KEMENTERIAN KESIHATAN MALAYSIA

GARIS PANDUAN PELAKSANAAN

AKREDITASI

HOSPITAL & INSTITUSI PERUBATAN KEMENTERIAN KESIHATAN MALAYSIA

UNIT AKREDITASI & PIAWAIAN
CAWANGAN KUALITI PENJAGAAN PERUBATAN
BAHAGIAN PERKEMBANGAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA

KEMENTERIAN KESIHATAN MALAYSIA

Diterbitkan pada tahun 2023 oleh Cawangan Kualiti Penjagaan Perubatan,
Bahagian Perkembangan Perubatan

Cawangan Kualiti Penjagaan Perubatan
Bahagian Perkembangan Perubatan
Kementerian Kesihatan Malaysia
Aras 4-7, Blok E1, Kompleks E
Pusat Pentadbiran Kerajaan Persekutuan
62590 PUTRAJAYA

PENGHARGAAN

PENAUNG:

YBHG. TAN SRI DATO' SERI DR. NOOR HISHAM BIN ABDULLAH
Ketua Pengarah Kesihatan Malaysia

PENASIHAT:

YBHG. DATO' DR. ASMAYANI BINTI KHALIB
Timbalan Ketua Pengarah Kesihatan (Perubatan)
Kementerian Kesihatan Malaysia

YBRS. DR. MOHD AZMAN BIN YACOB
Pengarah Perkembangan Perubatan
Bahagian Perkembangan Perubatan
Kementerian Kesihatan Malaysia

PENULIS:

DR. NOOR SUHAILA BINTI ABU BAKAR (Ketua Penulis)
Ketua Penolong Pengarah Kanan
Cawangan Kualiti Penjagaan Perubatan
Bahagian Perkembangan Perubatan
Kementerian Kesihatan Malaysia

DR. FUAD RIDHA BIN MAHABOT
Ketua Penolong Pengarah Kanan
Cawangan Kualiti Penjagaan Perubatan
Bahagian Perkembangan Perubatan
Kementerian Kesihatan Malaysia

DR. BHARATHI GANATHIPAN
Ketua Penolong Pengarah Kanan
Cawangan Kualiti Penjagaan Perubatan
Bahagian Perkembangan Perubatan

PENYUMBANG:

DR. AHMAD MUZAMMIL BIN ABU BAKAR

DR. NURHANANI BINTI MAT NAWI

EN. SAHALUDIN BIN SHARIF

PN. NASRIAH BINTI AZIZ

EN. FAUZI BIN MANSOR

PENYEMAK & PENYUNTING:

YBRS. DR. NOR HAYATI BINTI IBRAHIM
Timbalan Pengarah
Cawangan Kualiti Penjagaan Perubatan
Bahagian Perkembangan Perubatan
Kementerian Kesihatan Malaysia

YBRS. DR. FEROUS BIN ALIAS
Timbalan Pengarah Kesihatan Negeri (Perubatan)
Jabatan Kesihatan Negeri, Negeri Sembilan
Kementerian Kesihatan Malaysia

YBHG. DATO' DR. ABDUL RAHIM BIN ABDULLAH
Ketua Pegawai Eksekutif
Malaysian Society for Quality in Health (MSQH)

YBRS. DR. MOHD ANIS BIN HARON @ HARUN
Pengarah
Institut Kanser Negara
Kementerian Kesihatan Malaysia

PEREKA GRAFIK:

PUAN AZLINA BINTI ABDUL AZIZ
Institut Kanser Negara

PUAN NUR DIYANA BINTI ALBAKRI
Institut Kanser Negara

Dan juga setinggi-tinggi penghargaan kepada individu dan organisasi yang telah terlibat secara langsung atau tidak dalam menghasilkan garis panduan ini dan juga ucapan terima kasih kepada sesiapa yang akan terlibat dalam melaksanakan program akreditasi hospital/institusi perubatan Kementerian Kesihatan Malaysia.

"Pensijilan akreditasi hospital memberi refleksi kepada pematuhan standard akreditasi kesihatan antarabangsa sekaligus meningkatkan kepercayaan orang awam kepada penyampaian kesihatan di fasiliti KKM".

YBHG. TAN SRI DATO' SERI DR. NOOR HISHAM BIN ABDULLAH
Ketua Pengarah Kesihatan Malaysia

“Penambahbaikan secara berterusan dalam menjalankan kerja sedia ada seperti yang digariskan di dalam piawaian akreditasi memastikan perkhidmatan kesihatan yang diberikan lebih efisyen, selamat dan berkualiti”.

YBHG. DATO’ DR. ASMAYANI BINTI KHALIB
Timbalan Ketua Pengarah Kesihatan (Perubatan)
Kementerian Kesihatan Malaysia

"Melalui proses akreditasi secara berterusan, pengukuhan pengurusan organisasi perubatan, *clinical governance,* perubatan berasaskan bukti, aktiviti kualiti, etika perubatan serta sistem penyampaian kesihatan yang memfokuskan kepada kepuasan pesakit/pelanggan turut boleh dipertingkat".

YBRS. DR. MOHD AZMAN BIN YACOB
Pengarah Perkembangan Perubatan
Bahagian Perkembangan Perubatan
Kemnterian Kesihatan Malaysia

SKOP PANDUAN

Akreditasi hospital merupakan suatu proses penilaian pematuhan perkhidmatan kesihatan kepada piawaian yang ditetapkan. Ianya menjadi penanda aras kepada sesebuah hospital/insitusi perubatan dan membantu menilai pencapaian fasiliti kesihatan (termasuk hospital, institusi perubatan dan klinik kesihatan) secara berkala dan berterusan. Malah, melalui pensijilan akreditasi yang berterusan mampu mengukuhkan keyakinan pesakit dan komuniti terhadap kualiti dan keselamatan penyampaian kesihatan di fasiliti KKM.

Garis panduan pelaksanaan penilaian akreditasi ini bertujuan untuk memberi pendedahan latar belakang program akreditasi KKM kepada individu seperti berikut:

- Timbalan Pengarah Kesihatan Negeri (Perubatan)
- Penyelaras Akreditasi Negeri
- Pengarah Hospital atau Institusi Perubatan KKM
- Timbalan Pengarah Klinikal/Pengurusan Hospital atau Institusi Perubatan KKM
- Ketua-ketua Jabatan
- Penyelaras Akreditasi Hospital atau Institusi Perubatan KKM
- *Liaison Officer* Jabatan
- Kakitangan Syarikat Konsesi yang menyelia Hospital atau Institusi Perubatan KKM

ISI KANDUNGAN

SEJARAH PROGRAM AKREDITASI HOSPITAL/INSTITUSI PERUBATAN KKM

1999

Perjanjian di antara KKM dan *Association of Private Hospital Malaysia* (APHM) untuk menubuhkan *Malaysian Society for Quality in Health* (MSQH). **Pekeliling KPK Bil. 2 1999**–*Ministry of Health Policy* on *Accreditation of Healthcare Facilities & Services* telah dikeluarkan.

2004

MSQH dilantik sebagai pembekal perkhidmatan iaitu penilaian dan latihan akreditasi bagi hospital/institusi perubatan KKM.

2009 - 2012

Pendedahan akreditasi dan latihan telah dimulakan untuk semua hospital/institusi perubatan KKM.

2012 - 2014

Pensijilan akreditasi hospital/institusi perubatan menjadi *Key Performance Indicators* (KPI) YB Menteri Kesihatan dan Ketua Pengarah Kesihatan.

2014

Pemantauan akreditasi telah dijadikan sebagai salah satu indikator *Hospital Performance for Accountability* (HPIA). KKM seterusnya menjalankan *Training of Trainers* (ToT) untuk Akreditasi mengikut zon bagi melahirkan lebih ramai *champions* akreditasi di peringkat JKN/Hospital.

2021

Pensijilan akreditasi telah dijadikan salah satu indikator Pelan Strategik Program Perubatan 2021-2025 yang mana sasaran **100% *Lead Hospital* mendapat pensijilan akreditasi sebelum 2025.**

PEKELILING KETUA PENGARAH KESIHATAN
BIL. 2/1999


TAN SRI DATO' (DR.) ABU BAKAR SULEIMAN

KETUA PENGARAH KESIHATAN MALAYSIA
DIRECTOR GENERAL OF HEALTH MALAYSIA

Timbalan Ketua Pengarah Kesihatan (Kesihatan Awam)

Timbalan Ketua Pengarah (S & T)

Pengarah Bahagian Perkhidmatan Pergigian

Pengarah Bahagian Perkhidmatan Farmasi

Pengarah Hospital Kuala Lumpur

Pengarah Kesihatan Negeri ____________

TERIMA

Y. Bhg. Dato'/Tuan/Puan,

Surat Pekeliling Ketua Pengarah Kesihatan Bil. 2/1999

Perkara: "Ministry of Health Policy on Accreditation of Healthcare Facilities and Services"

1. Latarbelakang

Satu pendekatan yang menyeluruh dalam menjamin kualiti perkhidmatan perubatan di kalangan 'Healthcare Providers' sama ada di sektor awam maupun di sektor swasta adalah amat diperlukan.

Oleh itu, satu persetujuan telah dicapai di antara Kementerian Kesihatan Malaysia dan Badan-badan Profesional Perubatan untuk menubuhkan 'Malaysian Society for Quality in Health (MSQH)'. Pertubuhan ini akan melaksanakan 'Malaysia Healthcare Accreditation Programme'.

2. Tujuan

Surat pekeliling ini bertujuan untuk membentangkan garis panduan Kementerian Kesihatan Malaysia berhubung dengan Pelaksanaan 'Accreditation of Healthcare Facilities and Services' di kalangan 'Healthcare providers'.


TAN SRI DATO' (DR.) ABU BAKAR SULEIMAN

KETUA PENGARAH KESIHATAN MALAYSIA
DIRECTOR GENERAL OF HEALTH MALAYSIA

3. Tindakan

Pengarah Kesihatan Negeri adalah bertanggungjawab mengedarkan pekeliling ini ke semua jabatan di bawah pentadbiran Dato'/Tuan.

Pengarah-Pengarah Kesihatan Negeri juga diminta mengadakan perbincangan dengan pengarah-pengarah jabatan berkenaan bagi merancang pelaksanaan aktiviti ini mengikut tahap persediaan dari pihak MSQH. Untuk Fasa Pertama, MSQH akan melaksanakan aktiviti untuk Hospital-Hospital.

Oleh yang demikian Pengarah-Pengarah Hospital adalah diminta untuk berhubung dengan MSQH bagi merancang pelaksanaan serta memastikan kelicinan proses memperolehi status akreditasi tersebut.

4. Pertanyaan

Sebarang pertanyaan mengenai pekeliling ini hendaklah dikemukakan kepada:

Pengarah Perkembangan Perubatan
Bahagian Perkembangan Perubatan
Kementerian Kesihatan Malaysia
(u/p: Dr. M.A. Kadar Marikar)

Sekian terima kasih.

" BERKHIDMAT UNTUK NEGARA "

Saya yang menurut perintah,

(TAN SRI DATO' (DR) ABU BAKAR B. SULEIMAN)
Ketua Pengarah Kesihatan Malaysia

s.k.

Timbalan Ketua Pengarah Kesihatan (Perubatan)

Pengarah Perkembangan Perubatan

Pengarah Amalan Perubatan

Presiden MSQH) Sila maklumkan perkara
) ini kepada agensi-agensi
Presiden APHM) yang berkenaan

OBJEKTIF PROGRAM AKREDITASI KKM

PENYAMPAIAN KESIHATAN YANG BERKUALITI
Memastikan pelaksanaan pemantauan kualiti perkhidmatan rawatan pesakit di hospital/institusi perubatan adalah selari dengan keperluan piawaian kebangsaan dan antarabangsa.

KESELAMATAN PESAKIT & KAKITANGAN FASILITI
Keperluan mematuhi piawaian terkini berkaitan infrastruktur dan persekitaran hospital/institusi perubatan bagi menjamin keselamatan pesakit dan kakitangan yang bekerja di hospital/institusi perubatan.

PENGURUSAN SISTEMATIK
Pengurusan operasi hospital/institusi perubatan yang jelas dan seragam bagi memberi impak penjimatan kos pengurusan pesakit secara keseluruhan.

PENAMBAHBAIKAN YANG BERTERUSAN
Penerapan budaya kerja yang baik secara berterusan bagi menjamin kesinambungan kualiti penyampaian perkhidmatan rawatan perubatan.

STANDARD AKREDITASI MSQH EDISI KE-6*

27
STANDARDS

HOSPITAL WIDE SERVICE STANDARDS
(1 – 7)

SPECIFIC SERVICE STANDARDS
(8 -27)

* Rujukan: https://www.membership.msqh.com.my/accreditation/index.php/6th-edition-standards

Standard ini akan disemak oleh MSQH mengikut keperluan semasa dan garis panduan ini akan mengambil kira edisi baharu yang akan diterbitkan pada masa akan datang.

