Guidelines for the Management of Mortality and Morbidity in Health Facilities

Version 3

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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 by 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:

- Develop 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 ensure compliance to best practice.
- Manage patient complaints and assure patient and physician rights are upheld.
- Govern the use of narcotics, controlled and semi-controlled medications.
- Strengthen health tourism and assure ongoing growth.
- Assure management of health informatics, e-health and promote innovation.

The Guidelines for the Management of Mortality in Morbidity in Health Facilities aims to fulfil the following overarching DHA Strategic Priorities (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.
- Leading global efforts to combat epidemics and infectious diseases and prepare for disasters.
- Pioneering prevention efforts against non-communicable diseases.

ACKNOWLEDGMENT

The Clinical Audit and Control Department (CACD) developed this Guideline in collaboration with Health Policy and Standards Department (HPSD) and Subject Matter Experts. HRS 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

Clinical guidelines are increasingly becoming part of current practice and will become more common over the next decade. These Clinical Guidelines aim to improve the quality and the level of healthcare provided to the clients. Healthcare providers can use these guidelines to answer specific questions in day-to-day practice and as an information source for continuing professional education.

This document presents a framework to DHA licensed healthcare professionals and health facilities to effectively and efficiently, manage all aspects of Mortality and Morbidity.

Key updates:

1. Updated definitions
2. Recommendation Three: Management of Mortality and Morbidity Committee Meetings
3. Recommendation Four: Data Collection and Risk Classification for Morbidity Cases.
4. Recommendation Five: Criteria for reviewing mortality cases in a healthcare facility.
5. Recommendation Six: Training, Education, and Disciplinary Action by facility.
6. Updated mortality and morbidity committee report (appendix 1)
7. Mortality and Morbidity Process Maps (appendix 4 and 5)
8. Appendix 6: Quality Indicators (for internal use only and not required for submission to DHA unless requested)
9. Appendix 7: The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
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11. Appendix 9: Quarterly healthcare facility report

DEFINITIONS

Death: is the permanent cessation of all biological functions that sustain a living organism.

Device-Related Infection: This is an infection that occurs when bacteria or other pathogens colonize on a medical device implanted in the body, such as catheters, ventilators, or artificial joints.

Hospital Acquired Infection (HAI): This refers to an infection that a patient develops while in a hospital or other healthcare facility that wasn't present or incubating at the time of admission. It also includes infections acquired in the hospital but appearing after discharge.

Morbidity: are complications that occur causing the patient to need further intervention or prolonged stay in hospital.

Mortality: is the in-hospital deaths for patients under the care of a defined specialty.

Readmission: This refers to the re-hospitalization of a patient shortly after their discharge, typically within 30 days, often due to complications or the reoccurrence of the initial medical issue that warranted the original admission, but it can also be for a different, unrelated reason.

ABBREVIATIONS

CACD	:	Clinical Audit and Control Department
CEO	:	Chief Executive Officer
DHA	:	Dubai Health Authority
FPPE	:	Focused Performance Professional Evaluation
HF	:	Health Facility
HPSD	:	Health Policy and Standards Department
HRS	:	Health Regulation Sector
KPIs	:	Key Performance Indicators
MMC	:	Mortality and Morbidity Committee
MOM	:	Minutes of Meeting
NCEPOD	:	National Confidential Enquiry into Patient Outcome and Death
TOR	:	Term of Reference

1. BACKGROUND

This document serves as a comprehensive guide to the Hospital Morbidity and Mortality Committee (MMC), outlining its roles and responsibilities as stipulated in its Terms of Reference.

- Mortality and morbidity reviews serve as foundational components in delivering high-quality clinical care. In the health regulation sector, we consider these reviews crucial to clinical governance and vital in the pursuit of quality improvement.
- Conducting mortality and morbidity reviews is obligatory, and the outcomes should be open to review by the regulatory body when needed.
- Primarily, consultant medical staff bear the responsibility to oversee mortality and morbidity reviews within their specialties, with support from the divisional management team.
- The procedures for conducting these reviews need to be strong and efficient to extract lessons from patient care scenarios and to pinpoint alterations in practice that can prevent fatalities or decrease morbidity in the future.
- Reviewing mortality and morbidity data should be a standard practice, with the acquired knowledge being disseminated within the specialty and the division.
- Cross-divisional insights will be disseminated through the upward thematic reporting of the review outcomes.

2. SCOPE

2.1. To effectively and efficiently manage all aspects of Mortality and Morbidity in DHA licensed Health Facilities.

3. PURPOSE

3.1. To define clear roles and obligations for staff participating in mortality and morbidity reviews, ensuring the Trust is fulfilling its commitment to learning and continual enhancement, specifically:

3.1.1. Healthcare professionals will leverage mortality and morbidity reviews to confirm the safety of their services, propagate learning, and enhance patient outcomes.

3.1.2. The outcomes of the reviews should offer assurance that the Trust is maximizing learning from episodes of care resulting in death.

4. APPLICABILITY

4.1. DHA licensed Health Facilities holding in-patient beds and Healthcare Professionals executing day-case interventional procedures.

5. **RECOMMENDATION ONE:** RESPONSIBILITIES OF THE MORTALITY AND MORBIDITY COMMITTEE

5.1. Review and audit the health records for all mortality and morbidity cases taking place in the health facility.

5.2. Identify potentially preventable factors associated with the mortality and morbidity cases in health facility and recommend improvement measure to minimize the mortality and morbidity rates.

5.3. All mortalities must be reported to CACD – HRS within 35 days, with an exception for mortality cases also identified as sentinel events, which are accepted to be reported within 45 days **Appendix 1**.

5.4. All reports and case documents are prepared, endorsed by the relevant stakeholders, and subsequently submitted to the HRS-CACD team monthly. For Grade 3 and 4 morbidities, it is imperative to specify the name of the doctor involved in the incident.

5.5. A quarterly report from each healthcare facility is mandated for submission.

5.5.1. This report should encompass the areas of concern, implemented solutions, conclusions, and action plans derived from previous HMMC meetings.

