PERIOPERATIVE MORTALITY REVIEW (POMR) 2022

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CLINICAL AUDIT UNIT
MEDICAL CARE QUALITY SECTION
MEDICAL DEVELOPMENT DIVISION MOH

CLINICAL AUDIT DEFINITION

"A quality improvement process that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery."

Principles for Best Practice in Clinical Audit, National Institute of Clinical Excellence (NICE), 2002

TYPES OF CLINICAL AUDIT

STANDARD BASED AUDIT	ADVERSE OCCURRENCE SCREENING AND CRITICAL INCIDENT MONITORING	PEER REVIEW	PATIENT AND SERVICE USER SURVEYS
A cycle which involved defining standards, collecting data to measure current practice against those standards and implementing any changes deemed necessary.	Peer review cases which have caused concern / unexpected outcome. The multi-disciplinary team discusses individual anonymous cases to reflect upon the way the team functioned and to learn for the future.	An assessment of the quality of care to improve clinical care. Individual cases are discussed by peers to determine whether the best care was given, include interesting or unusual. Mortality and morbidity review is a specific peer review process that looks at specific, non-random cases with adverse outcomes such as death or injury to see what lessons can be drawn.	In terms of clinical audit, surveys can be a useful tool where measuring compliance against your criteria requires information that can only be obtained from the patient and or the service user.

GLOBAL SURGERY 2030: KEY MESSAGES (The Lancet April 2015)

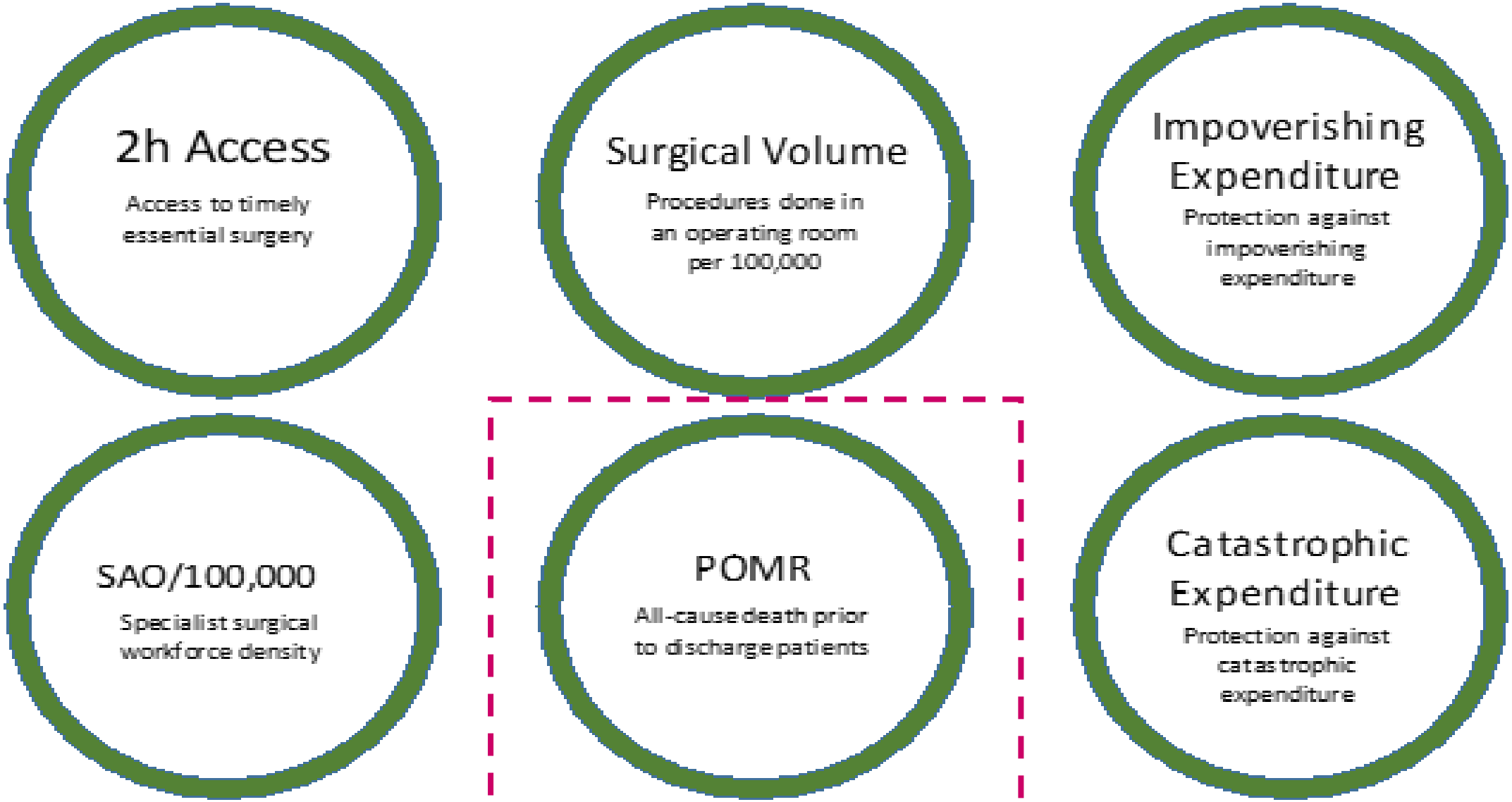
- 5 BILLION people lack access to safe, affordable surgical & anaesthesia care when needed.
- 143 MILLION additional procedures needed annually to fill unmet need.
- 33 MILLION USD per year face catastrophic expense after surgical care.
- Investment in surgical & anaesthesia care saves lives and promotes economic growth
- Surgery is an indivisible, indispensable part of healthcare