HOSPITAL WIDE SERVICE STANDARDS

- *Service Standard 1: Governance, Leadership and Direction*
- *Service Standard 2: Environmental and Safety Services*
- *Service Standard 3: Facility and Biomedical Equipment Management and Safety*
- *Service Standard 4: Nursing Services*
- *Service Standard 5: Prevention and Control of Infection*
- *Service Standard 6: Patient and Family Rights*
- *Service Standard 7: Health Information Management System (HIMS)*
- *Service Standard 8: Emergency Services*
- *Service Standard 9: Clinical Services-Non Specific Facility*
- *Service Standard 9A: Clinical Services-Medical Related Services*
- *Service Standard 9B: Clinical Services-Surgical Related Services*
- *Service Standard 9C: Clinical Services-Obstetrics and Gynaecology Services*
- *Service Standard 9D: Clinical Services-Paediatric Services*
- *Service Standard 9E: Clinical Services-Cardiology Services*

- *Service Standard 15: Pathology Services*
- *Service Standard 16: Blood Transfusion Services*
- *Service Standard 17: Rehabilitation Medicine Services*
- *Service Standard 17A–J: Allied Health Professional Services*
- *Service Standard 18: Pharmacy Services*
- *Service Standard 19: Central Sterilising Supply Services (CSSS)*
- *Service Standard 20: Housekeeping Services*
- *Service Standard 21: Linen Services*
- *Service Standard 22: Food Services*
- *Service Standard 23: Forensic Medicine Services*
- *Service Standard 23A: Mortuary Services*
- *Service Standard 24: Standards for General Application–Generic*
- *Service Standard 25: Medical Assistant Services*
- *Service Standard 26: Standards for Clinical Research Centre*
- *Service Standard 27: Deceased Organ and Tissue Donation & Promotion*

* Rujukan: https://www.membership.msqh.com.my/accreditation/index.php/6th-edition-standards

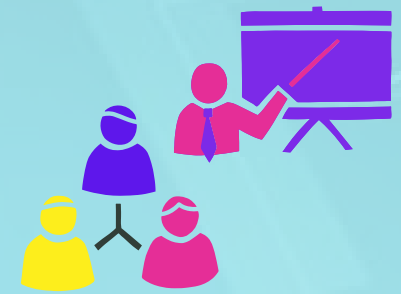
Standard ini akan disemak oleh MSQH mengikut keperluan semasa dan garis panduan ini akan mengambil kira edisi baharu yang akan diterbitkan pada masa akan datang.

ELEMEN YANG TERDAPAT DALAM PELAKSANAAN AKREDITASI HOSPITAL/INSTITUSI PERUBATAN

Semua elemen ini penting dalam pengurusan organisasi secara keseluruhan sama ada melibatkan pengurusan klinikal atau bukan klinikal, berdasarkan standard akreditasi MSQH edisi ke-6.

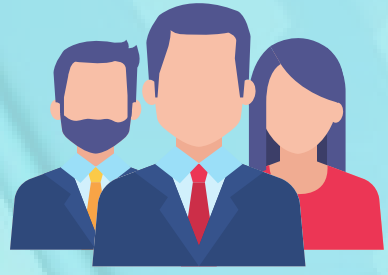
KOMPONEN PENTING DALAM STANDARD

PENGURUSAN ORGANISASI



- Pelantikan jawatan-jawatan utama
- Visi/Misi jabatan
- Carta organisasi termasuk *reporting relationship*
- Polisi umum hospital/institusi perubatan
- Peranan MDAC/MAC
- *Credentialing & privileging*
- Laporan pengurusan kewangan
- Pembabitan Ketua Jabatan/Unit dalam membuat perancangan

PENGURUSAN SUMBER MANUSIA



- Pengurusan sumber manusia berdasarkan keperluan/perundangan/beban kerja
- Latihan spesifik (*post basic*) ikut keperluan
- Kompetensi kakitangan
- Penilaian keperluan latihan (*Training needs assessment*)
- Struktur/Perancangan latihan
- Lantikan individu mengikut kompetensi

POLISI DAN PROSEDUR

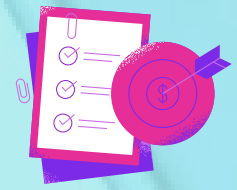
- Kemaskini polisi berdasarkan bukti perubatan (*evidence based medicine*)/pekeliling terkini sekurang-kurangnya setiap dua (2) tahun
- Polisi dalaman hospital/institusi perubatan
- Polisi dalaman jabatan
- Audit pematuhan kepada polisi sedia ada
- Pengurusan rekod perubatan

FASILITI DAN ALATAN PERUBATAN

- Bangunan yang mematuhi keperluan perundangan dan peraturan yang telah ditetapkan oleh kerajaan
- Keadaan ruang dan fasiliti menepati keperluan kawalan infeksi
- Kecukupan peralatan mengikut kesesuaian lokasi dan tugas yang dilaksanakan
- Pemantauan penyelenggaraan dan pembersihan alat perubatan dan bukan perubatan secara berkala
- Kompetensi pegawai yang membuat penyelenggaraan/kawalan kualiti

AKTIVITI KUALITI YANG BERTERUSAN

- Pelan risiko kebakaran dan bencana
- Kod kecemasan
- *Key performance indicator*
- Kajian dan keperluannya
- *Tracking and trending*
- Analisis data, langkah penambahbaikan dan pemantauan
- *Incident reporting* (IR) dan/atau *root cause analysis* (RCA) dilaksanakan
- Perbincangan dan penambahbaikan atas analisis data



KEPERLUAN KHUSUS

- Beberapa *standard* yang mempunyai spesifikasi khusus untuk dipatuhi berdasarkan keperluan perundangan, pekeliling dan kawalan jangkitan infeksi

PEMIKIRAN BERASASKAN RISIKO DAN ANALISIS RISIKO

- Fasiliti perlu membuat perancangan (*business continuity plan*) berdasarkan risiko-risiko yang telah dikenalpasti bagi memastikan tiada gangguan perkhidmatan
- Penilaian risiko perlu dibuat dan diambil tindakan sewajarnya

METODOLOGI PELAKSANAAN PENILAIAN AKREDITASI HOSPITAL

PENYEMAKAN REKOD DAN DOKUMEN

Dokumen yang diperlukan mestilah yang telah dikemaskini dan disahkan.
Pastikan dokumen atau rekod mudah dicapai (*access*) dan didapatkan semula (*retrieve*).

ANALISIS PENCAPAIAN

Pencapaian atau indikator yang dipantau perlu direkodkan serta dibuat analisis. Analisis juga perlu disusuli dengan pelan penambahbaikan berterusan (*continuous improvement*), dibuat penambahbaikan dan dipantau semula.

TEMUBUAL

Kakitangan hospital/ institusi perubatan ditemubual sebagai bukti setiap polisi atau amalan penyampaian kesihatan telah dicapai, difahami dan diamalkan.

PEMERIKSAAN FASILITI

Fasiliti akan dinilai secara keseluruhan bagi memastikan keselamatan dan kebersihan fasiliti.

PEMERHATIAN

Penilaian terhadap implementasi polisi sedia ada dibuat dengan pemerhatian secara langsung.

PERANAN DAN TANGGUNGJAWAB INDIVIDU

BAGI PELAKSANAAN AKREDITASI HOSPITAL/INSTITUSI PERUBATAN KKM

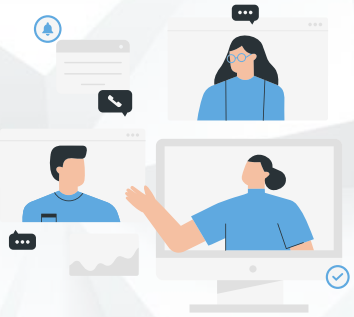
PERANAN KKM DALAM MENJAYAKAN PROGRAM AKREDITASI

Libat Urus (*Engagement*) antara Cawangan/Bahagian dan Pembekal Luar

- Bertanggungjawab dalam libat urus di antara Cawangan serta Bahagian lain dalam memastikan kelancaran pelaksanaan akreditasi di hospital/institusi perubatan.
- Bertanggungjawab dalam libat urus bersama pembekal luar akreditasi.

Pengurusan Peruntukan Kewangan bagi Penilaian dan Latihan Akreditasi oleh Pembekal Luar

- Pengurusan pembentangan peruntukan kewangan yang diperlukan bagi hospital/institusi perubatan KKM menjalani penilaian atau latihan akreditasi oleh pembekal luar.



Latihan Pemahaman Akreditasi Mengikut Zon

- Pelaksanaan *Training of Trainers* (ToT) mengikut zon untuk melahirkan lebih ramai *champions* di peringkat negeri dan hospital/institusi perubatan.
- Penekanan terhadap pemahaman pelaksanaan akreditasi dan *standard* yang digunakan.
- Membantu JKN/hospital/institusi perubatan dalam melaksanakan *mock survey* sebelum penilaian MSQH dijalankan.

PERANAN KKM DALAM MENJAYAKAN PROGRAM AKREDITASI

Pelaporan dan Analisis Data Penilaian Akreditasi

- Menilai laporan penilaian pembekal luar ke atas hospital/institusi perubatan KKM.
- Membuat analisis serta memastikan penggunaan data yang dianalisis dalam perancangan pembangunan fasiliti kesihatan.

Pusat Rujuk kepada Perkara Berkaitan Akreditasi Hospital/Institusi Perubatan KKM

- Menjadi rujukan bagi peringkat negeri serta hospital/institusi perubatan bagi sebarang perkara berkaitan akreditasi.

Merangka dan Merancang Hala Tuju Akreditasi Hospital/Institusi Perubatan KKM

- Bertanggungjawab dalam merancang perkembangan serta memastikan pembudayaan akreditasi di hospital/institusi perubatan KKM.

PERANAN JABATAN KESIHATAN NEGERI DALAM PEMERKASAAN AKREDITASI

1 Membuat Perancangan Mengikut Kesediaan Hospital/Institusi Perubatan

- JKN perlu membuat perancangan strategik dan hala tuju akreditasi bagi setiap hospital di bawah seliaan negeri masing-masing mengikut kesediaan hospital.
- Mengenalpasti faktor penghalang ke arah pencapaian akreditasi hospital serta menjalankan langkah susulan yang diperlukan.

2 Memberi Latihan dan Mengenalpasti *Champions* Akreditasi

- JKN perlu mengenalpasti Penyelaras Akreditasi Negeri dan *champions* akreditasi di peringkat negeri.
- JKN bersama Penyelaras Akreditasi Negeri dan *champions* negeri perlu memberi latihan kepada kakitangan hospital.
- Membantu pihak hospital dalam menjalankan *mock survey* akreditasi bagi menilai kesediaan hospital.

3 Terlibat Secara Aktif Bersama Hospital Bagi Membuat Penilaian Akreditasi Kendiri

- Penilaian kendiri serta pemantauan secara berkala perlu dijalankan oleh JKN bersama pihak hospital. Jika diperlukan, bantuan dari KKM atau JKN berdekatan boleh diusahakan.
- JKN perlu bekerjasama dengan pihak hospital dalam proses penambahbaikan masalah yang ada (*closing gap*).

4 Mengemukakan Permohonan Peruntukan Kepada Sekretariat Teknikal Akreditasi KKM

- Permohonan peruntukan bagi tujuan latihan atau penilaian atau kedua-duanya perlu dilakukan oleh pihak JKN.
- JKN perlu mengemukan permohonan yang lengkap bersama surat sebut harga dari pembekal perkhidmatan bagi mendapatkan kelulusan Pengarah Perkembangan Perubatan.

PERANAN PENYELARAS AKREDITASI NEGERI

1

- Mendapatkan maklum balas mengenai kesediaan hospital.
- Membuat lawatan ke hospital untuk kenalpasti masalah dan bantu hospital.

2

- Memanjangkan maklum balas mengenai kesediaan hospital bagi menjalani penilaian akreditasi kepada KKM secara formal.

3

- Mengikuti latihan akreditasi dari pembekal perkhidmatan atau *Training of Trainers* (ToT) mengikut zon yang dianjurkan di peringkat kementerian.
- Membuat *echo training* bagi membantu hospital.

4

- Membuat pemantauan berkala serta mengkoordinasikan *mock survey* bagi hospital yang bakal menjalani penilaian akreditasi.

PEMBUDAYAAN AKREDITASI DI HOSPITAL/INSTITUSI PERUBATAN

PERANAN PENGURUSAN TERTINGGI HOSPITAL/INSTITUSI PERUBATAN

1. Memacu dan mengetuai pembudayaan akreditasi di hospital/institusi perubatan.
2. Membuat pemantauan berkala terhadap keselamatan fasiliti.
3. Memastikan polisi hospital/institusi perubatan yang digunakan dalam perkhidmatan harian sentiasa dikemaskini.

