"A novel and effective ophthalmology morbidity and mortality meeting: Eight Years of Learning and Improvement"

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The ROYAL COLLEGE of OPHTHALMOLOGISTS

Introduction

- The Royal Colledge of Surgeons reccomends all surgeons participate in M&Ms (1).
  - No formal guidance from the Royal College of Ophthalmologists.
- Our department introduced M&M meetings in 2016, supported by a unique data tool: the "glitch book".
- This poster presents 8 years of experience using this tool to support patient safety and quality improvement (2,3).
- We advocate for wider adoption of structured M&Ms in ophthalmology.

Methods

- The **glitch book** is a physical log in the operating theatre.
- Glitches are based on Morgan et al.'s (4) concept of "glitches"—intraoperative deviations of any size or severity.
- Any team member can record unplanned/inadvertent events during surgery that could/did cause harm.
- Entries inform M&M discussions, focusing on:
  - Actionable change
  - Patient safety
  - Quality improvement
- Approximately 40 entries/year





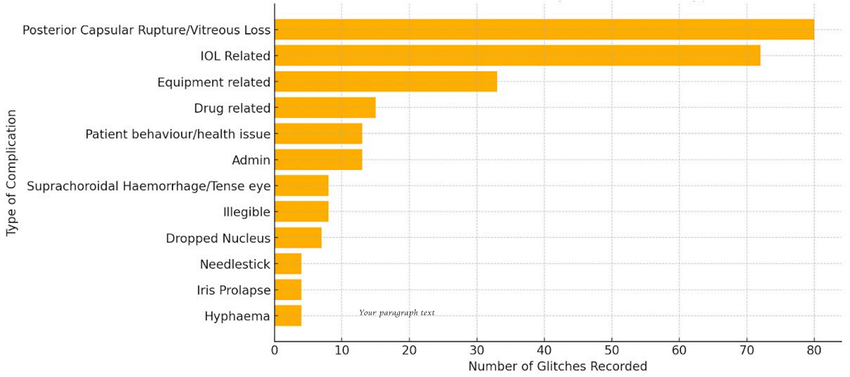

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Figure 1: Glitches recorded by complication type



Results

- 261 glitches recorded since 2018 (figure 1) .
  - Cataract-related glitches dominate which reflects high surgical volume.
- Word cloud of participant feedback includes: "Training", "Share", "Open" highlighting perceived value (figure 2).
- Examples of practice change from M&M discussions:
  - Changed intraocular lens (IOL) brand after increased Posterior Capsular Rupture (PCR) incidents.
  - Replaced cataract chair following team-raised safety concerns.

Limitations

- Glitch book is theatre-based and misses postoperative complications:
  - No entries for known issues like retained lens fragments or refractive errors.
  - Implementing a parallel reporting tool in eye casualty may address this.
- Undereporting bias may occur in the glitch book and is difficult to measure.



Figure 2: Word Cloud formed from MDT attendee feedback



Conclusion

- The glitch book has:
  - Supported a non-blame culture of safety and shared learning.
  - Engaged all team members in identifying and addressing patient safety issues.
  - Created a structured, effective M&M process in ophthalmology.
- Our experience offers a practical model for other departments looking to implement M&Ms.

References

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