The Lancet, April 2015

LANCET METRICS

Category	Indicator	Definition	Target by 2030
Timeliness Capability	2-hour access to 3 Bellwether procedures	%age of population <2 hours from surgical facility	Min. 80% coverage
Capability Capacity	SAO provider density	No of SAO providers per 100,000 pop'n	20 per 100,000 pop'n
Capacity	Surgical volume	No of procedures per 100,000 pop'n	5000 per 100,000 population
Safety Quality	Perioperative mortality rate	No of in-hospital deaths per total surgical procedures	100% tracking
Affordability	Protection against impoverishing expenditure	%age of population protected	100% protection
Affordability	Protection against catastrophic expenditure	%age of population protected	100% protection

WORLDBANK INDICATORS



http://data.worldbank.org/indicator

DEFINITION

Any death occurring within the total length of hospital stay within the same admission of a surgical or gynaecological procedure done under general or regional anaesthesia including death in operation theatre (OT) before induction of anesthesia.

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PRINCIPLES

POMR

71 HOSPITALS

1 INSTITUTE

CONFIDENTIAL

- Reports and data

ANONYMITY

- Doctors reporting deaths
- Patients involved
- Doctors involved

OBJECTIVE

- Assessment
- Case review

EVALUATION

- Quality of care

PROFESSIONAL STANDARD

- CPG
- Clinical Pathway
- Audit

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OBJECTIVES

Highest possible standard quality of care

1. **Awareness & Understanding**

2. **Identify issues and problems**

3. **Objective and independent assessment**

4. **Identify avoidable factor and risk**

5. **Assist in legal requirement (potential Medicolegal)**

4. **Regulate plan of action**

DIRECTIVES

KETUA PENGARAH KESIHATAN MALAYSIA
DIRECTOR GENERAL OF HEALTH MALAYSIA
Kementerian Kesihatan Malaysia
Aras 12, Blok E7, Kompleks E,
Pusat Pentadbiran Kerajaan Persekutuan
62590 PUTRAJAYA

Tel.: 03-8000 8000
Faks: 03-8889 5542
Email: anhisham@moh.gov.my

Ruj.Tuan:
Ruj.Kami: KKM.600-28/2/2 Jld. 4 (5)
Tarikh: 13 **Julai 2022**

SEPERTI SENARAI EDARAN

YBhg. Dato' Indera/ Datuk/ Dato'/ Datin/ Tuan/ Puan,

PELAKSANAAN GARIS PANDUAN *IMPLEMENTATION OF PERIOPERATIVE MORTALITY REVIEW (POMR) (3rd EDITION)* 2022

Adalah saya dengan segala hormatnya merujuk kepada perkara di atas.

2. Sebagaimana maklum, kadar *perioperative mortality* dan kadar pelaporan *perioperative mortality* telah digariskan sebagai salah satu daripada enam indikator bagi inisiatif *Global Surgery* 2030 dimana menjelang tahun 2030 kadar pelaporan POMR disasarkan pada kadar 100%. Sehingga Jun 2022, POMR sebagai salah satu aktiviti audit klinikal kebangsaan telah pun dilaksanakan di 72 buah hospital berpakar Kementerian Kesihatan Malaysia (KKM). Ia bertujuan untuk memastikan kualiti perkhidmatan dan penjagaan perawatan pesakit yang menjalani pembedahan adalah mengikut tatacara yang telah digariskan oleh KKM. Di samping itu, ia juga dapat mengenal pasti kekangan yang dihadapi dalam penjagaan pesakit pembedahan agar langkah-langkah

Bersama-sama ini dilampirkan sesalinan Garis Panduan *lementation of Perioperative Mortality Review* (POMR) (*3rd Edition*) 2 dan Garis Panduan Pengisian Borang POMR 2022 (Edisi ke-2) buat kan pihak YBhg. Dato' Indera/ Datuk/ Dato'/ Datin/ Tuan/ Puan. barang maklumat lanjut boleh berhubung dengan Sekretariat POMR, t Audit Klinikal, Cawangan Kualiti Penjagaan Perubatan, Bahagian kembangan Perubatan (Dr. Faizah Muhamad Zin/ Dr. Puteri Fajariah gat Mohd Ghazali/ Dr. Zawaniah Brukan Ali) di talian 03-88831210/ 95/ 1523; atau e-mel: cau.mdd@moh.gov.my. Kerjasama daripada ng. Dato' Indera/ Datuk/ Dato'/ Datin/ Tuan/ Puan amatlah dihargai dan ahului dengan ucapan ribuan terima kasih.

kian.