PERANAN KETUA JABATAN

1. Memastikan pembudayaan akreditasi di jabatan masing-masing.
2. Sentiasa menekankan pematuhan kepada standard akreditasi.
3. Memastikan polisi/prosedur di jabatan dikemaskini.

PERANAN PENYELARAS AKREDITASI HOSPITAL/INSTITUSI PERUBATAN

1. Membantu Pengarah Hospital/Institusi Perubatan dalam merancang/menyelia aktiviti ke arah pensijilan akreditasi.
2. Membuat pemantauan berkala terhadap implementasi standard akreditasi di hospital/institusi perubatan.

PERANAN *LIAISON OFFICER*

1. Membantu Ketua Jabatan/Unit dalam memastikan pelaksanaan akreditasi di jabatan/unit berjalan lancar.
2. Membantu dan memastikan dokumentasi Jabatan/Unit yang berkaitan dikemaskini dan dimuktamadkan serta disahkan sejajar dengan keperluan akreditasi dan situasi semasa seperti pandemik COVID-19.

PERANAN JURUTERA DAN PENGURUS FASILITI

1. Memastikan pematuhan keselamatan dan kebersihan fasiliti selaras dengan standard akreditasi.
2. Memberi kerjasama sepenuhnya kepada Pengurusan Tertinggi fasiliti KKM ke arah pensijilan akreditasi.

Setiap warga hospital/institusi perubatan wajib bekerjasama dan berusaha mematuhi piawaian akreditasi bagi memastikan penyampaian perkhidmatan kesihatan yang berkualiti dan selamat.

PERANAN PENGARAH HOSPITAL/ INSTITUSI PERUBATAN DAN KETUA JABATAN

1 **Memberi hala tuju berkenaan akreditasi kepada kakitangan.**
Memaklumkan kepada semua kakitangan termasuk kakitangan kontraktor perkhidmatan sumber luar (*outsourced*) berkaitan hala tuju akreditasi.

2 **Membuat pemantauan berkala bagi fasiliti/infrastruktur dan kenalpasti masalah.**
Mendapatkan kerjasama dari jurutera hospital/institusi perubatan dan kontraktor perkhidmatan sokongan hospital/institusi perubatan bagi isu-isu infrastruktur/alatan perubatan.

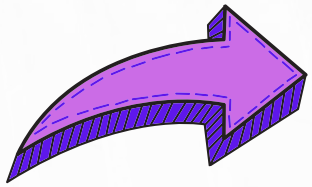
3 **Mencari penyelesaian bagi setiap masalah/isu yang telah dikenalpasti.**
Berdasarkan isu yang dikenalpasti, permohonan penambahbaikan kepada pemegang taruh (*stakeholder*) yang berkaitan.

4 **Membuat mesyuarat dan mendapatkan maklum balas berkala daripada setiap jabatan berkenaan kesiapsiagaan menuju penilaian.**
Menunjukkan komitmen yang akan dicontohi oleh kakitangan lain.

5 **Memastikan pelaksanaan akreditasi dilakukan mengikut jadual perancangan.**

PERANAN INDIVIDU MENUJU AKREDITASI

PROSES MENUJU PENILAIAN AKREDITASI



LATIHAN

Perlu mendapat pendedahan program akreditasi hospital/institusi perubatan.

Penyediaan dokumen berdasarkan kriteria pada *standard* akreditasi.

KENALPASTI MASALAH

Kenalpasti masalah serta isu infrastruktur serta alatan perubatan yang berkaitan. dengan skop kerja.

Analisis tahap risiko bagi setiap isu yang dikenalpasti.

RANCANGAN PENAMBAHBAIKAN

Merancang proses penambahbaikan ke atas setiap isu.

Memastikan setiap isu ditangani mengikut jadual yang telah dirancang.

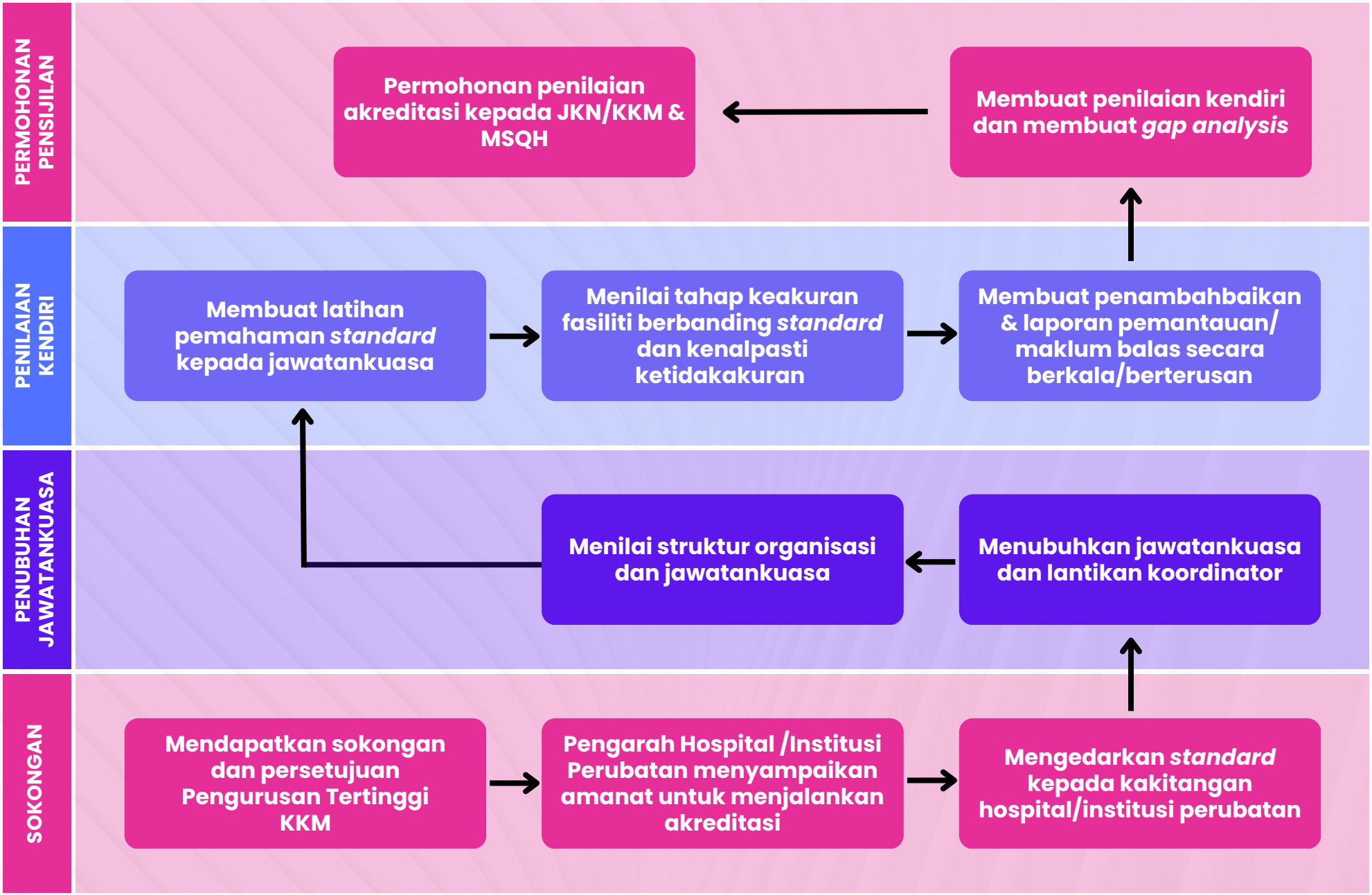
AMBIL TINDAKAN

Mengambil tindakan segera berdasarkan isu dan analisis risiko yang telah dilaksanakan dan dilaporkan kepada Pengarah Hospital/Institusi Perubatan.

PEMANTAUAN BERTERUSAN

Memastikan pemantauan berkala dilakukan secara berterusan dan didokumenkan.

LANGKAH HOSPITAL/INSTITUSI PERUBATAN KE ARAH PENSIJILAN AKREDITASI



CARTA ALIR PROSES PERMOHONAN PENILAIAN AKREDITASI OLEH PIHAK JKN/INSTITUSI PERUBATAN & KKM

Petunjuk:

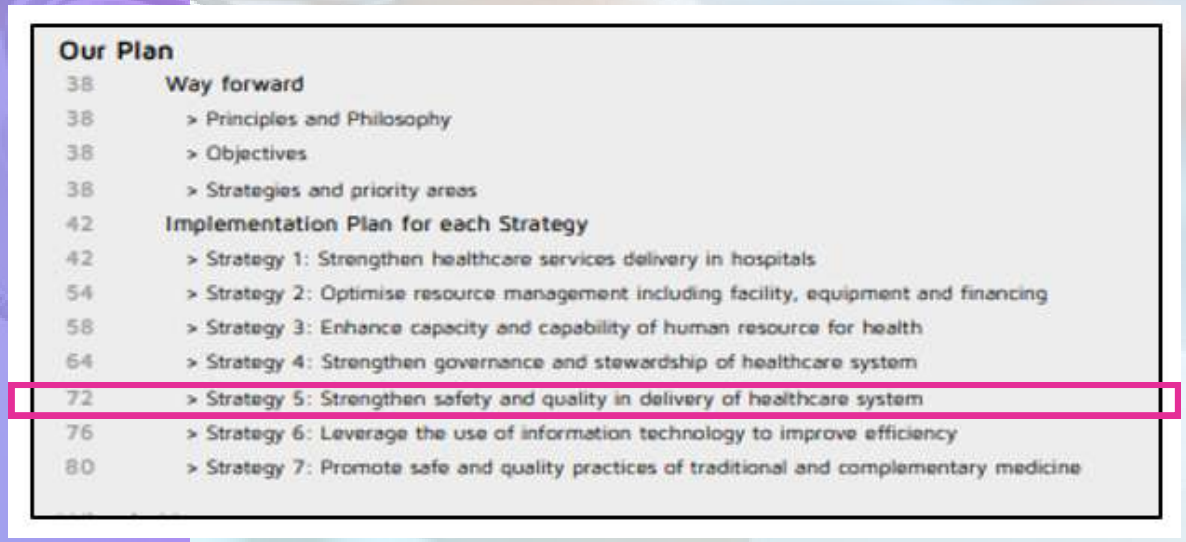
- UAP: Unit Akreditasi & Piawaian, KKM
- CKPP: Cawangan Kualiti Penjagaan Perubatan, KKM
- PPP: Pengarah Perkembangan Perubatan
- JKN: Jabatan Kesihatan Negeri

HALA TUJU PROGRAM AKREDITASI KKM

Pelan Strategik Program Perubatan 2021-2025 yang telah dirasmikan oleh YBhg. Tan Sri KPK pada 4 Jun 2020 telah menggariskan 100% *Lead Hospitals* untuk kluster mendapat pensijilan akreditasi pada tahun 2025.

Sasaran ini adalah bertujuan agar pemerkasaan budaya akreditasi di semua hospital/institusi perubatan KKM dapat diperkukuhkan terutamanya di hospital/institusi perubatan yang mempunyai perkhidmatan kesihatan yang lebih kompleks dan menyeluruh.

