MOH DIRECTIVE 04/2013

DIRECTIVES FOR MORTALITY AND MORBIDITY SYSTEMS REVIEW FOR PRESCRIBED HEALTHCARE INSTITUTIONS: REGULATION 12A (1)(b) OF THE PRIVATE HOSPITALS AND MEDICAL CLINICS REGULATIONS (CAP 248, RG 1)

Purpose of Directives

These revised Directives are issued under Section 11 of the Private Hospitals and Medical Clinics (“PHMC”) Act and Regulation 12A (1)(b) of the PHMC Regulations. They set out the requirements for prescribed healthcare institutions to establish a consistent system for reviewing mortality and morbidity (“M&M”) cases that occur in healthcare institutions.

2 These Directives supersede the Directives for Review of Mortality and Morbidity for Prescribed Healthcare Institutions issued in January 2011.

3 The review of M&M cases shall focus on identifying and addressing systems failures and process gaps at the local department and/or institutional level to facilitate quality and patient care improvements across systems of care to prevent the occurrence or recurrence of similar events.

Definitions of key terms

4 In these Directives, unless otherwise specified:

   a) **clinical incident** refers to an event or circumstance which could have resulted, or did result, in harm to a patient; and, includes a complaint to that effect.

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5 Where the focus of review is on the individual specialist’s performance in practice and professional competencies, the M&M Quality Assurance Committee (“M&M QAC”) may, at its discretion, refer such cases to the Peer Review Learning Quality Assurance Committee (“PRL QAC”) for review under the Directives for Peer Review Learning for Prescribed Healthcare Institutions.
b) **error** refers to the failure to carry out a planned action as intended or the application of an incorrect plan.

c) **mortality** refers to an in-patient death in a prescribed healthcare institution.

d) **morbidity** refers to a clinical incident, such as an adverse event or a complication and excludes:
   (i) mortality; or,
   (ii) a clinical incident that is notifiable under the *Directives for Review of Serious Reportable Events for Prescribed Healthcare Institutions* ("SRE Directives").

e) **preventable** describes an event that could have been anticipated and prepared for but which occurs because of an error or systems failure.

f) **systems failure** refers to a fault, breakdown or dysfunction within the prescribed healthcare institution’s operational methods, processes or infrastructure.

**Applicability**

5 These Directives are applicable to:

   a) all healthcare institutions and classes of healthcare institutions as prescribed in the Sixth Schedule to the PHMC Regulations.
   b) all M&M Quality Assurance Committees (“QACs”) involved in reviewing M&M cases that occurred in prescribed healthcare institutions.

**Establishment of M&M QACs**

6 The licensee of a prescribed healthcare institution is to establish, for the purpose of learning and improvement, systems:

   a) to identify suitable M&M cases in the institution for systems review;
   b) to establish one or more M&M QAC(s) at the local department or institutional level to conduct M&M systems reviews;
   c) to ensure that the findings of the M&M QAC systems reviews are adequately documented; and
   d) to ensure that the recommendations of the M&M QAC(s) are implemented, as appropriate.

**Excluded Cases**

7 The licensee shall convene a separate disciplinary inquiry where a case referred to the M&M QAC for systems review involves:
a) a criminal act or deliberate patient harm;
b) the use of alcohol or illicit drugs;
c) a deliberate unsafe act; or
d) professionally unethical practice,

on the part of the registered healthcare professional(s) who attended to the patient, regardless of whether these actions were identified prior to the commencement or during the course of an M&M QAC systems review.

8 The licensee shall ensure that policies are in place for suspension, limitation, reduction of clinical privileges or termination at the point when such cases are being referred for disciplinary inquiry to prevent imminent harm or danger to any individual and that such policies are complied with.

Policy

9 The licensee shall ensure that the prescribed healthcare institution maintains written documentation setting out the policy and procedures on the conduct of M&M QAC systems reviews, as described in these Directives, including but not limited to the following:

a) objectives of M&M QAC systems reviews;
b) relevant statutory provisions under which M&M QAC systems reviews are performed;
c) composition of M&M QACs;
d) terms of reference of M&M QACs;
e) timeframe for M&M QAC systems reviews;
f) frequency of M&M QAC meetings; and
g) process and activities of M&M QAC systems reviews.

10 The licensee shall ensure that the above policies and procedures are reviewed annually and regularly updated to ensure effectiveness of the M&M QACs.

Composition of M&M QACs

11 The M&M QAC shall comprise at least three (3) or more clinical staff (e.g. doctors, nurses, allied health professionals, etc.) and may include non-clinical staff (e.g. staff from medical record office and medical affairs department, etc.), as appropriate and necessary.

12 The M&M QAC may include one or more representative(s) from another prescribed healthcare institution, students attached to the healthcare institution or such other person(s) as the Director may appoint.

13 Depending on the size of the prescribed healthcare institution and volume of cases to be reviewed:

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2 As stipulated in the respective professional codes of conduct
a) the same members may sit on multiple QACs to review M&M cases, Serious Reportable Event cases and/or Peer Review Learning cases, and
b) these reviews may be held concurrently,

provided that each review is carried out in accordance with the requirements of the respective Directives.

Review of M&Ms

14 The M&M QAC shall assess and categorise each mortality according to the classification criteria set out in Annex A and:

a) refer all Category 3 mortalities and clinical incidents notifiable under the SRE Directives to the SRE QAC; and,
b) review all remaining mortalities and morbidities.

15 The aim of the M&M QAC systems review shall be to:

a) review the selected M&M cases to identify systems failures, contributory factors and process deficiencies and, following the review,
b) recommend specific interventions at the local department and/or institutional level to improve patient care and to prevent the occurrence or recurrence of similar events.

Timeframe for Review

16 The licensee shall ensure that M&M QAC systems reviews are carried out in a timely manner so that the appropriate action is taken to address recommendations for improvement.

17 All M&M cases shall be reviewed no later than three (3) months from their date of occurrence.

Documentation

18 The licensee shall ensure that the following is documented, and shall furnish the Director, as and when required by him, with:

a) the activities of the M&M QAC(s), including M&M QAC systems review findings and recommendations;
b) the total number of deaths reviewed by the M&M QAC(s) with their respective category as defined in Annex A;
c) details of the implementation status of specific recommendations made by the M&M QAC(s); and

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3 This will apply even if the death was due to care provided at another institution. The notification that is made to the Ministry of Health should indicate this as a concern.
d) such records relating to any other quality assurance activity undertaken by the M&M QAC(s).

19 To ensure that the requirements of these Directives are complied with, the Director may, at his discretion, authorise relevant MOH officials to attend and be present during M&M QAC discussions or to conduct periodic checks.

Dated this 26th day of December 2013

Prof K Satku
Director of Medical Services
Ministry of Health
Singapore
CATEGORISATION OF DEATHS

Category 1: Expected death

Includes death:

   a) due to terminal illness (anticipated by clinicians and family);
   b) following cardiac or respiratory arrest before arriving at the hospital; or
   c) which occurred despite medical interventions.

Category 2: Unexpected death which was not reasonably preventable.

Category 3: Unexpected death which was possibly preventable and was:

   a) due to lack of treatment or delay in treatment; or
   b) caused by medical intervention.

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4 Adapted from Western Australia Review of Mortality