5TH EDITION MSQH HOSPITAL ACCREDITATION STANDARDS

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MSQH 5th Edition Hospital Accreditation Standards

What are the changes?

- The standards and assessment tool have been incorporated into one set of document to facilitate the hospitals and surveyors in the survey process.

- Evidence of compliance for each criterion is listed in the assessment tool to enable better understanding and interpretation of the standards by the service providers and also to avoid discrepancies in interpretation among the surveyors and between surveys.

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MSQH 5th Edition Hospital Accreditation Standards

- Core criteria have been identified in each service standard.
- Reviewed and refined criteria in the 4th Edition Hospital Accreditation Standards
- Additional special requirements, e.g. vector and pest control (Standard 2), indoor air quality (Standard 3), Patient Centred Care (Standard 6), Angiography (Standard 14), vending machine (Standard 22), etc.
- New rating system and accreditation status decision making process.

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LIST OF 5TH EDITION STANDARDS

4TH EDITION STANDARDS			5TH EDITION STANDARDS		
SN	STD NO.	STANDARD	SN	STD NO.	STANDARD
1	1	GOVERNANCE, LEADERSHIP & DIRECTION	1	1	GOVERNANCE, LEADERSHIP & DIRECTION
2	2	ENVIRONMENTAL AND SAFETY SERVICES	2	2	ENVIRONMENTAL AND SAFETY SERVICES
3	3	FACILITY AND BIOMEDICAL EQUIPMENT MANAGEMENT AND SAFETY	3	3	FACILITY AND BIOMEDICAL EQUIPMENT MANAGEMENT AND SAFETY
4	4	NURSING SERVICES	4	4	NURSING SERVICES
5	5	PREVENTION AND CONTROL OF INFECTION	5	5	PREVENTION AND CONTROL OF INFECTION
6	6	PATIENT AND FAMILY RIGHTS	6	6	PATIENT AND FAMILY RIGHTS
7	7	HEALTH INFORMATION MANAGEMENT SYSTEM	7	7	HEALTH INFORMATION MANAGEMENT SYSTEM
8	8	EMERGENCY SERVICES	8	8	EMERGENCY SERVICES

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4TH EDITION STANDARDS			5TH EDITION STANDARDS		
SN	STD NO.	STANDARD	SN	STD NO.	STANDARD
9	9	CLINICAL SERVICES (GENERIC)	9	9	CLINICAL SERVICES – NON-SPECIALIST FACILITY (FOR DISTRICT HOSPITALS)
10	9A	CLINICAL SERVICES - CARDIOLOGY SERVICES	10	9A	CLINICAL SERVICES – MEDICAL RELATED SERVICES
11	9B	CLINICAL SERVICES – ONCOLOGY 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
12	10	ANAESTHETIC SERVICES	16	10	ANAESTHETIC SERVICES
13	11	OPERATING SUITE SERVICES	17	11	OPERATING SUITE SERVICES
14	12	AMBULATORY CARE SERVICES	18	12	AMBULATORY CARE SERVICES

4TH EDITION STANDARDS			5TH EDITION STANDARDS		
SN	STD NO.	STANDARD	SN	STD NO.	STANDARD
15	13	CRITICAL CARE SERVICES (GENERIC) - Applicable for ICU, HDU, CCU, NICU, PICU & Burns Care Unit	19	13	CRITICAL CARE SERVICES - ICU/CCU/CICU/CRW/HDU/BURNS CARE UNIT
16	13A	CRITICAL CARE SERVICES - LABOUR/DELIVERY SERVICES	20	13A	CRITICAL CARE SERVICES - SCN/NICU/PICU/PHDW
17		CHRONIC DIALYSIS TREATMENT	21	13B	CRITICAL CARE SERVICES - LABOUR/DELIVERY SERVICES
			22	13C	CHRONIC DIALYSIS TREATMENT
18	14	RADIOLOGY/DIAGNOSTIC IMAGING SERVICES	23	14	RADIOLOGY/DIAGNOSTIC IMAGING SERVICES
19	15	PATHOLOGY SERVICES	24	15	PATHOLOGY SERVICES
20	16	BLOOD TRANSFUSION SERVICES	25	16	BLOOD TRANSFUSION SERVICES

