
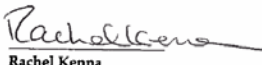



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1.0 Introduction

Our Lady's Children's Hospital Crumlin (OLCHC) is committed to providing a safe, effective and high quality nursing care to children and their families. An important element of nursing practice is to learn from one's experiences and the experiences of colleagues to reveal the knowledge and skills used in everyday practice, and to identify areas of practice which require development.

The Morbidity & Mortality (M&M) Conference is a forum to examine patient incidents and adverse outcomes and originated in the early 20th Century from the pioneering work of Dr. Ernest Codman, a surgeon in Massachusetts General Hospital, who had a strong interest in healthcare quality and patient outcomes. The M&M became a feature of medical education following the publication in 1910 of the Flexner Report into medical education in the US and Canada (Flexner 1910).

For many years, these conferences were attended by medical personnel only, but there is an increasing awareness of the importance of reviewing the system wide processes and factors which impact on patient care and outcomes (Deis et al. 2008). The OLCHC Nursing Outcomes Review Group was established in 2014 to provide nurses with a forum similar to the M&M for reviewing and reflecting on case studies to contribute to the ongoing development and improvement of nursing care and practice.

2.0 Definition of Guidelines

This document provides written instruction and guidance to nursing staff in OLCHC who are developing, presenting and reviewing cases study at the Nursing Outcomes Review Group. Guidelines must be accurate, up to date, evidence-based, easy to understand, non-ambiguous and emphasise safety. When followed they should lead to the required standards of performance.

3.0 Definition

Nursing Outcomes Griffiths (1995) adapted Donabedian's description of health outcomes to define nursing outcomes as the effect of nursing care on the health and welfare of individuals or populations. Examination and measurement of nursing outcomes should also reflect the structures and processes which influence and contribute to those outcomes (Griffiths 1995).


Reflective Practice: is the practice of reflecting on or paying critical attention to one's practice in order to engage in a process of continuous learning by gaining insight into the knowledge, theories and values which inform our everyday practice (Schon 1983, Bolton 2010).

Case Study: a situation in real life that can be looked at or studied to learn about something (Merriam-Webster 2014)

Morbidity & Mortality Conference: a forum for presenting and peer-reviewing incidents and adverse events occurring during patient care. The purpose of the M&M conference is to learn from incidents and errors and to prevent recurrence of the event and also recurrence of the circumstances which led to these events. The conference is non-punitive and is focused on the goal of improving patient care. (Tichansky et al. 2012)

4.0 Applicable to

These guidelines are applicable to all nurses who are engaged in supporting, developing, presenting and reviewing cases studies at the Nursing Outcomes Review Group and all nurses that are attending the group.

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5.0 Indications for the Nursing Outcomes Review Group

5.1 M&M Vs Review of Nursing Outcomes

The goal of M&M meetings is to provide healthcare professionals with the opportunity to discuss errors and adverse events in an open manner, and offers a forum for regular 'peer-review' of clinical performance, identifications of problems and wider clinical learning (Mitchell et al. 2013). However, the term 'M&M' implies that only cases with an adverse outcome are reviewed, rather than a system based approach to reviewing patient outcomes. Furthermore, substantial learning can be achieved from positive patient outcomes which have been achieved as a result of a high standard of care.

Therefore, the Nursing Outcomes Review Group does not use the title 'M&M' to describe its activity. Instead, both positive and negative outcomes of nursing care will be reviewed. Case studies will focus on the outcomes of nursing care / practice and the structures and processes which influenced the child's care.

