Morbidity and Mortality Conference
Dedicated to QI

Description
The morbidity and mortality conference at Huntington Hospital is the main didactic session dedicated to developing competency in practice based learning and improvement and systems based practice. In 2013, the decision was made to redesign this conference in order to focus on quality and patient safety, prioritizing the analysis of unexpected and adverse outcomes in a systematic and non-punitive manner.

Aim
To create a resident run conference whereby a resident uninvolved in the cases performs a systems audit to address all six of the core competencies as mandated by the ACGME: patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism and systems based practice.

Identify areas of improvement in the care of the patient, both at the system level and the individual level.

Provide a forum to discuss medical error and adverse events openly without blame.

Methods
Patient cases are tracked on a monthly basis based on the following outcomes:
- Unexpected outcome, including death
- Readmission to hospital within 30 days of initial discharge
- Any patient issue which could reflect a system or practice related problem
- Any complication of a procedure or lack of procedure that prolonged the hospital stay or caused readmission, morbidity or mortality
- Any adverse outcome resulting in temporary or permanent disability

A systems based audit is then performed by a resident uninvolved in the care of the patient. Potential causative and contributing factors under the following general categories are addressed:
- Patient factors (comorbidities, non-adherence, social issues, etc.)
- Process factors (systems related issues such as protocol, guidelines, compliance, etc.)
- Material/equipment factors (availability of specific equipment, failure of equipment, etc.)
- Personal factors (availability, training, experience, etc.)

Results
Residents perform a systems audit through the use of one of the three systems audit tools diagrammed below. The six ACGME core competencies are addressed in the systems audit. A powerpoint presentation is completed by the resident, which discusses specific areas for improvement followed by a short didactic to address any medical knowledge deficiencies. The monthly conference allows for an open conversation between the graduate medical education department and the quality improvement department, facilitating a strong relationship.

Outcomes and Lessons Learned
Our experience demonstrates that the integration of a structured systems audit into the monthly morbidity and mortality conference increased resident awareness of systems-based practice, enhanced the perceived educational value, and led to meaningful improvements in patient care and safety throughout our institution.

The monthly morbidity and mortality conference has facilitated a discussion between graduate medical education and quality improvement department. This in turn has sparked interest among the residents to participate with ongoing quality improvement projects within our institution.

REFERENCES
Soare I, Watteland PH. A systems approach to morbidity and mortality conferences. The American Journal of Medicine 2010; 123: 667-682