***Lead hospital* diharap bersama-sama *non-lead hospital* mendapatkan pensijilan akreditasi dan membudayakan akreditasi secara berterusan.**



HALA TUJU PROGRAM AKREDITASI KKM

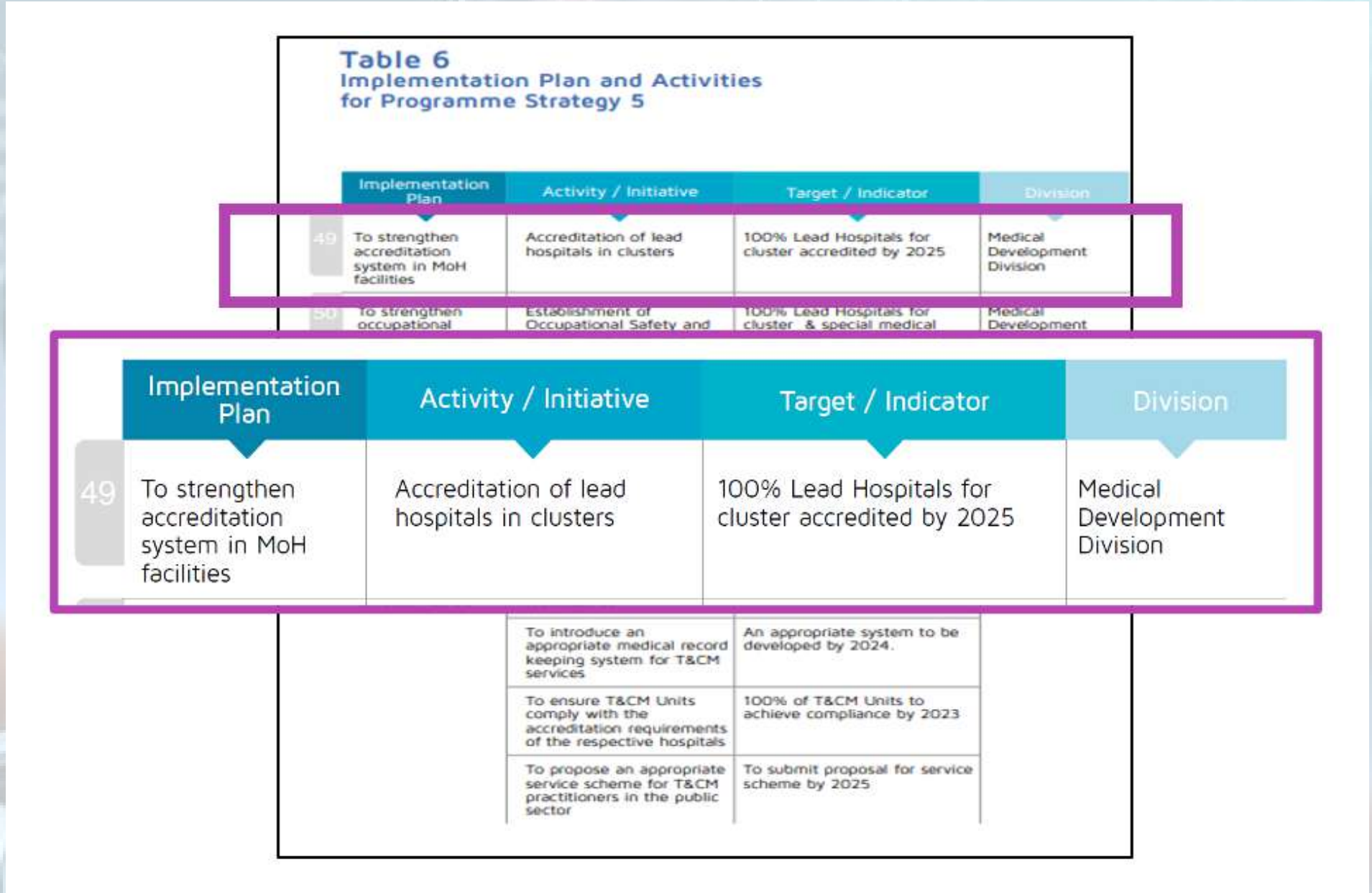


Table 6
Implementation Plan and Activities for Programme Strategy 5

	Implementation Plan	Activity / Initiative	Target / Indicator	Division
49	To strengthen accreditation system in MoH facilities	Accreditation of lead hospitals in clusters	100% Lead Hospitals for cluster accredited by 2025	Medical Development Division
50	To strengthen occupational	Establishment of Occupational Safety and	100% Lead Hospitals for cluster & special medical	Medical Development
		To introduce an appropriate medical record keeping system for T&CM services	An appropriate system to be developed by 2024.	
		To ensure T&CM Units comply with the accreditation requirements of the respective hospitals	100% of T&CM Units to achieve compliance by 2023	
		To propose an appropriate service scheme for T&CM practitioners in the public sector	To submit proposal for service scheme by 2025	

PELAN STRATEGIK PROGRAM PERUBATAN 2021-2025

SASARAN: 100% *LEAD HOSPITALS* MENDAPAT PERSIJILAN AKREDITASI SEBELUM/PADA 2025

2021	2022	2023	2024	2025
12 (58%)	11 (76%)	10 (80%)	8 (98%)	12 (100%)

ISU:

Kekangan masa bagi pembaharuan kontrak.

Maka, perubahan strategi dilakukan kepada sasaran indikator seperti berikut:

2021	2022	2023	2024	2025
4 (40%)	-	7 (26%)	16 (64.3%)	15 (100%)

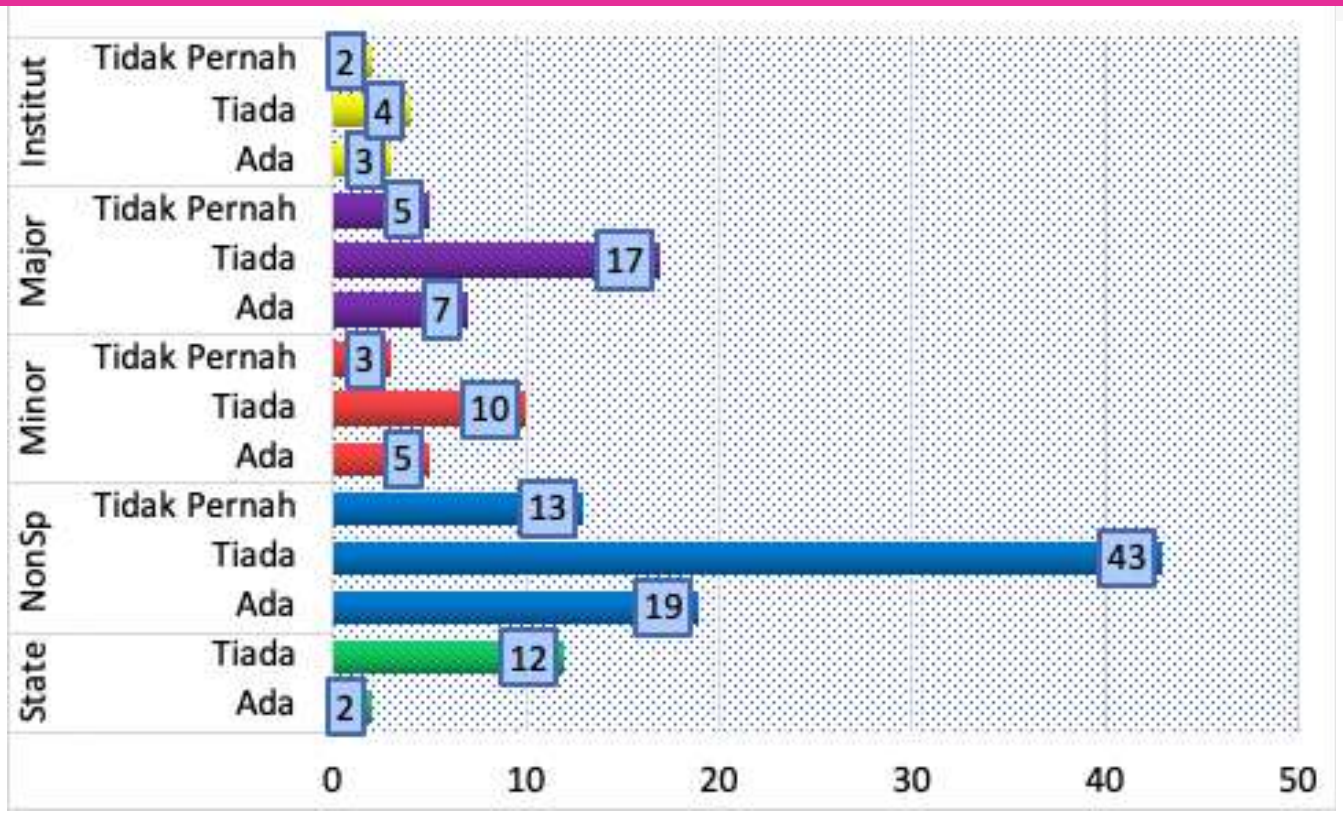
TARIKH KEMASKINI : 31.01.2023

STATUS AKREDITASI *LEAD HOSPITALS* KKM

42 ***LEAD HOSPITALS***

13 *Lead Hospitals* (31 %) mempunyai pensijilan akreditasi setakat ini

STATUS PENSIJILAN AKREDITASI HOSPITAL / INSTITUSI MENGIKUT KATEGORI



BILANGAN HOSPITAL

TARIKH KEMASKINI : 31.01.2023

SENARAI *LEAD HOSPITAL* YANG MEMPUNYAI PENSIJILAN AKREDITASI MSQH

Bil	Hospital	Tarikh Tamat Akreditasi
1	Hospital Keningau	02/08/2023
2	Hospital Queen Elizabeth	02/10/2023
3	Hospital Selayang	04/11/2023
4	Hospital Teluk Intan	04/12/2023
5	Hospital Sibu	10/4/2023
6	Hospital Kota Marudu	10/10/2023
7	Hospital Bintulu	01/12/2025
8	Hospital Sultanah Nora Ismail, Batu Pahat	10/11/2025
9	Hospital Kuala Lipis	19/09/2023
10	Hospital Sultan Hj Ahmad Shah, Temerloh	20/11/2023
11	Hospital Tengku Ampuan Afzan, Kuantan	24/04/2023
12	Hospital Tuanku Ampuan Najihah, Kuala Pilah	25/11/2024
13	Hospital Beaufort	30/10/2023

SENARAI *LEAD HOSPITAL* YANG TIADA PENSIJILAN AKREDITASI MSQH

Bil	Negeri	Hospital
1	Kedah	Hospital Sultanah Bahiyah
2	Kedah	Hospital Sultan Abdul Halim
3	Kedah	Hospital Kulim
4	P. Pinang	Hospital Pulau Pinang
5	P. Pinang	Hospital Seberang Jaya
6	Perak	Hospital Taiping
7	Perak	Hospital Seri Manjung
8	Selangor	Hospital Tengku Ampuan Rahimah, Klang
9	Selangor	Hospital Sungai Buloh
10	Selangor	Hospital Serdang
11	N. Sembilan	Hospital Tuanku Ja'afar, Seremban
12	Melaka	Hospital Melaka
13	Johor	Hospital Sultanah Aminah, Johor Bahru
14	Johor	Hospital Sultan Ismail Johor Bahru
15	Johor	Hospital Pakar Sultanah Fatimah, Muar
16	Terengganu	Hospital Sultanah Nur Zahirah, Kuala Terengganu
17	Terengganu	Hospital Kemaman
18	Kelantan	Hospital Raja Perempuan Zainab II, Kota Bharu
19	Kelantan	Hospital Tanah Merah
20	Kelantan	Hospital Sultan Ismail Petra, Kuala Krai
21	Sabah	Hospital Tawau
22	Sabah	Hospital Duchess Of Kent
23	Sarawak	Hospital Umum Sarawak
24	Sarawak	Hospital Sri Aman
25	Sarawak	Hospital Sarikei
26	Sarawak	Hospital Miri
27	Wilayah	Hospital Putrajaya
28	Wilayah	Hospital Kuala Lumpur
29	Perak	Hospital Raja Permaisuri Bainun

TARIKH KEMASKINI : 31.01.2023

PENCAPAIAN 2020 & 2021

2020		2021	
BIL	**NAMA HOSPITAL**	**BIL**	**NAMA HOSPITAL**
1.	Hosp. Kepala Batas (*Focus*) **S**	1.	Hosp. Serian (*Focus*) **S**
2.	Hosp. Temenggong, Kulai (*Focus*) **P**	2.	Hosp. Kuala Lipis (*Focus*) **S**
3.	Hosp. Batu Gajah **P**	3.	Hosp. Kota Marudu (*Focus*) **P (LH)**
4.	Hosp. Tunku Ampuan Najihah **T (LH)**	4.	Hosp. Tumpat **P**
		5.	Hosp. Jerantut **P**
		6.	Hosp. Parit Buntar **P**
		7.	Hosp. Tengku Anis **P**
		8.	Hosp. Gerik **P**
		9.	Hosp. Bentong **P**
		10.	Hosp. Wanita & Kanak-kanak Likas **INS**
		11.	Hosp. Sultanah Nora Ismail, BP **T (LH)**
		12.	Hosp. Bintulu **T (LH)**

P – Hospital Primer
S – Hospital Sekunder
T – Hospital Tertiari
INS – Institusi Perubatan
LH – *Lead Hospital*

***Laporan rasmi penilaian akreditasi yang telah diterima dari pihak MSQH – dikemaskini pada 31/01/2023**

PERANCANGAN 2023

Bil	Negeri	Nama Hospital	Persijilan MSQH Tamat (Tahun)	Tarikh Penilaian
JANUARI				
1	WP.Putrajaya	Institut Kanser Negara (LH)	2022	16/01/2023 - 18/01/2023
FEBRUARI				
2	N.Sembilan	Hospital Jelebu	2022	13/02/2023 - 15/02/2023
3	WP. Putrajaya	Hospital Putrajaya	2022	14/02/2023 - 16/02/2023
4	Perak	Hospital Tapah	2022	20/02/2023 - 22/02/2023
5	Kelantan	Hospital Tumpat (*Focus Survey*)	2022	Febuari 2023
MAC				
6	Sabah	Hospital Tambunan	2019	06/03/2023 - 08/03/2023
7	Sarawak	Hospital Kapit	2022	13/03/2023 - 15/03/2023
MEI				
8	Sabah	Hospital Papar	2022	08/05/2023 - 10/05/2023
9	Perlis	Hospital Tuanku Fauziah, Kangar	2020	08/05/2023 - 10/05/2023
10	Sabah	Hospital Ranau	2022	15/05/2023 - 17/05/2023
11	Sarawak	Hospital Miri (LH)	2022	15/05/2023 - 17/05/2023
12	Perak	Hospital Seri Manjung (LH)	2021	22/05/2023 - 24/05/2023
JUN				
13	P.Pinang	Hospital Balik Pulau	2022	06/06/2023 - 08/06/2023
14	Sabah	Hospital Semporna	2022	12/06/2023 - 14/06/2023
15	Sabah	Hospital Tenom	2022	19/06/2023 - 21/06/2023

Justifikasi pemilihan hospital adalah berdasarkan maklum balas yang dikumpulkan oleh setiap JKN dari setiap hospital di negeri masing-masing dan turut diambilkira daripada maklumat yang diterima hasil perbincangan pihak MSQH dengan hospital sendiri.