5.2 Inclusion criteria for case studies

Case studies should have a high learning value for nurses, and may include examples of:

- a high standard of care which achieved positive patient outcomes
- a poor or unintended outcome which might have been due to, or worsened by, error or system problems, e.g. medication error, patient / parent complaint
- "near-misses," where there was an error or misstep in care delivery that could have led to a poor patient outcome
- an interesting or unique case that may provide new learning and inquiry
- an incident of poor communication which led to, or could have led to, a poor patient outcome

6.0 Guidelines on the Nursing Outcomes Review Group

6.1 Meetings of the Nursing Outcomes Review Group

- The Nursing Outcomes Review Group will meet monthly
- All nurses are invited to attend the meeting and to present a case study
- Nurses are invited to submit a brief summary of an incident or outcome to be considered for presentation at the meeting (See Section 5.0 for suggested case studies)
- Presentations will be structured using the ISBAR framework (See Section 6.2)
- Presenters will be given a template MS PowerPoint presentation which will include the ISBAR framework (Appendix 1)
- Each presenter will be assigned a mentor to assist them in developing the presentation and identifying the learning points and recommendations
- The meeting will be moderated by a nurse who will be responsible for timekeeping, facilitating the discussion and for summarising the recommendations and actions
- If during the discussion a point is raised which is not directly related to the topic in hand, this will be 'parked' for later consideration as this may warrant a session of its own.
- Outline of the meeting – each meeting will last 30 minutes
 - 10 minute - Presentation
 - 10 minute - Group discussion
 - 5 minute - Summary of recommendations and action plan
 - 5 minutes – Brief presentation / update on a nursing initiative in OLCHC

6.2 ISBAR Framework

The use of a standardised framework to structure and present case studies, for example, the SBAR framework, has been shown to improve the quality of presentations and attendees' educational outcomes (Dargon et al. 2012, Mitchell et al. 2012, 2013). The Nursing Outcomes Review Group will use the ISBAR Framework (*Identify, Situation, Background, Assessment/Analysis & Recommendations*) to structure the case study presentation (Table 1).



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Table 1: ISBAR Framework for the Nursing Outcomes Review Group

Identification	Presenter identifies themselves and their department Indicates their role in this situation	
Situation Statement of the problem	Patient age and gender Admitting diagnosis Brief description of incident or outcome	
Background Clinical information pertinent to adverse outcome	Patient History: Main nursing problems Summary of nursing care Incident / Outcome	Relevant patient history including: Date of admission Relevant medical history <i>*Include vital signs / lab results only if relevant to the incident / outcome</i> Summarise the main nursing problems and the goals of nursing care Summary of relevant nursing care Summary of this incident / outcome Any specific information relevant to the incident How / when was it identified What was done
Assessment & Analysis Evaluation of what happened and why it happened	What happened? Describe sequence of events leading to incident / outcome Why did it occur? Provide description of fundamental cause(s) of the incident / outcome in relation to, but not limited to, the following factors: <div> Human factors* <i>Breakdown in communication Error in the planning or delivery of care Error of judgement Specialist knowledge or experience Recognition of the early warning signs of the incident or outcome</i> </div> <div> System factors* <i>Staffing or skill mix levels Availability of information to support practice Coordination of care</i> </div> <div> Patient related factors* <i>Child's condition Child's hospital experience Role of the parents</i> </div> Note: Do not forget to consider the factors which positively contributed to the incident or outcome Present literature relevant to the incident or outcome	
Recommendations Evidence-Based Practice Proposed actions to prevent future similar problem	*Identify how the incident or outcome could: <ul style="list-style-type: none"> <i>Be replicated in the case of a positive incident or outcome</i> <i>Be better managed</i> <i>Be prevented- what could have been done differently</i> Identify learning point(s) from case	

* **Note:** Items in *italics* may or may not be relevant to each particular case study. Please select the criteria as required

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6.3 Actions arising from the Nursing Outcomes Review Group (Appendix 2) (See also Section 7: Special Considerations)

- Following each meeting, an action will be identified and a plan devised to implement this action.
- An annual report will be prepared which will summarise the actions and their implementation over the preceding year

6.4 Barriers to an effective Nursing Outcomes Review Group

Attributing individual blame

Travaglia and Debono (2009) found the principal barrier to M&M conferences was the apportioning of blame for an incident to an individual, rather than consideration of the systems and processes which contributed to the incident.

The purpose of the Nursing Outcomes Review Group is to facilitate learning from events and incidents and to improve nursing practice as a result, rather than attributing blame to an individual.

Fear of disclosure

Disclosing errors and adverse events, and one's own involvement in those events, during M&M conferences can result high levels of anxiety and stress, which can result in the counterproductive situation that healthcare professionals are unwilling to disclose events from their own practice (Travaglia & Debono 2009).

In order to be both effective and educationally valuable, the Nursing Outcomes Review Group will be structured to facilitate supportive, respectful, non-judgemental and constructive review.

7.0 Special Considerations

7.1 Respect and Non-Judgemental Approach

Each meeting will open with a standard statement which outlines:

- the focus of meeting which is to learn from the incident being reviewed and to ensure this learning is applied to improve patient care and outcomes.
- the importance of a non-judgemental culture
- the universality of human error


The review of each case study will focus on the patient outcomes, and the impact of structures and process on the child's care. The review should not include a critique of the personality traits and characteristics of healthcare professionals involved in the incident, unless this is specifically relevant to the incident.

7.2 Confidentiality and Data Protection

The opening statement will also refer to the confidentiality of the content, patient and personnel being discussed. When preparing the case study, presenters will be asked to use a pseudonym for the child.

7.3 Managing Risk (See Appendix 2)

If, during the course of the case study, any aspect of patient risk is identified, this will be escalated and managed through the OLCCH structures as appropriate, e.g. local Line Manager, Divisional Nurse Manager, Nurse Practice Committee, Nurse Education Committee, Senior Nursing Management Team.

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8.0 Implementation Plan

Communication and Dissemination

- Guidelines will be posted on the hospital Intranet and placed in the Nurse Practice Folder in each area
- Email will be circulated to all relevant staff informing them that the guideline has been issued
- Information will be circulated in NPDU Newsletter

Training

- A mentor will be assigned to each nurse who is presenting at the Nursing Outcomes Review Group to support them in preparing their presentation, analysing the event and identifying the recommendations for practice.


9.0 Evaluation and Audit

Evaluation and Audit includes:

- Feedback from attendees at the Nursing Outcomes Review Group will contribute to the ongoing development of the meetings
- Feedback from nursing staff on the guidelines to contribute to ongoing guideline development
- An annual report will be prepared which will summarise the recommendations arising from each meeting and their implementation

10.0 References

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Appendix 1: MS PowerPoint Template for presenting Case Studies

Nursing Outcomes Review Group



Date: / / 20



Identification

- Presenter's name
- Presenter's role / grade
- Presenter's department
- Presenter's role in this incident or event

1.



Background *(can be spread across 2 slides if needed)*

Theme	Details
Patient History:	Relevant patient history including: Date of admission Relevant medical history Include vital signs / lab results if relevant to the incident / outcome
Main nursing problems	Summarise the main relevant nursing problems and the goals of nursing care

3.



Assessment & Analysis *(can be spread across 2-3 slides)*

- What happened – describe sequence of events leading to the incident
- Was the issue escalated and how – what sequence
- Why did it occur – consider the causes in relation to:
Human Factors:

System Factors:

Patient Factors:
- Present literature pertinent to the incident or outcome

5.

Situation

- Patient age and gender
- Admitting diagnosis
- Brief description of incident or outcome

2.



Background *(can be spread across 2 slides if needed)*

Theme	Details
Summary of nursing care	Summary of relevant nursing care received
Incident / Outcome	Summary of this incident / outcome Any specific information relevant to the incident How / when was it identified How was it managed


4.



Recommendations

- Identify how the incident or outcome could:
Be replicated in the case of a positive incident or outcome
Be prevented
Be better managed
- Identify learning point(s) from case study

6.

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Appendix 2: Process for Managing the Content and Outcomes of the Nursing Outcomes Review Group

