Manual for Clinical Governance Framework

Version 1.0

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Health Policies and Standards Department

Health Regulation Sector (2023)

INTRODUCTION

- Health Regulation Sector (HRS) forms an integral part of Dubai Health Authority (DHA) and is mandated DHA Law No. (14) of the year (2021) amending some clauses of law No. (6) of 2018 pertaining to the Dubai Health Authority (DHA), to undertake several functions including but not limited to:
- Developing regulation, policy, standards, guidelines to improve quality and patient safety and promote the growth and development of the health sector;
- Licensure and inspection of health facilities as well as healthcare professionals and ensuring compliance to best practice.
- Managing patient complaints and assuring patient and physician rights are upheld;
- Governing the use of narcotics, controlled and semi-controlled medications;
- Strengthening health tourism and assuring ongoing growth; and
- Assuring management of health informatics, e-health and promoting innovation.

The Manual for Clinical Governance aims to fulfil the following overarching DHA Strategic Priorities (2022-2026):

Pioneering Human-centered health system to promote trust, safety, quality and care for patients and their families.

- Make Dubai a lighthouse for healthcare governance, integration and regulation.
- Pioneering prevention efforts against non-communicable diseases.
- Foster healthcare education, research and innovation.

ACKNOWLEDGMENT

The Health Policy and Standards Department (HPSD) developed this Manual in collaboration with Subject Matter Experts and would like to acknowledge and thank these health professionals for their dedication toward improving quality and safety of healthcare services in the Emirate of Dubai.

Health Regulation Sector

Dubai Health Authority

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EXECUTIVE SUMMARY

The application of Clinical Governance framework in Health facilities is an important factor in achieving and implementing high quality care delivered to patients in Dubai. In this way, DHA can ensure that services provided are safe, high quality and effective, which creates an environment of trust between the patient and the system

It is important for DHA to define all the qualities of the clinical governance frame work to guarantee proper application. Therefore, this manual establishes the characteristics and set of duties on health facilities operating in Dubai.

DEFINITIONS

Adverse Events: includes any unanticipated, undesirable or potentially dangerous occurrence within the health facility.

Clinical Audit: A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Clinical Effectiveness: Involves ensuring that patients receive the most appropriate care and treatment, based on the best available evidence.

Clinical Governance: is the system by which the health facilities, managers and clinicians share responsibility and are held accountable for patient care, through minimizing of risks and continuous monitoring and improvement of clinical and nonclinical services.

Conflict of Interest: shall refer to the conflict between an external entity's private interests and its official responsibility toward the health facility being grandfathered.

Failure Mode and Effects Analysis (FMEA) is a proactive risk assessment tool that evaluates a process to identify potential failures and their effects. A method that helps health care organizations identify and eliminate process failures for the purpose of preventing adverse events.

Focused Professional Practice Evaluation (FPPE): is a process whereby the medical staff evaluates the privilege-specific competence of the practitioner that lacks documented evidence of competently performing the requested privilege(s) at the organization.

Grandfathering: An external competent entity which oversees and supports a health facility to meet the requirements for clinical governance.

Mortality: Is the in-hospital deaths for patients under the care of a defined consultant or specialist.

Near Miss (or close call): is a patient safety event that did not reach the patient.

Ongoing Professional Practice Evaluation (OPPE): is a summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behaviour, professional growth and clinical results in DHA licensed health facilities. The information gathered during the process is factored into decisions to maintain, revise, or revoke existing privilege(s) prior to or at the end of the privilege-renewal cycle.

Risk Management: Coordinated activities that aim to identify, control and minimise threats within the health facility which will enhance the efficiency and effectiveness of services provided to the patient.

Risk Matrix: A tool that helps evaluate and rank the level of risk associated with deficiencies or noncompliance issues that are identified during surveys or reviews of health care organizations. The risk matrix is part of the Survey Analysis for Evaluating Risk (SAFER) process, which is a scoring approach that aims to improve patient safety and quality of care.

