**BACKGROUND**

- In Philadelphia, 1935, the earliest precursor to the Morbidity and Mortality Rounds (M&M) was developed to facilitate discussion among physicians by open review of cases reflecting error, to share knowledge about fatalities and to improve practice.
- Since then, M&M have become more common in both surgical and medical specialties.
- M&M have been found to have two primary uses:
  1. To review incidents in order to identify the causes of adverse events and to develop strategies for quality improvement, and
  2. To be an educational tool for staff, particularly residents.
- Evidence for the use of M&M as a quality improvement surgical initiative is best demonstrated by a 40% decrease in gross mortality over 4 years at an academic center through a mandatory structured M&M's in conjunction with a physician report card system.
- Despite widespread use, there are no validated or standardized recommendations to guide the structure and process of M&M's as a quality improvement initiative.

**THE PROBLEM**

- Within the University of Calgary, Division of Neurology, M&M occur quarterly as both an educational and quality improvement opportunity. Anonymous cases are presented and discussed, with potential cognitive and system contributors identified using the Ottawa Morbidity and Mortality model.
- However, from September 2014 to June 2015, eight cases were presented at the Division of Neurology Morbidity and Mortality Rounds, with none leading to any formal quality improvement initiatives.

**OBJECTIVE**

- To build an understanding of the current structure and process used to identify, report, evaluate and respond to cases brought forth to M&M's within the Division of Neurology.

**METHODS**

- The project was screened using the A Project Ethics Community Consensus Initiative (ARECCI) Ethics Screening.
- Stakeholders were identified as:
  - Neurology Residents
  - Neurology Quality Improvement Committee
  - Informal M&M subcommittee
  - Neurology Division Head
  - Neurologists
  - Patients

**RESULTS**

- A modified SIPOC diagram was used as the process mapping tool. Requirements for inputs and Requirements for outputs were added (SIRPORC).

**DISCUSSION**

- There was some variability regarding the perception of current ownership of M&M.
- Because the current expectation is that the resident follows through on the "clinical bottom line" generated at M&M, the resident was identified as the customer.
- There was some variability regarding the perception of current ownership of M&M.
- Of the limitations that were identified based on the current design, there were seen as contributing most to the lack of action on clinical bottom lines over the past year:
  1. Having a resident alone as the customer for initial output of M&M may not be ideal as the initiative may require significant time, accountability and support of leaders within the Division.
  2. Currently the M&M committee is not well defined, in terms of membership and mandate including its role in measuring action performance on M&M's quality improvement initiatives.
  3. There are currently no specific guidelines for what components are required in the "clinical bottom line" that is generated at M&M.

**NEXT STEPS**

- Re-evaluating the M&M committee membership, mandate and role in measuring action performance on M&M's quality improvement initiatives.
- Creating a specific guideline for required components of the "clinical bottom line" so that it is well defined and actionable.
- Defining who the best customer (individual or team) is for acting on the generated "clinical bottom line".
  - eg. resident, plus assigned staff with expertise in the area under supervision of M&M subcommittee.

**REFERENCES**