

# 2<sup>nd</sup> International Conference on Healthcare & Hospital Management and 6<sup>th</sup> International Conference on Medical & Nursing Education

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## LIFE AFTER DEATH: RESUSCITATING THE MORBIDITY AND MORTALITY CONFERENCE TO INCORPORATE PATIENT SAFETY CONCEPTS AND HARM PREVENTION

**Nirvanas Goolsarran<sup>a</sup>** and **Christine Garcia<sup>b</sup>**

<sup>a</sup>Stony Brook University, USA

<sup>b</sup>University of Pittsburgh Medical Center, USA

**Statement of the Problem:** Morbidity and Mortality (M&M) conference is a traditional forum that provides residents with an opportunity to discuss medical errors. Conventionally, most of the allotted time is spent on case presentation, therapeutic debates and assignment of individual blame. This is a lost opportunity to teach fundamental principles of patient safety, error analysis and strategies for system wide improvement. What was tried? To promote patient safety education in our internal medicine residency program, we restructured the content of M&M to include a multidisciplinary team with a strong emphasis on teaching principles of patient safety and system wide improvement strategies. The chief resident presents a structured timeline of the case. The conference follows an interactive small group format in which each resident cohort group is assigned specific safety tasks. The PGY-1 group is assigned to conduct an error analysis. The PGY-2 group is tasked to conduct a Root Cause Analysis (RCA) with both systems and individual contributors. To promote culture, a crucial aspect of patient safety, the PGY-3 group is charged with conducting a resident peer review to determine if standard of care was met. At the end of the session, take home points, summary slides and task assignments are reviewed to the large group of residents. What lessons were learned? M&M conference modeled after system-wide error analysis demonstrated high resident satisfaction with the patient safety learning objectives on post surveys. We also observed that cognitive errors were the most commonly identified error in all the cases. This resulted in the development of cognitive error/diagnostic reasoning lecture series for our residents. In addition, the new M&M format has generated six successful system-wide process improvements at our institution over the past year. We demonstrate that M&Ms can be used to effectively teach principles of patient safety, and create system wide improvements.