SCHOOL OF MEDICINE
OBSTETRICS & GYNECOLOGY

STANDARD OPERATING PROCEDURE or GUIDELINES

MORBIDITY AND MORTALITY CONFERENCE

SCOPE/APPLICABILITY:
All faculty and residents

PURPOSE:
The Department will conduct case reviews at M&M in order to benefit from the experiential learning that occurs with review of actual cases and also to consider and prioritize improvements to broader hospital systems that affect patient care. The purpose is "to provide a safe venue for residents, faculty, and staff to identify areas of improvement, and promote professionalism, ethical integrity, and transparency in assessing and improving patient care." It also "…provides a forum to teach curriculum on quality improvement and medico legal issues to residents and students and to foster a climate of openness and discussion about medical errors."

The M&M conference will consist of monthly conferences during which two cases will be reviewed as selected by the presenters and approved by the Departmental Quality and Patient Safety Officer (QSO) and/or the M&M Directors, from a group of cases proposed by the senior resident (in conjunction with the appropriate attending or fellow from each service) on each of the GYN, GYN Oncology, Urogynecology, Labor and Delivery, and MFM services.

The senior resident from each of the above services will discuss possible cases with a previously designated fellow from the division, if a fellowship exists, or a previously designated faculty member from the division. They will then send ONE TO TWO cases to the department M&M Director. Ideally, one obstetrical case and one gynecologic case will be chosen to be presented by the previously designated residents.

PROCEDURE:

ROLES AND RESPONSIBILITIES
M&M Director(s) Role:

- Ensure timelines are followed
- Ensure appropriate cases are selected
- Inform all faculty involved in case that their case will be presented (within and outside the department)
- Invite relative stake holders to attend conference
- Open the conference with an overview of the purpose of M&M and brief points about why the case selected; reiterate no finger-pointing – focus on systems of care rather than individual errors
- Facilitate and engage the audience in the discussion
- Close with Key Take Home Points

Resident Presenter Role:

- Prepare the case presentation
- Review the presentation with the assigned Faculty mentor in advance

Faculty Mentor role:

- Assist with identification of cases
- Review the resident's presentation in advance and be prepared for the topic

IDENTIFYING CASES FOR M&M PRESENTATION

- In general, cases should be selected from the entire practice population (inpatient or outpatient)
- A case should emphasize one or more of the following:
    - A poor or unintended outcome that might have been due to error or systems problems
    - A "near miss" or "good catch" where there was an error that could have led to a poor patient outcome, but it was caught before it reached the patient
- Throughout the rotation, CFP resident/fellow, GYN chief, Gyn Onc chief, Urogyn chief, MFM chief and L&D chief will discuss with appropriate divisional faculty possible M&M cases from recent admissions, discharges or OR cases, ideally focusing on cases that bring up provider error, patient error, and systems errors with the goal of improving systems to prevent the same errors in the future.
- List of reportable cases for OB
    - Obstetrical Indicators
        - Maternal Mortality
        - Unplanned readmissions
        - Maternal cardiopulmonary arrest
        - Unplanned removal, injury or repair of organ during operative procedure
        - Excessive maternal blood loss
        - Excessive length of stay
        - Eclampsia
        - Unplanned postpartum return to the OR
        - Post-operative infections
        - Post-operative VTE/PE
        - Unplanned admission to intensive care unit
    - Neonatal Indicators
        - Birth trauma
        - Unexpected Intrauterine fetal demise &/or term stillborn
- List of reportable cases for GYN
    - Gynecological Indicators
        - Mortality on Gyn service
        - Unplanned readmission with 14 days
        - Admission after return to the emergency room for the same problem
        - Cardiopulmonary arrest
        - Unplanned admission to intensive care unit
        - Unplanned return to the operating room during the same admission

- Ambulatory surgery patient admitted or retained for complication of surgery or anesthesia
- Excessive blood loss
- Unplanned removal, injury or repair of organ during operative procedure
- Discrepancy between preoperative diagnosis and postoperative tissue report
- Post-operative infections
- Post-operative VTE/PE

PREPARATION OF CASE PRESENTATION

- Do not—in any way—blame individuals for their errors, as this must be bred as a safe and professional space
- 100% confidentiality must be maintained
- Ensure to include the following statement to all documents and emails pertaining to the case: *This material is produced in connection with, and for the purpose of the Patient Safety Evaluation System and/or Review Organization established at the University of New Mexico Hospital, and is therefore confidential Patient Safety Work Product ("PSWP") and/or confidential peer review material of the University of New Mexico Hospital as defined in 42 C.F.R. § 3.20 and/or the Review Organizations Immunity Act, Section 41-9-1 et seq., NMSA 1978 as amended (ROIA). As such, it is confidential and is protected under federal law 42 C.F.R. §3.206 and/or ROIA. Unauthorized disclosure of this document, enclosures thereto, and information therefrom is strictly prohibited.*