Root Cause Analysis (RCA): a systematic and comprehensive reactive methodology for identifying the gaps in hospital systems and processes of care that may not be immediately apparent and which may have contributed to a sentinel event or near miss of a serious incident

Sentinel Event: a sudden, and severe patient safety event at the health facilities that could have resulted in death, permanent harm, severe temporary harm, and results in any event that listed as SE in, and not primarily related to the natural course of the patient's illness or underlying condition. A patient safety event can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error.

ABBREVIATIONS

AE : Adverse Events

CG : Clinical Governance

DHA : Dubai Health Authority

FPPE : Focus Professional Practice Evaluation Process

FMEA : Failure Mode and Effects Analysis

HRS : Health Regulation Sector

HP : Healthcare Professionals

MD : Medical Director

NM : Near Miss

OPPE : Ongoing Professional Practice Evaluation

PPI : Patient and public involvement

PQR : Unified Professional Qualification Requirements

SE : Sentinel Event

1. BACKGROUND

Clinical Governance is a framework where health facilities are held accountable for the continuous improvement of the quality of services and the high standards of care, to establish a flourishing clinical environment. It's often thought of in terms of the seven pillars of clinical governance clinical effectiveness, risk management, patient experience and involvement, communication, resource effectiveness, strategic effectiveness, and learning effectiveness. The impact of clinical governance is positive, both on health facilities and healthcare professionals. Clinical governance creates a sense of transparency between the facility and the patient, which builds on trust and positive patient care outcomes. In terms of healthcare professionals, the constant assessment of clinical practices and techniques allows healthcare professionals to regularly build on their skills and adopt new techniques for better care provision.

2. SCOPE

2.1. Clinical Governance (CG) framework implementation.

3. PURPOSE

3.1. To set the framework for CG for Health Facilities under the jurisdiction of Dubai Health Authority (DHA).

3.2. To ensure health facilities implement CG.

3.3. To enhance the quality and safety of care provided in all DHA licensed health facilities.

4. APPLICABILITY

4.1. The below listed DHA licensed health facilities and healthcare professionals working in them:

4.1.1. Hospitals

4.1.2. Day Surgical Centres

5. CHAPTER ONE: CLINICAL LEADERSHIP

5.1. Effective clinical governance requires strong leadership from healthcare professionals who are responsible for ensuring that care is safe, effective, and patient-centred. This includes setting the strategic direction for clinical services, ensuring compliance with regulations and standards, and managing risk.

5.2. All Health Facilities should have in place a CG system to assure the continuous improvement of quality and patient safety.

5.2.1. The clinical governance system should include a designated CG Lead who is responsible to oversee and report on CG.

5.2.2. The clinical governance lead should be a member of the higher leadership team, with an authority and accountability duty, for example the Medical Director (MD).

5.2.3. Clinical Governance Committee (or equivalent) can include and is not limited to the leads of the below committees/groups:

a. Mortality and Morbidity

b. Sentinel Events

c. Quality and Safety

d. Audit & Effectiveness

e. Infection Prevention and Control

f. Patient Experience & Engagement

g. Ethical Committee

h. Health Records

i. Drug & Therapeutics

j. Patient Safety Review

5.2.4. Resources for the CG lead should be made available to assure identification and improvement of quality and patient safety.

5.2.5. The committee should be accountable to implement CG, and the continuous improvement of patient services and clinical outcomes.

5.2.6. The committee should meet on a monthly basis and regularly monitor, oversee and document all areas related to CG in the health facilities as per DHA Policy.

5.2.7. Committee members should undergo ongoing education and training to improve and implement appropriate measures for CG.

5.3. Clinical leaders should have the following competencies:

5.3.1. Clinical Expertise.

a. Clinical leaders should have a deep understanding of clinical practice and the healthcare environment in which they work, through qualifications and/or experience.

5.3.2. Strategic Thinking.

a. Clinical leaders need to be able to think strategically about the long-term goals of their organization and how to achieve them.

b. Clinical leaders require the ability to analyse data, identify trends, and make decisions based on evidence and best practice.

5.3.3. Collaborative Skills.

a. Clinical leaders should be able to work collaboratively with other healthcare professionals, patients, and stakeholders.

b. Clinical leaders require the ability to build relationships, communicate effectively, and work towards common goals.