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4TH EDITION STANDARDS			5TH EDITION STANDARDS		
SN	STD NO.	STANDARD	SN	STD NO.	STANDARD
21	17	REHABILITATION MEDICINE SERVICES	26	17	REHABILITATION MEDICINE SERVICES
		ALLIED HEALTH PROFESSIONAL SERVICES			ALLIED HEALTH PROFESSIONAL SERVICES
22	17A	PHYSIOTHERAPY SERVICES	27	17A	PHYSIOTHERAPY SERVICES
23	17B	OCCUPATIONAL THERAPY SERVICES	28	17B	OCCUPATIONAL THERAPY SERVICES
24	17C	DIETETIC SERVICES	29	17C	DIETETIC SERVICES
25	17D	SPEECH-LANGUAGE THERAPY SERVICES	30	17D	SPEECH-LANGUAGE THERAPY SERVICES
26	17E	AUDIOLOGY SERVICES	31	17E	AUDIOLOGY SERVICES
27	17F	OPTOMETRY SERVICES	32	17F	OPTOMETRY SERVICES
28	17G	HEALTH EDUCATION SERVICES	33	17G	HEALTH EDUCATION SERVICES
29	17H	MEDICAL SOCIAL SERVICES	34	17H	MEDICAL SOCIAL SERVICES
30	17I	PSYCHOLOGY COUNSELLING SERVICES	35	17I	PSYCHOLOGY COUNSELLING SERVICES
31	17J	CLINICAL PSYCHOLOGY SERVICES	36	17J	CLINICAL PSYCHOLOGY SERVICES

4TH EDITION STANDARDS			5TH EDITION STANDARDS		
SN	STD NO.	STANDARD	SN	STD NO.	STANDARD
32	18	PHARMACY SERVICES	37	18	PHARMACY SERVICES
33	19	CENTRAL STERILISING SUPPLY SERVICES (CSSS)	38	19	CENTRAL STERILISING SUPPLY SERVICES (CSSS)
34	20	HOUSEKEEPING SERVICES	39	20	HOUSEKEEPING SERVICES
35	21	LINEN SERVICES	40	21	LINEN SERVICES
36	22	FOOD SERVICES	41	22	FOOD SERVICES
37	23	FORENSIC MEDICINE SERVICES	42	23	FORENSIC MEDICINE SERVICES
38	23A	MORTUARY SERVICES	43	23A	MORTUARY SERVICES
39	24	STANDARDS FOR GENERAL APPLICATION - GENERIC	44	24	STANDARDS FOR GENERAL APPLICATION - GENERIC
			45	24A	STANDARDS FOR CLINICAL RESEARCH CENTRE
			46	25	MEDICAL ASSISTANT SERVICES

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SURVEY ITEM & SELF-ASSESSMENT	
SERVICE STANDARD 1 : GOVERNANCE, LEADERSHIP AND DIRECTION	
	PREAMBLE *Each Facility shall have a body ultimately responsible for all aspects of the Facility's operations. This is commonly called the Board of Directors/Facility Management or other similar name. For the purposes of these Standards, this group shall be called "The Governing Body". The Governing Body may delegate its duties and functions to the Person In Charge (PIC) of the Facility who shall be responsible for the organisation, management and control of the Healthcare Facility and services.* *For private healthcare facilities, a license or registration is required which relates to the services.*
TOPIC 1.1 STANDARD 1.1.1	**ORGANISATION AND MANAGEMENT** *The Governing Body shall adopt a governing framework that constitutes the internal legislation that will meet the particular needs and complexities of the management of the Facility and the range of services. These may be called Facility Operational Policies and Medical Staff By-Laws, which include Rules and Regulations, Terms of Reference, Policies, Resolutions or other similar terms and they shall govern the actions of the Board and Management of the Facility. The governing framework is essential for the governance of the Facility.*

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
1.1.1.1	The Governing Body shall ensure that the Vision, Mission and values statements, goals and objectives are identified, clearly documented and measurable; these reflect the Facility's roles and aspirations in the community that it serves. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.			
	EVIDENCE OF COMPLIANCE 1. Vision, Mission and values statements, goals, and objectives of the Facility are available; endorsed and dated by the Governing Body. ☐ 2. Evidence of planned reviews of the above statements. ☐			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
	3. These statements are communicated to all staff (orientation programme, minutes of meeting, etc). ☐ 4. Achievement of goals and objectives are monitored, reviewed and revised accordingly. ☐ Facility Comments:			
1.1.1.2	The Governing Body shall ensure that in defining the roles of the Facility, the needs of the community to be served are addressed and shall include policies and procedures on Patient and Family Rights with input from the Board of Visitors. EVIDENCE OF COMPLIANCE 1. Board of Visitors ☐ 2. Policy on Patient and Family Rights ☐ 3. Patient's charter ☐ Facility Comments:			
1.1.1.3 CORE	The Governing Body shall adopt a governing framework in accordance with statutory and other legal requirements. EVIDENCE OF COMPLIANCE 1. License to operate (Private Healthcare Facility)/Gazettement letters and supporting documents (Public Healthcare Facility) ☐ 2. Appointment of full time Person In Charge (PIC) in accordance with the Fourth Schedule in Private Healthcare Facilities and Services Act 1998 and Regulations 2006. ☐ 3. Facility Operational Policies ☐ 4. Medical Staff By-Laws ☐ Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 1.2:	**HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT**
STANDARD 1.2.1	***The Governing Body shall make adequate provision for the delegation of authority to the Person In Charge to ensure the achievement of the Facility's Vision, Mission, values, goals and objectives.***