Timeline for case preparation:

- ***4 Weeks prior to M&M presentation***: an email will be sent from department administration to each Chief and the Departmental Safety Officer/M&M Director(s) to initiate the case selection process. In response to this email (and after discussion with the designated fellow or faculty), each Chief should provide a brief description of his or her proposed case(s) (1-2 cases only) to the entire recipient list (i.e.: Reply All).
- ***2-3 weeks prior to the M&M presentation***: The M&M Director(s) will select two cases to be presented at the month's M&M; following case selection the resident and the faculty mentor will work on creating M&M presentation
- ***1 week prior to the M&M presentation:*** Resident presenter sends presentation to the M&M Director(s) and faculty mentor for review and feedback.

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CONFERENCE FORMAT

- Limit presentation to 10 minutes allowing for 15 minutes of discussion
- PowerPoint should include
    - Timeline of events
    - Describe how the patient care issue cause harm or potential harm
    - Root cause analysis using "5 whys" or "Fishbone diagram"
    - Identification of causal factors or contributing factors (Attachment A and B)
    - Recommend any clinical or system changes/improvements

FOLLOW UP OF SYSTEMS ISSUES

- M&M conference may begin with a brief discussion from the Departmental Quality & Safety Officer covering changes in systems that were identified through previous M&M presentations and case review and prioritized for action.
- Hospital systems issues should be entered into the patient safety event portal as appropriate.

[DO NOT EDIT BELOW THIS POINT]

Prepared by: ___Gillian Burkhardt, MD_____________

Chair Approval: ______________________ Date: _11/15/2023__

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ATTACHMENT A: RCA Causal Factor Definitions

Category	Definition
Human Factors	Refers to environmental, organizational and job factors, and human and individual characteristics, which influence behavior at work in a way which can affect health and safety
Patient Identification	Use of name, date of birth as primary identifiers
Physical Assessment/Reassessment	Was physical assessment/reassessment completed appropriately and timely for the patient’s presenting problem
Patient Observation	Was the observation of the patient conducted appropriately and timely for the patient’s presenting problem
Care Planning	Was the care plan completed and implemented
Medication Management	Any issues with the ordering, dispensing and/or administration of a medication
Continuum of Care/Discharge Planning	Any issues with the continuation of care either inpatient or after discharge (discharge planning)
Equipment/Maintenance Management	Is equipment checked, maintained as required
Physical Environment	Any contributing physical environment factors (such as slippery floor, location of patient in relation to nurses’ station)
Security Systems	What type of security systems were to be in place; what prevented implementation of these systems
Competency/Orientation/Training/Credentialing/Privileging	Any factors related to the competency of involved staff including experience, orientation, training (Medical Staff: Privileging and Credentialing)
Staffing	Were all scheduled staff present? If not, were those staff replaced?
Supervision of Staff	Was required supervision of staff appropriate?
Staff Performance	Did staff perform as expected?
Availability, Accuracy and Completeness of Information	Identify any issues related to the availability, accuracy and/or completeness of information (example: Cerner did not accept orders)
Technology/Adequacy of Technical Support	Was technology a factor? Availability of technology? Function of the technology?
Communication Among Participants	Was information communicated to required parties? Any communication that was vague, incomplete or ambiguous? Were there barriers to communication?
Communication with Patient/Family	Was information communicated to family as needed; in those cases, in which it applies, was information communicated to allow for informed consent?
Current Policy/Procedure	Does the policy/procedure fit with practice?
Staff Orientation / Training / Education	Does orientation/training fully address the issue identified; did lack of orientation/training contribute to the incident?
Other	

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ATTACHMENT B: Contributing Factors Definition

CONTRIBUTING FACTOR DESCRIPTIONS

LACK OF **ACCESS/FINANCIAL** RESOURCES
Systemic barriers, e.g, lack or loss of healthcare insurance or other financial duress, as opposed to noncompliance, impacted their ability to care for themself (e.g, did not seek services because unable to miss work or afford postpartum visits after insurance expired). Other barriers to accessing care: insurance non-eligibility, provider shortage in their geographical area, and lack of public transportation.

ADHERENCE TO MEDICAL RECOMMENDATIONS
The provider or patient did not follow protocol or failed to comply with standard procedures (i.e, non adherence to prescribed medications).

FAILURE TO SCREEN/INADEQUATE **ASSESSMENT** OF RISK
Factors placing the individual at risk for a poor clinical outcome recognized, and they were not transferred/transported to a provider able to give a higher level of care.

CHRONIC DISEASE
Occurrence of one or more significant pre-existing medical conditions (e.g, obesity, cardiovascular disease, or diabetes).