5.3.4. Risk Management.

a. Clinical leaders need to be able to identify and manage risks that could potentially harm patients, health workers, or the organization.

b. Clinical leaders require the ability to conduct risk assessments, develop risk management strategies, and monitor and review risks regularly.

5.3.5. Quality Improvement

a. Clinical leaders should be committed to continuous quality improvement, regularly reviewing and evaluating clinical care and services to identify areas for improvement.

5.3.6. Patient Centeredness

a. Clinical leaders should be committed to providing patient-centred care, ensuring that patients are involved in decision-making (such as the plan of care, initial assessments, discharge planning etc.) and that services are responsive to patient

needs. Patient experience surveys and patient satisfaction surveys have to be conducted to ensure that the services are responsive to patient needs.

5.3.7. Ethical and Professional Conduct.

a. Clinical leaders should uphold ethical and professional standards in their practice, ensuring that care is provided with integrity, respect, and compassion.

5.4. Health Facilities with less than twenty (20) clinical and allied health staff may opt to adopt grandfathering approach for clinical governance.

5.4.1. A Memorandum of Understanding should be in place between the health facility and the external grandfathering health entity.

5.4.2. The grandfathering entity must have sufficient and competent healthcare professionals to assist in clinical governance.

5.4.3. Both parties should put in place measures to avoid conflict of interest.

6. CHAPTER TWO: CLINICAL EFFECTIVENESS

6.1. Clinical effectiveness is a measure of the degree of which a specific intervention works. It ensures that any practice conducted in a clinical setting is designed to provide the best results for the patient.

6.2. Clinical effectiveness is enhanced through applying evidence-based practice approach in managing patients, improving the level of care provided to patients by exploring new forms of research to explore and implement the evidences, changing clinical practice and developing new protocols and guidelines.

6.3. Health facilities are required to implement the below to achieve clinical effectiveness within CG framework and through multidisciplinary teamwork to achieve the best outcomes:

6.3.1. Evidence-based practice

a. Adoption of evidence-based practice to ensure that patients receive the most appropriate care and treatment based on the best available evidence.

b. Keeping up-to-date with the latest research, guidelines, and best practice, and using this information to inform clinical decision-making.

6.3.2. Clinical Guidelines

a. Prioritising implementation of DHA published clinical guidelines.

b. Implementing evidence-based recommendations for clinical practice, developed by specialized and well-established organizations.

c. Ensuring that their adoption standardizes and promotes best practices as well as ensures that care is based on the best available evidence.

6.3.3. Quality Improvement

a. Commitment to continuous quality improvement, regularly reviewing and evaluating clinical care and services to identify areas of risk and improvement.

b. Monitoring and reviewing clinical outcomes, using data to identify trends, implementing strategies to improve the safety and quality of care delivery continuously implementing strategies to improve patient care and service delivery.

c. Continuously implementing strategies to improve patient care and service delivery.

6.3.4. Patient-centred care

a. Adopting a patient-centred approach to care, ensuring that care is tailored to the individual needs and preferences of each patient and/or family member.

b. Involvement of patients and/or family member in decision-making, listening to their concerns, and ensuring that care is responsive to their needs.

6.3.5. Clinical audit

a. Review and evaluation of clinical care and services to identify areas for improvement.

b. Identify areas where care is not meeting best practice standards, and inform quality improvement initiatives.

6.3.6. Education and Training

a. Ongoing education and training to ensure that clinicians are up-to-date with the latest evidence, technologies, and best practices

b. Providing opportunities for professional development, continuing education, and skills training.

c. Encouraging journal clubs, seminars, scientific meeting and case discussion.

6.3.7. Credentialing and scope of clinical practice

a. Define the scope of clinical practice for healthcare professionals through outlining the specific procedures and techniques that they are authorised to perform as well as any limitations on their practice.

b. Monitor the practices of healthcare professionals to ensure that they are operating within their designated scope of clinical practice scope.

c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered.

7. **CHAPTER THREE:** CLINICAL AUDIT

7.1. The purpose of clinical auditing is to consistently monitor clinical practice and identify opportunities for improvement in the clinical field. The data collected from clinical audit is important to develop patient care, help professional development, form a recognition of accountability and make sure healthcare resources are being used effectively.

7.2. Clinical audit should provide a systematic process for monitoring and evaluating the quality of clinical care and services.