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
1.2.1.1	The Person In Charge (PIC) acts in accordance with the policies, delegated authority, and instructions of the Governing Body; and is responsible for the organisation, management and control of the Facility. EVIDENCE OF COMPLIANCE 1. Authorisation of all policies within the Facility ☐ 2. Chairing of Credentialing and Privileging Committee ☐ 3. Establish Continuing Medical Education (CME) Committee ☐ 4. Establish/conduct Professional and Disciplinary Committee meetings ☐ Facility Comments:			
1.2.1.2	The Person In Charge (PIC) shall attend all meetings of the Governing Body. EVIDENCE OF COMPLIANCE 1. Attendance of PIC in minutes of meetings of Governing Body. ☐ Facility Comments:			
1.2.1.3	The performance of the Person In Charge (PIC) shall be regularly reviewed by the Governing Body.			

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 1.3:	**POLICIES AND PROCEDURES**
STANDARD 1.3.1	***The Governing Body through the Person In Charge (PIC) shall ensure that documented and dated policies and procedures in line with the requirements of the relevant regulations are available to guide all staff, including medical practitioners and locums, patients and visitors in respect of the operations of the Facility.***

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
1.3.1.1	In determining policies and procedures, the Person In Charge (PIC) shall consider both external and internal factors relevant to the Facility and shall ensure that policies are: a) clearly articulated in understandable language; b) recorded in policy manuals; c) determined only on the basis of adequate information and consultation; d) able to guide those making decisions; e) capable of being implemented; f) relevant with current Acts, Regulations and By-Laws. EVIDENCE OF COMPLIANCE 1. Facility-wide Operational Policies ☐ 2. Medical Staff By-Laws ☐ 3. Departmental policies and procedures ☐ 4. Policies are relevant with current Acts, Regulations and By-Laws. ☐ Facility Comments:			
1.3.1.2	The Person In Charge (PIC) shall ensure that the activities of the Facility are monitored and consistent with written policies. EVIDENCE OF COMPLIANCE 1. Results of audits ☐ 2. Reports on supervisory visits (24 hours nursing report) ☐ 3. 24 hours Facility reports (Maintenance Department's report) ☐			

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 1.4:	**FACILITIES AND EQUIPMENT**
STANDARD 1.4.1	***The Governing Body through the Person In Charge (PIC) has the overall responsibility for ensuring the provision of appropriate facilities and equipment so as to enable the achievement of the objectives of the Facility, in keeping with relevant Acts, Regulations and By-Laws.***