Namun, sebarang perubahan kepada kesediaan hospital boleh dimaklumkan kepada Unit Akreditasi & Piawaian, KKM.

TARIKH KEMASKINI : 31.01.2023

PERANCANGAN 2023

Bil	Negeri	Nama Hospital	Persijilan MSQH Tamat (Tahun)	Tarikh Penilaian
JULAI				
16	Sabah	Hospital Kota Belud	2022	04/07/2023 - 06/07/2023
17	Pahang	Hospital Jengka	2021	10/07/2023 - 12/07/2023
18	Sabah	Hospital Lahad Datu	2022	10/07/2023 - 12/07/2023
19	Johor	Hospital Segamat	2019	24/07/2023 - 26/07/2023
20	Pahang	Hospital Sultanah Hajjah Kalsom, Cameron Highlands	2022	24/07/2023 - 26/07/2023
21	Johor	Hospital Kota Tinggi	2013	31/07/2023 - 02/08/2023
OGOS				
22	Sarawak	Hospital Sarikei (LH)	2021	07/08/2023 - 09/08/2023
23	Sabah	Hospital Tawau (LH)	2022	14/08/2023 - 16/08/2023
24	N.Sembilan	Hospital Jempol	2022	14/08/2023 - 16/08/2023
SEPTEMBER				
25	Terengganu	Hospital Besut	2021	04/09/20203 - 06/09/2023
26	Pahang	Hospital Muadzam Shah	2022	11/09/2023 - 13/09/2023
27	Sabah	Hospital Tuaran	2021	18/09/2023 - 20/09/2023
OKTOBER				
28	Sabah	Hospital Queen Elizabeth II	2022	2/10/2023 - 04/10/2023
29	Kedah	Hospital Sultan Abdul Halim (LH)	2019	16/10/2023 - 18/10/2023
30	Sabah	Hospital Pitas	2019	16/10/2023 - 18/10/2023
31	Sabah	Hospital Kudat	2022	30/10/2023 - 1/11/2023
NOVEMBER				
32	Sabah	Hospital Duchess of Kent, Sandakan (LH)	N/A	6/11/2023 - 8/11/2023

TARIKH KEMASKINI : 31.01.2023

PERANCANGAN 2024

BIL	NEGERI	NAMA HOSPITAL	PERSIJILAN MSQH TAMAT	MAKLUMBALAS
1	KEDAH	Hospital Sultn Abdul Halim, Sg Petani (LH)	2019	Perancangan Pensijilan Pada 2023
2		Hospital Jitra	November 2023	Tinjauan Berterusan
3		Hospital Sultanah Maliha, Langkawi	2019	Perancangan Persijilan Pada 2024
4		Hospital Kulim (LH)	2019	Perancangan Persijilan Pada 2023
5	PULAU PINANG	Hospital Kepala Batas	2023	Perancangan Persijilan Pada 2023
6		Hospital Sungai Bakap	2018	Perancangan Persijilan Pada 2024
7	PAHANG	Hospital Raub	September 2023	Tinjauan Berterusan
8		Hospital Kuala Lipis (LH)	September 2023	Tinjauan Berterusan
9		Hospital Rompin	2022	Perancangan Persijilan Pada 2023
10		Hospital Pekan	2022	Perancangan Persijilan Pada 2024
11		Hospital Tengku Ampuan Afzan, Kuantan (LH)	April 2023	Tinjauan Berterusan
12	TERENGGANU	Hospital Kemaman (LH)	Disember 2014	Perancangan Persijilan Pada 2024
13	KELANTAN	Hospital Tanah Merah (LH)	2012	Perancangan Persijilan Pada 2024
14		Hospital Gua Musang	2022	Tinjauan Berterusan
15		Hospital Pasir Emas	2022	Tinjauan Berterusan
16	PERAK	Hospital Bahagia Ulu Kinta	2022	Perancangan Persijilan Pada 2023
17		Hospital Teluk Intan (LH)	Disember 2023	Perancangan Persijilan Pada 2023
18		Hospital Slim River	Disember 2023	Tinjauan Berterusan
19	WILAYAH	Hospital Rehabilitasi Cheras	Julai 2023	Tinjauan Berterusan
20	SELANGOR	Hospital Serdang (LH)	2017	Perancangan Persijilan Pada 2024
21		Hospital Sungai Buloh (LH)	2022	Perancangan Persijilan Pada 2024
22	MELAKA	Hospital Melaka (LH)	2021	Perancangan Persijilan Pada 2023/2024
23		Hospital Jasin	2021	Perancangan Persijilan Pada 2023
24	NEGERI SEMBILAN	Hospital Tampin	2020	Tinjauan Berterusan
25		Hospital Tuanku Jaafar, Seremban (LH)	2019	Perancangan Persijilan Pada 2024
26	JOHOR	Hosp Temenggong Seri Maharaja Tun Ibrahim, Kulai	September 2023	Tinjauan Berterusan
27		Hospital Sultan Ismail, Johor Bharu (LH)	2015	Sasaran Pelan Strategik
28	SABAH	Hospital Kinabatangan	2022	Perancangan Pensijilan Pada 2024
29		Hospital Queen Elizabeth II	2022	Tinjauan Berterusan
30		Hospital Keningau (LH)	Ogos 2023	Perancangan Pensijilan Pada 2024
31		Hospital Kota Marudu (LH)	April 2023	Perancangan Pensijilan Pada 2024
32		Hospital Mesra Bukit Padang	April 2023	Perancangan Pensijilan Pada 2024
33	SARAWAK	Hospital Kanowit	April 2023	Tinjauan Berterusan
34		Hospital Serian	Julai 2023	Tinjauan Berterusan
35		Hospital Sri Aman (LH)	N/A	Perancangan Pensijilan Pada 2024
36		Hospital Umum Sarawak (LH)	2018	Perancangan Pensijilan Pada 2024

Justifikasi pemilihan hospital adalah berdasarkan maklum balas yang dikumpulkan oleh setiap JKN (diterima daripada setiap hospital). Namun, pemuktamadan senarai ini akan diputuskan semasa Mesyuarat Halatuju Akreditasi Hospital & Institusi Perubatan KKM yang akan diadakan pada akhir tahun sebelum tahun penilaian yang sebenar.

TARIKH KEMASKINI : 31.01.2023

PERANCANGAN 2025

BIL	NEGERI	NAMA HOSPITAL	PERSIJILAN MSQH TAMAT	MAKLUMBALAS
1	KEDAH	Hospital Kuala Nerang	2015	Perancangan Persijilan Pada 2023
2		Hospital Yan	2017	Perancangan Persijilan Pada 2024
3		Hospital Sultanah Bahiyah, Alor Setar (LH)	2014	Sasaran Pelan Strategik
4		Hospital Sik	2020	Perancangan Persijilan Pada 2024
5	PULAU PINANG	Hospital Bukit Mertajam	N/A	Perancangan Persijilan Pada 2024
6		Hospital Pulau Pinang (LH)	2012	Sasaran Pelan Strategik
7		Hospital Seberang Jaya (LH)	2018	Perancangan Persijilan Pada 2024
8	KELANTAN	Hospital Sultan Ismail Petra, Kuala Krai (LH)	2008	Sasaran Pelan Strategik
9		Hospital Machang	2022	Tinjauan Berterusan
10		Hospital Raja Perempuan Zainab II. Kota Bharu (LH)	2009	Sasaran Pelan Strategik
11	TERENGGANU	Hospital Sultanah Nur Zahirah, Kuala Terengganu (LH)	2009	Sasaran Pelan Strategik
12	PAHANG	Hospital Sultan Hj Ahmad Shah , Temerloh (LH)	2023	Perancangan Persijilan Pada 2024/2025
13	PERAK	Hospital Kuala Kangsar	Oktober 2023	Tinjauan Berterusan
14		Hospital Cangkat Melintang	Disember 2023	Perancangan Persijilan Pada 2023
15		Hospital Sungai Siput	2023	Tinjauan Berterusan
16		Hospital Raja Permaisuri Bainun, Ipoh (LH)	2015	Sasaran Pelan Strategik
17		Hospital Batu Gajah	2024	Tinjauan Berterusan
18		Hospital Taiping (LH)	2009	Sasaran Pelan Strategik
19	SELANGOR	Hospital Kuala Kubu Bharu	Oktober 2023	Tinjauan Berterusan
20		Hospital Selayang (LH)	2023	Tinjauan Berterusan
21		Hospital Shah Alam	N/A	Perancangan Persijilan Pada 2024
22		Hospital Ampang	2010	Perancangan Persijilan Pada 2024
23		Hospital Tengku Ampuan Jemaah, Sabah Bernam	2022	Tinjauan Berterusan
24		Hospital Orang Asli Gombak	N/A	Perancangan Persijilan Pada 2025
25	MELAKA	Hospital Alor Gajah	N/A	Perancangan Persijilan Pada 2024/2025
26	NEGERI SEMBILAN	Hospital Port Dickson	2014	Perancangan Persijilan Pada 2024
27		Hospital Tuanku Ampuan Najihah, Kuala Pilah (LH)	2024	Sasaran Pelan Strategik
28	JOHOR	Hospital Tangkak	2014	Perancangan Persijilan Pada 2024
29		Hospital Enche' Besar Hajjah Khalsom, Kluang	2015	Perancangan Persijilan Pada 2025
30		Hospital Pakar Sultanah Fatimah, Muar (LH)	2014	Perancangan Persijilan Pada 2025
31		Hospital Pontian	2014	Perancangan Persijilan Pada 2023
32	SABAH	Hospital Queen Elizabeth (LH)	2023	Tinjauan Berterusan
33		Hospital Beaufort	Oktober 2023	Tinjauan Berterusan
34		Hospital Kunak	Oktober 2023	Tinjauan Berterusan
35		Hospital Sipitang	September 2023	Perancangan Persijilan Pada 2023
36	SARAWAK	Hospital Sibu (LH)	April 2023	Tinjauan Berterusan

Justifikasi pemilihan hospital adalah berdasarkan maklum balas yang dikumpulkan oleh setiap JKN (diterima daripada setiap hospital). Namun, pemuktamadan senarai ini akan diputuskan semasa Mesyuarat Halatuju Akreditasi Hospital & Institusi Perubatan KKM yang akan diadakan pada akhir tahun sebelum tahun penilaian yang sebenar.

TARIKH KEMASKINI : 31.01.2023

PENILAIAN AKREDITASI–MENGIKUT STANDARD MSQH EDISI KE-6

Nilai *rating* bagi setiap standard: 1 atau 2 atau 3 atau 4

LULUS

RATING 4: ***80 – 100% = EXCELLENT***

RATING 3: ***60 – 79% = GOOD***

GAGAL

RATING 2: ***40 – 59% = FAIR***

RATING 1: ***0 – 39% = POOR***

***SILA RUJUK DOKUMEN STANDARD MSQH EDISI KE-6:**

- Fasiliti boleh meletakkan nota *Not Applicable* (NA) bagi kriteria yang tidak relevan atau tidak terpakai.
- Bagi kriteria yang mendapat rating 1 & 2 atau NA, fasiliti perlu memberikan kenyataan/alasan di ruangan *Facility Comment*. Akan tetapi kriteria yang mendapat *rating* 3 juga sebaik-baiknya disertakan dengan kenyataan atau alasan untuk rujukan.
- Bagi standard yang mendapat rating 2, *surveyor* akan membuat penilaian risiko yang sewajarnya.