7.3. Clinical audit should be carried biannually and results should be reported to DHA, health facility should ensure:

7.3.1. Clear audit objectives are identified:

a. Clear objectives that are aligned with the goals of the organization as well as local and federal regulations and the needs of patients.

b. Identify specific areas of clinical care and services that require the need to be evaluated and improved based on the Clinical Audit Project Scoring Criteria (**Appendix 1**).

c. After identifying the audit objectives health facilities should submit a request for clinical audit to DHA by using the Clinical Audit Proposal Request (**Appendix 2**).

d. The health facilities can conduct more frequent clinical audits which are reported internally.

7.3.2. Robust data collection

a. Data collection processes should ensure the collection of accurate and reliable data.

b. The clinical audit data collection should ensure robust methodology.

7.3.3. Data analysis

a. Strong data analysis processes to interpret accurate findings.

b. The findings will be presented to the concerned department in power point presentation and minutes of meeting should be recorded.

c. All will be incorporated in the Clinical Audit Report. (**Appendix 3**)

7.3.4. Action planning

a. Development and implementation of action plans to address areas of clinical care that need improvement as well as monitoring and evaluating effectiveness of these plans based on the Clinical Action Plan Follow up Template. (**Appendix 4**)

7.3.5. Communication and Feedback

a. Effective communication of the audit findings to clinicians, managers and other stakeholders as well as providing feedback on the effectiveness of action plans.

7.3.6. Continuous improvement

a. Ensuring that clinical audit is a continuous process of improvement.

b. Utilizing the findings of the audit to inform ongoing quality improvement initiatives and regularly review and evaluate clinical care and services to identify areas of for improvement.

8. CHAPTER FOUR: TRAINING AND EDUCATION

8.1. Health care providers should never stop learning. It is vital that staff in the clinical field are always updated and continue learning to professionally develop and stay up to date. Developing their skills will enable them to be more efficient in doing their jobs. However, support must be available from the facility to facilitate their professional development.

8.2. Training and education can involve attending courses and conferences (referred as Continuous Professional Development), Identifying and discussing weaknesses, conducting relevant exams and having opportunities for professional development.

8.3. To achieve an effective education and training pillar, health facilities should ensure:

8.3.1. Continuous professional development for all staff.

a. Ensuring the ongoing education and training for healthcare professionals based on the facility scope.

8.3.2. Providing regular opportunities for professional development, including training on new techniques, technologies, and best practices in clinical care.

a. Aligning the HP training requirements to satisfy the CME requirement mandated in the Professionals Qualification Requirements (PQR).

8.3.3. Training on clinical governance principles

a. Providing training on the principles and concepts of clinical governance for all staff members, not just clinical staff of the facility.

b. Education and training on the key components of clinical governance, including risk management, quality improvement, clinical audit, and patient and public involvement.

8.3.4. Specialized training

a. Specialized training for staff members who are responsible for implementing clinical governance initiatives.

i. Training on specific skills and competencies, such as risk assessment, data analysis, and quality improvement methodologies.

ii. Effective clinical governance requires training on data analysis and reporting.

8.3.5. Professional Practice Evaluation

a. The health facility shall perform Ongoing Professional Practice Evaluation (OPPE). The information gathered during the evaluation is factored into decisions to maintain, revise, or revoke existing privilege(s). The Medical Director /Assigned Designee is responsible for the integration of the data and information on medical staff and taking appropriate actions.

b. Focus Professional Practice Evaluation Process (FPPE) should be performed by a competent professional practice evaluation committee. The evaluation should be

performed in a manner that is objective, equitable and consistent. DHA will conduct the FPPE as needed based on their internal process.

9. CHAPTER FIVE: STAFFING AND STAFF MANAGEMENT

9.1. Recruiting qualified health care professionals who are appropriate for the job is essential for ensuring high-quality, patient-centred care. Staff management requires maintaining a professional relationship, defining their roles, responsibilities and scope of practice, and addressing underperformance.

9.2. The health facilities should have in place comprehensive approaches and plans for recruiting and allocating competent and qualified healthcare professionals as per the Professional Qualification Requirement (PQR).

