator. The case is then reviewed by the MPMR panel.

The review of the case is directed by a number of guiding questions that have been formulated by York Central Hospital. These include:

- What issue(s) triggered this multi-professional review?
- Is there evidence to sustain the issue(s) that triggered the review?
- Are there any recommendations for change or action that would address the issue(s)?
- Based on a review of the case, are there any other areas of concern that should be addressed?
- Did the treatment plan make the best use of the available people and resources?
- Was the treatment plan followed accordingly?
- Was the management and treatment appropriate and timely?
- Were the results of all tests or investigations reported in a timely manner?
- Are there any recommendations for change or action that would address other issues identified in this review?
- What was the cause of death (e.g., progression of disease, as the result of treatment or lack of treatment)?

Results and recommendations are collated by the Chief of Staff and Chief of Nursing/Professional Practice Leader. The Chief of Staff then deals with any recommendations directed towards the physicians, and the Chief of Nursing/Professional Practice Leader deals with any recommendations directed towards all other professions. This may include recommendations for specific programs. These types of recommendations would be brought forward through the program to the program's Quality Committee to develop strategies/initiatives and implementation plans to address the recommendation(s).

The Chief of Staff then communicates with the department or individual generating the concern that led to the MPMR.

Upon completion of each individual review process, the patient's next of kin are informed of the outcome of the review and any steps that will be taken to address the issues arising from the process if appropriate. Some reviews are conducted at the request of staff, not the next of kin. This requirement creates an answerability component to the review and facilitates the building of bridges in communication with the hospital's clients.

EXPERIENCE

Since the first review of this kind at York Central Hospital in 1999, four reviews have been completed. The reviews were conducted given the circumstances of the case and/or a request from a staff member, physician or patient/family member. Each review identified issues requiring action and formulated recommendations.

An example of one such case reviewed by the MPMR process involved a critically ill patient in which there was an unexpected outcome. The family of the patient and a physician requested the MPMR. The case was reviewed by key professional staff and physicians who cared for this patient. A number of issues related to documentation, critical thinking and integration, communication, and orientation and supervision of new staff were identified over the course of the review. Notwithstanding some professional issues that were identified and dealt with by an individual's manager, a number of changes were implemented relating to the orientation requirements for new staff, supervision of new hires and enhancements to nursing rounds. The result of the MPMR was communicated to the family by the Chief of Staff.

Overall, the MPMR process has been well received at York Central Hospital. Every review conducted thus far has reported 100% attendance rates for all professionals involved, and only positive feedback has been received by the co-chairs of the review – the Chief of Staff, Dr. Rama Bhat, and the Chief of Nursing/Professional Practice Leader, Ms. Ainsley Lee.

The co-chairs report that the individuals involved in past MPMRs participated actively in the process and felt valued and respected by virtue of the fact that they were consulted in the matter. Participants are informed that any disciplinary actions or individual specific follow-up generated as a result of the case review will be handled confidentially with the individual(s) involved, by either the physician or nursing/professional practice chief. This has created a sense that individual and group interests are being respected rather than reinforcing the traditional hierarchical structure of disciplinary action. To date, no need for formal disciplinary action has arisen from any MPMR that has been conducted. However, it is understood that feedback and appropriate intervention will be provided by the respective chief when warranted.

Given that the review takes place in the absence of the patient's next of kin and without the recording of detailed minutes, it has been found that the process has been perceived as a safe environment within which open discourse is permissible without fear of reprisals or bias.

The co-chairs have made efforts to foster an environment of increased communication and collaboration, as well enhance positive interdisciplinary relations. At the outset of each review, the co-chairs outline how the meeting is to be conducted and clarify that no blame-placing will be permitted. It is stated that the review is to deal with fact only and will set out to determine what contributed to the event in question. The co-chairs see their role as one of managing the meeting rather than mediating or controlling the discussion. The co-chairs have been careful to employ diplomatic language in their contributions to discussions and to frame their questions in general, non-accusatory terms.

It has been found that by allowing participants to be involved in fashioning the change process, dialogue has been created between the various groups, and forthright discussions are taking place. The process has helped develop an understanding of the shared responsibilities and accountabilities involved in clinical decision-making and patient care. It has also helped emphasize the importance of the responsibilities held by non-physician staff with respect to patient care. Furthermore, it has been noted that the reviews have created a forum within which to address the need for increased resources, support or skills, as well as an opportunity to express frustrations and voice concerns.

However successful this process has been for the organization, there is more work to be done. In order to truly develop a sustainable culture of quality healthcare in the absence of error finding and blame-placing, the organization must increase staff awareness of the MPMR. Although the investment in the process can be substantial in terms of time and energy, the return is great.

Outcomes

While there are sometimes individual lessons that can be learned from the process, many times the outcome of the review has been the need for system/process change. Some cases have highlighted the need for educational, mentoring or leadership initiatives within a particular program or profession. In response, new roles, leadership programs and additions to the orientation program have been devised and implemented.

Overall, York Central Hospital staff have demonstrated a commitment to ensuring the recommendations from MPMRs have been successfully implemented. This can be partly attributed to having individual Program Directors included in the review process, and as a result, implementation of initiatives can be monitored at the program or service level. Attempts have been made through the review process to create a feedback loop within the collective of individuals involved, in order to ensure that results can be achieved through collaboration.

