Teaching Tool 6 – Morbidity and Mortality Rounds

CanMEDS Leader

Patient safety and quality improvement

Instructions for Learner:

- Observe and take (non-identifying) notes on your Leader Role activities in day-to-day practice
- Remember to be cautious about confidentiality when taking notes
- Review with faculty as arranged or initiate a review of your case reports to get feedback

Completed by: _____

Case report ID: _____

1. Provide an overview of this case (i.e. summary)

2. Describe the setting: *Workplace*

   ☐ Ward ☐ Clinic ☐ OR ☐ ER ☐ Other: _____

3. Outline any other relevant information about this case and/or organization and/or team.

4. What quality gaps, safety gaps or stewardship gaps were identified?

5. What were the contributing factors to the safety, quality, or stewardship problem?

6. What could be done to improve things?

7. What was the patient and family's perspective?

8. What did you learn from this that you will take into your future practice?

9. What is KNOWN (in literature) about this problem? Possible solutions?

10. How did this case affect you personally?

11. What are the TOP two or three 'take home points' from this case?

12. What can be done?
    a. What can you do?
    b. What can others do?

13. Planning for improvement

#	Top areas for improvement identified in this case	Who is responsible for improvements?	What can be done?
1.			
2.			
3.			

Other notes/reflections:

☐ Patient safety applies to this situation
☐ Patient safety does not apply to this situation

Patient Safety IN THIS SITUATION	Rating			Comments	Areas or ideas for improvement?
	Done	Not done	Not applicable		
I recognized the patient safety incident, and was able to classify it as: 1) A harmful incident results in harm to the patient, Harm occurred due to medical care as opposed to underlying medical condition. 2) A no harm incident reaches a patient but does not result in any discernible harm, 3) A near miss does not reach the patient					
I contributed to a safety culture including demonstrating commitment to openness, honesty, fairness, and accountability. Include examples of how.					
I reported the incident(s) and safety hazard(s) and/or notified my supervisor. Include who, how and when.					
I met the immediate and ongoing care needs of the patient, limited further harm, and provided ongoing monitoring and care.					
I explained to the patient what unexpected event					

Patient Safety IN THIS SITUATION	Rating			Comments	Areas or ideas for improvement?
	Done	Not done	Not applicable		
or change happened. Include who, how and when.					
I apologized that it happened. Include who, how and when.					
I explained what would happen next including explicitly discussing prevention with future patients. Include who, how and when.					
I/we analyzed the patient safety incident(s) to enhance systems of care. Include who, how and when.					
I/we planned a debriefing to manage the emotional impact. Include who, how and when.					
OTHER:					

Other notes/reflections:

5. Summarize your TOP two or three areas of strength?

6. Planning for improvement

#	Summarize your TOP two or three personal areas for improvement over the next four to eight weeks?	How are you going to work on your personal improvement priorities over the next four to eight weeks?	How will you know that you have achieved the needed improvement in your personal priority areas?
1.			
2.			
3.			