9.3. The health facilities should ensure all HP have the appropriate qualifications, knowledge and experience to provide safe, high-quality care consistent with patient needs and ongoing professional development to maintain their skills.

9.4. Staffing levels should not compromise patient safety and provision of high quality of care.

10. CHAPTER SIX: RISK MANAGEMENT AND REPORTING

10.1. Risk management is an essential component of effective CG, helping healthcare organizations identify, assess, and manage risks to patient safety and quality of care. The system should create a responsible, blame free culture of learning where the staff feel safe and comfortable enough to report mistakes and incidents.

10.2. To achieve effective risk management within a CG framework the health facilities should adopt:

10.2.1. Risk assessment

a. Ensuring the implementation of a systematic process for identifying and assessing risks to patient safety and quality of care.

10.2.2. Conducting risk assessments on a regular basis by using standardized risk assessment tools, such as Risk Matrix or FMEA, and involving a range of stakeholders in the risk assessment process.

10.2.3. Risk mitigation strategies

a. Development and implementation of risk mitigation strategies.

b. Developing and implementing policies and procedures to address identified risks and ensure that strategies are reviewed and updated on a regular basis.

10.2.4. Reporting and learning from incidents

a. Providing a culture of reporting and learning from incidents.

b. Encouraging staff to report incidents, near misses (NM) and adverse events (AE) while also using this information to identify areas for improvement and implement changes to prevent future incidents (refer to DHA sentinel event reporting policy).

10.2.5. Quality improvement initiatives

a. Commitment to continuous quality improvement through review and evaluation of clinical care and services to identify areas for improvement and implement quality initiatives to address these.

10.2.6. Staff training and education

a. Ongoing staff training and education to ensure that all staff are aware of the risks associated with clinical care and services, and have the knowledge and skills to manage these risks effectively.

10.2.7. Regular monitoring and evaluation

a. Regular monitoring and evaluation of risk management strategies and processes to ensure that they are effective in managing risks to patient safety and quality of care.

b. Reviewing incident reports, monitoring the effectiveness of risk mitigation strategies, and implementing changes as needed.

10.2.8. Sentinel events initial report should be sent within 72 hours of identification and by using the primary report of SE. The final report should be sent within forty-five (45) days

10.2.9. The health facilities should embed a system for risk management which aims to support and enable staff to report incidents when things go wrong in a timely and transparent manner.

10.2.10. Risk identification and treatment approaches must be revised as needed to ensure early identification of risks in clinical services.

10.2.11. Risks should be analysed in order to improve safety and a proactive review must be undertaken annually.

10.2.12. Risk reports should be raised to the health facilities board of Directors or Governance for evaluation and decision.

10.3. Mortality & Morbidity Reviews:

10.3.1. This part should be read in conjunction with the DHA Guidelines for the Management of Mortality and Morbidity in Health Facilities.

10.3.2. Health facilities should form internal Mortality & Morbidity Committee.

10.3.3. Committee is responsible to review and document the cases related to mortality and morbidity on monthly basis.

10.3.4. Health facilities should submit the Mortality and Morbidity reports to the Medical Complaints Section in DHA within thirty- five (35) days from the date of death.

a. All mortality reports shall comply with the requirements set out in the Guidelines for the Management of Mortality and Morbidity in Health Facilities. (**Appendix 5**).

11. CHAPTER SEVEN: PATIENT AND PUBLIC INVOLVMENT

11.1. Improving the quality of care requires the involvement of patients and the public, especially in facilities with a high-risk rating scale. Their feedback is used to enhance services and

establish a higher level of quality in the service delivery for patients and the public. This happens through different channels of feedback surveys, a well-constructed complaint monitoring and recording system, and basic patient feedback.

11.2. Patient and public involvement (PPI) is an essential component of effective clinical governance, helping healthcare organizations to understand and respond to the needs and priorities of patients and the wider community. Here are some key requirements for achieving effective PPI within a clinical governance framework.

11.2.1. Clear objectives

a. Effective PPI requires clear objectives that are aligned with the goals of the organization and the needs of patients and the wider community.

b. Effective PPI requires the involvement of identifying specific areas of clinical care and services that require input from patients and the public and setting clear goals for PPI activities.