5.5.2. Furthermore, it is essential that the report integrates an analysis of all morbidities observed within the facility, supplemented by a trend analysis.

5.6. Submit Mortality and Morbidity Report through the MMC Chairperson to Medical Complaints Section (MCS), Clinical Audit & Control Department (CACD), HRS, within 35 days, from the date of death **Appendix 1**.

5.7. Any investigation materials that have been gathered. This may include, but is not limited to, peer review reports, additional testimonies, supplementary patient file documents, and other relevant materials, to be kept prepared and ready to be shared with the HRS team in case the team requires more data, it should be done through the Hospital Quality representative or Risk Manager to CACD – HRS team via email **MC_HRS@dha.gov.ae**.

6. **RECOMMENDATION TWO:** ROLES OF THE MORTALITY AND MORBIDITY COMMITTEE

6.1. The Medical Director/Chief Executive Officer (CEO) of the health facility should nominate the members of the MMC.

6.2. The Medical Director should not be a part of the MMC.

6.3. The MMC should comprise of a chairperson, a co-chairperson, a quality representative, a secretary

and additional committee members.

6.4. Morbidity Reporting list should be developed aligned with the specialties available at the Health Facility and aligned with internal policies and procedures, local laws, regulations, policies & guidelines and current international best practice.

6.4.1. All physicians involved in morbidity cases graded 3, 4, and 5 should be mentioned in the case summary report submitted to HRS.

6.4.2. Efforts will be made to avoid referring morbidity cases to the medical liability committee or medical practice committee.

6.4.3. Facilities will have the primary responsibility to review trends and the involved physicians and take necessary actions. However, if issues persist with repeated reporting of the same morbidity category or the same doctor's involvement, the facility will be held accountable and must provide justification to the HRS team and a possible referral to MLC/MPC will be considered.

6.5. Facilities must take corrective action to prevent their recurrence.

6.6. The CEO and Medical Director should address any reports or KPIs indicating a trend of morbidity or mortality diagnoses or physicians with high rates of medical mistakes. Actions taken should be proportionate to the severity of the case and documented as evidence in the hospital's personnel folder.

6.7. **Chairperson**

6.7.1. The Chairman of the MMC should have the overall responsibility of the outcomes of the committee. In addition, the Chairman should do the following:

a. Lead, facilitate and moderate the discussions during the meetings by giving equal chances to all members to express their views and to avoid bias.

b. Report the status of the MMC to the Health Facility, Medical Director/CEO and to CACD, DHA.

c. Provide the Key Performance Indicators (KPIs) to CACD, DHA quarterly (**Appendix 2**).

d. Place relevant items on the agenda.

e. Sign and endorse the Minutes of Meeting (MOM).

6.8. **Co- Chairperson**

6.8.1. Will assist the Chairperson in achieving the objectives of the MMC.

6.8.2. In the absence of the Chairperson, the Co-Chairperson will take over the role of the Chairperson.

6.9. **Quality Representative**

6.9.1. Quality Representative is a regular member of the MMC with additional responsibilities as follows:

a. Review the health records of all cases of death in the hospital and Dead-On Arrival (DOA) cases and follow up any issues of concern.

b. Review the health records of:

i. Report all morbidities identified.

ii. Report all health facility deaths.

iii. Prepare periodic statistical reports related to Morbidity and Mortality **Appendix 2**.

iv. Others.

6.10. **Secretary**

6.10.1. Prepare agenda and send invitations for the meetings.

6.10.2. Record and distribute the MOM copy of case records for discussion after the approval of the Chairperson.

6.10.3. Liaise and coordinate with MMC.

7. **RECOMMENDATION THREE:** MANAGEMENT OF THE MORTALITY AND MORBIDITY COMMITTEE MEETINGS

7.1. **Frequency**

7.1.1. Meet on a monthly basis, as defined by the Committee's schedule.

7.2. **Participation**

7.2.1. Members should actively engage in discussions in a transparent and open manner.

7.3. **Outcome**

7.3.1. Each meeting should result in at least one improvement plan or awareness initiative.

7.4. **Agenda**

7.4.1. Members are expected to send the topics that they need to discuss during the meetings to the Secretary at least four (4) days prior to the scheduled date of the meeting.

7.4.2. Urgent topics can be added to the agenda after obtaining the approval from the chairperson.

7.4.3. The agenda will be prepared by the Chairperson and the Secretary and distributed at least two (2) days prior to the next scheduled meeting.

7.4.4. Although every effort should be made to restrict the discussions to the topics as per the

agenda, any last minute topics can be discussed after the approval of the Chairperson.

7.5. **Meetings**

7.5.1. The MMC should meet according to the death occurrence in health facility and adhere to the mentioned period in DHA Circular to avoid violations.

7.5.2. The Chairman should call for unscheduled meetings when necessary. Every effort should be made not to conflict these meetings with other scheduled meetings.

7.5.3. The MMC should assign other sub-committees and/or taskforce groups to perform specific tasks and report to the MMC as deemed necessary.

7.5.4. The time allocated for the MMC meeting as per the Committee Chairperson decision.

7.5.5. The secretary should prepare and sign the MOM and it should be approved and endorsed by the Chairperson.

7.6. **Minutes of Meeting (MOM)**

7.6.1. The MOM should be distributed to the members.

7.6.2. The MOM of the previous meeting should be approved at the beginning of each meeting and changes discussed should be reflected in the next MOM **Appendix 3**.

7.6.3. All members should ensure the confidentiality of the deliberations that take place during the meeting.

7.6.4. The MOM should reflect only the points, recommendation and decisions that were discussed. The MOM should be concise and not narrative.

7.6.5. The MOM should reflect the name(s) and reason(s) for any member(s) who have reservations on the recommendations or decisions taken.

7.6.6. The MOM should indicate the members who were Present, Apologized or Absent.

7.6.7. The MOM should be distributed to all the MMC members five (5) working days prior to the next meeting with a copy to Health Facility's Medical Director & CEO.

7.6.8. The copies of all the MOMs should be kept in the Health Facility Mortality and Morbidity records.

7.7. **Quorum**

7.7.1. The MMC meeting requires the minimum presence of 50% +1 of the members to constitute a formal quorum.

7.7.2. The MMC meeting requires a quorum within fifteen (15) minutes from the specified time. Failure to achieve quorum would mean that the meeting is automatically cancelled.

7.7.3. The MMC Chairperson should notify Health Facility Medical Director/CEO in writing when three consecutive meetings have not achieved quorum.

7.8. **Official Leave, Apology and Absence**

7.8.1. The members should attend all the meetings. In case anybody is on official leave, the appointed acting, if applicable, will attend the meetings. If the member has no acting, then the member will be considered on official leave.

7.8.2. Members who cannot attend the meeting need to apologize in writing or verbally through contacting the secretary of the MMC.

7.8.3. If an apology is not received prior to commencing the meeting, then the member will be considered absent.

7.8.4. If the member considered absent for more than three (3) times without a valuable reason,

then the Chairperson of the MMC should notify the Health Facility Medical Director/CEO in writing and request the replacement of the member. **Note:** a sample for the MOM is provided in **Appendix 3**.

8. RECOMMENDATION FOUR: DATA COLLECTION AND RISK CLASSIFICATION FOR MORBIDITY CASES

8.1. Refer to the Mortality and Morbidity process maps in **appendix 4 and 5.**

8.2. **Data Sources**

8.2.1. To utilize both electronic and paper patient records, laboratory results, radiology reports, morbidity reports, and death reports as primary sources for data collection.

8.3. **Data Confidentiality**

8.3.1. It's imperative to maintain strict confidentiality.

8.3.2. Access to this data is restricted only to authorized committee members.

8.3.3. Once a morbidity is identified or a mortality occurs, the relevant data should be locked.

8.3.4. This lock pertains to prior notes and orders, ensuring it does not impede the care of living patients who remain admitted in the facility.

8.4. **Morbidity Cases:**

8.4.1. Identified cases should be collected and promptly reported to MMC to initiate necessary investigations.

8.5. **Grade 1 and 2 Morbidities:**

8.5.1. Exclude these from being categorized as morbidities as thus are incidents.

8.6. **Grade 3 and 4 Morbidities:**

8.6.1. These are categorized as high-risk cases, necessitating swift investigation and obligatory reporting to CACD-HRS.These should be investigated by risk managers if conformed to be referred to MMC for further review, and mandatory reporting to HRS – CACD as a case summary on a monthly basis using the approved formats.

8.7. **Grade 5 Morbidities**:

8.7.1. Recognized as a sentinel event; for further details, kindly refer to the sentinel event guidelines management and reported to HRS – CACD.

8.8. All Mortalities must be reported to CACD–HRS within 35 days, with an exception for mortality cases also identified as sentinel events, which are accepted to be reported within 45 days.

8.9. **Analysis and Reporting**

8.9.1. Highly recommended to use statistical methods for identifying trends in morbidity and mortality.

8.9.2. Use quality indicators for risk-adjusted mortality rates for yearly comprehensive analyses. **(appendix 6).**

8.10. **Recommendations and Follow-Up**

8.10.1. Refer to the **NCEPOD** Table for determining final outcomes and action plans.

8.10.2. Instead of simply determining if cases meet standards, outcomes should be categorized based on the **NCEPOD** table score.

8.10.3. This score will guide the necessary action plans and highlight areas for facility improvement and possible referral to MLC/MPC accordingly – for more details please referral to **Appendix 7 .**

8.11. **Documentation**:

8.11.1. Clearly document and disseminate recommendations to relevant departments. Tracking: Assign members to monitor the implementation of recommendations and report back to MMC.

8.11.2. The utilization of the **Clavien Dindo classification** for surgical incidents is strongly recommended.

8.11.3. The utilization of the **WHO classification** for Medical incidents is strongly recommended.

9. RECOMMENDATION FIVE: CRITERIA FOR REVIEWING MORTALITY CASES IN A HEALTHCARE FACILITY

9.1. **Unanticipated Death:**

9.1.1. Death with unclear cause despite a clear diagnosis and treatment.

9.1.2. Death without obvious risk factors for imminent demise.

9.1.3. Sudden and unanticipated death in healthcare facilities for young population of 18 years and above.

9.1.4. Deaths occur in the emergency department after being triaged alive.

9.1.5. Death within 48 hours of hospital admission.

9.1.6. Death following hospital admission for a work-related injury that was poorly managed by the medical team, leading to a fatality within the facility (exceptions apply if all appropriate measures were taken and the case was managed according to guidelines).

9.1.7. Death resulting from a sudden transition in the level of care, either from a higher to a lower level or vice versa.

9.2. **Inpatient Deaths:**

9.2.1. Post-Procedure Death: Within 14 days following any medical, surgical, or radiologically guided invasive procedure.

9.2.2. Full-Term Infant Mortality: Excludes known congenital anomalies and unbooked cases.

9.2.3. Maternal Death: Associated with pregnancy, birth, and the puerperium.

9.2.4. Stillbirth and Neonatal Deaths: Includes pregnancy loss from 24+0 weeks onwards, intrapartum s:llbirths, early neonatal deaths, and severe brain injuries like Hypoxic Ischemic Encephalopathy.

9.2.5. Medication-Related Deaths: Includes medication errors and adverse drug reactions.

9.2.6. Healthcare-associated infection (HAI): Deaths associated with infection occurring in a patient during the process of care in a hospital or other healthcare facility that was not present or incubating at the time of admission.

9.2.7. Trends or Patterns: Deaths are part of a trend or pattern of adverse events or unexpected outcomes.

9.3. **Post-Discharge Deaths:**

9.3.1. Within 28 Days: Any Deaths occurring within 28 days after hospital discharge for the same condition.

9.3.2. Frequent Hospital Visits: Deaths among patients with frequent hospital, PHC, or emergency department visits, excluding those who le> against medical advice.

9.4. **Exclusions:**

9.4.1. Deaths occur upon arrival at the emergency department (excluding post-discharge

deaths)

9.4.2. Any stillbirths previously diagnosed as congenital anomaly cases.

9.4.3. Infants born extremely preterm (before 32 weeks of gestation), those diagnosed with life-incompatible chromosomal/genetic conditions, congenital anomalies, or preterm infants weighing less than 1000g at birth.

9.5. **Eligibility criteria for inclusion (morbidity):**

9.5.1. Cases may be included based on, but not limited to the criteria mentioned in **appendix 8.**

9.6. **General Exclusion Criteria for (Morbidity):**

9.6.1. Refusing treatment with a signed refusal form

9.6.2. Discharging against medical advice

9.6.3. Prior admission to another healthcare institution (only applicable for cases of hospital-acquired infections) but Notification is mandated by the facility identifying the morbidity.

9.6.4. Scheduled surgical procedures or elective readmissions.

9.6.5. Excessive postpartum bleeding due to an identified morbidly adherent placenta or placenta previa grade 4.

9.7. **Disclaimer:** The hospital M&M committee may also review cases not explicitly covered by these criteria if there are concerns about patient safety or quality of care. The above list is not exhaustive; leadership should review and get involved in cases where the quality of care has impacted the patient's outcome, leading to death. If the hospital M&M committee determines that the case was handled both adequately and appropriately, with no issues or concerns regarding the quality of care, then the committee should be held accountable for the final decision

outlined in the mortality format.

10. RECOMMENDATION SIX: TRAINING, EDUCATION, AND DISCIPLINARY ACTION BY FACILITY

10.1. Orientation: Offer an introductory program for new members in the committee. **Continuing** Education: Promote participation in relevant educational programs for all relevant staff.

10.2. **Performance Review and Monitoring in the department:**

10.2.1. Doctors may undergo rigorous performance reviews and continuous monitoring (ongoing practice professional evaluation) to assess and improve their clinical skills and decision-making.

10.3. **Training and Education:**

10.3.1. Additional training and education may be mandated to address identified areas of weakness and enhance overall clinical competency.

10.4. **Peer Support and Wellness Programs:**

10.4.1. Doctors may be referred to peer support or wellness programs to address stress, burnout, or other personal issues that may be contributing to the errors.

10.5. **Supervision:**

10.5.1. Increased supervision may be required to ensure patient safety and guide the physician toward better clinical practices for a minimum of 60 days duration.

10.6. **Restriction of Privileges:**

10.6.1. Based on the severity of the incident or morbidity, a doctor's clinical privileges might be limited or modified, potentially restricting the ability to perform certain procedures or

manage specific conditions.

10.7. **Referral for Professional Assessment by the HRS – CACD team:**

10.7.1. Physicians may be referred for a professional competency assessment to objectively evaluate their clinical skills and knowledge.

10.8. **Employment Actions:**

10.8.1. Employers (CEO or board members) have the right to take actions ranging from written warnings to termination of employment, depending on the organizational policies and the nature of the mistakes made.

10.9. **Licensing Actions by HRS:**

10.9.1. When all fails, the medical licensing department and CACD team should be notified, action can include referral to MPC team and issue of warning letter, penalty or suspension, or revocation of the medical license.

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APPENDICES

APPENDIX 1: MORTALITY AND MORBIDITY COMMITTEE REPORT

CLINICAL AUDIT AND CONTROL DEPARTMENT **HEALTH REGULATION SECTOR, DUBAI HEALTH AUTHORITY**	
Patient's Details	
Name of Deceased:	
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 ☐ If Yes please choice is it ☐ Reporting ☐ Notification
Type of morbidity: ☐Medical ☐ Surgical If medical - **WHO Grading** Score : : ☐1 ☐ 2 ☐3 ☐ 4 ☐ 5 If Surgical - **Clavien Dindo classification** Score : ☐1 ☐ 2 ☐3 ☐ 4 ☐ 5 • brief clinical summary of the morbidity case:	
Mortality Case	☐ Yes ☐ No
Type of Death:☐ Death on Arrival ☐ Inpatient Death ☐ Stillbirth ☐ Post-Discharge Deaths ☐ Unanticipated Death	
☐ Others (specify)	
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	
5. Is it a Occupational related injury	☐ Yes ☐ No
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:		
Outcome Based on **NCEPOD** scoring system	☐1 ☐ 2 ☐3 ☐ 4 ☐ 5☐ 6	
Action Taken	☐ Yes ☐ No	
If Yes, describe action taken here:	Assigned to	Date & Time of Completion
M&M Committee Conclusion:		
Summary of **Committee Conclusion:**		
M&M Committee 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:

APPENDIX 2: MORTALITY AND MORBIDITY COMMITTEE MEASURES (KPI DASHBOARD)

Measures	Target	Q1	Q2	Q3	Q4	YTD	Comments
Rate of unplanned re-admission within 28 days							
The total number of unplanned admissions	Numerator					0	
Total number of admission	Denominator					0	
Rate of medication error (Rate per 100,000)							
Number of medication error incident	Numerator					0	
Total number of medication prescription	Denominator					0	
Device-related health care associated infections (composite score)							
Number of targets met	Numerator					0	
Total number of targets	Denominator					0	
Catheter-associated Urinary Tract Infections (CA-UTI)							
Number of CA-UTIs	Numerator					0	
Total number of catheter days	Denominator					0	
Central Line Associated Primary Bloodstream Infection							
Number of Central Line Associated Primary Bloodstream Infections	Numerator					0	
Total number of days catheter in place	Denominator					0	
Ventilator Associated Pneumonia							
Number of Ventilator Associated Pneumonia cases	Numerator					0	
Total number of ventilator days	Denominator					0	
Rate of Surgical Site Infection (SSI)							
Number of surgical site infections	Numerator					0	
Total number of surgeries	Denominator					0	

In Hospital Mortality Rate							
Number of in-patient deaths	Numerator					0	
Total number of admissions	Denominator					0	

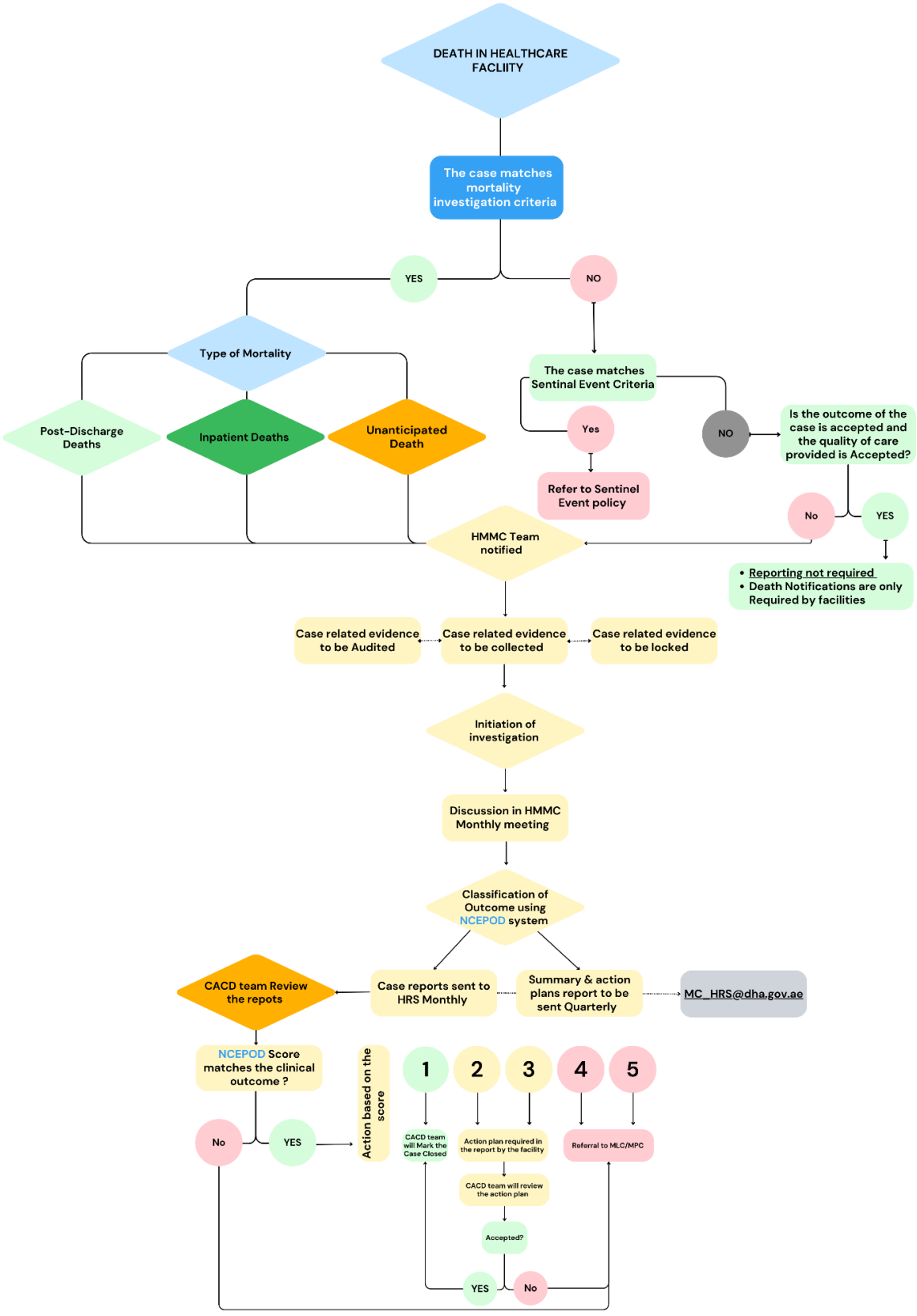
In Hospital Maternal death Rate							
Number of Maternal deaths are those that occur during pregnancy, childbirth	Numerator					0	
total number of live births in the hospital	Denominator					0	

In Hospital Still birth Rate							
total number of stillbirths that occurred in the hospital	Numerator					0	
Count the total number of births (both live births and stillbirths)	Denominator					0	

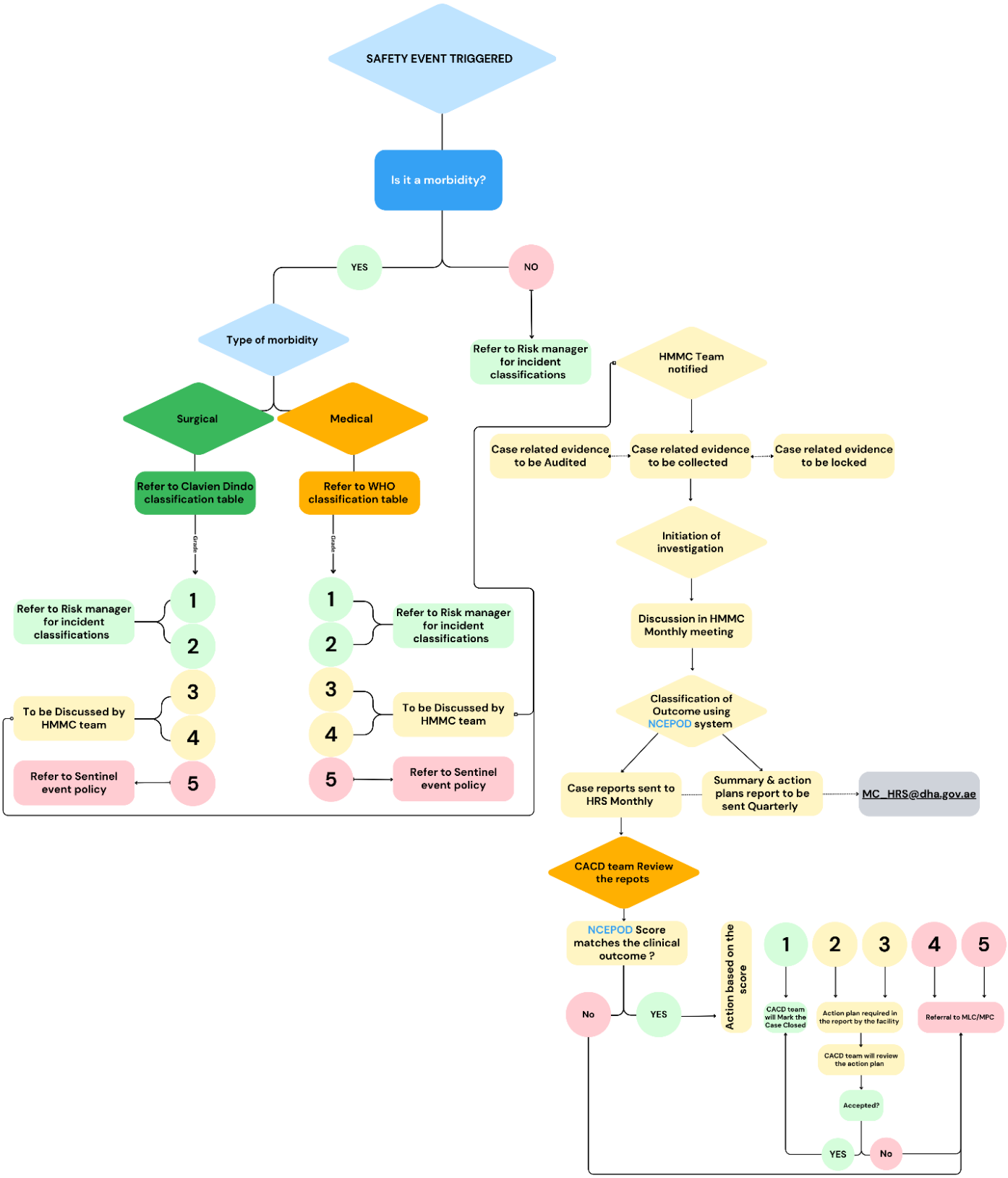
APPENDIX 3: MINUTES OF COMMITTEE MEETINGS

Minutes of Meeting of the Mortality and Morbidity Committee (MMC)- sample					
Date:			Time:		
Venue:					
Attendees					
1.					
2.					
Apologies/Absent					
1.					
2.					
Minutes of Meeting					
	Topic	Discussion	Action Taken	Assigned to	Date and time of Completion
1.					
2.					

APPENDIX 4: MORTALITY PROCESS MAP



APPENDIX 5: MORBIDITY PROCESS MAP



APPENDIX 6: QUALITY INDICATORS*

*FOR INTERNAL USE ONLY NOT REQUIRED FOR SUBMISSION TO DHA UNLESS REQUESTED.

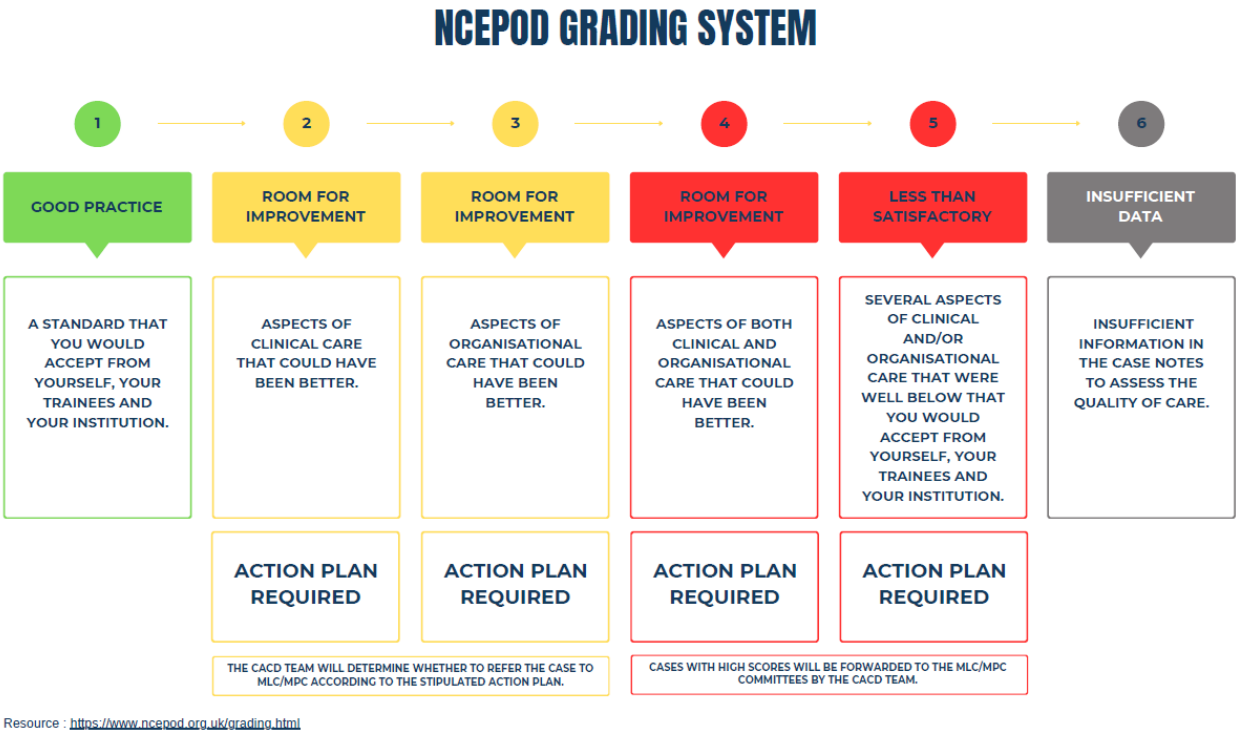
Morbidity Rates (Incidence per 1,000/10,000)	
Quality Domain	**Population Health**
Scope	Incidence of diseases or conditions within the facility.
Goal	Monitor and reduce the incidence of specific diseases or conditions.
Desired Outcome	Lower morbidity rates, indicating healthier population within the facility's catchment area.
Primary Point of Collection/ reporting	Facility Quality office / Health regulation sector
Data Collection Source/System	Electronic Health Records (EHR), incidents reporting systems
Indicator Definition	Incidence of a particular disease or condition per 1,000 or 10,000 population at the facility.
Numerator	Number of new cases of a specific disease or condition within a defined period.
Inclusions/Exclusions	May exclude pre-existing conditions or those not relevant to the scope of services provided by the facility or based on the exclusion criteria in the approved DHA Guidelines and policy
Patient Safety Indicators (Rates of Incidents)	
Quality Domain	**Safety**
Scope	Measurement of harmful events such as infections, falls, or medication errors within the facility.
Goal	Minimize and prevent patient safety incidents.
Desired Outcome	A safer environment resulting in fewer incidents, promoting trust and care quality.
Primary Point of Collection/ Reporting	Facility Quality office / Health regulation sector
Data Collection Source/System	Incident reports, safety surveillance, pharmacy records, Electronic Health Records (EHR), incidents reporting systems
Indicator Definition	Rate of specific patient safety incidents within the facility.
Numerator	Number of specific patient safety incidents.
Inclusions/Exclusions	Exclusions may include incidents unrelated to direct patient care or that are considered non-preventable or based on the exclusion criteria in the approved DHA Guidelines and policy
Readmission Rates (Frequency per 100 Admissions)	
Quality Domain	**Clinical Care**
Scope	Tracking the frequency of readmissions to the facility within 30 days post-discharge.
Goal	Reduce unnecessary readmissions through improved care coordination and discharge planning.
Desired Outcome	Lower readmission rates, indicating better initial treatment and follow-up care.
Primary Point of Collection / Reporting	Facility Quality office / Health regulation sector
Data Collection Source/System	Admissions records, follow-up care reports , Electronic Health Records (EHR), incidents reporting systems.
Indicator Definition	Proportion of patients readmitted to the facility within 30 days of discharge.

Numerator	Number of readmissions within 30 days post-discharge for a cohort of discharged patients.
Inclusions/Exclusions	Exclusions might include planned readmissions or transfers from other facilities , or based on the exclusion criteria in the approved DHA Guidelines and policy
Severity Indices (Category Frequency)	
Quality Domain	**Clinical Outcomes**
Scope	Categorization and tracking of morbidity cases by severity.
Goal	Identify trends in severity of conditions to improve patient care and infection control.
Desired Outcome	Balanced severity indices with fewer cases in more severe categories.
Primary Point of Collection/ Reporting	Clinical documentation / Case management / Facility Quality office / Health regulation sector
Data Collection Source/System	Clinical documentation, EHR, severity classification systems.. Electronic Health Records (EHR), incidents reporting systems
Indicator Definition	Distribution of morbidity cases across predetermined severity categories.
Numerator	Number of cases in each severity category.
Inclusions/Exclusions	May exclude conditions not treated within the facility or those without established severity categories , or based on the exclusion criteria in the approved DHA Guidelines and policy
Surgical Complication Rates (Rate per 100 Procedures)	
Quality Domain	**Clinical Care**
Scope	Monitoring complications arising during or post-surgery.
Goal	Decrease the occurrence of surgical complications.
Desired Outcome	Safer surgical procedures with minimized complications, improving overall patient outcomes.
Primary Point of Collection/ reporting	Surgical department / Post-operative care unit/ Facility Quality office / Health regulation sector
Data Collection Source/System	Surgical reports, post-operative monitoring records., Electronic Health Records (EHR), incidents reporting systems
Indicator Definition	The rate of complications noted during or after surgical procedures.
Numerator	Number of complications occurring out of 100 surgical procedures.
Inclusions/Exclusions	Typically excludes minor complications not requiring additional treatment or based on the exclusion criteria in the approved DHA Guidelines and policy
In-Hospital Mortality Rate (Rate per 1,000 Admissions)	
Quality Domain	**Clinical Outcomes**
Scope	The number of patient deaths occurring within the hospital.
Goal	To minimize in-hospital deaths through improved quality of care.
Desired Outcome	Reduced mortality rates, reflecting better patient outcomes and care efficiency.
Primary Point of Collection / Reporting	Hospital mortality committee / Clinical governance // Facility Quality office / Health regulation sector
Data Collection Source/System	Hospital admissions and discharge records, death certificates, Electronic Health Records (EHR), incidents reporting systems
Indicator Definition	The rate of patient deaths per 1,000 hospital admissions.
Numerator	Number of patient deaths occurring within the hospital.

Inclusions/Exclusions	May include all deaths irrespective of cause; exclusions could apply for palliative care cases if the purpose of admission is end-of-life care , or based on the exclusion criteria in the approved DHA Guidelines and policy
Perioperative Mortality Rate (Rate per 100 Surgical Procedures)	
Quality Domain	**Surgical Outcomes**
Scope	Deaths related to surgical procedures within a specified timeframe post-surgery.
Goal	To decrease mortality associated with surgery through enhanced surgical and anesthetic care.
Desired Outcome	A decrease in perioperative mortality, indicating safer surgical practices and postoperative care.
Primary Point of Collection /Reporting	Surgical department / Anesthesiology department/ Facility Quality office / Health regulation sector
Data Collection Source/System	Operating theatre logs, postoperative follow-up records, Electronic Health Records (EHR), incidents reporting systems
Indicator Definition	The rate of deaths occurring during surgery or within a defined period post-surgery (e.g., 30 days).
Numerator	Number of deaths during or within the specified period after surgical procedures.
Inclusions/Exclusions	Exclusions may include non-surgical deaths or patients who were not candidates for surgery due to high preoperative risk , or based on the exclusion criteria in the approved DHA Guidelines and policy

APPENDIX 7: THE NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME AND

DEATH (NCEPOD)



APPENDIX 8: GENERAL EXCLUSION CRITERIA FOR MORBIDITY

Trigger / Morbidity	Exclusion	Reporting to HRS
30-day readmission at the same facility for the same condition	• Case who was discharged in the first encounter against medical advice. • Planned and documented readmissions. • A readmission for maintenance chemotherapy.	Required
48-hour emergency department return visit	• Case who was discharged in the first encounter against medical advice • Cases of medications refills • Planned and documented revisit .	Required
Unplanned 48-hour post-surgery return	• Planned and documented RE - surgery.	Required
ICU readmission after discharge from ICU within 48 hours.	N/A	Required
Preoperative and postoperative diagnosis discrepancies	N/A	Required
Medication administration errors	N/A	Required
Surgical site infection	• Infection caused by admission in another facility , Organisms that is not related to hospital setting infection please use CDC index for more reference https://www.cdc.gov/hai/infectiontypes.html	Required
Hospital-acquired infections including device related infections.	• Infection caused by admission in another facility , Organisms that is not related to hospital setting infection please use CDC index for more reference https://www.cdc.gov/hai/infectiontypes.html	Required
Injuries to organs or vessels requiring surgical repair, blood transfusion, or an extended hospital stay	N/A	Required
Unplanned post-surgical ICU admission.	• Planned and documented ICU transfer after Surgical Procedure	Required

Maternal morbidity that occurs from the intrapartum through the immediate postpartum period (24 hours), requiring the transfusion of 2 or more units of packed red blood cells (PRBC) and/or unplanned admission to the intensive care unit (ICU).	• Cases of identified morbidly adherent placenta or Placenta previa Grade 4	Required
Postoperative pulmonary embolism	N/A	Required
Postoperative DVT (secondary DVT for inpatient)	N/A	Required
Adverse even following an anesthesia or deep sedation use .	N/A	Required
Prolonged fluoroscopy use with cumulative dose of > 1500 rads to a single filed.	N/A	Optional , Required for facility with interventional radiology services .
Delivery of radiotherapy to a wrong body region or more than > 25 % of the planned dose.	N/A	Optional , Required for facility with interventional radiology services .
Ischemic injury to a harvested organ compromises its viability, leading to the failure of the harvesting process.	N/A	Optional , Required for facility with organ donations services .
Cases of Failure of proper preservation of an harvested organ leading to preservation injury during transport, resulting in transplantation failure due to complete damage to the harvested organ.	N/A	Optional , Required for facility with organ donations services .

Cases of patients who are an alive organ donor who experience significant psychological distress, necessitating admission to a mental health department or intervention from mental health services.	N/A	Optional , Required for facility with organ donations services .
Organ recipients who develop malignancies following long-term use of immunosuppressive medications, particularly when delays or failures in acquiring the organ occur.	N/A	Optional , Required for facility with organ donations services .
Donors who encounter cardiovascular incidents subsequent to organ transplantation.	N/A	Optional , Required for facility with organ donations services .

APPENDIX 9: QUARTERLY HEALTHCARE FACILITY REPORT

Health Regulation Sector **Clinical Audit and Control Department** **Medical Complaints Section**
Quarterly Healthcare Facility Report **Comprehensive Review and Analysis** **Facility Name:**

Introduction
Reporting Period: **HMMC Chairperson:** **Medical Director of the facility:** **Quality Representative:**
Areas of Concern & Implemented Solutions (Mandatory)
• Detailed description of identified areas of concern. • Summary of solutions implemented to address these concerns. • Any relevant data or statistics to support the findings.
Conclusions & Action Plans from HMMC Meetings (Mandatory)
• Summary of key conclusions from recent Health Management and Monitoring Committee (HMMC) meetings. • Outline of action plans developed based on these conclusions. • Timeline or roadmap for implementing these action plans.

Analysis of Morbidities (Mandatory):
• Comprehensive analysis of all morbidities observed within the facility. • Data visualization (charts, graphs) showing morbidity trends. • Discussion of potential causes and implications of these trends.
Related KPI data. (to be submitted separately in a unified Excel sheet that will provided by the CACD team)
• Rate of unplanned re-admission within 28 days • Rate of medication error (Rate per 100,000) • Device-related healthcare-associated infections • Rate of Surgical Site Infection (SSI)
Trend Analysis (Required only at the end of the Year)
• In-depth trend analysis over the reporting period. • Comparative data from previous periods. • Predictions or forecasts based on current trends.
Conclusion
• Overall summary of the report's findings. • Reiteration of the importance of these findings for future planning and quality improvement.
HMMC Chairperson Declaration
I, [Chairperson's Name], in my capacity as the Chairperson of [Committee's Name], hereby declare that the information provided in this report is accurate and truthful to the best of my knowledge and belief. I affirm that no part of this report has been falsified, tampered with, or altered in any manner. I acknowledge and endorse the content of this report, including all data, findings, and the evidence presented therein. Furthermore, I approve the action plan outlined in this report and its implementation. I understand and accept my responsibility for the veracity of the information contained in this report. If any part of this report is found to be inaccurate, misleading, or false by either the inspection team or the medical complaints section, I accept full accountability for such discrepancies. I recognize that this declaration is a commitment to uphold the highest standards of integrity and responsibility in the presentation and use of this report's information.

The Report Prepared by	**Designation**	**Date and Signature**

The Report Approved by	**Designation**	**Date and Signature**
		03/01/2024 10:31:00
Medical Director Name		**Date and Signature**

For Clinical Audit & Control Department use only:		
The Report Reviewed by	**Designation**	**Date and Signature**
The report Approved by	**Designation**	**Date and Signature**