Generally, the recommendations from MPMRs have been made bearing in mind that their purpose is to prevent recurrence of the sentinel event and to improve management as a whole; thus, the importance of following up at the implementation stage is stressed throughout the process.

Conclusion

The multi-professional review process has met with a positive response at York Central Hospital and, to date, has served as the driving force behind the implementation of a number of systemic and professional changes. The process has proven valuable in identifying areas in need of improvement as well as highlighting areas that are successfully meeting the needs of patients and staff, thereby reinforcing York Central Hospital's commitment to excellence in patient care. HQ

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The CIHI/CIHR Adverse Events Project Notes from the Canadian Institute for Health Information web site (CIHI.ca)

Hospital Quarterly will cover the study of adverse events in healthcare, its impact, subsequent policy development and evidence-based best practices. To set the frame work here is a brief description of the CIHI/CIHR Adverse Events Project. This is the first study of its kind in Canada which will provide the healthcare sector with information about the numbers and types of adverse events that occur in hospitals. It will also assess the extent to which routinely collected data could be used to support continuous monitoring of adverse events in Canadian hospitals.

An adverse event, as defined by a similar Australian study, is "an unintended injury or complication which results in disability, death or prolonged hospital stay and is caused by healthcare management." This is the definition that will be used by the researchers in the study. By identifying the number and types of adverse events, this study will contribute to improving quality of care. This CIHI/CIHR-sponsored research study is the first step to help improve the safety of Canada's health system.

This research study is jointly-funded by the Canadian Institute for Health Information and the Canadian Institutes of Health Research. The lead researchers are Dr. Ross Baker, University of Toronto, and Dr. Peter Norton, University of Calgary. The study, being led by Dr. Baker and his colleagues from across Canada, is based on reviews of randomly selected patient hospital records by specially-trained physicians and nurses who are part of the research team. A random sample of hospitals in the following provinces is expected to participate: British Columbia, Alberta, Ontario, Quebec and Nova Scotia. The study will determine the number and types of adverse events in Canadian hospitals and will also determine the availability of routinely collected data that, if appropriately monitored, could serve to reduce the occurrence of preventable adverse events. University Research Ethics Boards in each province where the study will be conducted will review and approve the research proposal before hospital consent is obtained to participate in the study. Hospitals in Quebec also require that their own review boards approve the study before they can participate. In addition, an independent Ethics/Legal Advisory Committee is being set up by CIHI and CIHR to assist the researchers with any issues that may arise during the course of the research.

The final report will be released to the public in 2004 and published in a peer-reviewed journal or monograph.

On the same theme, The Royal College of Physicians and Surgeons has established a National Steering Committee on Patient Safety, chaired by Dr. John Wade, and is currently developing a framework and suggested plan on patient safety efforts in Canada. The research funded by CIHR/CIHI complements these efforts by providing a first detailed looked at the numbers of adverse events in Canadian hospitals. Their web site is **http://rcpsc.medical.org/**.

Family Input: Of Critical Importance in Patient Hospitalization and Internal Reviews

Brian Nemerovsky

Quality improvement must encompass patients' families. Patient safety, optimal patient care, and compassion towards families is of paramount importance in a healthcare setting, and including family members is a valuable tool in achieving these goals.

The paper from York Centre Hospital, and the review process it describes, came about largely as a result of the death of a woman, Blanche Nemerovsky, from a heart attack in 1996. She had been admitted suffering symptoms of a heart attack. After her death, at the request of the family, the hospital conducted an internal review, identifying, among other areas, that communication between health professionals and communication with the family was problematic. Specifically, areas of utmost importance like communication between the most responsible physician and the family, between the physician and the nurses and between the nurses and the family, were all found in need of improvement. This would include the taking of a detailed patient history from the family by the doctor. Moreover, nurses also play a key role in transmitting critical information from family members to the physician.

The Process

In this particular case, the family enlisted the services of the College of Nurses of Ontario and the College of Physicians and Surgeons of Ontario (the regulatory bodies), eventually leading to the involvement of the regional coroner. As the result of a coroner's investigation, the following recommendation was made: "That York Central Hospital should develop and institute a multi-disciplinary death review process for the purpose of critically and comprehensively addressing patient care process issues in all cases of unexpected deaths or whenever family members (or others) express concerns about patient deaths."

It therefore follows that families need to be actively included in the review process in order to present their

experiences with the hospital during the patient's stay, both with respect to communication issues, as well as any other areas of concern. A multi-disciplinary death review cannot hope to, "critically and comprehensively address patient care process issues" if the input of family members is not actively solicited as part of the review process. Undoubtedly, as well, family members will feel isolated from a process that does not directly involve them, and are far less likely to be satisfied by the outcome since their concerns are never heard first-hand, in the same respectful fashion as the input of healthcare professionals. Many legal actions are commenced by families solely to get proper answers to their questions about what happened to their loved ones. An inclusive process that shows families that everyone is striving to get to the truth will do much to lessen the likelihood of a lawsuit.

Conclusions

Complete participation in a fully documented process will provide families with a concrete way in which to understand what transpired during their relative's hospitalization, in order to work through the grieving process in a constructive manner and begin the road to closure. Any process that excludes families will be unsuccessful if the goal of hospital administrators is to enhance the quality of care of patients, and the satisfaction of family members. Administrators should strive to create an atmosphere of trust for the patient and the family in a time of vulnerability and need. HQ

Dedicated to the memory of my mother, Blanche Nemerovsky, who died on April 14, 1996.