JENIS PENSIJILAN AKREDITASI BAGI STANDARD MSQH

1 PENSIJILAN PENUH EMPAT (4) TAHUN

- Setiap hospital *wide service standard* hendaklah mendapat *rating* 3 atau 4.
- Setiap *core criteria* di dalam setiap *service standard* hendaklah mendapat *rating* 3 atau 4.
- Prestasi keseluruhan untuk setiap *service standard* juga bergantung kepada keadaan semasa tahap keselamatan pesakit dan kakitangan dari segala perkara/aspek/elemen/anasir yang berada di sekeliling mereka.

2 PENSIJILAN FOKUS SATU (1) TAHUN

- Jika gagal memenuhi kriteria untuk mendapat pensijilan 4 tahun.

3 TIADA PENSIJILAN/GAGAL

- Jika didapati sesuatu fasiliti tidak selamat dari segi infrastruktur/proses dalam penyampaian kesihatan kepada pesakit dan juga boleh mengancam keselamatan kakitangan hospital/institusi perubatan.

PEMANTAUAN BERKALA AKREDITASI

- Hospital yang berjaya mendapat pentauliahan akreditasi selama empat (4) tahun perlu menghantar laporan kemajuan berkala secara tahunan kepada MSQH,

  1. Laporan pada bulan ke-12
  2. Penilaian *Surprise Surveillance* pada bulan ke-24
  3. Laporan pada bulan ke-36

- Status bagi setiap kriteria dan *service standards* yang mendapat *rating* 1 dan 2 semasa penilaian akreditasi perlu dilaporkan kepada MSQH. Status bagi kriteria *CORE* dan *mandatory service standards* yang mendapat rating 3 juga perlu dilaporkan kepada MSQH.

- Untuk tujuan penambahbaikan, pihak hospital/institusi perubatan sentiasa digalakkan untuk mengemaskini status kriteria dan *service standards* yang mendapat *rating* 3 ke bawah.

KESIMPULAN

- Pembudayaan akreditasi secara berterusan di hospital/institusi perubatan KKM adalah penting demi menjamin pengukuhan *good clinical governance* serta pengurusan hospital yang lebih efisyen dan sistematik serta memberi impak penjimatan kepada pengurusan kewangan fasiliti kesihatan secara keseluruhan.

- Inisiatif ini dapat memastikan penyampaian kesihatan yang selamat kepada pesakit yang dirawat malah kepada kakitangan hospital/institusi perubatan serta pelawat.

- Melalui program akreditasi, mutu serta kualiti penyampaian kesihatan yang berfokus kepada kepuasan pelanggan dapat dipertingkatkan.

RUJUKAN

- **STANDARD MSQH EDISI KE-6**
  https://www.membership.msqh.com.my/accreditation/index.php/6th-edition-standards

- **PELAN STRATEGIK PROGRAM PERUBATAN 2021-2025**
  https://www.moh.gov.my/moh/resources/Pelan_Strategik_KKM.pdf

Standard 1 – GOVERNANCE, LEADERSHIP & DIRECTION

1.1 Organisation & Management

1.1.1	**Governing framework**
1.1.1.3 (CORE)	1. License to operate 2. Appointment of full time Person In Charge (PIC) 3. Facility Operational Policies 4. Medical Staff By-Laws or equivalent 5. Medical Staff By-Laws or equivalent to address the disciplines under Cluster Services (where applicable)
1.1.1.4 (CORE)	1. Current organisation chart of the Facility endorsed by the Governing Body 2. Appointment letters of members of the Governing Body, its officers, and committees 3. Job descriptions 4. Terms of Office/Tenure of officers 5. Terms of Reference of committees 6. Minutes of Facility-wide Management Committee meetings 7. Minutes of Board meetings
1.1.2	**Appoinment of PIC / hospital director**
1.1.2.6 (CORE)	1. Establishment of MDAC/MAC 2. Appointment letter of members of MDAC/MAC 3. Terms of Reference of MDAC/MAC 4. Minutes of meetings
1.1.5	**External services**
1.1.5.1 (CORE)	a) date and duration of contract; b) system for quality control of outsourced services; c) procedures for managing shortfall in service; d) involvement in performance measurement.

1.2 Human Resource Development & Management

1.2.2	**Appointment, verification of Credentials and Privileging**
1.2.2.1 (CORE)	1. Appointment and reappointment policy according to services listed in the hospital license; 2. Credentialing and privileging policies; 3. Minutes of meeting of Credentialing and Privileging Committee; 4. Evidence of compliance to procedure privileged to do against areas.
1.2.2.3 (CORE)	1. Written policies and procedures for Appointment, Credentialing and Privileging. 2. Credentialing and privileging criteria
1.2.2.4 (CORE)	1. Minutes of meetings of Credentialing and Privileging Committee 2. Criteria for privileging rights; 3. Recommendations from referee; 4. Presence of relevant Head of Service at award to the individual at C&P Committee meeting.

1.2.3	**Effective human resource management system**
1.2.3.1 (CORE)	1. Staff master plan; 2. Staff patient ratio appropriate to level of care; 3. Duty roster; 4. Job description; 5. Policy and procedures on qualification verification.
1.2.3.6 (CORE)	1. Staff satisfaction survey, suggestions and grievance reporting, and processing mechanisms; 2. Evidence of actions taken.
1.2.5	**Staff continuous education, orientation and in-service programs**
1.2.5.3 (CORE)	1. A facility-wide staff development plan is available, dated and reviewed; 2. Minutes of Training Committee; 3. Training calendar; 4. Contents of training programmes; 5. Training records on continuing education activities; 6. Allocation of training budget.
1.2.6	**Facility as teaching centre**
1.2.6.1 (CORE)	1. Memorandum of agreement; 2. Joint management committee; 3. Minutes of meetings; 4. Contracts where applicable (private institutions); 5. Compliance with the Memorandum of Agreement/contract.

1.3 Policies & Procedures

1.3.1	**Documented and dated policies and procedures**
1.3.1.1 (CORE)	1. Facility-wide Operational Policies; 2. Medical Staff By-Laws; 3. Departmental policies and procedures; 4. Policies are relevant with current Acts, Regulations and By-Laws.
1.3.1.3 (CORE)	1. Policies and procedures are updated, endorsed and dated; 2. Evidence of periodic review.
1.3.1.4 (CORE)	1. Circular or memos on new policies; 2. Training and briefing on the current policies and procedures; 3. Circulation list and acknowledgement; 4. Audits on staff compliance.

1.4 Facilities & Equipments

1.4.1	**Appropriate facilities and equipment with relevant Acts and Regulations**
1.4.1.2 (CORE)	1. Planned Preventive Maintenance records; 2. Planned Replacement Programme where applicable; 3. Complaint records; 4. Asset inventory.

1.5 Safety & Performance Improvement Activities

1.5.1	**Risk Management Program**
1.5.1.1 (CORE)	1. Establishment of Risk Management Program; 2. Implementation and monitoring of risk assessment activities: a) Risk Register; b) Risk assessment reports; c) Root Cause Analysis (RCA) report; d) action plans; e) remedial measures; f) clinical audit; g) investigation, correction and preventive actions of sentinel events.
1.5.1.4 (CORE)	1. Specific performance indicators; 2. Records on tracking and trending analysis; 3. Remedial measures taken.
1.5.1.5 (CORE)	1. Accessibility of results on safety and performance improvement activities; 2. Evidence of feedback via communication on results of performance improvement activities; 3. Minutes of meetings discussing quality performance indicators; 4. Utilization of results of safety and performance improvement activities.
1.5.1.7 (CORE)	1. Staff health screening and medical check-up records; 2. Identification of staff health risk factors, workload monitoring and stress management; 3. Infectious diseases prevention program; 4. Staff anti-smoking programme; 5. Staff healthy lifestyle campaign; 6. Staff training on: sharps and needle stick injury, OSH, ergonomics, waste disposal; 7. Post exposure management; 8. Handling aggressive patients/visitors; 9. Universal/standard precautions.

2.1 Organisation & Management

2.1.1	**Activities related to Environmental and Safety Services**
2.1.1.1 (CORE)	Operational policies of the Environmental and Safety Services: a) Environmental, Safety and Health; b) Fire Safety; c) Disaster Management: External & Internal Disaster, Business Recovery Plan; d) Hazardous Material and Recyclable Waste Management; e) Security Services; f) Vector and Pest Control.
2.1.1.3 (CORE)	Environment and Safety Service Committees: a) Appointment of a Chairperson and Secretary; b) Terms of Reference; c) Committee members; d) Tenure of membership; e) Frequency of meetings; f) Minutes of meetings.
2.1.1.5 (CORE)	Management of ESH Committee and sub committees: 1. Approved Committee Organisation Charts 2. Organisation charts that are approved by the PIC and accessible.
2.2.1	**Qualified staff for designated Committees**
2.2.1.1 (CORE)	1. Certificates of qualification and registration of committee members. 2. Attendance to relevant training, e.g. safety officer registered with DOSH and attended NIOSH training. 3. Staff training records

2.3 Policies & Procedures

2.3.1	**Documented and dated ESH policies and procedures**
2.3.1.1 (CORE)	ESH Policy statement: 1. Written, signed and dated ESH Policy; 2. The Policy statement poster is displayed throughout the Facility; 3. Documented policies and procedures for the service; 4. Policies and procedures are consistent with regulatory requirements and current standard practices; 5. List of Policies and procedures that are relevant, updated, endorsed and dated; 6. Evidence of periodic review.
2.3.1.2 (CORE)	1. Minutes of committee meetings on development and revision on policies and procedures; 2. Minutes of meeting with evidence of cross reference with other departments; 3. Documented cross departmental policies.

2.3.1.4 (CORE)	1. Compliance with policies and procedures through: a) interview of staff on practices; b) verify with observation on practices; c) results of audit on practices; d) practices in line with established policies and procedures.

2.4 Facilities & Equipments

2.4.1	**Safe, appropriate facilities and equipment**
2.4.1.3 (CORE)	Specialized equipment: 1. List of personnel authorised by the Person In Charge (PIC) to operate specialised equipment; 2. Training records; 3. Staff profile of authorised personnel; 4. Competency assessment records; 5. Certificate / registration of competent person as required;

2.5 Safety & Performance Improvement Activities

2.5.1	**Continuous safety and performance improvement activities (through HIRARC)**
2.5.1.1 (CORE)	1. Planned performance improvement activities; 2. Records on performance improvement activities; 3. Minutes of performance improvement meetings; 4. Performance improvement studies; 5. Records on innovation if available.
2.5.1.3 (CORE)	1. System for incident reporting, which include: a) Training of staff b) Procedure on incident/accident reporting c) Methodology of incident reporting d) Register/records of incidents; 2. Completed incident reports; 3. RCA; 4. Corrective and preventive action plans; 5. Remedial measure & review of remedial measure; 6. Reports to Relevant Authorities as required; 7. Minutes of meetings of ESH Committee; 8. Acknowledgment by Head of Service and PIC/Hospital Director; 9. Feedback given to staff regarding incident reporting.
2.5.1.4 (CORE)	1. Specific performance indicators monitored; 2. Records on tracking and trending analysis; 3. Records on workplace inspection and drills; 4. Records on analysis HIRARC; 5. Remedial measures taken.

2.5.1.7 (CORE)	1. Staff health screening; 2. Identification of health risk factors; 3. Infectious diseases prevention program/activities; 4. Anti-smoking program; 5. Healthy lifestyle campaign; 6. Staff training on a) sharps and needle stick injury management; b) Occupational Safety and Health; c) ergonomics; d) biohazard waste disposal. 7. Medical check-up record; 8. Post exposure management; 9. Universal/standard precautions.

2.6 Special Requirements

2.6.1	**Environment, safety & health programs**
2.6.1.1 (CORE)	1. ESH Committee is established; 2. Organisation chart of ESH Committee; 3. Terms of Reference of the ESH Committee; 4. Schedule of meetings for the year; 5. Minutes of meetings.
2.6.1.4 (CORE)	1. Environment and Safety audit schedule and reports; 2. Risk Register and risk assessment report; 3. Health Promotion program; 4. Staff health surveillance record and statistics; 5. Minutes of meetings, reports and records on environmental, occupational safety and health activities; 6. Incident reports and RCAs; 7. Business Continuity Report on follow-up actions; 8. Corrective and preventive measures; 9. Reports to relevant authorities, e.g., sharps injury to MOH, Lost Time Accident to DOSH; 10. Recovery plan for Business Continuity; 11. Sustainability Program.
2.6.1.5 (CORE)	1. Valid registration of SHO with DOSH; 2. Appointment of Safety and Health Officer; 3. Job description.
2.6.2	**Fire Safety**
2.6.2.1 (CORE)	1. Building drawing approved by Fire Authority; 2. Continuous Monitoring Information System (CMIS) is functional and linked to the fire station where applicable.
2.6.2.2 (CORE)	1. Approved as built drawings by relevant professionals.
2.6.2.3 (CORE)	1. Annual fire inspection report by Fire Authority; 2. Current Fire Safety Certificate is available for buildings; 3. Facility's report on rectification of recommendations by Fire Authority where required.
2.6.2.4 (CORE)	1. Fire extinguishers have valid inspection certificates; 2. Testing of fire extinguishers; 3. Maintenance records; 4. Functional fire alarm system.
2.6.2.10 (CORE)	1. Current evacuation plans are available; 2. Clear signage to assembly areas.