CLINICAL SKILL/QUALITY OF CARE (PROVIDER OR FACILITY PERSPECTIVE)
Personnel were not appropriately skilled for the situation or did not exercise clinical judgment consistent with standards of care (e.g, error in the preparation or administration of medication or unavailability of translation services).

POOR **COMMUNICATION**/LACK OF CASE COORDINATION OR MANAGEMENT/ LACK OF CONTINUITY OF CARE (SYSTEM PERSPECTIVE)
Care was fragmented (i.e, uncoordinated or not comprehensive) among or between healthcare facilities or units, (e.g, records not available between inpatient and outpatient or among units within the hospital, such as Emergency Department and Labor and Delivery).

LACK OF **CONTINUITY OF CARE** (PROVIDER OR FACILITY PERSPECTIVE)
Care providers did not have access to individual's complete records or did not communicate their status sufficiently. Lack of continuity can be between prenatal, labor and delivery, and postpartum providers.

CULTURAL/RELIGIOUS, OR LANGUAGE FACTORS The provider
or patient demonstrated that any of these factors was either a barrier to care due to lack of understanding or led to refusal of therapy due to beliefs (or belief systems).

DELAY
The provider or patient was delayed in referring or accessing care, treatment, or follow-up care/action.

DISCRIMINATION
Treating someone less or more favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication and shared decision-making. (Smedley et al, 2003 and Dr. Rachel Hardeman).

ENVIRONMENTAL FACTORS
Factors related to weather or social environment.

INADEQUATE OR UNAVAILABLE **EQUIPMENT/TECHNOLOGY**
Equipment was missing, unavailable, or not functional, (e.g, absence of blood tubing connector).

INTERPERSONAL RACISM
Discriminatory interactions between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as lack of respect, suspicion, devaluation, scapegoating, and dehumanization. (Jones, CP, 2000 and Dr. Cornelia Graves).

KNOWLEDGE - LACK OF KNOWLEDGE REGARDING IMPORTANCE OF EVENT OR OF TREATMENT OR FOLLOW-UP
The provider or patient did not receive adequate education or lacked knowledge or understanding regarding the significance of a health event (e.g, shortness of breath as a trigger to seek immediate care) or lacked understanding about the need for treatment/follow-up after evaluation for a health event (e.g, needed to keep appointment for psychiatric referral after an ED visit for exacerbation of depression).

INADEQUATE **LAW ENFORCEMENT** RESPONSE
Law enforcement response was not in a timely manner or was not appropriate or thorough in scope.

LEGAL
Legal considerations that impacted outcome.

MENTAL HEALTH CONDITIONS
The patient had a documented diagnosis of a psychiatric disorder. This includes postpartum depression. If a formal diagnosis is not available, refer to your review committee subject matter experts (e.g, psychiatrist, psychologist, licensed counselor) to determine whether the criteria for a diagnosis of substance use disorder or another mental health condition are met based on the available information.

INADEQUATE COMMUNITY **OUTREACH**/RESOURCES
Lack of coordination between healthcare system and other outside agencies/organizations in the geographic/cultural area that work with maternal health issues.

LACK OF STANDARDIZED **POLICIES/PROCEDURES**
The facility lacked basic policies or infrastructure germane to the individual's needs (e.g, response to high blood pressure, or a lack of or outdated policy or protocol).

LACK OF **REFERRAL** OR CONSULTATION
Specialists were not consulted or did not provide care; referrals to specialists were not made.

SOCIAL SUPPORT/ISOLATION - LACK OF FAMILY/ FRIEND OR SUPPORT SYSTEM
Social support from family, partner, or friends was lacking, inadequate, and/or dysfunctional.

STRUCTURAL RACISM
The systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage white people through inequities in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc. – (Adapted from Bailey ZD. Lancet. 2017 and Dr. Carla Ortique)

SUBSTANCE USE DISORDER – ALCOHOL, ILLICIT/ PRESCRIPTION DRUGS
Substance use disorder is characterized by recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems or disability. The committee may determine that substance use disorder contributed to the death when the disorder directly compromised their health status (e.g, acute methamphetamine intoxication exacerbated pregnancy- induced hypertension, or they were more vulnerable to infections or medical conditions).

TOBACCO USE
The patient's use of tobacco directly compromised the patient's health status (e.g, long-term smoking led to underlying chronic lung disease).

TRAUMA
The individual experienced trauma: i.e,, loss of child (death or loss of custody), rape, molestation, or one or more of the following: sexual exploitation during childhood plus persuasion, inducement, or coercion of a child to engage in sexually explicit conduct; or other physical or emotional abuse other than that related to sexual abuse during childhood.

UNSTABLE HOUSING
Individual lived "on the street," in a homeless shelter, or in transitional or temporary circumstances with family or friends.

VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)
Physical or emotional abuse perpetrated by current or former intimate partner, family member, friend, acquaintance, or stranger.

OTHER
Contributing factor not otherwise mentioned. Please provide description.

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