



# PERIOPERATIVE MORTALITY REVIEW (POMR)

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# DEFINITION

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

# EXCLUSION CRITERIA

Surgery performed elsewhere/ during previous admission but patient was admitted and died during the present admission **WITHOUT SURGICAL INTERVENTION**

Diagnostic and/ or therapeutic procedures carried out by physician and other non-surgeons

Radiological procedures performed solely by the Radiologist without a surgeon's involvement

Endoscopy (e.g. OGDS/ Colonoscopy/ ERCP) performed under sedation or/and LA

Surgery performed outside OT complex, e.g. Procedure room

Obstetric deaths (Pregnancy > 28 weeks). Ectopic pregnancy (< 28 weeks) are included

# ANAESTHESIA REPORT REQUIRED

**For Death Category 1 or 2**

**Death occurring in ICU/ HDW**

**Death occurring in OT/Recovery room**

**Report which is requested by the Surgeon**

# DEATH CATEGORY

Category 1 : Anaesthesia is the main contributory factor

Category 2 : Death is due to both anaesthetic and surgical factors

Category 3 : Surgery is the main contributory factor

Category 4A : High risk death where management was substandard

Category 4B : High risk death where management was satisfactory

Category 5 : Unexpected death where patient was expected to make full recovery eg. AMI, PE

Category 6 : Cause of death undetermined due to insufficient information or otherwise

Category 7 : Death due to pre-admission factors, where management was substandard

# PRINCIPLES

POMR

54 HOSPITALS

1 INSTITUTE



**CONFIDENTIAL**

- Reports and data

**ANONYMITY**

- Doctors reporting deaths
- Patients involved
- Hospital involved

**OBJECTIVE**

- Assessment
- Case review

**EVALUATION**

- Quality of care

**PROFESSIONAL  
STANDARD**

- CPG
- Clinical Pathway
- Audit

# OBJECTIVES

Highest possible standard of care

1

Awareness & Understanding



3

Objective and independent assessment

assessment  
is to  
**INCREASE**  
quality.



2

Identify issues and problems



4

Identify avoidable factor and risk



# HOW?





# 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

# WAY FORWARD

1

COMMITTEE



2

EDUCATION &  
TRAINING



3

VPOMR  
REPORTING



4

ANALYSIS

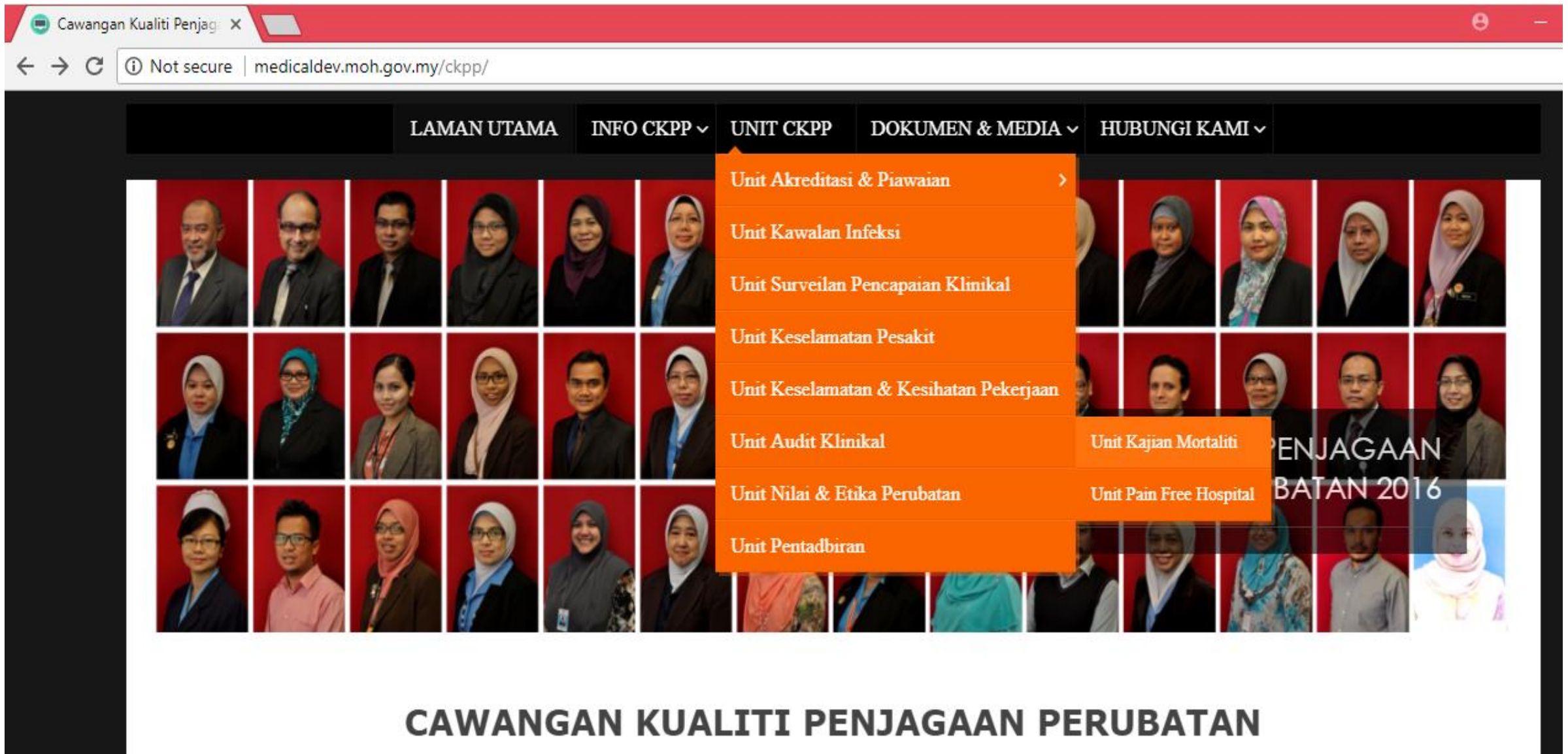


5

POMR REPORTS/  
BULLETIN



# BULLETIN/ REPORTS: [www.medicaldev.moh.gov.my/ckpp](http://www.medicaldev.moh.gov.my/ckpp)



The screenshot shows a web browser window with the URL [www.medicaldev.moh.gov.my/ckpp/](http://www.medicaldev.moh.gov.my/ckpp/). The page features a navigation bar with the following items: LAMAN UTAMA, INFO CKPP, UNIT CKPP, DOKUMEN & MEDIA, and HUBUNGI KAMI. The 'UNIT CKPP' dropdown menu is open, listing the following units: Unit Akreditasi & Piawaian, Unit Kawalan Infeksi, Unit Surveilans Pencapaian Klinikal, Unit Keselamatan Pesakit, Unit Keselamatan & Kesihatan Pekerjaan, Unit Audit Klinikal, Unit Nilai & Etika Perubatan, and Unit Pentadbiran. The background of the page displays a grid of staff members' portraits. A semi-transparent banner on the right side of the grid reads 'PENJAGAAN PERUBATAN 2016'.

**CAWANGAN KUALITI PENJAGAAN PERUBATAN**



THANK YOU