2.6.2.12 (CORE)	1. Assignment letter 2. Fire Response Training records 3. Minutes of fire safety meetings
2.6.2.13 (CORE)	1. ERT and incident management team (IMT) are established; 2. Emergency procedures and disaster control room facilities are available; 3. Training records; 4. Minutes of fire safety meetings.
2.6.2.14 (CORE)	1. Approved fire evacuation and recovery plan and procedures; 2. Staff awareness on fire evacuation plan and procedures; 3. Staff assignment and response card; 4. Training records for all staff including on-site outsourced staff.
2.6.2.15 (CORE)	1. Records and reports on annual fire drills; 2. Staff attendance list.
2.6.3	**Disaster Management**
2.6.3.2 (CORE)	1. Internal Disaster Plan that include potential internal disasters; 2. Internal Disaster Plan with specified colour codes; 3. List of relevant agencies and their contact numbers; 4. Adequate resources as per disaster plan; 5. Records on relevant staff training on the Internal Disaster Plan; 6. Staff response card; 7. Reports on the Disaster Drill and actual disaster; 8. Revision of Internal Disaster Plan as necessary.
2.6.3.3 (CORE)	1. Appropriate Internal Disaster Plan; 2. Designated Command Centre; 3. Drills and training records; 4. Reports on the Disaster Drill and actual disaster (if applicable); 5. Evaluation on Disaster Drill and actual disaster (if applicable); 6. Revision of Internal Disaster Plan as necessary; 7. Control copy of Internal Disaster Plan is easily accessible to staff; 8. Staff awareness on Internal Disaster Plan.
2.6.4	**Hazardous Material Management**
2.6.4.1 (CORE)	1. Valid report on CHRA by competent person.
2.6.4.2 (CORE)	1. Records on staff training
2.6.4.5 (CORE)	1. Chemical and scheduled wastes are properly labelled and not mixed with other wastes; 2. Appropriate storage facilities for clinical, chemical, electronic and radioactive waste; 3. Eyewash and shower for chemical handling; 4. Handwashing facilities.
2.6.4.8 (CORE)	1. Approval letter from Department of Environment for transporting scheduled waste outside the premises; 2. Consignment note available.

2.6.6	**Security Services**
2.6.6.1 (CORE)	1. Valid Security Risk Assessment Report
2.6.6.2 (CORE)	1. Functional security system is available, e.g. card access, CCTV, locks, barrier, etc; 2. Recommend CCTV to have minimum 14 days of storage capacity; 3. Procedure and practice of control access after visiting hours; 4. Reports on performance of the security system; 5. Security incident reports.
2.6.7	**Vector & Pest Control**
2.6.7.1 (CORE)	1. Vector and pest control schedule as per agreement and records on activities.

Standard 3 – FACILITY AND BIOMEDICAL EQUIPMENT MANAGEMENT AND SAFETY

3.1 Organisation & Management

3.1.1	**The Facility and Biomedical Equipment Management and Safety Services organization**
3.1.1.2 (CORE)	1. Clearly delineated current organisation chart with line of functions and reporting relationships; 2. Organisation chart of the service is endorsed, dated and accessible; 3. The organisation chart is revised when there is a major change.
3.1.1.3 (CORE)	1. The Contract Agreement between the Facility and the external service provider(s); 2. Evaluation of service provider performance.
3.1.1.7 (CORE)	1. Records are available but not limited to the following: a) statistics on technical performance indicators for previous and current years; b) asset register; c) maintenance records for previous and current years; d) accident/incident reports; e) staffing number and staff profile; f) staff training records.

3.2 Human Resource Development & Management

3.2.1	**The Facility and Biomedical Equipment Management and Safety Services staffing**
3.2.1.1 (CORE)	1. The head of service or any management staff shall possess certified healthcare facility manager (CHFM); 2. The head of service or any management staff shall possess at least 3 years experiences in healthcare facility management.
3.2.1.3 (CORE)	1. Number of staff and qualification should commensurate with workload; 2. Staff to have valid registration with professionals and relevant authorities bodies; 3. Staffing pattern; 4. Duty roster.

3.3 Policies & Procedures

3.3.1	**Appropriate documented policies and procedures**
3.3.1.1 (CORE)	1. Documented policies and procedures for the service; 2. Policies and procedures are consistent with regulatory requirements and current standard practices; 3. Policies and procedures are updated, endorsed and dated; 4. Evidence of periodic review.
3.3.1.4 (CORE)	1. Compliance with policies and procedures through: a) interview of staff on practices; b) verify with observation on practices; c) results of audit on practices; d) practices in line with established policies and procedures.

3.3.1.6 (CORE)	1. Policies and procedures for emergency response plan (ERP) during outages of water, electricity, medical gas suppy, communication system, internet; 2. Contact numbers of staff in-charge/relevant authorities/ vendors/suppliers is made available; 3. Flow chart on line of communication.

3.4 Facilities & Equipments

3.4.1	**Adequate & appropriate facilities and equipment**
3.4.1.1 (CORE)	1. Adequate facilities, equipment and proper utilisation of space within the Facility for staff and outsourced service providers: a) As built drawings; b) Appropriate office and workshop; c) Appropriate equipment for repairs, testing, calibration, etc.
3.4.1.3 (CORE)	Maintenance program: 1. Operation and Maintenance Manual; 2. Maintenance records; 3. Calibration, testing and commissioning records; 4. Asset register; 5. Planned Predictive Maintenance (PdM); 6. Planned Preventive Maintenance (PPM); 7. Planned Corrective Maintenance; 8. Planned Replacement Program; 9. Complaint records; 10. Records on work orders; 11. Log book and log sheet.

3.5 Safety & Performance Improvement Activities

3.5.1	**Safety and performance improvement activities**
3.5.1.4 (CORE)	1. Specific performance indicators monitored; 2. Records on tracking and trending analysis; 3. Remedial measures taken where appropriate.
3.5.1.7 (CORE)	1. Staff health screening; 2. Identification of health risk factors; 3. Infectious diseases prevention program/activities; 4. Anti-smoking program; 5. Healthy lifestyle campaign; 6. Staff training on: a) sharps and needle stick injury management; b) Occupational Safety and Health; c) ergonomics; d) biohazard waste disposal. 7. Medical check-up record; 8. Post exposure management; 9. Universal/standard precautions.

3.6 Special Requirements

3.6.1	**Biomedical equipment management**
3.6.1.1 (CORE)	Compliance with acts: 1. Relevant documents pertaining to Medical Device Act 2012 and MS2058 are available; 2. Evidence of medical devices/equipment procured from licensed establishment; 3. Medical device registration certificate from MDA.
3.6.1.5 (CORE)	1. Asset register is available and maintained.
3.6.1.8 (CORE)	1. All licenses/certificates for equipment are current and complied with; 2. Equipment used for Radiology/Diagnostic Imaging, Medical Laboratory and Nuclear Medicine have certifications from relevant agencies/authorities.
3.6.2	**Facility Management**
3.6.2.1 (CORE)	1. Facility is managed by certified Healthcare Facility Manager; 2. Planned Preventive Maintenance (PPM) schedule (Plan and Actual); 3. Contract agreements for outsourced services; 4. Job Sheet/Maintenance report.
3.6.2.11 CORE)	1. All licences/certificates should be current and complied with.
3.6.3	**Building requirements**
3.6.3.3 (CORE)	1. Design of the ceiling in critical areas such as isolation room, microbiology room, Sterile Store, operating theatre, Intensive Care Unit comply with specific requirements, i.e. seamless type.
3.6.5	**Sewage and sewerage system**
3.6.5.1 (CORE)	1. Inspection and checking of the as built drawing shows no exposed sewer lines over critical clinical and support services areas.
3.6.6	**Air conditioning and ventilation system**
3.6.6.1 (CORE)	1. Air conditioning and ventilation systems are complied with the requirements of the relevant Acts, statutory requirements, and local building codes.
3.6.8	**Medical gases**
3.6.8.2 (CORE)	Staff competencies with medical gas system: 1. Competency Certificate of Competent Person and Authorised Person; 2. Staff training records.
3.6.8.12 (CORE)	Plant Monitoring System: 1. Records on testing of the alarm system; 2. Verification on inspection of the Medical Gas monitoring Alarm Panel.
3.6.9	**Medical air system**
3.6.9.1 (CORE)	Medical Air supply: 1. Verification upon inspection; 2. PMT certificate; 3. As Built Drawing to be endorsed by professional engineer

3.6.12	**Vertical transport system**
3.6.12.1 (CORE)	Elevators: 1. Valid and current certificate of fitness; 2. Yearly license by DOSH; 3. The design, size and specification of lift comply with Private Healthcare Facilities and Services Act 1998, and Regulations 2006; 4. Verification of lift Operation and Maintenance (O&M) and lift drawing endorsed by manufacturer, Professional Mechanical Engineers and inspected by DOSH; 5. Records on maintenance and inspection.
3.6.13	**Water supply**
3.6.13.1 (CORE)	1. Minimum storage of 48 hours water supply; 2. Verification of as built drawing for cold water system for kitchen, suction tank, storage tank.
3.6.14	**Electrical System**
3.6.14.3 (CORE)	Electrical Standby Generator: 1. Evidence of emergency electrical generator supply; 2. Dedicated electrical board for emergency power supply and clearly labelled; 3. The switched-socket outlet is red-coloured rocker; 4. Endorsed as built drawings of emergency power supply; 5. Relevant test reports; 6. Test report for eight (8) hours consumption; 7. Evidenced as in endorsed as built drawings; 8. Verification as evidenced through inspection; 9. As built drawings; 10. Verification by inspection; 11. Relevant test reports
3.6.14.4 (CORE)	Uninterrupted Power Supply System (UPS) 1. Endorsed as built drawing; 2. Periodic maintenance records; 3. Verification through actual site inspection.
3.6.14.10 (CORE)	Maintenance: 1. Scheduled maintenance shall follow recommendation from manufacturer / supplier / installer; 2. Records on maintenance and evidenced through as built drawings.
3.6.15	**Electrical System for Critical Areas**
3.6.15.1 (CORE)	Isolated Power Supply System (IPS) [for operating theatres, critical care area]: 1. Endorsed as built drawing; 2.Periodic maintenance records; 3. Evidenced upon actual site inspection.

Standard 4 – NURSING SERVICES

4.1 Organisation & Management

4.1.1	**Organisation, direction and coordination of nursing services**
4.1.1.2 (CORE)	Organisational structure of the Nursing Services: 1. Clearly delineated current organisation chart with line of functions and reporting relationships between the PIC, Head of the Nursing Services and staff; 2. At each service level, a unit organisation chart is available which reflects the working relationships between consultants, medical practitioners and staff of the Nursing Services; 3. Organisation chart of the service is endorsed, dated and accessible. 4. The organisation chart is revised when there is a major change in any of the items

4.2 Human Resource Development & Management

4.2.1	**Nursing Services staffing**
4.2.1.5 (CORE)	Nursing staffing patterns: 1. Manpower planning and forecast of staffing needs; 2. Qualified staff and patient ratio meet regulatory requirements; 3. Staff credentials and privileges; 4. Verification of staffing needs in respective nursing service unit as reflected by: a) current assigned duty roster; b) patient acuity level of care; c) skill mix; d) written contingency plan for turnover and absenteeism; e) documented staff deployment communication.
4.2.1.7 (CORE)	Orientation program for new staff: 1. Policy requiring all new staff to attend a structured orientation program; 2. There is Nursing Services orientation programme with relevant topics and supported by an individual area/unit specific orientation program.
4.2.1.13 CORE)	Credentialing and of privileging for nurses in specialised areas: 1. Documented policies and procedures are established to govern the credentialing and privileging processes; 2. There is a systematic validation process for each individual staff member of their credentials; 3. Skills competency is assessed regularly; 4. Letters of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly.