11.2.2. Inclusive processes

a. Effective PPI requires inclusive processes that enable a diverse range of patients and members of the public to participate in decision-making processes.

b. Effective PPI requires ensuring that that PPI activities are accessible and inclusive, and that they are designed to enable meaningful participation by all stakeholders.

11.2.3. Training and support

a. Effective PPI requires training and support for patients and members of the public who are involved in decision-making processes.

b. Effective PPI requires providing information about the purpose and objectives of PPI, as well as training in communication, decision-making, and other relevant skills.

11.2.4. Collaboration and partnership

a. Effective PPI requires collaboration and partnership between healthcare organizations, patients, and members of the public.

b. Effective PPI requires building relationships with patients and the wider community, and working together to identify areas for improvement and develop solutions to address them.

11.2.5. Accountability and transparency:

a. Effective PPI requires accountability and transparency in decision-making processes.

b. Effective PPI requires ensuring that patients and the wider community have access to information about the decisions that are being made, and that they are able to provide feedback and input into these decisions.

11.2.6. Evaluation and feedback

a. Effective PPI requires ongoing evaluation and feedback to ensure that PPI activities are achieving their objectives and meeting the needs of patients and the wider community.

b. Effective PPI requires monitoring and evaluating PPI activities, and using feedback to make improvements and refine processes as needed.

11.3. The heath facilities should ensure it creates an open, honest and transparent environment for patients and their caregivers.

11.4. Patients should be encouraged to ask and receive information they need to participate in decisions related to their health.

11.5. The health facilities should ensure patients are encouraged to voice their opinion, provide feedback or make a medical complaint, If necessary.

11.6. There should be a patient group established for regular feedback of services provided.

12. CHAPTER EIGHT: SELF ASSESSMENTS

12.1. Self-assessments encourage safety and excellence in patients care. Regular self-assessments ensure that health facilities are continuously revising their processes and services. Accompanying the self-assessments, are the frequent reports sent to DHA matched with inspection visits, which aims to maintain the high quality of care delivered. Health facilities should be committed on meeting and reviewing their practices to ensure all systems are functioning properly and efficiently.

12.2. The health facilities should identify, emphasize and ensure management of risk emerging from services provided.

12.3. The health facility should establish the responsibility of protecting the health, safety and trust of its employees.

12.4. The health facility should ensure the effective and efficient use of resources through evidence- based clinical practice.

12.5. In instances where health facilities have a self-assessment tool, this should be declared and reported to DHA.

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APPENDIX 1: Clinical Audit Project Scoring Criteria

Project acceptance criteria (Guidelines for Health Facilities for Clinical audit projects scoring)		
Section A: Project score		
Clinical audit projects that score 30 and over out of a possible 60 would be considered to be of high importance and priority.		
Suggested Project: Score each criterion 0- 4 as follows:		
0: The criterion has no relevance. 1: The criterion has some but very little relevance. 2: The criterion is met in part. 3: The criterion is almost fully met. 4: The criterion is fully met.		
Criteria	**Explanation of Criteria**	**Scoring**
1- Direct impact on patients	A judgment based on anticipated outcomes of the project, considering direct patient benefit.	(_____x 2) =
2- Potential for change	You should anticipate the potential for any change with your project and have the support of those who can effect change	(_____x 2) =
3-Existence of evidence-based guidelines	Are you comparing current practice against evidence-based standards?	(_____x 2) =
4- Risk	Some treatments/procedures are of greater risk to patients or staff. Clinical risk assessment should help categorize projects for this criterion.	(___x 1) =
5- Cost	The cost implications of the study should be assessed i.e. consider the resources involved in treatment and interventions. The higher the cost to the trust, the higher the score.	(___x 1) =
6- Frequency Volume	It makes little sense to audit treatments or conditions that are rarely seen.	(___x 1) =
7- Direct involvement of patients	A high scoring projects should be able to demonstrate direct patient involvement	(___x 1) =
8- Relation to National/ Organizational/Local priorities	High scoring projects focus on National priority areas/ organizational and local priority areas	(___x 1) =
9- Relation to Complaints/ Clinical incidents	Some projects may be related to a common cause of patient complaints or to common cause of clinical incidents.	(___x 1) =
10- Wide variation in practice	This information would be available from the opinions	

	of staff within the relevant area.	(___x 1) =
11- Multidisciplinary Project	High scoring projects will adopt a multidisciplinary approach	
		(___x 1) =
12- Interface project	e.g. A high scoring project would demonstrate that it involves working across both the partnership and acute setting.	
		(___x 1)

