On approval of the rules for confidential audit in healthcare organisations

Unofficial translation

Order of the Minister of Healthcare of the Republic of Kazakhstan No. KR DSM-164/2020 of October 28, 2020. Registered with the Ministry of Justice of the Republic of Kazakhstan on October 30, 2020 under No. 21561

Unofficial translation

In obedience to sub-paragraph 104 of Article 7 of the Code of the Republic of Kazakhstan of July 7, 2020 "On Public Health and the Healthcare System", **I HEREBY ORDER**:

1. That the rules for confidential audit in healthcare organisations shall be approved pursuant to the Annex hereto.

2. That in the manner prescribed by the laws of the Republic of Kazakhstan, the Department for Organisation of Medical Care of the Ministry of Healthcare of the Republic of Kazakhstan shall:

1) ensure state registration hereof with the Ministry of Justice of the Republic of Kazakhstan;

2) provide placement hereof on the internet resource of the Ministry of Healthcare of the Republic of Kazakhstan;

3) within ten working days after state registration hereof with the Ministry of Justice of the Republic of Kazakhstan, provide to the Legal Department of the Ministry of Health of the Republic of Kazakhstan information on execution of actions stipulated by sub-paragraphs 1) and 2) of this paragraph.

3. The supervising Vice-Minister of Healthcare of the Republic of Kazakhstan shall be charged with the control of execution hereof.

4. This Order shall be put into effect ten calendar days after the date of its first official publication.

Minister of Healthcare
of the Republic of Kazakhstan *A. Tsoy*

Annex to Order
of the Minister of Healthcare
of the Republic of Kazakhstan
No. KR DSM-164/2020
dated October 28, 2020

Rules for confidential audit in healthcare organisations

Chapter 1. General provisions

1. These Rules for Confidential Audit in Healthcare Organisations (hereinafter the Rules) have been developed in compliance with sub-paragraph 104 of Article 7 of the Code of the Republic of Kazakhstan of July 7, 2020 “On Public Health and Healthcare System” and in order to reduce maternal and infant mortality rates, determine the procedure for conducting confidential audit in healthcare organisations.

2. Confidential audit shall be carried out by the healthcare organisation which carries out the audit (hereinafter referred to as the HO) based on a contract for the provision of confidential audit services.

Chapter 2: Procedures for conducting confidential audit in healthcare organisations

3. Confidential audit shall be carried out on:

1) maternal mortality;

2) perinatal mortality;

3) infant mortality;

4) critical cases in obstetrics.

4. A supervisor shall be appointed for each area of confidential HO audit (maternal, perinatal, infant mortality and critical obstetric cases).

5. Regional Confidential Audit Coordinators (hereinafter referred to as RCAC) for each area shall be appointed by the Office of Health of Oblasts and Cities of republican status.

6. The HO shall ensure that confidential audits are conducted and that analytical information based on the results of confidential audits is provided to the authorised body in the field of healthcare.

7. Confidential audit of maternal mortality shall be carried out to:

1) identifying medical and non-medical causes and factors leading to maternal deaths, including social and familial causes;

2) assessing, on the basis of evidence-based medicine, maternal deaths, identifying adverse factors at the community level as well as at the level of health care organizations;

3) developing specific recommendations with an intersectoral (departmental) approach to improve the quality of care for pregnant women, women in labour and childbirth.

8. The RCAC shall undertake the following activities:

1) upon receiving information on a case of death of a woman during pregnancy, childbirth and the postpartum period in the region (regardless of cause), informs the HO within 3 working days and starts the collection of information;

2) collects documentation, copy and anonymise the medical records of the deceased woman;

3) informs medical workers who participated in providing medical care to the deceased woman, conducts their anonymous questionnaire

4) conducts an anonymous questionnaire survey of relatives of the deceased patient, with questionnaires and (or) questionnaires filled out anonymously (no signatures and data on the identity of the woman, data on the locality and medical staff);

5) impersonal documentation and anonymous questionnaires are sent to the HO.

9. The HO shall ensure that confidential audits are carried out and that analytical information based on the results of the audit is made available to the competent health authority.

10. The HO shall ensure that set-up, interim and final meetings as well as educational seminars are organised for the RCAC Maternal Mortality.

11. Confidential audit on perinatal and infant mortality shall be carried out to:

1) identify medical and non-medical causes leading to perinatal and infant deaths, including social and familial causes;

2) assess, on the basis of evidence-based medicine, cases of perinatal and infant mortality, identifying negative factors at the community level, as well as at the level of medical organisations;

3) develop specific recommendations with a multisectoral (departmental) approach to improve the quality of care for newborns and children;

4) verbally notify the HO representative of each case of perinatal, infant death within 72 hours;

5) ensure quality completion of the confidential audit questionnaire;

6) send completed questionnaires, anonymised copies of all medical documents for each perinatal death within 1 month to the HO representative;

7) send to the HO representative an expert evaluation of the case of death;

8) participate in the meetings of the HO by attending in person or via video link;

9) participate in the development of the final report of the HO;

10) anonymise copies of all medical documents for each perinatal death case;

11) assist in the completion of the questionnaires by the medical staff;

12) perform the technical work of completing the medical documentation before sending it to the HO.

12. The HO shall ensure that confidential audits are carried out and that analytical information based on the results of the audit is provided to the authorised health authority.

13. The HO shall organise inception, interim and final meetings as well as educational seminars for RCAC on perinatal and infant mortality.

14. Audit of critical cases in obstetric practice shall be the study of cases of life-threatening conditions via anonymous questionnaires to the medical personnel who have treated the patient, the woman herself and others, and discussion at a working group meeting at the level of the medical organisation.

15. The following critical cases in obstetric practice shall be audited:

1) haemorrhage accompanied by hysterectomy and haemotransfusion;

2) obstetric sepsis;

3) severe pre-eclampsia with complications and eclampsia.

16. A working group of physicians shall be established in the region and a person responsible for auditing critical cases in obstetric practice shall be appointed for auditing critical cases in obstetric practice.

17. The responsible person shall ensure:

1) the completion of a questionnaire by medical staff;

2) interviewing the woman by a trained member of the audit working group to reconstruct the events as reported by the woman;

3) written record of the incident by the health worker involved.

18. The meeting of the working group for the analysis of critical cases in obstetric practice shall be attended by:

1) the person responsible for the analysis of critical cases in obstetric practice;

2) the medical staff directly involved in the critical case;

3) a psychologist (if available);

4) members of the critical incident audit working group in obstetric practice. 19.

19. The working group for auditing critical cases in obstetric practice shall:

1) examine the management of the woman from her admission to the maternity clinic to discharge (door-to-door approach), identifying the elements of care that were carried out in a professional manner as well as those that were not carried out in a professional manner;

2) analyse factors or causes contributing to inadequate care, as well as factors or causes preventing the provision of quality care;

3) identify the stages of health care delivery for improvement;

4) develop actions or solutions (recommendations) that are proposed and implemented to ensure quality care when new cases requiring emergency obstetric care arise.

20. Each meeting shall be documented.

21. The responsible person for auditing critical cases in obstetric practice at the health care institution providing obstetric and gynaecological care shall submit a monthly report and recommendations for the prevention of critical cases in HO.

22. The HO shall analyse the reports of the responsible persons for auditing critical cases in obstetric practice and send the regional summary information quarterly by the 10th day of the month following the reporting period to the approved health authority.