4.3 Policies & Procedures

4.3.1	**Documented and dated policies and procedures for Nursing Services**
4.3.1.1 (CORE)	1. Documented Policies and Procedures, Protocols, Manuals and Guidelines are available to guide nursing care for general care of all patients and high risk patients as those mentioned; 2. Policies and procedures on patient nutrition and hygiene; 3. Policies and procedures are consistent with regulatory requirements and current standard practices; 4. Evidence of periodic review of policies and procedures; 5. The policies and procedures are endorsed and dated.
4.3.1.9 (CORE)	Nursing care plan: 1. Implementation of Nursing Care Plan based on patient's need; 2. Documented Nursing Care Plan signed and dated; 3. Continuity of patient care i.e. during handover; 4. Patient discharge plan includes patient education; 5. Evidence based nursing services such as Bundle of Care is adopted; 6. Compliance to National Patient Safety Goals related to nursing services.

4.5 Safety & Performance Improvement Activities

4.5.1	**Continuous safety and performance improvement activities.**
4.5.1.4 (CORE)	1. Specific performance indicators monitored; 2. Records on tracking and trending analysis; 3. Remedial measures taken where appropriate; 4. Review performance indicators if trending shows consistent achievement over one year.(where applicable).

Standard 5 – PREVENTION & CONTROL OF INFECTION

5.1 Organisation & Management

5.1.1	**Vision, Mission, goals and objectives of the Facility towards safe infection control**
5.1.1.3 (CORE)	Hospital Infection and Antibiotic Control Committee (HIACC): a) Appointment of a Chairperson b) Terms of Reference c) Committee members d) Tenure of membership e) Frequency of meetings
5.1.1.4 (CORE)	The Prevention and Control of Infection (PCI) Team and Antimicrobial Stewardship (AMS) Team: 1. Minutes are accessible, disseminated and acknowledged by the members; 2. Attendance list of members with adequate representatives of the committee; 3. Frequency of meetings as scheduled; 4. Discussion and resolutions are implemented.

5.2 Human Resource Development & Management

5.2.1	**PCI staffing**
5.2.1.3 (CORE)	1. PCI - Post basic /advanced diploma infection control qualification. 2. AMS – AMS pharmacist has AMS pharmacist training program
5.2.1.5 (CORE)	1. Full time staff (Infection Control Nurse) in accordance with national norm commensurate with bed occupancy rate. 2. Appointed pharmacist (AMS trained, when available) 3. Availability of in each ward/unit. • link nurses/link personnel • ward pharmacist (where applicable) 4. Census and statistics
5.2.1.11 CORE)	The PCI services and AMS relevant activities: 1. Facility-wide orientation programme - PCI & AMS 2. Link nurses/link personnel orientation programme 3. Pharmacist orientation program 4. Outsourced services' staff orientation programme - PCI 5. Patient and family members orientation checklist - PCI

5.3 Policies & Procedures

5.3.1		**Documented and dated policies and procedures of Infection Control Services**
	5.3.1.1 (CORE)	Written policies and procedures for the PCI services and AMS relevant activities: 1. Facility-wide infection control policies and procedures which are customized to the complexity of the services provided. 2. Facility-wide Antimicrobial policy which are customized to the complexity of the services provided. 3. Current Ministry of Health Policies and Procedures on Infection Control are available for reference (updates). 4. An AMS protocol that is available for reference. (e.g. Ministry of Health Protocol on Antimicrobial Stewardship in Healthcare Facilities) 5. Evidence of periodic review of policies and procedures. 6. The policies and procedures are endorsed and dated.
	5.3.1.4 (CORE)	Evidence of compliance with policies and procedures and evidence based guidelines (WHO/ CDC/MOH): 1. Infection control practices (on-site observation) in each of the areas mentioned; 2. Audit reports on infection control practices; 3. Healthcare associated infection outbreak investigations and reports investigated and reported investigations and reports; 4. Staff health status report on cases related to infection control; 5. Compliance with National or local antibiotic guidelines; 6. Data collection on Antimicrobial resistance reports; 7. Data collection on usage of broad spectrum or restricted antimicrobials.
	5.3.1.9 (CORE)	The HIACC reviews: 1. Minutes of HIACC meeting 2. Reports on: - a) healthcare associated infection rates; b) surveillance data on infections and infection potentials; c) implementation of infection control policies; d) Antimicrobial usage of broad spectrum and restricted antimicrobials; e) Any pertinent relevant report (e.g outbreak report). 3. Records on pertinent findings submitted to the appropriate source for necessary action to be taken.

5.4 Facilities & Equipments

5.4.1	**Adequate and appropriate facilities and equipment to prevent and control the risks of infection throughout the Facility.**
5.4.1.2 (CORE)	1. Manufacturers' instructions on medical devices and disinfectants for prevention and control of infection are in place for reference. 2. Material Safety Data Sheet (MSDS) for chemical used is available. 3. Records and observation on practices.

5.5 Safety & Performance Improvement Activities

5.5.1	**Continuous safety and performance improvement activities of the PCI and AMS relevant activities.**
5.5.1.4 (CORE)	1. For Infection Control, there is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) percentage of staff trained in Prevention and Control of Infection practices; b) Rate of healthcare associated infections; c) number of resistant organisms to antibiotics within a specified period of time. 2. For Antimicrobial stewardship, there is tracking, and trending of specific performance indicators for at least one (1) of the following: a) percentage of appropriate and complete antimicrobial prescriptions b) percentage of prescriptions with indications that are in keeping with national or local antimicrobial guidelines c) Percentage of empirical prescriptions that are reviewed by 72 hours

Standard 6 – PATIENT & FAMILY RIGHTS

6.1 Patient and Family Rights

6.1.1	**Provision that supports patient and family rights from the point of accessing care**
6.1.1.1 (CORE)	There is documented Patient and Family Rights Policy as identified in relevant laws and regulations.
6.1.1.3 (CORE)	On-site observation on compliance with policies and procedures.
6.1.2	**Process to respond to patient and family's request for services related to patient's personal values and spiritual beliefs and religion.**
6.1.2.1 (CORE)	1. Patient's religion and beliefs are identified 2. Orientation checklist addresses the needs of patient.
6.1.4	**Protection of patient's possessions from theft or loss**
6.1.4.1 (CORE)	1. Policy on patients possessions and records 2. On-site observation on compliance with the above policy.
6.1.5	**Protection of patients from physical injury by outsiders, other patients and staff and patient who are at risk of injuring themselves.**
6.1.5.2 (CORE)	Policy on risk identification and implementation of safety measures for infants, children, the elderly, disabled individuals, and others. 1. Policy on accompanying relatives 2. Evidence of compliance to the policy on risk identification. 3. Standard operating procedures on handling of high risk patients. 4. Register of visitors after visiting hours for high risk wards/areas.
6.1.5.4 (CORE)	Monitoring remote and isolated areas of the facility 1. Availability of monitoring facilities in remote and isolated areas. 2. Records on monitoring/surveillance reports
6.1.7	**Confidentiality of patient's medical and other health information.**
6.1.7.4 (CORE)	The Facility ensures patient health information as confidential. 1. Policy on safeguarding of patient information 2. Policy on release of patient's medical record. 3. Code of conduct of medical records staff 4. Secured health information system with restricted access levels 5. Restricted access to Medical Records Unit 6. System for recording and monitoring movement of medical records. 7. Computer-on-wheel / tablets, etc. should be automatically shutdown after 3 minutes when not in used. (should have crossed - reference to Standard 7) 8. Policy on no photograph EMR / hardcopy record

6.1.8	**The Facility supports patients' and families' rights to participate in the care process.**
6.1.8.2 (CORE)	Patient and the family are informed about the outcomes of care and treatment, including where appropriate the unanticipated outcomes. 1. Interview of patient 2. Documentation in the medical records 3. Consent form where applicable
6.1.12	**Grievance Mechanism**
6.1.12.1 (CORE)	1. Policy on grievance mechanism 2. Patient orientation checklist 3. Patient Charter 4. Brochure on Patient and Family Rights
6.1.13	**Continuity of Care**
6.1.13.1 (CORE)	1. Policy on after discharge care/follow up care 2. Appointment system for follow up care 3. Home visit where applicable 4. Brochure/leaflet on extended care

6.2 Informed Consent

6.2.1	**Patient's informed consent**
6.2.1.1 (CORE)	Documented policies and procedures: 1. Policy on informed consent without abbreviation 2. Standard Operating Procedures (SOP) on obtaining consent 3. Signed consent forms
6.2.1.3 (CORE)	Documented informed consent before surgery, anaesthesia, use of blood and blood products, procedure sedation and other high risk treatments and procedures. 1. Signed consent forms. 2. Explanation given and documented at the time of taking consent. 3. Validity of the signed consent form is 30 days.

6.4 Organ, Tissue and Cell Donation

6.4.1	**Policies and procedures are available and consistent with relevant laws and regulations**
6.4.1.3 (CORE)	1. Availability of trained staff to facilitate the organ, tissue and cell donation and transplantation. 2. Staff training records (not less than 20 hours) and certification

Standard 7 – HEALTH INFORMATION MANAGEMENT SYSTEM (HIMS)

7.1 Organisation & Management

7.1.1	**HIMS Services organisation and administration related to patient care**
7.1.1.2 (CORE)	1. Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the HIMS Services and staff of the HIMS Services. 2. Organisation chart of the service is endorsed, dated and accessible. 3. The organisation chart is revised when there are any major changes
7.1.1.7 (CORE)	Statistical information is available from the HIMS Services or elsewhere as determined by the Facility and distributed to appropriate committees and relevant staff: 1. The type and amount of information maintained to meet the statutory requirements include information about major clinical services should be made available.
7.1.1.9 (CORE)	A Medical Records Committee: 1. Appointment letters for Chairman and committee members. 2. Terms of Reference 3. Minutes of meeting 4. Medical records audit report 5. Current and approved abbreviations list

7.2 Human Resource Development & Management

7.2.1	**HIMS qualified and trained staffing**
7.2.1.1 (CORE)	1. Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services) 2. Appointment/assignment letters 3. Certification 4. Training and competency records

7.3 Policies & Procedures

7.3.1	**Written policies and procedures for HIMS Services**
7.3.1.1 (CORE)	1. Documented policies and procedures for the service. 2. Policies and procedures are consistent with regulatory requirements and current standard practices. 3. Evidence of periodic review of policies and procedures (every 3 years). 4. The policies and procedures are endorsed and dated.

7.3.1.2 (CORE)	1. Minutes of committee meetings on development and revision on policies and procedures. 2. Minutes of meeting with evidence of cross reference with other departments. 3. Documented cross departmental policies. 4. Reference to relevant policies, procedures, protocols, manuals and guidelines, such as Guidelines for Management of Medical Records, Ministry of Health. 5. Others policies and procedures included. 6. Electronic information system security policies.
7.3.1.4 (CORE)	1. Compliance with policies and procedures through: a) interview of staff on practices; b) verify with observation on practices; c) results of medical records audit on practices; d) practices in line with established policies and procedures. e) Audit report on user access for EMR (Reference : GHOP_JCT 2016 Page 50 5.9.3.2 General Condition for Access of EMR in facility)
7.3.1.9 (CORE)	1. Policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel is in place. 2. Guidelines for management of medical records, electronic information system security and user access control policies (paper based and electronic information systems). 3. Mechanisms are in place to support Facility-wide and HIMS functions even in case of unexpected failure or emergency.
7.3.1.11 (CORE)	1. Written informed consent is taken in accordance with guidelines and regulatory requirements. 2. On-site observation on completeness of consent form.

7.4 Facilities & Equipments

7.4.1	**Adequate physical facilities and equipment for HIMS Services.**
7.4.1.1 (CORE)	1. On-site inspection of storage areas ensures records are stored safely. 2. Preventive measures for possible destruction of records by fire, water and pest. 3. Access control for authorized personnel. 4. Policy on distribution of medical records addresses the issues of confidentiality and security.

7.5 Safety & Performance Improvement Activities

7.5.1	**Continuous safety and performance improvement activities of the HIMS Services.**
7.5.1.4 (CORE)	1. Specific performance indicators monitored. 2. Records on tracking and trending analysis. 3. Remedial measures taken where appropriate

7.6 Special Requirements

7.6.1	**Maintenance of accurate medical record.**
7.6.1.2 (CORE)	1. Sampling of medical records to validate: a) Only healthcare professionals made entries to the records; b) Each entry is dated with time and signed by the care provider with name and designation written down.
7.6.1.4 (CORE)	1. Abbreviations and symbols list which have been approved by the Medical Records Committee. 2. Sampling of medical records on-site to validate compliance to the abbreviations list.
7.6.2	**Appropriate information on the patient and treatment provided on each medical record.**
7.6.2.3 (CORE)	1. Sampling of medical records to validate entry of alert notation.

KEMENTERIAN KESIHATAN MALAYSIA

UNIT AKREDITASI & PIAWAIAN
CAWANGAN KUALITI PENJAGAAN PERUBATAN
BAHAGIAN PERKEMBANGAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA