MALAYSIAN SOCIETY FOR Quality IN Health

STANDARDS MALAYSIA

Hospital Accreditation Survey Process Guide 2017

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MSQH Policies and Procedures

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Purpose of the Malaysian Hospital Accreditation Survey Process Guide

This document is the survey policy and process guide for the Malaysian Healthcare Accreditation Program developed, implemented and co-ordinated by the Malaysian Society for Quality in Health, a healthcare standards and accreditation body established as a result of a tripartite memorandum of understanding between the Malaysian Ministry of Health (MOH), Association of Private Hospitals Malaysia (APHM) and Malaysian Medical Association (MMA).

The contentsof this document may change from time to time at the discretion of the MSQH Committee, to reflect changes in strategy, policy direction and process guide consequent to reforms in the international and the Malaysian health care arena, inputs and feedback from its stakeholders, as well as from external and internal clients of MSQH.

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MSQH: Hospital Accreditation Survey Policy and Process Guide

Contents

FOREWORD

The Malaysian Society for Quality in Health (MSQH) acknowledges that hospital care is a growing and ongoing important force in the healthcare industry. With the ever increasing demand on accountability and the need to ensure Safety and Quality in Healthcare, MSQH Hospital Accreditation Program has been tailored to fulfill these needs. The standards have been developed to facilitate focus on patient care with safer outcomes. The 5th Edition Hospital Standards are written so as to be applicable to various levels and types of public and private hospitals in the Malaysian Healthcare Industry. These include primary, secondary and tertiary facilities and medical/specialist medical centres. The standards are designed to cover whole organization and the range of services provided in the facility.

This Hospital Accreditation Process Guide provides hospitals with a mechanism to demonstrate their accountability in safety and quality of products and services that are delivered to their customers. This process has taken into consideration the requirements of the Private Health Care Facilities and Services Act 1998 and its corresponding Regulations 2006 and all other healthcare related laws and regulations including the Medical Device Act 2012 (enforcement in 2014). Additional focus on outcomes of care and patient safety requirements such as WHO Patient Safety Initiatives and Malaysian Patient Safety Goals has also been incorporated into the 5th Edition of the Hospital Accreditation Standards.

MSQH Hospital Accreditation Standards are developed by expert members of the relevant services from both the public and private healthcare sectors nationally. The MSQH Standards have undergone several reviews and editions including the current 5th Edition Standards with feedback from both public and private healthcare providers as well as the consumers. The 5th Edition Standards are available on the MSQH website for free download.

It is important for MSQH members to understand that the accreditation programme exists in a dynamic environment where medical knowledge, health technology, practices and expectations are ever changing. The emphasis and evidence of concern for Safety and Quality in healthcare is becoming critical in order to gain the trust of patients and stakeholders. Thus, the additional focus from assessment of structure and process including risk management shall provide evidence of quality outcomes and safer services which is vital in the certification process.

It is hoped that this document will help you understand the intent of the 5th Edition Standards and prepare yourselves to participate in the Hospital Accreditation Survey and Certification process.

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President MSQH

Assoc. Prof. Dr M.A. Kadar Marikar
Chief Executive Officer, MSQH
Chairman, Accreditation Committee

INTRODUCTION

The MSQH Hospital Accreditation Survey Process Guide is developed to help members, hospital staff and Surveyors to learn more about MSQH 5th Edition Hospital Accreditation Standards and Survey Process. This guide provides relevant information about the MSQH, the Accreditation Process, Eligibility criteria for Accreditation, How to Request for Accreditation, Preparation for Survey, the Onsite Survey Process Management and the Accreditation Decision.

The MSQH Hospital Accreditation Standards and Process benefits your organisation through/by:

1. Enabling your facility to comply with existing National Laws, Regulations and Statutory Requirements.

2. Compliance to licensing requirement (a minimum requirement).

3. Conforming to existing national standards for hospital which requires a team approach, thus promoting team building.

4. Creating an educational culture towards achieving a learning organisation.

5. Identifying risk in a systematic manner and enabling risk management within the facility, thus enhancing staff and patient safety.

6. Internalising and institutionalising a culture of Continuous Improvement in Safety and Quality in the facility.

7. Validation and certification of the Safety and Quality of Patient Care.

8. Strengthening community trust and public confidence. Being certified is evidence to patients and the community that your facility is committed to providing Quality and Safer Healthcare Services.

9. Establishing organisational credibility builds up staff morale and stakeholder confidence towards the facility.

SECTION A:
MSQH HOSPITAL ACCREDITATION PROGRAMME

A1 MSQH – WHO ARE WE?

The Malaysian Society for Quality in Health (MSQH) is a non-governmental and not for profit organisation established and registered with the Registrar of Societies in 1997. It is the brain child of the Ministry of Health (MOH) in partnership with the Association of Private Hospitals Malaysia (APHM) and Malaysian Medical Association (MMA).

1.1 The Malaysian Society for Quality in Health was established in 1997 with the vision of advocating, promoting, and supporting continuous quality improvements and safety in Malaysian healthcare arena. MSQH is recognized nationally and internationally as the leading Malaysian organization which promotes and improves safety and quality in the provision of healthcare services in Malaysia. Through active and smart partnerships with healthcare professionals, relevant facilities and agencies, and educational institutions involved in healthcare, MSQH has become the national voice in continuous quality improvement in healthcare facilities and services. In order to realize this vision, MSQH develops standards, plans and implements accreditation programmes, promotes safety and quality improvement in healthcare facilities, and organises opportunities for communication of ideas and exchange of experiences on current and best practices in health care. MSQH has also initiated the Patient for Patients Safety Movement to strengthen patients and family engagement in the delivery of healthcare services since 2014.

1.2 As an organisation which is committed to quality mindset that promotes the development of a quality and safety culture and a conducive environment for continuous quality improvement in the provision of safer healthcare, the MSQH espouses and propagates the following values:

- Safety
- Integrity
- Professionalism
- Patient and Family Centred
- Teamwork

A2 PURPOSE OF ACCREDITATION PROGRAMME

2.1 In its Operating Rules, the International Society for Quality in Health (ISQua) defines Accreditation as "a self-assessment and external peer review process used by healthcare organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the healthcare system."

2.2 The MSQH Hospital Accreditation Program (HAP) is a voluntary, independent programme supported and administered by healthcare professionals who are organised under the auspices of the **Malaysian Society for Quality in Health (MSQH),** a not for profit and non-governmental society formed subsequent to a tripartite Memorandum of Understanding between the Malaysian Ministry of Health (MOH), Malaysian Medical Association (MMA) and Association of Private Hospitals, Malaysia (APHM).

2.3 The Hospital Accreditation Program of MSQH provides an effective means whereby health care facilities can assess their level of performance against applicable national standards, which have been developed by expert healthcare professionals and are accepted for nation wide application in Malaysia. The MSQH 5th Edition Hospital Accreditation Standards provide a benchmark against which healthcare organisations can regularly assess their organizational/facility's performance and continuously improve in an ongoing and reiterative basis.

2.4 The accreditation survey visits organized by MSQH, made upon the request of a healthcare facility, provide opportunities for external peer review, mutual learning and education, validation of current performance assessment and sharing of best practices in the healthcare industry. The emphasis and focus of the Hospital Accreditation Program is on continuous improvement, and the promotion and propagation of a quality culture in the healthcare facility or organization.

2.5 The application of accreditation standards as benchmark for monitoring organizational performance and voluntary participation of a healthcare facility in the accreditation programme is vital to its continued success. In addition to continuous quality improvement,

the organization gathers and maintains momentum in organizational renewal through successive cycles of self assessment and this continually upgrade organizational performance. The facility must demonstrate continuity in leadership which ensures that continuous quality improvement is implemented and maintained throughout the organization. The healthcare facility is encouraged to promote ongoing discussion on the measurement of performance against the accreditation standards, and to provide evaluative and enabling feedback to the staff, medical practitioners, and clients on a regular basis.

2.6 The MSQH Hospital Accreditation Standards have been reviewed and updated. The 5th Edition Standards have been approved for implementation in July 2017. These standards have taken into account the current requirements of the Private Health Care Facilities & Services Act 1998 and its corresponding Regulations 2006 and other related current regulatory requirements. These updated Standards have additional focus on requirements of WHO Patient Safety Initiatives, Malaysian Patient Safety Goals and measurement of outcomes of services delivered.

A3 VALUE OF MSQH HOSPITAL ACCREDITATION

MSQH Hospital Accreditation provides:

3.1 <u>For Your Customers</u>

- tested performance standards that focus on quality and safety in patient care,
- assurance that your service meets or exceeds the quality health standards available in Malaysia and is recognised internationally,
- strengthening community trust in being certified is evidence to patients and community that your organisation is committed to providing Safe and Quality Healthcare Service,
- greater client satisfaction,
- trust in your staff's ability to respond appropriately to patient needs and to protect their rights,
- security in the knowledge that quality systems are in place to identify and remedy health problems.

3.2 For Your Facility

- comprehensive and structured analysis of performance,
- a broad based improvement in delivery of services,
- reduced re-work and rectifications, since things are done right the first time and every time,
- establishes organisational credibility, builds up staff and stakeholders' confidence towards the hospital,
- better outcomes of care,
- reduced risk and medical defence costs,
- confidence that you focus on safety, quality care and service excellence,
- enhanced public trust, image and competitive edge.

3.3 For the People Working in Your Facility

- a valuable learning experience through self-assessment, reflection, and challenge to tradition,
- empowerment to improve the processes and change current practices in delivery of care,
- enhanced teamwork, staff satisfaction, staff morale and confidence in the services that they deliver,
- provision with the right tools and new techniques and technology for safe and quality services in a low risk environment,
- being part of a client-focused team to achieve service excellence,
- equipping with a rigorous approach to continuous improvement,
- sharing knowledge through a nationwide network of quality health providers,
- esteem and endorsement by peers and the public for a conscious and active effort in maintaining high professional standards.

3.4 For the People Who Fund Your Facility

- confidence that your organisation is client focused,
- assurance that your organisation operates according to industry standards and meets international safety standards and requirements,
- success and sustainability of business through safer quality outcomes,

- confidence that risk is minimised and managed to create better shareholder value.

3.5 The MAIN BENEFITS gained by a healthcare facility from participating in the accreditation program are derived from various perspectives:-

- the educational process of self-assessment and gap analysis that precedes the accreditation survey,
- the internal bonding, team building, sharing of ideas and interactive cross departmental interfaces promote creation of ownership of the services and organization while the facility makes preparations for the accreditation survey,
- interactive exchange and lessons learnt with the survey team during the survey process, and
- the access to a network of peers from healthcare professionals for continued education, consultation and sharing of experiences.

3.6 Additional benefits are:

- A structured and comprehensive analysis of facility's infrastructure, inputs, processes, outputs and the impact of these on organizational performance and the clients;
- Identification of areas of strength which could be replicated and/or emulated by other departments and units within the facility;
- Identification of areas for further improvement which require re-thinking and rectification;
- Nurture of team spirit, improvement in teamwork which enhances job satisfaction and staff morale;
- Reduction of re-work and corrective action from proactive intervention and avoidance of mistakes;
- A culture of thinking "quality in all we do" resulting in a broad based improvement in the facility's performance;
- Demonstration to the public and clients a conscious and active effort to maintain ethical practice and professional standards of care;
- Valuable learning in reflecting, planning and changing traditional ways to new processes and state-of-the-art techniques;
- Rewarding outcomes from implementation of best practices;

- A culture of continuously identifying root causes and solutions to improve processes and outcomes;
- Access to and sharing of information, guidance and support to facilitate improving the quality of service and patient care;
- Greater internal client satisfaction and better health outcomes for external clients; and
- A competitive edge over providers who have yet to make the journey of gaining accreditation status.

A4 HOSPITAL SURVEY ELIGIBLITY CRITERIA

4.1 The MSQH may accredit any healthcare facility or service as defined by the Private Healthcare Facilities and Services Act 1998, which defines healthcare facility as any premises in which one or more member of the public receive healthcare services. Similar healthcare services in the public sector are also eligible to be surveyed and accredited.

Healthcare services include:

- Medical and surgical, dental, nursing, midwifery, allied health, pharmacy, and ambulance services and any other healthcare related services provided by single or group of healthcare professionals;
- Accommodation for the purpose of any of the above services;
- Any service for the screening, diagnosis, or treatment of persons suffering from any disease, injury or disability of mind or body;
- Any service for preventive or promotive health care purposes;
- Any service provided by any healthcare para-professional;
- Any service for curing or alleviating any abnormal condition of the human body by the application of any kind of medical technology.

4.2 To be eligible for an accreditation survey by MSQH, a healthcare facility shall:

- Be a member of MSQH;
- Be a healthcare facility in operation for a minimum of 12 months, either in the public or private sector; any new services to be included in the survey shall be in operation for a minimum of at least 6 months before the survey date;

- Be a provider of services for which the MSQH have applicable Accreditation Standards [MSQH will not survey the Traditional and Complimentary Medicine (TCM) Services.]
- Have a current and valid "license" as required by the Ministry of Health and any other relevant regulating body;
- Ensure the availability of all services necessary to fulfill the organisation's mission and objectives. (These services may be provided on site, or may be provided off-site by partnerships with acceptable community or regional resources);
- Complete and return a "Survey Application Form" to MSQH. The application must be signed by the Person-In-Charge (PIC) of the Hospital or an equivalent person with overall authority and responsibility for the healthcare facility.

A5 HOW TO REQUEST FOR A SURVEY

5.1 Healthcare Facility applying for a first accreditation survey must undergo a special accreditation training conducted by MSQH trainers (see Appendix I). The minimum time frame required for any Healthcare Facility to be eligible for survey is six months post training to allow time for the facility to make adequate preparation. The facility is required to send a request letter for training.

5.2. The request letter for survey and “Survey Application Form” shall be submitted to MSQH at least six (6) months before the expected date of survey. The application form for survey can be downloaded from the MSQH website (www.msqh.com.my). Confirmation of survey date will be provided in writing. All Private Healthcare Facilities are required to attach a copy of their current hospital license issued by the Ministry of Health. **Only services as stated in the license will be surveyed by the MSQH.**

Applications for survey remain valid for 12 months from the date of application unless significant changes affect the facility as described in 5.3.

Healthcare Facilities which are successful in their applications will be advised in writing of the processes that they must undergo including training and education (mandatory for facility going for first time survey) and self-assessment prior to the accreditation survey. The facility will also be informed on the costs associated with

preparations and the survey process. The actual survey dates will be decided by consultation between the facility and MSQH, which is responsible to line up a team of surveyors (agreed upon by the facility) appropriate to the complexity and level of healthcare services provided by the facility.

5.3. **If significant changes occur after the initial application for survey**, the information provided in the application form should be updated and notified to MSQH before the survey takes place. Changes which must be reported to MSQH prior to the accreditation survey include:

- Ownership change affecting organization and management of services;
- Significant variations in service volume;
- Addition of new type of health care services as approved by the regulating body;
- Deletion of an existing service;
- Change of site of provision of care;
- Major structural and infrastructural changes.

Changes which are unreported but observed by the survey team shall be included in the survey, and shall be part of the survey/assessment.

5.4. Any questions on the application process, survey scheduling, and the survey process may be addressed to the Executive Manager Technical and Client Services at MSQH, or email to msqh@msqh.com.my.

5.5. You are reminded of the heightened expectations in quality of care and services from a facility which is moving into the second or subsequent cycles of survey.

A6 ACCREDITATION SURVEY FEES

The MSQH is a national, non-governmental and not-for-profit organization. The fees charged to healthcare facilities for participating in the MSQH accreditation program are required to recover part of the expenses incurred in the organization of the survey team and the actual conduct of the accreditation survey. The latest fee structure approved by the MSQH Committee at the Annual General meeting (AGM) will apply.

A7 SURVEY PROCESS MANAGEMENT

7.1 The composition of the survey team and the survey date are determined by the Chief Executive Officer / Chairman of the Accreditation Committee, depending on (a) the type and location of the health care facility to be surveyed, (b) the range and complexity of services offered by the facility, (c) availability of the required number of surveyors with relevant expertise and (d) the availability of a chief surveyor to lead the survey team. Dates will be mutually agreed by both parties.

7.2 The MSQH assigns the surveyors, plans the itinerary and establishes the dates for each survey. The MSQH makes every effort to accommodate the time frame requested by the healthcare facility and co-ordinate the periods of availability of the survey team members. Therefore MSQH highly appreciates and values the reciprocal effort of a facility not to change the dates given for the survey except under extenuating circumstances. Dates will be mutually agreed by both parties.

7.3 Once the survey team schedule is identified, the Healthcare Facility is notified officially. The survey schedule is prepared in view to minimize travel and other related costs, and to optimize the time when the surveyors are available on site. Any changes to the survey schedule are wasteful of resources on the part of all parties. For this reason, Healthcare Facilities are urged to adhere to the agreed upon survey dates. List of Surveyors are also mutually agreed by both parties.

7.4 Detailed guideline for preparations (before, during and after the survey) which are required to be undertaken by the Healthcare Facility and MSQH for a successful accreditation survey are contained in the Procedure for Hospital Survey, which is available at MSQH and provided to facilities in the training package and on confirmation of the survey date.

7.5 Healthcare Facilities are expected to follow all advice and the guidelines given in this guide as much as possible. Any additional queries should be addressed to the Technical Officer who has been assigned by MSQH to facilitate the survey in your organization, or, in his/her absence, to the Executive Manager Technical and Client Services.

A8 VOTING MECHANISM

8.1 The Hospital Survey Report is forwarded to a panel of Councillors appointed by MSQH, who will vote on the Accreditation Status to be awarded. The MSQH appoints a panel of at least three (3) Councillors who determines the facility's Accreditation status award by a system of voting. These Councillors are experienced, healthcare professionals of high standing who have been appointed to the Malaysian Council of Healthcare Standards (MCHS).

8.2 Each member of the Council is sent a copy of the report and a voting form. Each member of this panel of Councilllors **independently reviews** the Final Survey Report, together with the Chief Surveyor's executive summary report and all ratings determined by the survey team for each of the Accreditation Standards and Services. Each Councillor makes an independent decision on the Accreditation Status to be awarded and gives a score based on a scale of 1 to 30. The final award decision made by MSQH is based on an average of their scores and the consensus opinion of the panel of Councillors.

8.3 Voting forms are returned to the MSQH Secretariat within five (5) working days from the time the Councillors receive the report, and the scores tallied. Accreditation is awarded or withheld by the voting panel. The facility is notified of the Council's decision by phone and in writing. The MSQH then confers the Accreditation Certificate at an Award Ceremony on a date appropriate to the facility.

8.4 The decision of MSQH on the accreditation status awarded is final.

8.5 In the event there is an appeal from the Healthcare Facility. The appeal process is available for further reference.

A9 ACCREDITATION STATUS DECISION

9.1 At the accreditation survey, the surveyors identify and commend on areas of excellence as well as highlight any opportunities for improvement, using currently accepted standards as the benchmark. The observations of the surveyors, together with individual recommendations on the accreditation status by each member of the

survey team are collated by the Chief Surveyor, who will forward this composite result with a final Hospital Survey Report to MSQH.

9.2 The final accreditation status decision is made based on a review of the Hospital Survey Report and recommendations of the survey team by a panel of three (3) Councillors, selected from the members of the Malaysian Council of Healthcare Standards (MCHS), a body chaired by the Director of Medical Development Ministry of Health Malaysia.

9.3 Three categories of Accreditation awards may be awarded, depending on the level of compliance to the standards attained by the healthcare facility which is undergoing the accreditation survey process.

9.4 The final award decision and the recommendations are forwarded by MSQH to the Chief Executive Officer (CEO), the owner, or the chair of the Governing Body of the surveyed facility. Release of any confidential information pertaining to the facility will be subject to written consent from the CEO, the owner or the chair of the Governing Body.

A10 ACCREDITATION STATUS

10.1 Four-Year Accreditation

10.1.1 For the award of Four-Year accreditation status, the Facility shall have to comply with the following requirements:

10.1.1.1 The following core service standards shall achieve overall rating of minimum 3:

i. Standard 1 - Governance, Leadership & Direction
ii. Standard 2 - Environmental and Safety Services
iii. Standard 3 - Facility and Biomedical Equipment Management and Safety
iv. Standard 4 - Nursing Services
v. Standard 5 - Prevention and Control of Infection
vi. Standard 6 - Patient and Family Rights
vii. Standard 7 - Health Information Management System (HIMS)

10.1.1.2 All clinical services standards including critical care services standards (Appendix V) shall achieve overall rating of at least 3.

10.1.1.3 Core criteria must achieve a rating of 4 or 3 for the standards to reach compliance. However, a core criterion rating of 2 may be acceptable, if the risk associated with the criterion is **Moderate** or **Low** as calculated on the risk matrix and the necessary action can be achieved within 12 months post award.

10.1.1.4 For other services, where there is overall rating of 2 or 1, risk assessment (by using the risk matrix) is required and the risk is categorized as **Moderate** or/and **Low**.

10.1.1.5 Decision for awarding accreditation status takes into consideration:

i. overall impact of the hospital services assures patient safety;
ii. recommended score from the surveying team and councillors aggregated score.

Accreditation Status	**Four-Year Accreditation**
Score	**20 - 30**

10.1.2 Additional recommendation based on the achievement for Four-Year accreditation status:

i) Excellent Achievement:
- All Service Standards should achieve a rating of 4;
- No score of 2 or 1 for any criteria in all service standards (No risk assessment).

ii) Good Achievement:
- Four-Year accreditation status but do not qualify for Excellent Achievement.

10.2 One-Year Accreditation

a. The above requirements (10.1.1) are not met.
b. Areas for improvement and recommendations can be rectified within 12 months period before the Focus Survey

Accreditation Status	**One-Year Accreditation**
Score	**10 - 19**

10.3 Non-Accreditation

a. The above requirements (10.1.1) are not met.
b. Areas for improvement and recommendations requires more than 12 months period to rectify**.**

Accreditation Status	**Non Accreditation**
Score	**1 - 9**

A11 FOCUS SURVEY

11.1 A healthcare facility which has been awarded One-Year Accreditation is encouraged to work towards a Focus Survey within the year, except where any improvements or rectification plans may be constrained by technical difficulties. This urgency is to allow the Accreditation Status and the display of the MSQH logo (which signifies a state of accreditation) to continue uninterrupted. The Focus Survey aims to:

- Assess the response and adherence of the facility to recommended actions from the most recent survey;
- Ascertain that quality performance is maintained or improved further;
- Consider the facility's eligibility to be given an additional three (3) years accreditation.

11.2 Depending on the size and complexity of the facility, and the number of areas which require to be re-assessed, the focus survey may take 1-2 days with a team of at least two (2) surveyors. Additional fee is applicable for a Focus Survey.

11.3 Before accepting the option of a *Focus Survey*, the healthcare facility is advised to consider carefully whether the major reasons for not achieving a four-year Accreditation (as spelt out in the result notification letter) can be satisfactorily addressed and rectified within the subsequent twelve (12) months. The facility must then achieve four-year Accreditation as **MSQH policy prohibits the granting of consecutive one year Accreditation award within the same cycle**. Otherwise, the facility may elect to undertake a full survey, when they are better prepared.

11.4 The Focus Survey is conducted using the MSQH standards which are current at the time of the focus survey. The scope, structure and reporting format for the Focus Survey is detailed in Appendix III.

11.5 A further three-year Accreditation is awarded if, through the *Focus Survey Report*, a facility is assessed as substantially complying with all relevant standards. The three-year award extends the accreditation period from the expiry of the one-year Accreditation and brings the facility in line with the standard four-year cycle.

A12 APPEAL MECHANISM

12.1 A healthcare facility has the right to make an appeal and request a review of the decision made by the MSQH with respect to the Accreditation status awarded. Possible grounds for appeal are:-

- Survey report is inaccurate;
- Relevant and significant evidence was not considered or was incorrectly interpreted;
- Inappropriate weight given to evidence;
- Decision inconsistent with evidence available; or
- Decision inconsistent with published criteria for accreditation.

12.2 An **intention to appeal** must be notified in writing to the MSQH within thirty (30) days of the notification of the result. A further thirty (30) days is given for the facility to prepare and submit the **details of the appeal in writing**, giving the reasons for questioning the accreditation award decision. MSQH shall receive and initiate the appeal process not later than 14 working days of receiving the details

from the hospital. An Appeal Fee must be submitted with the appeal letter to cover the administrative and other costs of processing the appeal.

12.3 The appeal will be considered by a review committee of at least three (3) members appointed by MSQH. **No person shall serve on the review committee if they have had any previous involvement in the consideration and determination of the accreditation decision under review**.

12.4 Copies of the appeal documentation are sent to each member of the survey team for their comments on the issues raised. The surveyors' comments together with the facility's appeal documentation are then submitted to MSQH for consideration by the Review Committee.

12.5 The MSQH may decide to uphold or reverse the original accreditation decision. During the appeal process, the facility's original Accreditation status remains. All recommendation by the Appeal Committee shall than be endorsed by the MCHS Chairman. The **decision of MSQH on the appeal is final** and no further avenue for appeal correspondence on the issue will be entertained.

A13 MAINTENANCE OF ACCREDITATION

13.1 Accreditation Status is awarded for four years, subject to the maintenance of standards. The Hospital Survey Report that accompanies each accreditation decision is a valuable educational resource for the organization. It details those areas where the facility's performance is commendable or needs improvement, and includes recommendations on how to meet or exceed the standards. After achieving Accreditation Status, the onus is on the healthcare facility concerned to maintain and further improve the level of performance, in accordance with the MSQH accreditation standards, which are also constantly being reviewed and updated.

13.2 A facility which has been awarded a four-year accreditation status is expected to submit two (2) progress reports to MSQH, the first **at twelve (12) months and the second at thirty six (36) months from the date of survey. While at the twenty four (24) months, a Surprise Surveillance Survey will be conducted.** The **Compliance Report** documents for each Service contains the

actions which have been taken to address surveyor comments and recommendations to improve compliance with the standards, and also includes the facility's current assessment on the status of compliance at the time of reporting. It is mandatory to report on every standard and criteria which had been rated as 1 or 2 at the previous survey.

13.3 These reports will be reviewed by MSQH technical officers and the Executive Manager Technical and Client Services. Acceptance of the report will be based on the completeness and evidence of compliance provided.

13.4 A Surprise Surveillance Survey will be conducted at any time during the 24th months of the accreditation period, on notification by MSQH of its intention. The Facility is given a written notice fourteen (14) days before the date of the visit. The Surprise Surveillance Survey will be subsequently at the convenience of the MSQH (see Appendix IV).

13.5 In addition to regularly scheduled surveys, the **MSQH reserves the right to re-survey a facility at any time** in the event of the following conditions:

- When MSQH has reason(s) to believe that a significant breach of compliance to the standards has occurred in the facility;
- When MSQH is advised of significant changes in the organization, e.g. change of ownership or managerial control, situation of acquisition or merger, or when the facility undergoes major infrastructure changes.

On notification by MSQH of its intention to re-survey, the healthcare facility is given a written notice to accept the re-survey within fourteen (14) days of the date of notice. The survey will subsequently be scheduled at the convenience of the MSQH. Failure to accept the re-survey will result in the withdrawal of accreditation status.

A14 WITHDRAWAL OF CERTIFICATION

MSQH scans the national newspapers daily to monitor developments in the healthcare industry. In the event of a major complaint appearing in the print media or if MSQH receives a complaint letter regarding a hospital, that facility is required to provide a timely response to the complaint. If the hospital's response to the complaint is unsatisfactory and the MSQH Ethics Committee feels that there may be issues of concern which compromises safety in service delivery, a team from MSQH may go on site to investigate.

Accreditation Status shall be withdrawn if the investigation reveals that safety and quality of care have been compromised at the hospital.

A15 CONFIDENTIALITY OF INFORMATION

In the course of its accreditation surveys, MSQH comes in contact with a wide range of information pertaining to the business and management of the facilities being assessed. MSQH believes in confidentiality of information; hence except where required by law, **MSQH will not release any information obtained through any survey** on any health care facility without prior written consent from the facility concerned. This commitment extends from the facility's business as well as any information obtained by way of client/patient interviews and interaction during the survey.

A16 PUBLIC RECOGNITION

15.1 A certificate of Accreditation, specifying the period of accreditation awarded, is provided to a healthcare facility after each successful survey. The current Certificate of Accreditation may be put on public display in the facility. Previous certificates may be either stored in archives or returned to the MSQH.

15.2 All certificates remain the property of the MSQH, and must be returned upon request by MSQH. Certificate of Accreditation

shall not be displayed in the facility if the accreditation status has expired.

15.3 The accreditation status of a facility is not transferable. If a facility is affected by acquisition or merger, the accreditation will discontinue if there are significant changes to the circumstances originally existing at the time of survey. The facility must inform MSQH within 30 days of any such changes. MSQH may extend accreditation status while making a decision whether the changes warrant the conduct of a special survey. Failure to notify MSQH of ownership and service changes, when uncovered, may result in withdrawal of the accreditation status.

15.4 The MSQH maintains a current list of accredited healthcare facilities, the information of which is also available on the MSQH website.

SECTION B:
PREPARATION
FOR THE ACCREDITATION SURVEY

B1 INTRODUCTION

1.1 At the accreditation survey, the facility and its staff must be ready to demonstrate that they have achieved substantial compliance to the current accreditation standards. The accreditation standards and the survey process are designed to assess the facility's performance as it relates to its vision and mission to provide quality services and care.

1.2 The five (5) principles underlying the accreditation process are:

i. client focus
ii. leadership
iii. commitment to quality, staff and patient safety
iv. empowerment and teamwork
v. managing processes, minimising risks and safer outcomes.

These principles are intended to promote an integrated team approach in the provision of safe patient care, treatment of clients, service delivery systems and continuous quality improvement activities.

1.3 Healthcare Facilities are encouraged to use the accreditation standards on an ongoing basis as a means of monitoring performance, identifying areas of major concerns, and implementing and sustaining improvements. The visit by the survey team merely serves as a means of internal system validation, external peer review and enabling of educational exchange on quality improvement initiatives.

B2 PREPARATION FOR THE SURVEY

First and foremost, the Board of Management and Governing Body of the healthcare facility must be committed to Patient Safety and quality of care as integral to its mission and objectives. Then the facility decides to make use of the MSQH accreditation standards as a means of achieving and maintaining quality service and safe care. On this decision, the Medical Director/CEO/Person In-Charge may submit a formal Application for Survey to MSQH.

On acceptance of the application, MSQH will provide the facility with the latest version of *Standards and Assessment Tool*. These documents are to be completed by the facility and submitted to MSQH six (6) weeks before the survey date to enable MSQH to check for completeness before distribution to the survey team for study, prior to the survey.

2.1 MSQH 5th Edition Hospital Accreditation Standards and Assessment Tool

The MSQH Hospital Accreditation Standard 5th Edition has both the standard and the assessment tool in the same document. This document is also termed the **MSQH Accreditation Guide**. The sections of the Guide includes the following:

i) Title of the Service Standard
ii) Preamble
iii) Area of focus:
- Organisation and Management
- Human Resource Development and Management
- Policies and Procedures
- Facilities and Equipment
- Safety and Performance Improvement Activities
- Special Requirements

iv) Standards
- Criteria for compliance
- Core Criteria

  A number of criteria have been identified as core to the standards. They include core processes with immediate

impact on patient safety and clinical effectiveness and evidence based standards with a clear purpose.

- Evidence of compliance

v) Facility Comments
vi) Self Rating
vii) Surveyor Findings
viii) Surveyor Summary & Overall Rating

2.2 Pre-Survey Self Assessment

Upon receipt of the MSQH 5th Edition Hospital Accreditation Standards inclusive of the self-assessment tool, the facility begins the self-assessment and repeats the process regularly, targeting the completion of the process before the date of the survey which is agreed with MSQH. When applying a rating, use the rationale and guidance provided under the guidelines for rating system (Appendix VI) to determine the level of compliance. **The completed Self-Assessment Tool shall be submitted to MSQH via electronically at least six (6) weeks before the date of the survey**. Reports on the results of tracking and trending of relevant Performance Indicators should also be submitted.

The technical officer designated to co-ordinate and facilitates the survey reviews the self-assessment documents, clarify any inconsistencies or doubts with the facility. Subsequently, request for the corrected documents before submitting the final self-assessment documents to the Chief Surveyor for review prior to the on-site survey.

2.3 Facility Profile

The Facility Profile should contain summary information about the size and structure of the facility, organisational management and service areas. This information enables the surveyors and the MSQH facilitator to be oriented to the facility and its current operations. The completed Profile together with the report on Performance Indicators should be submitted via email to MSQH at least six (6) weeks prior to the survey. Annual reports of the facility are helpful and, if available, may be submitted with the Facility Profile.

2.4 Preparation for the Survey

In preparation for the survey, several meetings may be conducted, consisting of several teams and involves a number of front line staff. This is to ensure the availability of participants during the survey interviews and to minimise disruption to the facility's daily activities. It is important for MSQH to plan the survey schedule in advance, in consultation with the facility.

At least six (6) weeks prior to the survey, the facility should develop a tentative Head of Department/Consultant interview schedule and provide this information to MSQH. The tentative interview schedule should be planned to accommodate as best as possible the smooth running of daily operations of the facility during the survey. This tentative schedule will be reviewed by the survey team and modified to suit the composition and needs of the team, when on site.

B3 MSQH SURVEY DOCUMENTATION

3.1 The facility undergoing an accreditation survey by MSQH should make available all relevant records and documents for the surveyors to view and review when the survey team is on site. This list is not exhaustive, and surveyors may request for additional documents to enable them to validate the level of compliance to the accreditation standards.

- Written vision and mission statement and values;
- Strategic direction or plan for 3, 5 or 10 years;
- Operational or business plans for 1 or 2 years;
- Goals and objectives of the organisation;
- Organisation chart with staff positions and job descriptions;
- Medical staff credentialing and privileging system;
- Compliance with current laws governing health care in Malaysia;
- Compliance with Ministry of Health policies, rules and regulations;
- Annual performance report;
- Facility floor plan; and
- Description of the quality improvement system;

- Documented quality improvement activities and projects;
- Reports of departures from policies and procedures;
- Audit reports
- Minutes of meetings of Governing Body, committees and sub-committees;
- Agreements covering arrangements with concessionaires and sub-contractors;
- Human Resource policies and procedures;
- Staff induction, orientation and continuing education programmes;
- Staff appraisal system;
- Response to recommendations from previous surveys, if applicable;
- Memorandum of Understanding (MOU) with institutions which use the facility for training of health personnel or other purposes affecting patient care.

3.2 At the time of the survey, these documents should be placed in a suitable, conveniently located room where the surveyors can review them and discuss survey findings, both during and after working hours. A key to the room should be provided to the Chief Surveyor to ensure security of the documents. Unless otherwise indicated by the survey team, minutes of meetings should be available for the previous two (2) years and should include committees' terms of reference, membership and frequency of meetings.

3.3 The committees for which documentation may be reviewed include:

- The Governing Body, Board of Management and its sub-committees;
- Management Committees;
- Medical and Dental Advisory Committee, and its sub-committees;
- Clinical departmental meetings;
- Professional Liaison Committees and similar inter-professional committees;
- Community interest groups;
- Residents' council or Consumer group, where such a group exists;

- The Internal Disaster Plan, records of attendance at fire prevention training, and reports on fire and internal evacuation drills;
- The External Disaster Plan and report of the most recent external disaster exercise involving other government agencies such as the police, fire department, etc;
- Occupational Health and Safety Committee;
- Volunteer Services.

3.4 Wherever the documents required to be reviewed by the survey team are needed to be located at the site of service delivery, these may be retained at such places so as not to adversely affect customer service during the survey. Examples of these are:-

- Diagnostic imaging
- Patient Health records
- Laboratory
- Pharmaceutical prescriptions and dispensing record
- Nuclear medicine records

3.5 A Survey Documentation Checklist is shown in Appendix II.

B4 EDUCATION & TRAINING SUPPORT

4.1 The MSQH offers numerous educational services to meet the individual needs of health care facilities. In the journey of preparations for the accreditation survey, health care facilities may wish to contact the MSQH to arrange for additional educational and enabling sessions. Please see Appendix I.

4.2 **PLEASE DO NOT CONTACT SURVEYORS DIRECTLY TO ARRANGE EDUCATIONAL SESSIONS**. This prohibition is necessary to ensure no surveyor is compromised in terms of eligibility to be selected as a member of the survey team at a later stage, and that there is no conflict of interest situation for any member of the survey team formed to survey a facility.

MSQH's direct involvement in the preparation and planning process ensures that the most up-to-date supporting documentation is provided and used.

B5 ORGANISATION OF HOSPITAL ACCREDITATION STANDARDS

5.1 The MSQH Accreditation Standards for Hospitals are grouped into five (5) focus areas, the performance level of which criteria are deemed to have impact on quality of service and safe care in the facility. They are:

i. Organisation and Management;
ii. Human Resource Development and Management;
iii. Policies and Procedures;
iv. Facilities and Equipment; and
v. Safety and Performance Improvement Activities.

5.2 The MSQH Accreditation Standards cover twenty-four (24) service standards with sub-sections covering a total of forty-four (44) services which are critical to the safe and quality of care given in hospitals, and have established criteria for each of them:

I. <u>Organisational wide Service Standards</u>

1. Governance, Leadership and Direction
2. Environmental and Safety Services
3. Facility and Biomedical Equipment Management and Safety
4. Nursing Services
5. Prevention and Control of Infection
6. Patient & Family Rights
7. Health Information Management System (HIMS)

II. <u>Service Standards</u>

8. Emergency Services
9. Clinical Services – Non-specialist Facility
   - 9A Clinical Services - Medical Related Services
   - 9B Clinical Services - Surgical Related Services
   - 9C Clinical Services - Obstetrics and Gynaecology Services
   - 9D Clinical Services - Paediatric Services
   - 9E Clinical Services - Cardiology Services

9F Clinical Services - Oncology Services

10. Anaesthetic Services
11. Operating Suite Services
12. Ambulatory Care Services
13. Critical Care Services: ICU/CCU/CICU/CRW/HDU/BURNS CARE UNIT
    - 13A Critical Care Services - SCN/NICU/PICU/PHDW
    - 13B Critical Care Services - Labour/Delivery Services
    - 13C Chronic Dialysis Treatment
14. Radiology/Diagnostic Imaging Services
15. Pathology Services
16. Blood Transfusion Services
17. Rehabilitation Medicine Services

    Allied Health Professional Services:
    - 17A Physiotherapy Services
    - 17B Occupational Therapy Services
    - 17C Dietetic Services
    - 17D Speech-Language Therapy Services
    - 17E Audiology Services
    - 17F Optometry Services
    - 17G Health Education Services
    - 17H Medical Social Services
    - 17I Psychology Counseling Services
    - 17J Clinical Psychology Services
18. Pharmacy Services
19. Central Sterilising Supply Services (CSSS)
20. Housekeeping Services
21. Linen Services
22. Food Services
23. Forensic Medicine Services
    - 23A Mortuary Services
24. Standards for General Applications
    - 24A Standards for Clinical Research Centre (CRC)

5.3 Each standard is reviewed and updated as and when feedback is received from the surveyors on issues of accuracy and interpretation. The technical contents and criteria are also updated in tandem with progress and changes in technology and best practices nationally and internationally.

B6 QUALITY MEASUREMENT FRAMEWORK

6.1 Dimensions of Quality

The quality of care shall be defined in the light of both technical standards and patients' expectations.

The most comprehensive and possibly the simplest definition of quality is that used by advocates of total quality management (W. Edwards Deming 1982): "Doing the right thing right, right away."

The following dimensions of quality have been adopted by MSQH and are used as the framework in the development of standards. Similar dimensions are also used for healthcare providers to define, analyse and measure the extent to which they are meeting the standards for clinical care and for management services that support service delivery. While all these dimensions are relevant to the various settings in healthcare, not all deserve equal weightage in every standard. Each dimension should be defined according to the local context and specific standards.

Accessibility: The degree to which healthcare services are unrestricted by geographic, economic, social, organisational or linguistic barriers.

Effectiveness of care: The degree to which desired results (outcomes) of care are achieved.

Efficiency of service delivery: The ratio of outputs of services to the associated costs of producing those services.

Continuity of services: Delivery of care by the same healthcare provider throughout the course of care (when appropriate) and appropriate and timely referral and communication between providers.

Safety: The degree to which the risks of injury, infection, or other harmful side effects are minimized.

Competency: Guarantee that an individual's knowledge and skills are appropriate to the service provided and assurance that the service provider's knowledge and skill levels are regularly evaluated.

Appropriateness: The degree to which service is consistent with a client's expressed requirements and has been provided in accordance with current best practice.

Patient Centred: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Responsiveness: The characteristics of respect for persons, client focus, encouraging client participation and client acceptability.

6.2 Performance Indicators

In the MSQH Hospital Accreditation Standards 5th Edition, specific Performance Indicators have been identified for each service standards. Healthcare facilities preparing to go for the Hospital Accreditation Survey are required to subscribe to these performance indicators. The MSQH **Performance Indicator Guidelines** describes the technical specifications i.e. rationale for the indicators, definitions, inclusion and exclusion criteria, numerators, denominators and data collection. It is hoped that this guidelines will assist healthcare facilities in the implementation of performance indicators as required under the MSQH current standards.

B7 FACILITY/HOSPITAL SELF-ASSESSMENT

Self-assessment, or self evaluation, is the underlying and fundamental basis of the accreditation process. Self-assessment serves as the mechanism by which hospitals evaluate their performance, on an ongoing basis, against a set of nationally accepted standards. The on-site survey represents merely an interim point when a hospital has its performance validated by external peer reviewers, and receives feedback on similar experiences and inputs of new ideas and techniques, to enable the facility to further improve its system, processes and minimise risks to ensure safer outcomes.

The self-assessment process is described below and reinforced in the summary guidelines preceding each standards document.

7.1 Identification of Teams or Working Groups

7.1.1 The focus of the accreditation program is each individual department or service. Thus the teams should be multidisciplinary healthcare teams. The self-assessment process requires the involvement of teams in each department or service unit, and encourages the participation of front-line as well as clinicians/executive staff. These teams work together and collaborate in assessing their level of compliance with the standards. They will eventually meet the surveyors for the peer review during the accreditation survey.

7.1.2 It is critical that the Person-In-charge of the facility leads the preparations for accreditation, and is involved in every step of the process. The management determines the number of teams and the members in each team who should complete the self-assessment using the MSQH standards as benchmark. MSQH recommends that depending on the size and complexity of the hospital, 10-15 teams should participate in the internal survey interview.

7.1.3 Each client/patient care team comprises of personnel who serve a particular group of clients/patients with similar needs and similar patterns of resource consumption. To identify these groups, the management of the hospital works from its vision and mission, through its goals and objectives and drills down to the types and scope of care, as well as the array of treatment regimen which is provided by the facility. Teams are preferably multi-disciplinary and cross-functional so that holistic care of patients needs are catered to.

7.2 Performance Rating

7.2.1 After the various working groups are formed, and the team members determined, each group works through the standards and discuss their level of compliance with each standard and the criteria within each standard. The team

identifies any shortfalls and implements ways and means of improvement to meet the standards and criteria. In this process, the team may use the Plan-Do-Check-Action cycle, with discussion and debate, followed by remedial action, until a consensus on ratings for the department or service unit is achieved.

7.2.2 Because self-assessments are conducted by teams that cut across departments, services and disciplines, and involves different levels of staff, it is imperative and important that individual teams and team members have an understanding of all sections of the standards document, and in-depth knowledge of the criteria which are applicable to his/her particular service area.

7.2.3 Self assessment at the facility continues on an iterative basis in all units and services until all standards and criteria are met with a rating either 4 or 3. It is recommended by MSQH that these discussions are incorporated or integrated into the regular meetings of units, sub-committees and committees, to help instill quality thinking and establish a culture of continuous improvement.

7.2.4 During the accreditation survey, surveyors compare the performance of the hospital against the standards and criteria, and record their assessments and observations. They will identify areas of excellence as well as areas which need further improvements. Areas of excellence will be recorded as commendations. The areas requiring improvement will be highlighted in the accreditation report as recommendations with clear references to the appropriate standard(s).

B8 ACCREDITATION SURVEY PROCESS

8.1 <u>The Accreditation survey serves to:</u>

- Assess the level of compliance of the hospital in the context of established Accreditation Standards;
- Provide experienced surveyors who act as educators during the survey process on the accuracy of self-assessment;

- Allow the surveyors to enable the hospital in upgrading its quality improvement activities through suggestion of ideas and guidelines for self-improvement wherever relevant.

8.2 Accreditation surveys are voluntary. Hospitals elect and choose to seek accreditation. The **decision to apply** for an accreditation survey therefore reflects the facilities' **commitment to examine and reflect on its own performance. Continuance with subsequent cycles of accreditation surveys is evidence of continued commitment of a learning organization to quality thinking and quality culture, and to use the skills and knowledge gained to continually improve organisational performance for the benefits of patients and staff.**

8.3 The Accreditation Survey Process involves a number of activities including onsite visits, team interviews, client interviews and documentation reviews. However, the most important aspect of the survey process is the team interviews by the surveyors.

8.4 <u>Notification of Survey & Pre-survey Logistics</u>

8.4.1 After approval of the application for survey, the hospital is notified of the tentative survey dates. This allows MSQH time to identify a suitable Chief Surveyor and team, find out their availability (both personally and officially) on the proposed dates, and arrange the logistics for the survey team to conduct the accreditation survey.

8.4.2 A Technical Officer who is assigned to facilitate the survey team will contact the Person-In-Charge of the hospital to be surveyed at least fourteen (14) days prior to the actual survey date to discuss the logistics in conducting the survey, namely transport, accommodation, tentative survey schedule, work space and expected administrative support for the surveyors during the survey.

8.4.3 Technical aspects discussed are the survey schedule, the facility representatives to the pre-survey briefing, and the conduct of the summation conference.

8.5 The Survey Team

8.5.1 Surveyors are usually given at least four (4) weeks notice of their participation in a survey, except for exceptional cases where a replacement is urgently required for someone who needs to withdraw at short notice. Matching surveyor competencies with the facility to be surveyed are described in the Policy for Surveyor Deployment.

8.5.2 MSQH nominates an experienced surveyor to be the Chief Surveyor, who will lead and coordinate the survey and the survey team members. He/She ensures that there are no internal or external conflict of interest issues during the survey. The Chief Surveyor acts as the spokesperson for the survey team.

8.5.3 **In some instances, a facility may be requested to permit the presence of Surveyor Observer(s) or non-Surveyor Observer(s). A Surveyor Observer is one who is undergoing a post-orientation observation survey preparatory to appointment as a full fledged surveyor. A non-Surveyor Observer may be a newly elected MSQH Board member, a new Councillor, a trainee MSQH staff, post-graduate students on elective posting at MSQH, or other persons who are nominated by MSQH to observe the survey process.**

8.6 Pre-Survey Assessment (PSA)

8.6.1 The PSA is the total documentation provided by the hospital through MSQH to the survey team, so that the surveyors can gain reasonable knowledge and understanding of the healthcare facility, its scope of services and dimensions of care provided, even before the survey team sets foot in the facility to be surveyed.

8.6.2 PSA requires the hospital to furnish the surveyors with relevant statistical information, pertinent description of facilities and of services provided, together with a completed set of survey documents, which shows the facility's self assessment of level of compliance to each standard and

criteria. This documentation shall be made available to MSQH not less than **six (6) weeks before the survey date**.

8.7 The Survey Process

8.7.1 The survey team normally arrives at the facility on the evening before the survey to allow the surveyors to settle in, and be given preliminary briefings by the Chief Surveyor in readiness for the survey proper which starts immediately after the pre-survey briefing at the hospital the next day. The surveyors conduct the survey according to the schedule proposed by the facility and as agreed by the survey team.

8.7.2 The Chief Surveyor briefs the hospital's representatives about the roles of each surveyor and any observer(s); confirms with the facility managers that all documentation for review is available, and allocate the surveyors according to the agreed survey schedule. He/she will troubleshoot whenever and wherever needed, and will ensure that the survey goes on effectively and efficiently.

8.7.3 The Chief Surveyor then finalises the assignment of the surveyors on the team to different areas in the healthcare facility as appropriate to their expertise and skill, ensuring that all service areas are covered.

8.7.4 Each Head of Department or head of service of a unit area will be interviewed by the surveyor assigned to that area, to assess that the level of compliance with the accreditation standards documented by the facility is factual and supported by physical findings and documentation. Some of the staff in the department may also be interviewed to assess consistency of practice with theory. Surveyors will observe actual work flow without interfering with daily operational activities of the service area. A random review is made of all documentation which supports the rating of compliance with the accreditation standards.

8.7.5 At the end of each day, the Chief Surveyor holds discussions with the survey team to countercheck and verify each other's findings and observations. This is to ensure that findings are

as accurate and comprehensive as possible and to facilitate inter-surveyor consistency. Any discrepancies in findings and/or opinions will be verified on site the next day, and any gaps in information remedied.

8.7.6 No document or information of any kind pertaining to the facility being surveyed is to be removed without the expressed consent (preferably in writing) of the owner, or Chief Executive Officer of the facility.

8.8 The Summation Conference

8.8.1 The purpose of the summation conference is for the **survey team to advise the facility in general terms of the major findings of the survey and opportunities for improvements.** This is necessary in order to highlight all important care areas which invoke any major recommendations, so that these are made known to the hospital, to ensure no surprises when the Survey Report is received. The summation conference also gives the **opportunity for the surveyors to receive any final clarifications and comments from the representatives of the facility, which might lead to refinement of the surveyors' comments.**

8.8.2 The summation conference is led by the Chief Surveyor with the full participation of the whole survey team. The duration of the summation conference may vary according to the size and complexity of the facility. Observers, surveyor or non-surveyor, do not participate in the Summation Conference.

8.8.3 The number and category of participants from the hospital at the summation conference should be agreed upon by prior discussion between Person-In-Charge of the hospital and the Chief Surveyor. The representatives from the healthcare facility should include the Hospital Director, members of the Executive Board, Medical Director (equivalent of Chief of Medical Staff) and selected heads of departments, whose presence will impact the future direction and performance of the hospital.

8.8.4 After the Chief Surveyor and all surveyors have given their brief commendations and areas for further improvements, the participants are given the opportunity to voice any doubts, request for clarification and other comments.

8.8.5 The summation conference is the final venue for discussion on any differing opinions, facts on the technical aspects of the survey, and compliance with the standards. **After the survey and the summation conference are over, there should be no communication or correspondence concerning the survey findings between the hospital with any member of the survey team.**

B9 AFTER THE SURVEY

9.1 At the summation conference, each member of the survey team may give the Person-In-Charge and the participants at the summation conference a statement on the general level of compliance with the accreditation standards, and impressions of the health care facility as had been observed and agreed by the team. **The surveyors do not give any indication of the accreditation status that will be recommended to MSQH**. All surveyors are expected to respect the confidentiality of any information learnt during the survey, and are not allowed to discuss any of their observations and findings after the survey is completed.

9.2 Soon after the Summation Conference, the Survey Team meets to discuss and agree on the surveyor ratings 4, 3, 2 or 1 for each criterion of every standard according to the service areas which have been surveyed. The MSQH facilitator acts as the secretary during this process to assist the Chief Surveyor.

9.3 All discussions on the observations and findings by the survey team, any commendations, and any recommendations should be completed on site. The surveyors document their comments and recommendations, modified as needed after team discussion, and submit their reports to the Chief Surveyor. The Chief Surveyor collates the surveyor ratings of each standard and criteria, completes a Survey Summary (which shows the departmental rating of 4, 3, 2 or 1 makes a summary of the surveyors' comments and

recommendations for all service areas, and writes the Chief Surveyor's Executive Summary Report for submission to MSQH.

9.4 After the surveyor rating is agreed for all criteria and standards and the rating for each department and unit is decided, the surveyors proceed to vote on the score and rating for the whole hospital which determines the recommended accreditation status for the hospital. The MSQH facilitator serves as the polling officer and recorder in this part of the process.

9.5 The survey team make recommendations to MSQH on the suggested Accreditation Status award for the facility surveyed by them. The detailed recommendations of the survey team for each service area together with the surveyors' ratings are forwarded to MSQH within one (1) week after completion of the survey. MSQH will process the information received as described under "Voting Mechanism" described in A8.

B10 SURVEY REPORT

10.1 The Hospital Survey Report is prepared by the Chief Surveyor with the secretarial support from MSQH and the technical officer who served as facilitator at the survey. This report contains comments on the areas of excellence and strength, as well as areas for further improvement in relation to the criteria and standards. The report should be completed within fourteen (14) days from the final survey date.

10.2 This report lists the following details and will form the guide by which the organization or facility could initiate and maintain their quality improvement activities:

- An evaluation of the key areas reviewed during the accreditation survey;
- Areas worthy of commendation;
- Results of any follow-up activity;
- Areas needing improvement;
- The accreditation status; and
- Validity period of the accreditation status.

APPENDIX I.

MSQH TRAINING AND EDUCATION PROGRAMMES

1. Awareness Education

Healthcare Facility which is yet to be accredited and is committed to learn more about the accreditation of healthcare facilities and services may request MSQH to conduct a talk or forum at its premises. This forum is meant to create awareness among the management and other relevant personnel regarding accreditation, its benefits and the process of self assessment. This educational session is particularly useful in situations when the Person-In-Charge of the facility is committed to the concept but unable to devote the time and energy to provide training and education for the managers, supervisors and other personnel.

The number of participants is limited only by the facility's resources. A nominal fee is payable to MSQH, in addition to reimbursing the traveling and accommodation expenses of the facilitator(s).

2. Training Workshop Package for Accreditation

MSQH currently offers training and workshop packages to hospitals which plan to undergo the accreditation process for the first time within the next 12 months.

This training package consists of session intended to introduce the subject of accreditation to managerial and executive staff of the hospital, followed by an interactive workshop for 40 to 50 persons who will be tasked to spearhead the accreditation process in the facility. The workshop will assist the hospital in conducting the gap analysis to seek evidence for compliance to the MSQH Standards. This workshop should also be attended by responsible persons from outsourced or contracted services, e.g. linen & laundry, food and catering, security and housekeeping, waste management, etc, wherever applicable.

The training and workshop package is a pre-requisite to application for the initial and first accreditation survey by MSQH. Depending on the state of preparedness of the healthcare facility seeking accreditation, the

training and workshop is recommended to be done at least 6 months before the survey.

Re-training or additional training, if deemed necessary, may be requested by the hospital management, or, recommended by MSQH in exceptional circumstances. Additional fees will apply.

3. Continuing Education Seminars and Courses

Depending on specific needs identified during the initial stages and subsequent cycles of preparation for accreditation survey, a healthcare organization or facility may request MSQH to send an expert from its governing body or panel of specialists to conduct special lectures and seminars at the hospital to update or upgrade the knowledge and skills of the staff. Examples of seminars which have been conducted in hospitals, in combination with other agencies and at other state level healthcare facilities are Medical Records, Infection Control, Safe Hospital Practices and Documentation of Policies and Procedures.

Educational courses targeted at facilitating quality improvement in other relevant areas are developed and organized as and when major areas of concern are identified by MSQH survey teams in the course of their assessment in various facilities.

From time to time, MSQH may organize regional and national level meetings, conferences and seminars relevant to quality improvement in healthcare facilities. These learning opportunities are made available by MSQH to ordinary and corporate members at a discounted rate.

Opportunities which are offered to MSQH to participate in local and international educational activities are offered to the surveyors or members of the Governing Body.

4. Training of Surveyors

MSQH surveyors are selected from a pool of senior healthcare personnel (e.g. Chief Executive Officers, General Managers, Executive Directors and/or Clinical Directors of healthcare facilities, Clinical Specialists, Directors of Nursing, Chief Nursing Officers and Senior Hospital Engineers) who have had at least 10-15 years in the provision of healthcare and healthcare related services. They must possess professional technical

and/or managerial expertise as well as necessary interpersonal and communication skills to fulfill their total role as **enablers, educators and evaluators**.

The selection of MSQH Surveyors follows stringent criteria. Potential candidates undergo special training in theory and practice before they are appointed as surveyors. Their training arms them with knowledge and understanding of the principles and requirements of the Hospital Accreditation Standards, so that they can objectively evaluate the level of compliance to MSQH standards, identify opportunities for commendation and improvement, and make recommendation for continuous quality initiatives.

After initial training, the selected candidates are required to undergo on-site practical training as an Observer Surveyor before they are deployed as a working member of a survey team.

APPENDIX II.

MSQH SURVEY DOCUMENTATION CHECKLIST

At the time of the survey, the survey team has to review many documents and records which will attest to the level of compliance to standards which the organization has achieved. Some of these documents, especially the current records, are located and may remain at the workplace to facilitate normal day-to-day operations. Other documents (especially the historical ones) may have been retrieved from storage.

It is recommended that all documentation required to be reviewed by the surveyors and which are not needed in the day-to-day delivery of services be placed in a suitably secure room within reasonable access by the surveyors. This may be the same room used by the survey team for discussions and report writing so that the documents are on hand for examination, further review and references while the surveyors discuss their observations and findings. A duplicate key to this room should be provided to the Chief Surveyor to allow access by the surveyors after normal work hours, if required.

Minutes of meetings should be available for the year prior to the survey, and should include terms of reference, committee membership and frequency of meetings.

- Written vision and mission statement and values;
- Strategic direction or plan for 3, 5 or 10 years;
- Operational or business plans for 1 or 2 years;
- Goals and objectives of the organization;
- Organisation chart with staff positions and job descriptions;
- Terms of reference of governing body, committees and sub-committees;
- Medical staff credentialing and privileging system;
- Compliance with current laws governing health care in Malaysia;
- Compliance with Ministry of Health policies, rules and regulations;
- Annual performance report;
- Facility floor plan; and
- Description of quality initiatives and the quality improvement system;
- Documented quality activities and projects;
- Policies and procedures directing work practice;
- Risk Management Plan;

- Reports of departures from policies and procedures;
- Minutes of meetings of Governing Body, committees and sub-committees;
- Agreements covering arrangements with contractors and sub-contractors;
- Human Resource policies and procedures;
- Human Resource policy manual or Employee Handbook;
- Staff induction, orientation and continued education programmes;
- Staff appraisal system;
- Response to recommendations from previous surveys, if applicable;
- Minutes, and supporting materials of meetings, of the governing body/owner(s) and its sub-committees;
- Minutes of management meetings;
- Minutes of Medical and Dental advisory committee, other committees and departmental meetings of the medical staff, except where prohibited by law;
- Minutes of professional committees and/or inter-professional advisory committees, if such committee exist;
- Minutes of meetings with community interest groups;
- Minutes of meetings of the residents' council/group, where such a group exists;
- The internal disaster plan, records of attendance at fire trainings, reports of fire and internal evacuation drills;
- The external disaster plan and report of the most recent external disaster exercise that involved government agencies such as the police, BOMBA (Fire Authority)
- Occupational health and safety reports;
- Most recent reports of visits from approving or accrediting agencies, where applicable, related to:

    - Diagnostic imaging
    - Fire safety, including inspection certificate
    - Laboratory
    - Drug control
    - Nuclear medicine
    - Occupational health and safety

- Medical staff and/or medical consultants manpower plan;
- Reports of private consultants, such as role studies, operational reviews, and other reports from funding or licensing sources;

- Reports of client/patient, staff, medical practitioners and volunteer surveys; and
- Client/patient and family letters of compliment and complaints, with follow-up action on problems identified.

The surveyors may also request access to review a sample of the following documents, where permitted by legislation:

- Patient Health records as evidence of a complete system;
- Credentialing and privileging system for medical staff;
- Records of credentialing and continued competency; and
- Personnel records.

APPENDIX III.

GUIDELINES FOR FOCUS SURVEY

The Focus Survey is conducted for a healthcare facility which has been awarded One Year Accreditation.

The facility is required, in the same way as for a full survey, to conduct a self assessment of all those departments/units which were rated 2 or 1. Other departments/units may also be surveyed. The findings are documented on the same edition of the survey standards documents. The self-assessment document, together with two copies of the latest service profile of the facility and a compliance report (recording responses to surveyor comments and recommendations in the survey report) must reach MSQH six (6) weeks before the focus survey date.

1. OBJECTIVE OF THE FOCUS SURVEY

A focus survey aims to:-

- assess the response and adherence of the healthcare facility to recommendations from the most recent survey,
- assess the level of compliance to standards in specific departments and services which were rated as 2 or 1
- ensure quality performance is maintained in the overall management of the facility in accordance with the Accreditation Status awarded
- assess whether the facility is eligible for an additional three (3) years Accreditation Status

2. SCOPE AND STRUCTURE OF THE FOCUS SURVEY

2.1. Scope and Duration of Survey

The focus survey is a follow up survey to a full survey which had been conducted within the past 12 months. Nonetheless, a thorough assessment is done on each of the areas of concern, that is, all departments or services which had been rated as 2 or 1.

The survey may take 1 to 2 days, depending on focus areas to be surveyed.

2.2. Format of Survey

The Focus Survey shall include:-

a) A briefing by the Person-In-Charge of the facility director or senior manager on compliance actions taken by the facility, with particular reference to those departments/services rated as 2 or 1.
b) A Focus Survey by the survey team on these areas of concern (site inspection, interview of staff and clients, review of documentation)
c) Random Survey on other departments or services to ascertain maintenance of compliance to standards
d) Debriefing/Summation Conference with Person-In-Charge of facilities, clinical representatives and other relevant key persons.

2.3. Survey Team and Surveyor Responsibilities

The survey team comprises of at least two (2) surveyors who had not participated in the previous survey of the facility. The actual number depends on the size of the facility and the number of foci to be assessed.

The responsibilities of the survey team include:-

i) An off-site review of the full Hospital Survey Report and the recommendations of the previous survey team to determine the task at hand.
ii) A thorough assessment of the entire department or service that received an overall rating 2 or 1.
iii) Re-assessment of all the criteria in other departments or services that were rated as 2 or 1.
iv) Identify and take note of any improved infrastructure or practice, and any remedial action or rectification works which have been undertaken through a review of documentation and observation.
v) Assess Safety and Performance Improvement Activities to note any further development in the range and type of activities.
vi) Note any addition or deletion of services in the facility in the past year.
vii) Hold a debriefing conference (similar to the summation conference) to discuss findings (without the ratings) with the Person-In-Charge and key personnel.

3. REPORTING AND ACCREDITATION STATUS DECISION

The surveyors confer on the current performance and level of compliance of the departments/services selected for assessment in the Focus Survey. The team takes into consideration the remedial actions and rectifications undertaken by the facility in response to the recommendations of the previous survey team.

The surveyors draw a consensus opinion on the award of accreditation status, based on their findings. Individual ballot voting is not required, although the recommendation to MSQH is made on the same Survey Team voting format.

A further three-year Accreditation is awarded if the focus survey team assesses the facility as having substantially complied with all relevant standards. The three-year award extends the accreditation period from the expiry of the one-year Accreditation period.

APPENDIX IV.

GUIDELINES FOR SURPRISE SURVEILLANCE SURVEY

1 SURPRISE SURVEILLANCE SURVEY

1.1 The Surprise Surveillance Survey is conducted to all accredited hospitals awarded a Four-Year Accreditation Status at the 24th month of accreditation period.

1.2 The facility is required, in the same way as for a full survey, to conduct a self-assessment of all departments/units.

1.3 MSQH will open the Surveillance Survey in electronic system16 weeks prior to the 24th month of the accreditation period.

1.4 This self-assessment document must reach MSQH through the electronic system six (6) weeks before 24th month of the accreditation period together with Standards and Assessment Tool for Chronic Dialysis Treatment (if applicable), two copies of the latest service profile of the facility, statistics on performance indicators and Endorsement Form (MSQH-Surv 25).

2 OBJECTIVE/RATIONALE

2.1 To ensure continuous compliance to Malaysian Society for Quality in Health (MSQH) Standards and foster CQI by MSQH Accredited Facilities and Services.

3 SURVEYORS FOR THE SURPRISE SURVEILLANCE SURVEY

3.1 MSQH CEO will select the team for the surprise surveillance survey. Each team constitutes a minimum of two (2) surveyors who were not involved as surveyors for the facility in the current cycle.

4 SELECTION OF SERVICES

4.1 Services selected for surprise surveillance survey to be related to Patient Safety and to include services rated overall as Partial Compliance/Non Compliance (PC/NC) in the previous survey.

5 NUMBER OF SURVEY DAY

5.1 One (1) day from 8:00am to 5:00pm

6 NOTIFICATIONS OF SURPRISE SURVEILLANCE SURVEY

6.1 Facility:
CEO shall inform the Person In Charge of the Facility two (2) weeks prior to the visit.

6.2 Surveyors:
One week before the date, the survey team shall be noted of their availability.

7 METHODS & ASSESSMENT

7.1 Surprise surveillance survey emphasis on general compliance to MSQH Standards for Healthcare Facilities Services (HCFS) especially for compliance to regulatory/statutory requirements and evidence of continuous quality improvement.

7.2 The Chief Surveyor will inform the facility on the selected services to be surveyed at the introduction briefing.

7.3 Surveyors will conduct the survey for services selected and validate the remedial actions taken on the recommendations from the previous survey.

7.4 A summation conference will be held at the end of the surprise surveillance survey. This summation conference shall be attended by the Person In Charge of the hospital and the Heads of Department.

8 REPORTING

8.1 On completion of the surprise surveillance survey, the survey team shall submit the report of its findings and recommendations to MSQH Secretariat.

9 ACCREDITATION STATUS DECISION

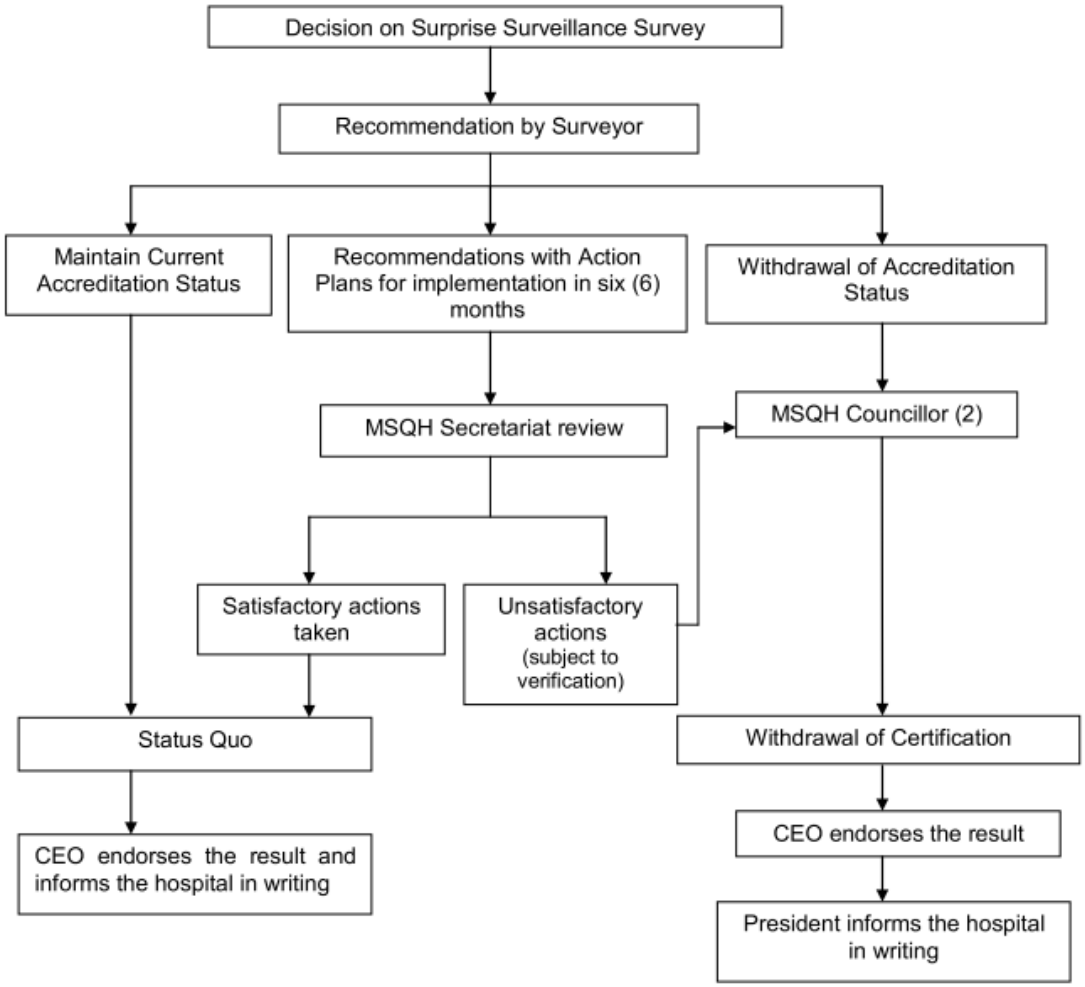
9.1 Decision on the continuation of the accreditation status will depend on the performance and impact on Patient Safety matters. The survey team will recommend one of the followings:

9.1.1 Maintain the current accreditation status

9.1.2 Recommendations with Action Plans for Implementation in six (6) months period subject to verification. The accreditation status for the Facility remains status quo.

9.1.3 Withdrawal of certification

Note:
Accreditation Status shall be withdrawn if the surprise surveillance survey reveals that safety and quality of care have been compromised by the facility. The MSQH shall submit the report to two (2) councillors for voting. In the event, no decision is reached; a third councillor will be requested to vote. Thereafter, the decision will be final.



ACCREDITATION STATUS DECISION FOR SURPRISE SURVEILLANCE SURVEY

APPENDIX V.
HOSPITAL ACCREDITATION STANDARDS, 5TH EDITION – STANDARD REFERENCE

No	Standard No.	Service Standard
1	1	Governance, Leadership & Direction
2	2	Environmental and Safety Services
3	3	Facility and Biomedical Equipment Management and Safety
4	4	Nursing Services
5	5	Prevention and Control of Infection
6	6	Patient and Family Rights
7	7	Health Information Management System
8	*8	Emergency Services
9	*9	Clinical Services - Non-specialist Facility *(for District hospitals)*
10	*9A	Clinical Services - Medical Related Services
11	*9B	Clinical Services - Surgical Related Services
12	*9C	Clinical Services - Obstetrics and Gynaecology Services
13	*9D	Clinical Services - Paediatric Services
14	*9E	Clinical Services - Cardiology Services
15	*9F	Clinical Services - Oncology Services
16	*10	Anaesthetic Services
17	*11	Operating Suite Services
18	*12	Ambulatory Care Services
19	*13	Critical Care Services - ICU/CCU/CICU/CRW/HDU/BURNS CARE UNIT
20	*13A	Critical Care Services - SCN/NICU/PICU/PHDW
21	*13B	Critical Care Services - Labour/Delivery Services
22	*13C	Chronic Dialysis Treatment
23	*14	Radiology/Diagnostic Imaging Services
24	*15	Pathology Services
25	*16	Blood Transfusion Services
26	*17	Rehabilitation Medicine Services
27	17A	Allied Health Professional Services - Physiotherapy Services
28	17B	Allied Health Professional Services - Occupational Therapy Services
29	17C	Allied Health Professional Services - Dietetic Services
30	17D	Allied Health Professional Services - Speech-Language Therapy Services
31	17E	Allied Health Professional Services - Audiology Services
32	17F	Allied Health Professional Services - Optometry Services
33	17G	Allied Health Professional Services - Health Education Services
34	17H	Allied Health Professional Services - Medical Social Services
35	17I	Allied Health Professional Services - Psychology Counselling Services
36	17J	Allied Health Professional Services - Clinical Psychology Services
37	*18	Pharmacy Services
38	19	Central Sterilising Supply Services (CSSS)
39	20	Housekeeping Services
40	21	Linen Services
41	22	Food Services
42	*23	Forensic Medicine Services
43	23A	Mortuary Services
44	24	Standards for General Application - Generic
45	24A	Standards for Clinical Research Centre

Clinical Services

APPENDIX VI.

GUIDELINES ON RATING SYSTEM – 5TH EDITION MSQH HOSPITAL ACCREDITATION STANDARDS

1. Use the following rating for each criterion in individual service standard and overall performance of each service standard to determine the level of compliance.

Rating	Rationale
4	**Excellent achievement**
	i(a) Rating of criteria in each service standard: 80% to 100% of evidence of compliance to the criteria have been achieved.
	i(b) For rating of overall performance of each service standard; an achievement of 80% to 100% of the maximum score of the applicable criteria shall be rated as 4. Example: The total score of criteria (numerator) divided by maximum score of applicable criteria (denominator). 128 (total score) x 100 = 80% 160 (4 x 40 applicable criteria)
3	**Good achievement**
	ii(a) Rating of criteria in each service standard: 60% to 79% of evidence of compliance to the criteria have been achieved.
	ii(b) For rating of overall performance of each service standard; an achievement of 60% to 79% of the maximum score of the applicable criteria shall be rated as 3. Example: The total score of criteria (numerator) divided by maximum score of applicable criteria (denominator). 96 (total score) x 100 = 60% 160 (4 x 40 applicable criteria)
2	**Fair achievement**
	iii(a) Rating of criteria in each service standard: 40% to 59% of evidence of compliance to the criteria have been achieved. For rating of 2, risk assessment needs to be performed.
	iii(b) For rating of overall performance of each service standard; an achievement of 40% to 59% of the maximum score of the applicable criteria shall be rated as 2. Example: The total score of criteria (numerator) divided by maximum score of applicable criteria (denominator). 64 (total score) x 100 = 40% 160 (4 x 40 applicable criteria)

Rating	Rationale
1	**Poor achievement**
	iv(a) Rating of criteria in each service standard: 0% to 39% of evidence of compliance to the criteria have been achieved. For rating of 1, risk assessment needs to be performed.
	iv(b) For rating of overall performance of each service standard; an achievement of 0% to 39% of the maximum score of the applicable criteria shall be rated as 1. Example: The total score of criteria (numerator) divided by maximum score of applicable criteria (denominator). 56 (total score) x 100 = 35% 160 (4 x 40 applicable criteria)

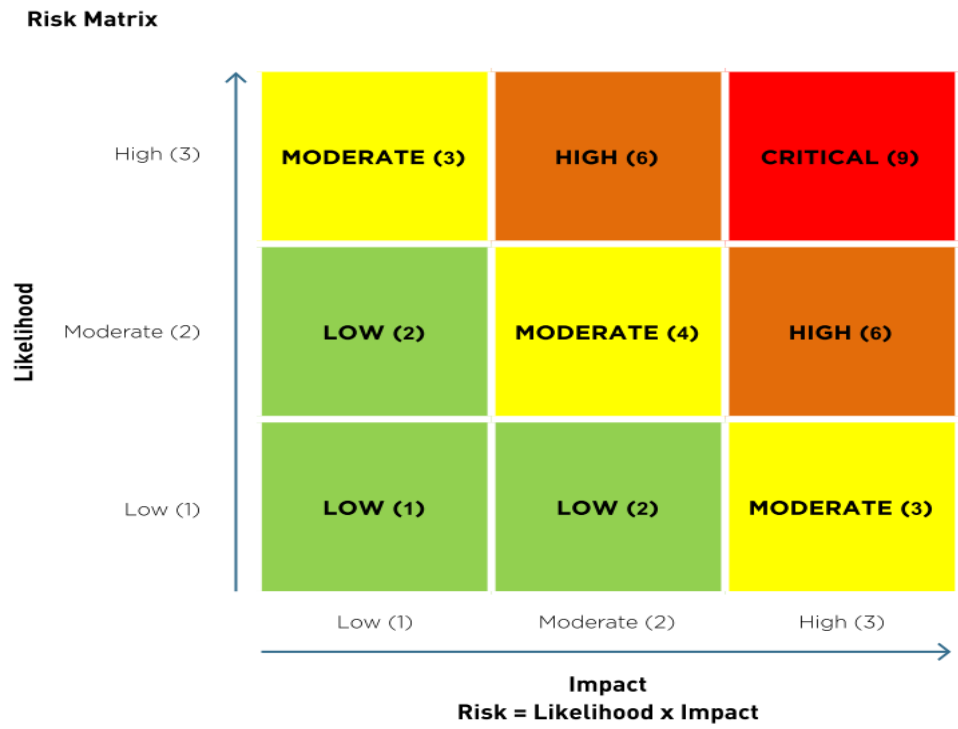
2. **Methodology for measuring overall achievement of each Service Standards**:

Every service standard shall be assessed and rated individually for the overall award accreditation status. The overall achievement of each service standard will be measured as follows:

a. Every core criterion shall achieve a rating of 4 or 3 to obtain the overall rating of 4 or 3 for the respective service standard.
b. All criteria achieving rating of 2 and 1 shall require risk assessment (by using the risk matrix). In the event, the overall risk is categorized as **Critical** and **High**, the overall rating of the service standard will be rated as 2 or 1.
c. Overall performance of each service standard is based on the impact on patient and staff safety.
d. For Centre of Excellence (COE) services to be listed in the certification award, the COE shall achieve overall rating of 4.
e. Criteria that are not applicable (NA) shall be excluded in the total tally of results for the specific service standards.

3. Risk Assessment

When a rating of 2 or 1 is given to any criterion during self-assessment, or by the survey team, a risk assessment needs to be carried out.



In completing the risk assessment, the risk associated with the criterion should be explicitly stated and a recommendation outlining how the risk will be addressed must be provided.

4. Not applicable (NA) criteria

a. In certain situation, depending on the type of facility, certain criteria in service standards may not be applicable to the facility.

b. Any criterion that is not applicable should be noted in the self-assessment under the Facility Comments and state why the criterion, or parts thereof, are not applicable.

c. Where the survey team finds evidence that the criterion is applicable (although indicated as not applicable by facility), this will be noted in the report and a rating given.

5. Award Status – Overall Facility Rating:

5.1 Four-Year Accreditation

5.1.1 For the award of Four-Year accreditation status, the Facility shall have to comply with the following requirements:

5.1.1.1 The following core service standards shall achieve overall rating of minimum 3:

i. Standard 1 - Governance, Leadership & Direction

ii. Standard 2 - Environmental and Safety Services
iii. Standard 3 - Facility and Biomedical Equipment Management and Safety
iv. Standard 4 - Nursing Services
v. Standard 5 - Prevention and Control of Infection
vi. Standard 6 - Patient and Family Rights
vii. Standard 7 - Health Information Management System (HIMS)

5.1.1.2 All clinical services standards including critical care services standards (Appendix V) shall achieve overall rating of at least 3.

5.1.1.3 Core criteria must achieve a rating 4 or 3 for the standards to reach compliance. However, a core criterion rating of 2 may be acceptable, if the risk associated with the criterion is **Moderate** or **Low** as calculated on the risk matrix and the necessary action can be achieved within 12 months post award.

5.1.1.4 For other services, where there is overall rating of 2 or 1, risk assessment (by using the risk matrix) is required and the risk is categorized as **Moderate** or/and **Low.**

5.1.1.5 Decision for awarding accreditation status takes into consideration:
i. overall impact of the hospital services assures patient safety;
ii. recommended score from the surveying team and councillors aggregated score.

Accreditation Status	**Four-Year Accreditation**
Score	**20 - 30**

5.1.2 Additional recommendation based on the achievement for Four-Year accreditation status:

i) Excellent Achievement:
- All Service Standards should achieve a rating of 4;
- No score of 2 or 1 for any criteria in all service standards (No risk assessment).

ii) Good Achievement:
- Four-Year accreditation status but do not qualify for Excellent Achievement.

5.2 One-Year Accreditation

a. The above requirements (5.1) are not met.
b. Areas for improvement and recommendations can be rectified within 12 months period before the Focus Survey

Accreditation Status	**One-Year Accreditation**
Score	**10 - 19**

5.3 Non Accreditation

a. The above requirements (5.1) are not met.
b. Areas for improvement and recommendations requires more than 12 months period to rectify.

Accreditation Status	**Non Accreditation**
Score	**1 - 9**

REFERENCES

1. Hospital Accreditation Survey Process Guide 4th Edition, Malaysian Hospital Accreditation Programme, June 2015
2. MSQH Surveyor Handbook, June 2015
3. ISQua: Guidelines and Principles for the Development of Health and Social Care Standards, 4th Edition Version 1.2, September 2015
4. The Australian Council on Healthcare Standards (ACHS), Risk Management and Quality Improvement Handbook. EQuIPNational, July 2013.
5. BS EN ISO31000:2009 Risk Management. Principle and Guideline, 2010-03-31