AWASAN KEMAKMURAN BERSAMA 2030'

ERKHIDMAT UNTUK NEGARA'

ng Ikhlas,

DATO' DR. ASMAYANI BT KHALIB
(MMC : 27622)
Timbalan Ketua Pengarah Kesihatan (Perubatan)
Kementerian Kesihatan Malaysia

N SRI DATO' SERI DR. NOOR HISHAM BIN ABDULLAH

GUIDELINE

IMPLEMENTATION OF PERIOPERATIVE MORTALITY REVIEW (POMR) IN THE MINISTRY OF HEALTH MALAYSIA

(3rd Edition)

2022

CLINICAL AUDIT UNIT
MEDICAL CARE QUALITY SECTION
MEDICAL DEVELOPMENT DIVISION
MINISTRY OF HEALTH MALAYSIA

GARIS PANDUAN PENGISIAN BORANG VPOMR

(Edisi ke-2)

2022

UNIT AUDIT KLINIKAL
CAWANGAN KUALITI PENJAGAAN PERUBATAN
BAHAGIAN PERKEMBANGAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA

INCLUSION CRITERIA

1.1 Inclusion Criteria

i. All perioperative deaths (pre-, intra- and post-operative).

ii. Patient had surgery performed elsewhere or during the previous admission and was readmitted (related to previous procedure) within 30 days of surgery and died.

iii. Referred case whereby patient had surgery elsewhere (at the referral centre) and died at the primary hospital (the referring hospital), i.e., operated on and sent back to the referring hospital.

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EXCLUSION CRITERIA

1.2 Exclusion Criteria

i. Diagnostic or therapeutic procedures carried out by physician and other non- surgeons
ii. Radiological procedures performed solely by the Radiologist without a surgeon's involvement
iii. Endoscopy (e.g., OGDS/ Colonoscopy/ ERCP) performed under sedation or local anaesthesia (LA)
iv. Surgery performed outside OT complex, e.g., Procedure Room
v. Obstetric deaths

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ANAESTHESIA REPORT IS REQUIRED

For Death Category 1 or 2

Death in the Intensive Care Unit (ICU)/ High Dependency Ward (HDW)

Death in the Operation Theatre (OT)/ Recovery Room/ Lock Bay/ Air Lock

Report which is requested by the Surgeon

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DEATH CATEGORY

CATEGORY		DESCRIPTION
Category 1		Anaesthesia is a major contributing factor in death.
Category 2		Deaths caused by anaesthesia and surgical factors.
Category 3		Surgery is a major contributing factor in death.
Category 4	Category 4A	High-risk mortality for which treatment does not meet the standards (substandard).
	Category 4B	High-risk mortality for which the treatment meets the standard.
Category 5		Unexpected mortality in which patient is expected to full recovery (e.g., AMI, PE).
Category 6		The cause of death is uncertain due to lack of information regarding the case.
Category 7		Death caused by the pre-admission factor of the ward, for which the treatment provided does not meet the standards (substandard).

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DEPARTMENT CODE

Code		Discipline / Fraternity
01 General Surgery	**a**	General Surgery
	b	Breast & Endocrine
	c	Vascular
	d	Plastic and Reconstructive
	e	Hepatobiliary
	f	Colorectal
	g	Upper Gastrointestinal
	h	Thoracic
02		Paediatric Surgery
03		Cardiothoracic Surgery
04		Urology
05		Gynaecology
07		Orthopaedic
08		Opthalmology
09		Otorhinolaryngology
10		Neurosurgery
17		Burn and Trauma
18		Others

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COMMITTEE

The implementation of POMR requires commitment from the State Health Department (SHD) and the specialist hospitals (including cluster hospitals) under their purview.

Every SHD is required to form a POMR Committee at the state and hospital level (for cluster hospitals, only the lead hospital and cluster hospitals with resident specialists)

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COMMITTEE (NATIONAL)

3.1 MOH level (National):

Advisor 1	Deputy Director General of Health (Medical)
Advisor 2	Director of Medical Development Division
Chairman	Senior Consultant (Surgeon/ Anaesthetist)
Deputy Chairman 1	Senior Consultant Surgeon (Surgical Based)
Deputy Chairman 2	Senior Consultant Anaesthetist
Secretariat	Deputy Director, Medical Care Quality Section
	Clinical Audit Unit, Medical Care Quality Section
Assessor	Senior Consultant Surgeons
	Senior Consultant Anaesthetists
*Representative (by invitation, no appointment)	Medical Services Development Section
	Medicolegal Section
	Specialist Hospital

- Appointment is by the Advisor. Appointment tenure is 3 years. Refer Appendix 1.

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COMMITTEE (STATE)

3.2 State level:

Advisor	State Health Director
Chairman	Deputy State Health Director (Medical)
Deputy Chairman 1	State Chief Surgeon (Surgical Based)
Deputy Chairman 2	State Chief Anaesthetist
Secretary	State POMR Coordinator
Member	Surgeons (Surgical based)/ National Assessor
	Anaesthetist/ National Assessor
	State Quality Officer
	State Matron/ Sister/ Nurse
	State Assistant Medical Officer
	Hospital's POMR Coordinator

- Appointment is by the Advisor. Appointment tenure is 3 years.

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COMMITTEE (HOSPITAL)

3.3 Hospital level:

Chairman	Hospital Director
Deputy Chairman 1	HOD/ Senior Consultant Surgeon (Surgical Based Discipline)
Deputy Chairman 2	*HOD/ Senior Consultant Anaesthetist
Secretary	Hospital POMR Coordinator
Member	Hospital Deputy Director (Surgical Directorate)
	*HOD Surgical Based Disciplines
	Surgeons (Surgical based)/ National Assessor
	Anaesthetist/ National Assessor
	Hospital Quality Officer
	Ward Matron/ Sister/ Nurse
	Assistant Medical Officer

- Appointment is by the Chairman. Appointment tenure is 3 years.
- *HOD = Head of Department

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NATIONAL COMMITTEE (ASSESSORS)

5. POMR ASSESSOR

5.1 Background

5.1.1 Assessors are selected based on their background of expertise in the field and sense of Commitment to the program.

5.1.2 The appointment of an Assessor is through the nomination and approval of the Head of Service of the respective clinical fraternity and POMR Chairman.

5.1.3 Head of Service of the Surgical based discipline and Anesthesiology will automatically be appointed as an Assessor.

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NATIONAL COMMITTEE (ASSESSORS)

5.2 Term of Reference

5.2.1 POMR Assessor must be a practicing clinician of various levels of experience and expertise in the Ministry.

5.2.2 The appointment is based on the Head of Service recommendation.

5.2.3 The appointment is exclusive to the holder and no representative is allowed to attend the POMR business meeting.

5.2.4 The appointment is valid in accordance with the date stated in the appointment letter or until the date of the retirement of an Assessor.

5.2.5 Failure to attend three (3) consecutive meetings may result in discontinuation of the appointment as an assessor.

5.2.6 All travel expenses (e.g., transportation fares/ mileage claim, lodging food and beverages) are under the responsibility of the respective department (PTJ) of the assessor.

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NATIONAL COMMITTEE (ASSESSORS)

5.3 Roles and Responsibilities

5.3.1 Assessors must agree to the POMR Assessor's Code of Conduct and Ethics (Appendix 1) of the POMR Committee.

5.3.2 Assessors are expected to review POMR cases. They are expected to make objective decisions on the quality of care based on evidence-based medicine, scientific data as well as local circumstances which may be peculiar to the hospital. Assessment of cases should not be delegated to other staff in the department, but it does not preclude the reviewer from obtaining views from other specialists.

5.3.3 Assessors are expected to prepare case summaries and reviews of selected cases, so that they may be published in the POMR bulletin on a regular basis. Such commentaries should be based on current accepted practice and evidence-based; references should preferably be quoted. Such an approach will enhance the scientific validity of the review.

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NATIONAL COMMITTEE (ASSESSORS)

5.3.4 Assessors will be expected to prepare POMR reports.

5.3.5 Assessors are encouraged to publish or present POMR papers at local and international meetings or conferences.

5.3.6 Assessors will be expected to assist the hospital nursing coordinators at their respective hospitals to ensure the smooth process of POMR reporting.

5.3.7 Assessors are expected to play a proactive role in liaising with the hospital directors and other clinicians to ensure the recommendations of the POMR can be implemented.

5.3.8 Assessors are expected to aid in education, training and awareness of POMR activities at the hospital, state or national level.

5.3.9 Assessors are expected to participate and contribute in POMR activities such as Conference, Workshop, Audit and Roadshow.

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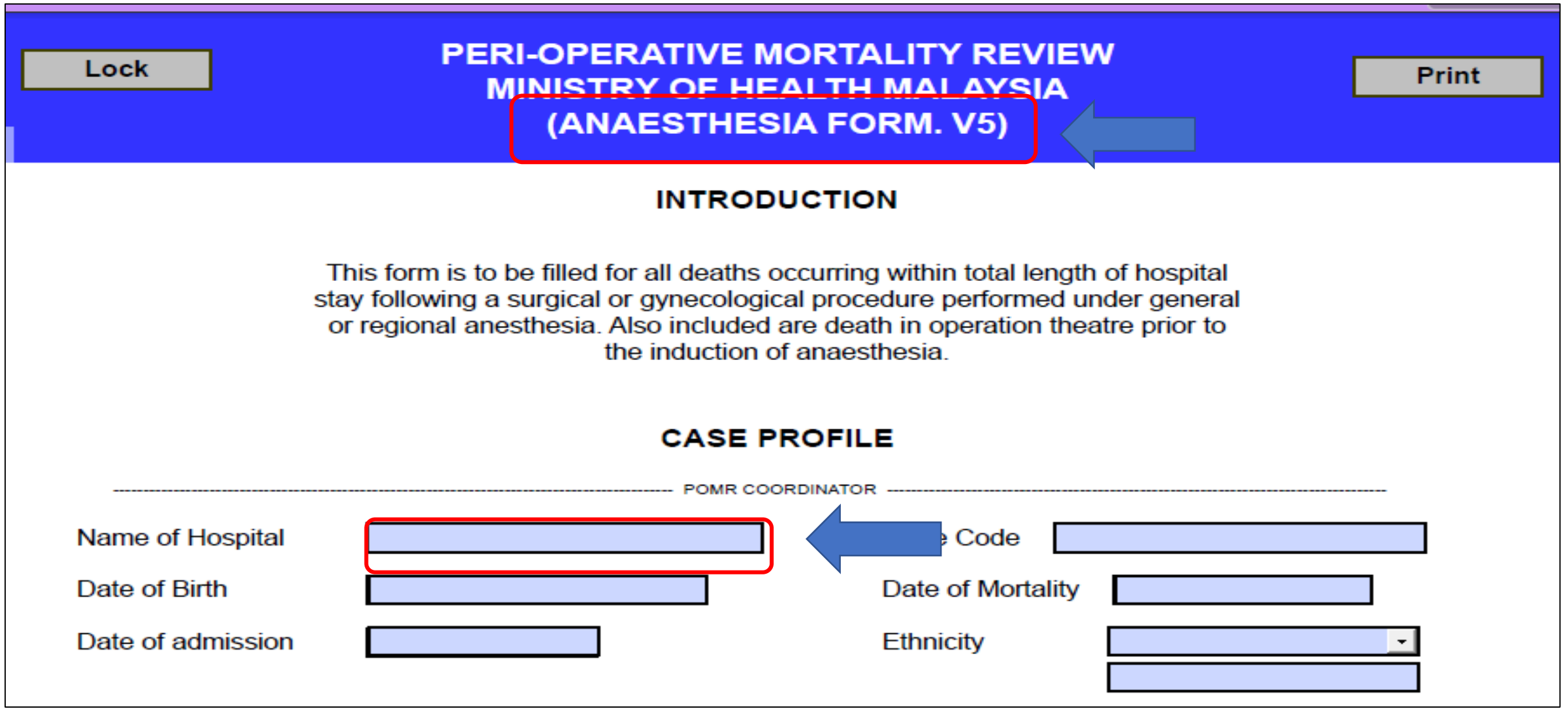
FORMS



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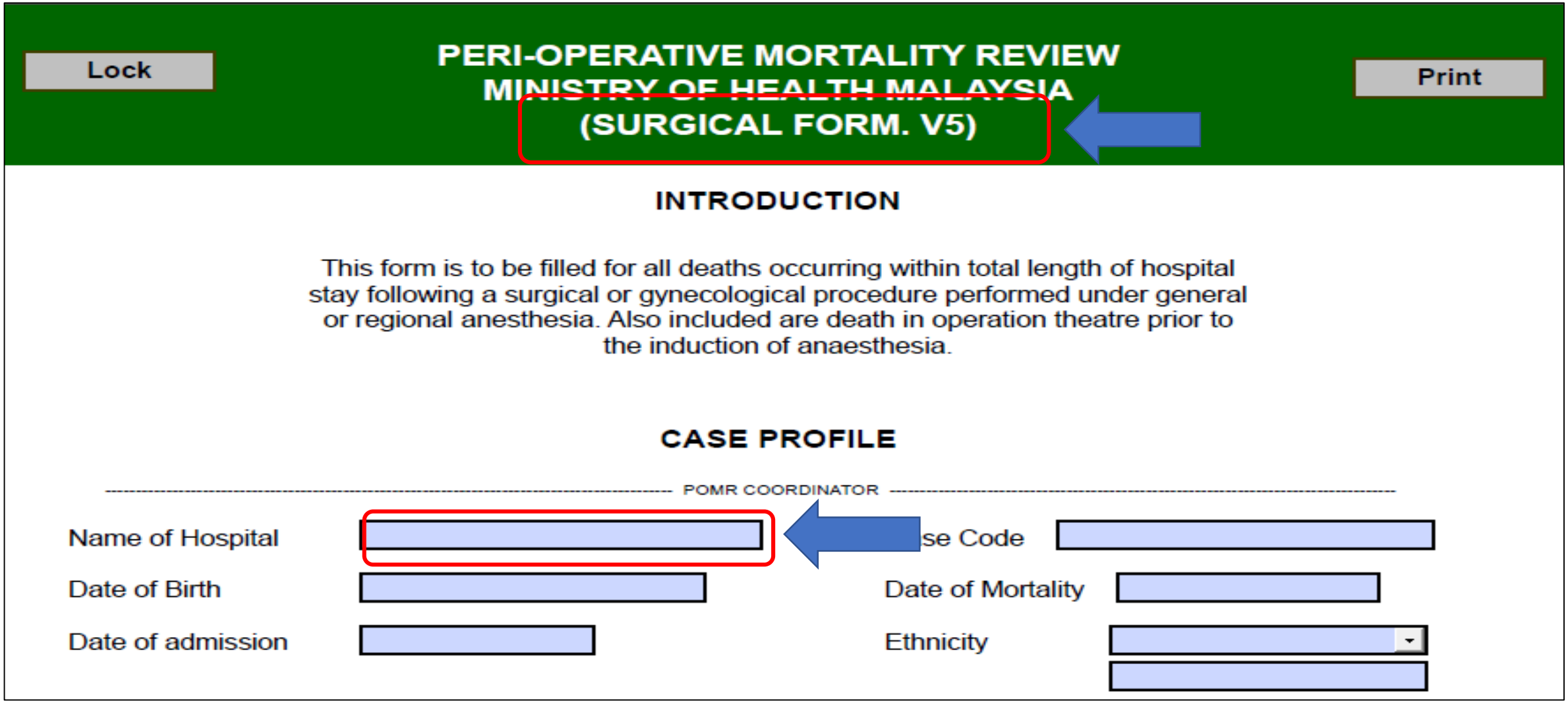

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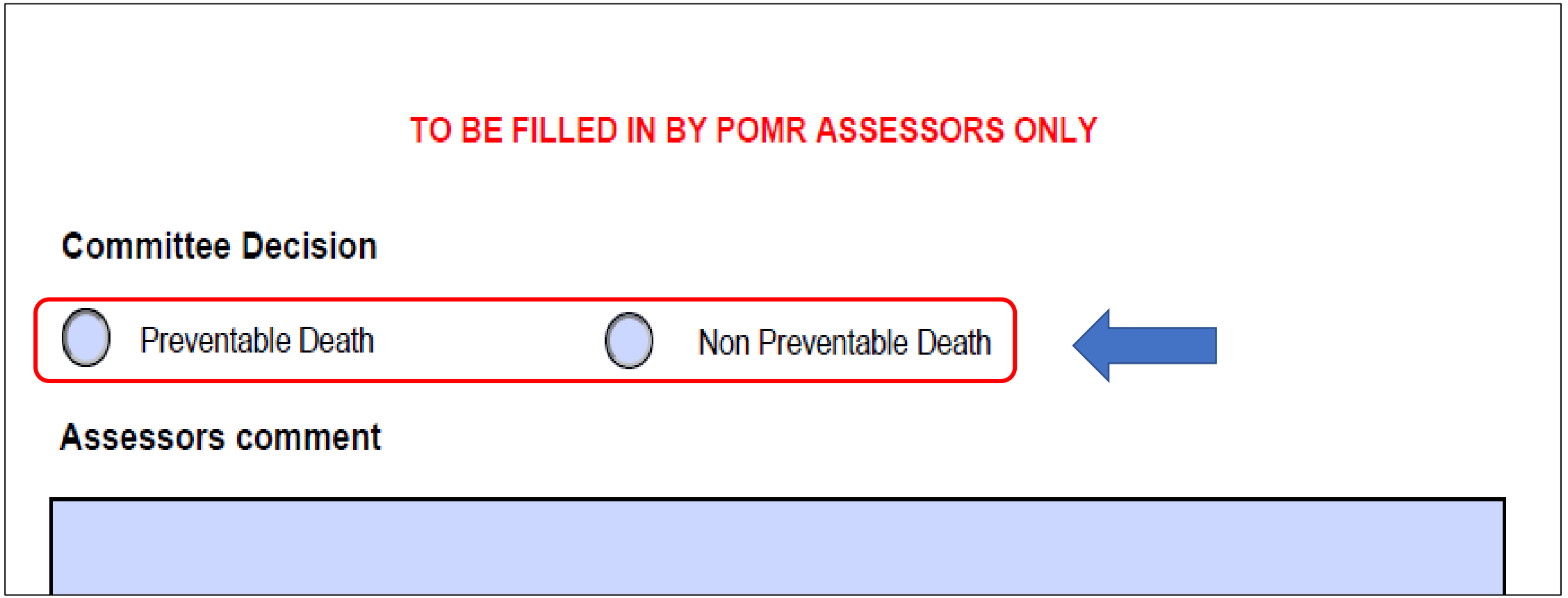

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HOW?

WHAT WE DO…

1. COMMITTEE

2. EDUCATION & TRAINING

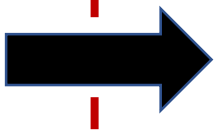
3. VPOMR REPORTING

4. ANALYSIS

5. POMR REPORTS/ BULLETIN

GAPS

- CONTINUITY OF CARE
- SYSTEMATIC DATA COLLECTION
- DATA SCARCITY
- POMR REPORT/ BULLETIN DISSEMINATION



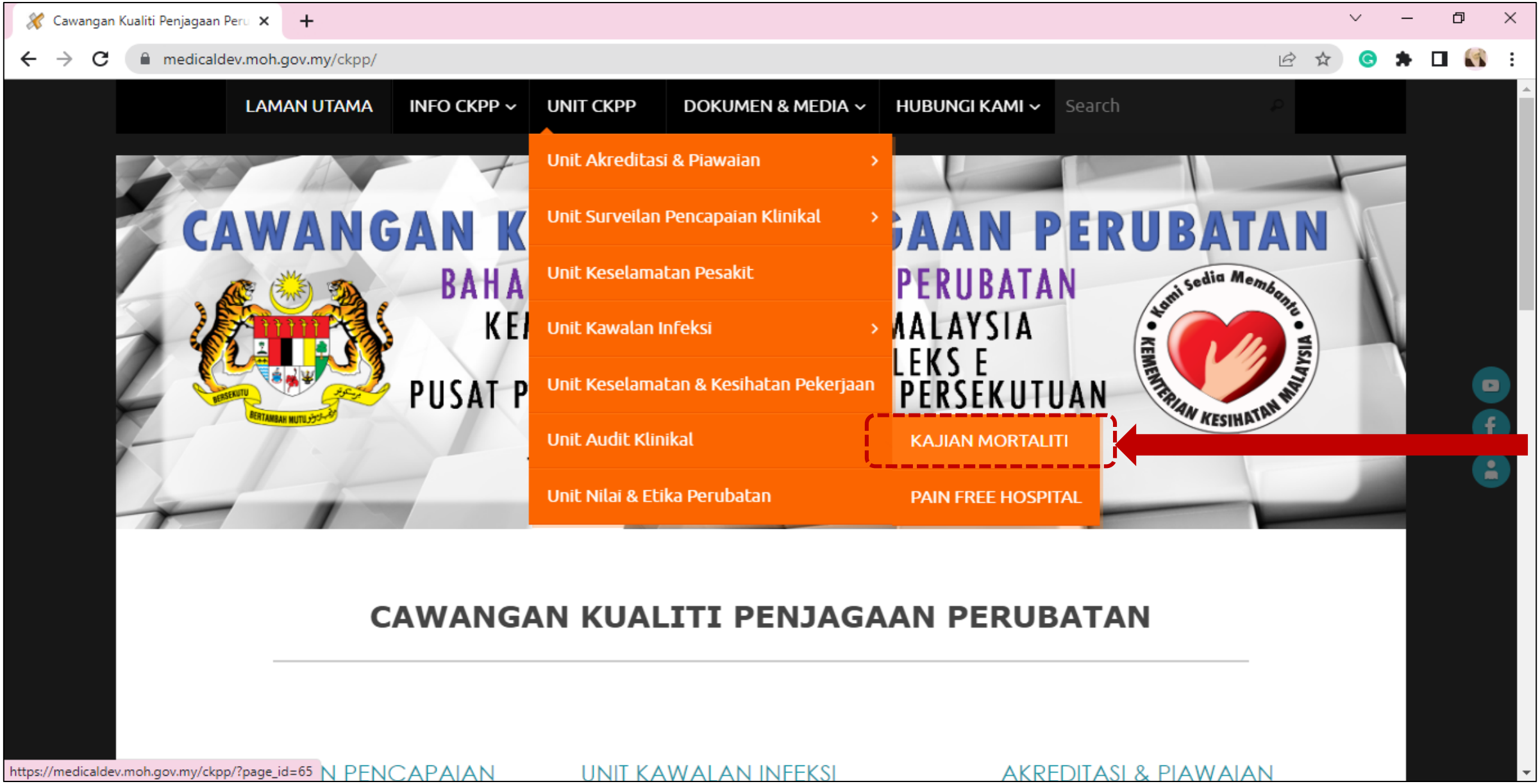
- TRAINING & COMPETENCIES
- SAFETY AND QUALITY OF CARE
- DATA MANAGEMENT & ANALYSIS
- ACTION ON REPORT AND RECOMMENDATIONS

LAMAN SESAWANG

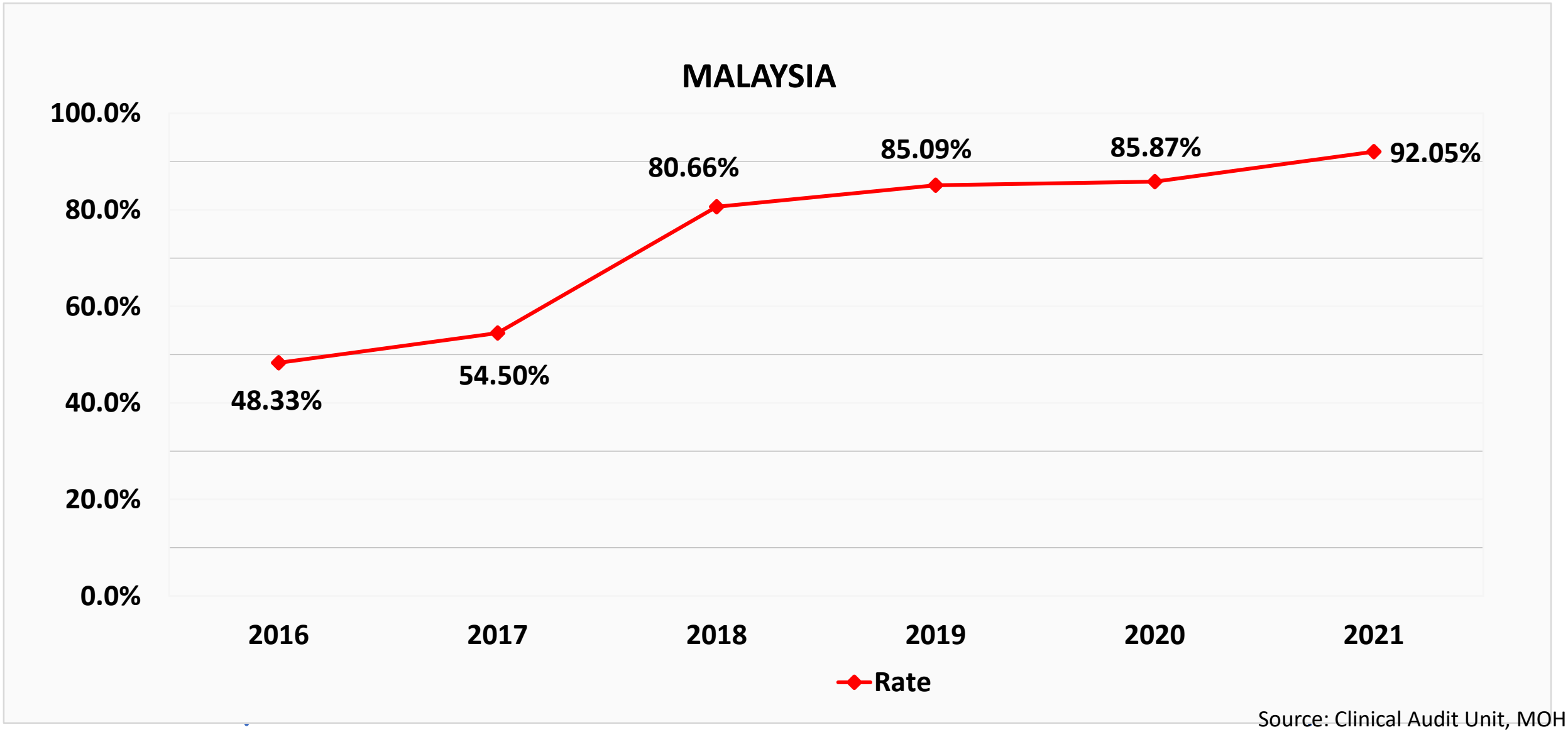
GARIS PANDUAN & ARAHAN SURAT : https://www.moh.gov.my/