APPENDIX 2: Clinical Audit Project Proposal Request

Health Facility/Specialty/Department:				
Audit lead:				
E-mail Address/Mobile number:				
Initial Date of submission:				
Audit Title:				
Audit Aspect:	☐ Structure	☐ Process	☐ Outcome	
Audit Status:	☐ New Audit	☐ 1st Re-audit	☐ 2nd Re-audit	
Background of the audit title: (Maximum 200 words)				
Audit Aim:				
Audit Objectives:				
Audit Standards: (Explicit criteria with targets /Evidence-based)				
Source of Evidence (Specify):				
☐ Internationally agreed:		☐ Dubai Health Authority:		
☐ Nationally agreed (across UAE):		☐ Locally agreed (across Hospital):		

Audit team			
Names	**Designation**	**Specialty**	**Role within project**

Stakeholders (Agreed and approved this Audit)		
Name	**Designation**	**Date**

Methodology				
Data Collection method:	☐ Retrospective	☐ Prospective		
Data Source:	☐ Patients records	☐ Others, Specify	☐ Questionnaire	☐ Direct Observation

Population & time period to be Audited: (within 2 years)			
Exclusion Criteria:			
Audit sample size:			
Method of Sample selection:			
Clinical Audit Proposal Request Sign-Off:			
Project Lead: By signing this form, I agree to ensure that the project cycle is completed, the results disseminated and report given to the Medical Complaint Section within the anticipated timescales. **Name of Project lead:** **Signature:** **Date:**			
Senior Clinician/ Head of Department: By signing this Clinical Audit Proposal Request, I confirm that this project has been agreed as part of the Clinical Audit Work plan(s) for the Directorate(s)/ Partnership(s) to which the project has applicability and that I will give my support to it. **Senior Clinician/ Head of the Department:** **Signature:** **Date:**			
Medical Director: By signing this Clinical Audit Proposal Request, I confirm that this project has been agreed as part of the Clinical Audit Work plan(s) for the Directorate(s)/ Partnership(s) to which the project has applicability and that I will give my support to it. **Medical Director:** **Signature:** **Date:**			
For DHA office use only			
DHA – Health Regulation Sector – Clinical Audit & Control Department – Medical complaint Section			
Clinical Audit Reviewer:			
Name:	**Received Date:**	**Reviewed Date:**	**Signature:**
Audit Cycle Timescale:			
Approval date:			
Report submission date: (should be submitted with: power point presentation & Audit tool with data)			
End date:			
Final Approval by CACD, Head of Section:			
Name:	**Received Date:**	**Reviewed Date:**	**Signature:**

Note: Clinical Audit proposal should be submitted to mc_hrs@dha.gov.ae with below requirements:

- Recent reference/s of the audit criteria.
- Audit tool.

APPENDIX 3: Clinical Audit Report

PART -A			
Health Facility/Specialty/Department:			
Audit lead (Healthcare provider)**:**			
E-mail Address/Mobile number:			
Audit team (Please specify names & Designation):			
Audit Title:			
Audit Status:	☐ New Audit	☐ 1st Re-audit	☐ 2nd Re-audit
Background of the audit: (Maximum 200 words)			
Audit Aim:			
Audit Objectives:			
Audit Standards: (Explicit criteria with targets /Evidence-based)			
Source of Evidence (Specify):			
☐ Internationally agreed:			
☐ Nationally agreed (across UAE):			
☐ Dubai Health Authority:			
☐ Locally agreed (across Hospital):			
Methodology			
Data Collection method:	☐ Retrospective	☐ Prospective	
Target group & time period to be Audited: (within 2 years)			
Exclusion Criteria:			
Audit Sample Size:			
Method of Sample selection:			

Audit Results & Interpretation		
Recommendations from the Audit team		
PART-B		
Discussion with stakeholder & Action Plan:		
Actions	**Responsible person**	**Estimated time to accomplish**
Signatures		
Name of the Audit lead: **Signature:** **Date:**	**Head of the Department:** **Signature:** **Date:**	**Medical Director:** **Signature:** **Date:**
Dubai Health Authority – Health Regulation Sector – Clinical Audit & Control Department – Medical Complaints Section		
Clinical Audit Reviewers		
Name:	**Received Date:**	**Reviewed Date:**	**Signature:**
Final Approval by CACD, Head of Section:		
Name:	**Received Date:**	**Reviewed Date:**	**Signature:**

Note: Clinical Audit Report should be submitted with below requirements:

- Signed minutes of meeting.
- Audit tool with data.
- Power Point Presentation slides.

APPENDIX 4: Clinical Audit Project Action Plan

Clinical Audit Title:		Department:		Project Lead:		Health Facility:	
S.N.	**Actions**	**Responsible person**	**Estimated date to accomplish**	**Completed (Y/N)**	**Completion date**	**Evidence**	**Signature**

Note: Kindly share with us the evidences of the action plan accomplishment.

APPENDIX 5: Health Facility Mortality and Morbidity Committee Report

CLINICAL AUDIT AND CONTROL DEPARTMENT HEALTH REGULATION SECTOR, DUBAI HEALTH AUTHORITY	
Patient's Details	
Name of Deceased/Patient:	
Date of Birth/ Age:	
Sex:	
Nationality:	
Emirates ID (For UAE Nationals/ UAE Resident):	
Passport No (For Non-UAE Resident):	
Health Facility Details	
Hospital Name:	
File No/ Health Card No.	
Date of Admission:	Time of Admission:
Date of Discharge:	Time of Discharge:
Date of Death:	Time of Death:
Death Notification Reference:	
Morbidity Case	☐ Yes ☐ No
☐ Adverse Drug Events ☐ Hospital Acquired Infection ☐ Pressure Sores ☐ DVT/ Pulmonary Embolism	☐ Patient Fall/ Injuries resulting thereof ☐ Return to ICU within 72 hours ☐ Unplanned return to OT within 24 hours ☐ Others (specify)
If Yes, brief clinical summary of the morbidity case:	
Mortality Case	☐ Yes ☐ No
Type of Death: ☐ Death on Arrival	☐ Inpatient Death ☐ Stillbirth
☐ Death within 24 hours of admission ☐ Death in operation table; Cath lab; radiology ☐ Death within 30 days of surgery resulting from surgery or anesthesia ☐ Others (specify)	☐ Maternal death during pregnancy/ labor/ or within 42 days of delivery ☐ Suicides of inpatient ☐ Covid-19
Brief clinical summary of event leading to death:	
Cause of Death	
1. Direct cause of death	
2. Intermediate cause of death	
3. Underlying cause of death	
4. Other significant condition contributing to death	
Possible Contributing Factors	

1. Equipment Problem: ☐ Yes ☐ No If Yes, describe here:
2. System/ Process/ Resources: ☐ Yes ☐ No If Yes, describe here:
3. Staffing Problem ☐ Yes ☐ No If Yes, describe here:
4. Communication Failure ☐ Yes ☐ No If Yes, describe here:
5. Others: ☐ Yes ☐ No If Yes, describe here:
Outcomes
Is the outcome appropriate to the clinical condition? ☐ Yes ☐ No If No, mention why:
Was the management appropriate to clinical condition? ☐ Yes ☐ No If No, mention why:
Action Taken: ☐ Yes ☐ No If Yes, describe action taken here: Assigned to: Date & Time of Completion:
Mortality and Morbidity Committee Conclusion:
Meets the standards of care: ☐ Yes ☐ No If No, mention why:

Mortality and Morbidity Action Plan & Recommendations:			
Action Required	**Yes/No**	**Assigned to**	**Date & Time of Completion**
Clinical Presentations (Educational Purposes)			
Peer Review			
Investigations			
Others (specify)			

Committee Members	
Name: Designation:	Signature: Date:
Name: Designation:	Signature: Date:
Name: Designation:	Signature: Date:
Committee Chairperson	
Name: Designation:	Signature: Date: