Supplementary Online Content


eAppendix A. Morbidity & mortality case summary saushec otolaryngology surgery service
eAppendix B. Pre-test: Morbidity and Mortality Conference
eAppendix C. SBAR Evaluation Tool: Month 0
eAppendix D.

This supplementary material has been provided by the authors to give readers additional information about their work.
ERROR CLASSIFICATION:

**Patient care**
- Nature of disease
- Patient non-compliance

**Medical knowledge**
- Error in H&P
- Error in differential diagnosis
- Error in laboratory or radiology evaluation
- Error in medical therapy
- Error in surgical planning
- Technical surgical errors
- Known complication of surgical procedure
- Error in intraoperative management

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**TABLE III.**

<table>
<thead>
<tr>
<th>Category</th>
<th>NCC MERP Definition</th>
<th>Additional Definitions for the Current Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>No error</td>
<td>A Circumstances or events that have the capacity to cause error</td>
<td></td>
</tr>
<tr>
<td>No harm</td>
<td>B An error occurred but did not reach the patient (“an error of omission” does reach the patient)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C An error occurred that reached the patient but did not cause harm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D Error reached the patient, and required monitoring to confirm that no harm resulted and/or required intervention to prevent harm</td>
<td></td>
</tr>
<tr>
<td>Harm</td>
<td>E Error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F Error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G Error occurred that may have contributed to or resulted in permanent patient harm</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>H Error occurred that required intervention necessary to sustain life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I Error occurred that may have contributed to or resulted in the patient’s death</td>
<td></td>
</tr>
</tbody>
</table>

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___Error in postoperative management

*Interpersonal and communication skills*

___Communication errors

*Professionalism*

___Fatigue

___Culture of patient care and safety

*Systems-based practice*

___Administrative errors

___Nursing errors

___Technician errors

___Equipment-related errors

___External departmental errors

*Practice-Based Learning and Improvement*

___Failure to use previous experience, literature, or training to prevent outcome/resolve complication

___Other ___________________

STANDARD OF CARE:

___Met

___Not met

___Indeterminate

RECOMMENDED ACTION:

___Intradepartmental discussion

___Intradepartmental examination for quality improvement project

___Interdepartmental discussion with contributing department

___Referral to Department of Surgery (Categories resulting in Harm or Death)

___Referral to Risk Management

___Referral to Anesthesia Department - Death within 48 hrs of surgery

FOLLOW-UP (QI/PS project identified?):

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Appendix B: Pre-test: Morbidity and Mortality Conference

1. Please identify yourself:

   Resident  Faculty  Other ______

2. Rate the current format of M&M case presentations for analyzing patient complications:

   Ineffective  1  2  3  4  5  6  7  8  9  10  Comprehensive

3. Rate the current M&M with regards to effectiveness for resident learning

   Worst  1  2  3  4  5  6  7  8  9  10  Best

4. How clear are specific patient complications as stated in each case presentation (ie. Death from acute MI)?

   Not at all  1  2  3  4  5  6  7  8  9  10  Perfect

5. How clearly are core causes for complications established in each case (ie. Systems-based practice, interpersonal communication)?

   Not at all  1  2  3  4  5  6  7  8  9  10  Perfect

6. After a case presentation, how effectively is it discussed how to avoid complication in the future (ie. Regular review of operating room equipment maintenance)?

   Terrible  1  2  3  4  5  6  7  8  9  10  Excellent
7. How well are opportunities for quality improvement and patient safety improvement discussed and recommendations made?

Terrible 1 2 3 4 5 6 7 8 9 10 Excellent

8. How much follow-up is given on past cases where efforts were made towards quality improvement?

None 1 2 3 4 5 6 7 8 9 10 Extensive

9. What are the most important elements needed in the M&M conference. (Rank from most important (1) to least important (7)

Established presentation format
Time-limited presentations
Resident-led discussion
Faculty-led discussion
Follow-up on changes based on previous M&Ms
Incorporate more quality improvement and patient safety improvement analysis
Categorize specific cause of complication
Appendix C: SBAR Evaluation Tool: Month 0

<table>
<thead>
<tr>
<th>Role - Situation</th>
<th>Faculty</th>
<th>Resident Poor/Disorganized</th>
<th>Student</th>
<th>Other Clear and Concise</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Statement of problem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Statement of procedure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Statement of adverse event</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Background**

1. HPI | 1 | 2 | 3 | 4 | 5 |
2. PMH/PSH/Meds, etc | 1 | 2 | 3 | 4 | 5 |
3. Labs/Imaging | 1 | 2 | 3 | 4 | 5 |
4. Describes reason for intervention | 1 | 2 | 3 | 4 | 5 |
5. Procedural Details | 1 | 2 | 3 | 4 | 5 |
6. Hospital Course | 1 | 2 | 3 | 4 | 5 |
7. Recognition of Complication | 1 | 2 | 3 | 4 | 5 |
8. Management of Complication | 1 | 2 | 3 | 4 | 5 |

**Assessment & Analysis**

1. Analysis of what happened and why | 1 | 2 | 3 | 4 | 5 |
2. Root Case Analysis | 1 | 2 | 3 | 4 | 5 |
3. Description of fundamental causes of error | 1 | 2 | 3 | 4 | 5 |
4. Identifies patient safety or QI areas | 1 | 2 | 3 | 4 | 5 |

**Review**

1. Presents evidence-based review of the literature | 1 | 2 | 3 | 4 | 5 |

**Recommendations**

1. Proposed actions to prevent future issues | 1 | 2 | 3 | 4 | 5 |
2. Identifies learning points | 1 | 2 | 3 | 4 | 5 |