LAMAN SESAWANG

BULLETIN/ REPORTS: www.medicaldev.moh.gov.my/ckpp

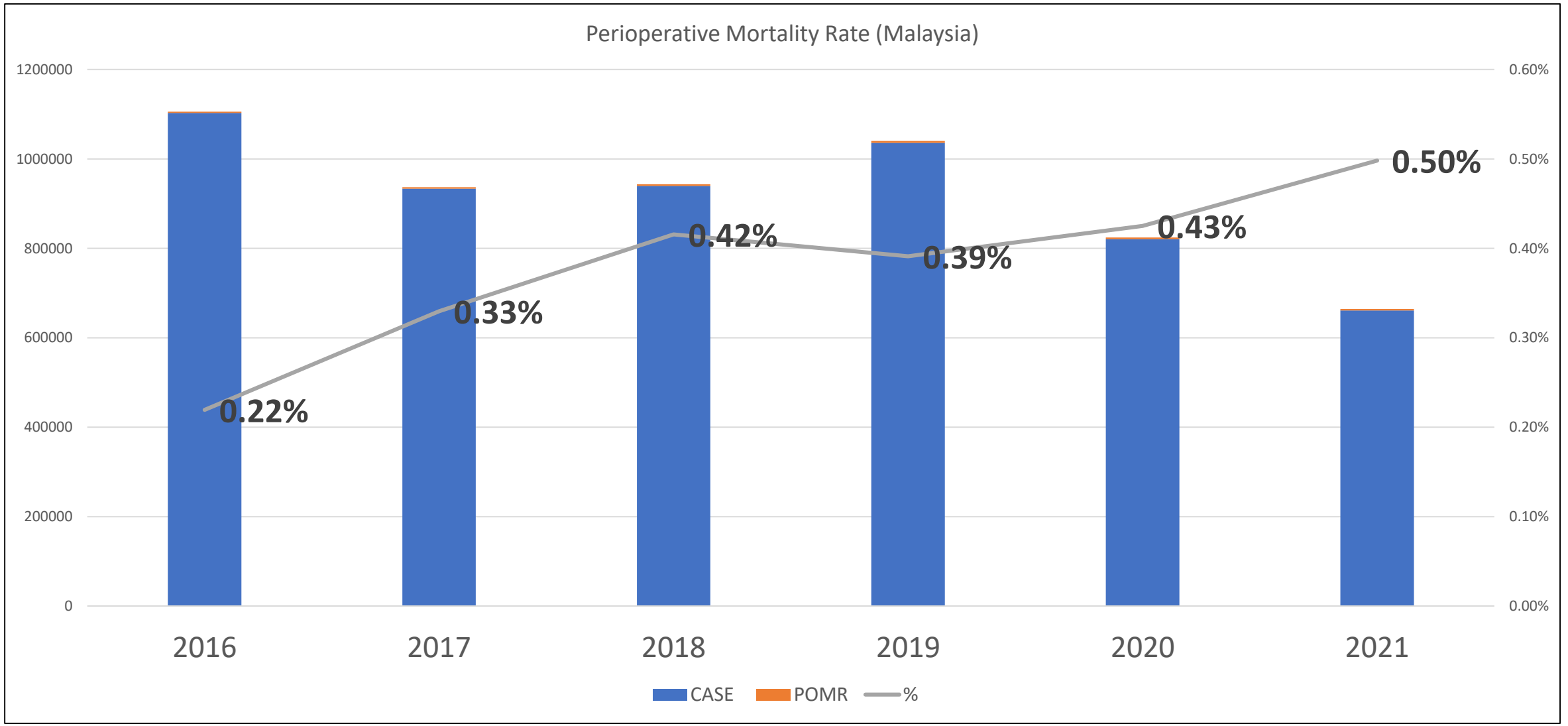


NATIONAL POMR REPORTING RATE
2016 – 2021



Source: Clinical Audit Unit, MOH

NATIONAL PERIOPERATIVE MORTALITY RATE
2016 – 2021



Source: Clinical Audit Unit, MOH

THANK YOU