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
1.4.1.1	The Person In Charge (PIC) ensures that facilities and equipment are adequate and safe for the level of services provided. EVIDENCE OF COMPLIANCE 1. Adequate facilities and equipment at each patient care area for safe care. ☐ 2. Appropriate type of equipment to match the complexity of services. ☐ 3. Planned replacement of equipment based on life cycle reports. ☐ 4. Planned refurbishment of the Facility/new facilities ☐ 5. Provision for budget allocation ☐ 6. Establishment of Procurement Committee ☐ Facility Comments:			
1.4.1.2 CORE	There is evidence that the Facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order. EVIDENCE OF COMPLIANCE 1. Planned Preventive Maintenance records, such as schedule, stickers, etc. ☐ 2. Planned Replacement Programme where applicable ☐ 3. Complaint records ☐ 4. Asset inventory ☐ Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT				
TOPIC 1.5:	**SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES**			
STANDARD 1.5.1	***The Governing Body through the Person In Charge (PIC) shall establish, implement and monitor Risk Management Programme with a systematic and effective safety and performance improvement plan throughout the Facility as required under the relevant Acts, Regulations and By-Laws.***			
	CRITERIA FOR COMPLIANCE:	SELF RATING	**SURVEYOR FINDINGS**	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
1.5.1.1 CORE	The Risk Management Programme refers to planned and systematic safety and performance improvement activities that shall include but not limited to risk reduction activities such as Mortality and Morbidity Reviews, Incident Reporting and Grievance Mechanism.			
	EVIDENCE OF COMPLIANCE 1. Establishment of Risk Management Committee or unit. ☐ 2. Implementation and monitoring of risk assessment activities:- a) Risk Register; ☐ b) Risk assessment reports; ☐ c) Root Cause Analysis (RCA) report; ☐ d) action plans; ☐ e) remedial measures; ☐ f) clinical audit (mortality and morbidity review, etc). ☐ Facility Comments:			
1.5.1.2	There are clearly assigned responsibilities for safety and performance improvement activities within the services.			
	EVIDENCE OF COMPLIANCE 1. Assigned officers ☐ 2. Letter of appointment/assignment ☐ Facility Comments:			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
1.5.1.3	The Risk Management System addresses World Health Organization (WHO) Global Patient Safety Initiatives and Malaysian Patient Safety Goals. a) World Health Organization (WHO) Global Patient Safety Challenges and Patient Safety Solutions (Appendix 1.a) b) Malaysian Patient Safety Goals (Appendix 1.b). The reporting system is through the "e-goals-patient safety" of the Ministry of Health, http://patientsafety.moh.gov.my/ as indicated in the Director General of Health, Malaysia's circular (Ref: KKM/87/P3/10/8/0Jld 7(11). EVIDENCE OF COMPLIANCE 1. Report on implementation of World Health Organization (WHO) Global Patient Safety Initiatives as indicated in the Appendix 1.a. ☐ 2. Report on implementation of Malaysian Patient Safety Goals as indicated in the Appendix 1.b. ☐ Facility Comments:			
1.5.1.4 CORE	There is tracking and trending of the following specific performance indicators for the service: a) percentage of patients leaving hospital against medical advice relative to all patients hospitalised within a specified period. b) percentage of incidents/accidents during hospitalisation of patients as percentage of all admitted patients. c) hospital wide patient satisfaction survey (six monthly basis) d) In addition, healthcare facilities are required to monitor any other two (2) indicators with tracking and trending analysis to support its goals and objectives.			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
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	a) The cardiologists undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities: i) as a single committee for all safety and performance improvement activities; ii) in multidisciplinary committees within the service; iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc. b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function. EVIDENCE OF COMPLIANCE 1. Performance improvement activities ☐ 2. Minutes of meetings ☐ 3. Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc. ☐ Facility Comments:			
9E.5.1.5 CORE	There is tracking and trending of specific performance indicators of the following where appropriate: a) electrocardiogram taken within 10 minutes after triaging as possible Acute Coronary Syndrome patients (Target: 100%) b) mortality and morbidity review of patients with acute myocardial infarction (Target: Mortality review - 100%; Morbidity discussion based on the department's discretion) c) Thrombolytic Therapy within 30 minutes after hospital arrival in patient with acute myocardial infarction "Door to Needle" Time (Target: 90%) d) percentage of patient who received Thrombolytic Therapy (TT) in patients admitted for acute myocardial infarction (Target: 90%)			

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
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	e) percentage of "Normal" Diagnostic Angiogram (Target: <5%) f) major complication rate during Diagnostic Coronary Angiogram (Death, acute myocardial infarction, stroke) (Target: <1%) g) major complication rate during Percutaneous Coronary Intervention (Death, acute myocardial infarction, stroke) (Target: ≤1%) h) Percutaneous Coronary Intervention (PCI) within 90 minutes after diagnosed as acute myocardial infarction "Door to Balloon" Time (Target: 90%)			
	EVIDENCE OF COMPLIANCE 1. Specific performance indicators monitored. ☐ 2. Records on tracking and trending analysis. ☐ 3. Minutes of mortality/morbidity audits meetings ☐ 4. Remedial measures taken where appropriate ☐			
	Facility Comments:			
9E.5.1.6	Feedback on results of safety and performance improvement activities are regularly communicated to the staff.			
	EVIDENCE OF COMPLIANCE 1. Results on safety and performance improvement activities are accessible to staff. ☐ 2. Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings. ☐ 3. Minutes of service/unit/committee meetings ☐			
	Facility Comments:			

SURVEY ITEM & SELF-ASSESSMENT	
TOPIC 2.6:	**SPECIAL REQUIREMENTS**
STANDARD 2.6.1	***SAFETY AND HEALTH PROGRAMMES*** ***The Management of the Facility promotes Occupational Safety and Health programmes that ensure a safe and healthy environment for patients, staff, visitors and outsourced service providers.***

	CRITERIA FOR COMPLIANCE:	SELF RATING	SURVEYOR FINDINGS	
			AREAS FOR IMPROVEMENT / RECOMMENDATIONS & RISK ASSESSMENT	SURVEYOR RATING
2.6.1.1 CORE	There is a multidisciplinary Occupational Safety and Health (OSH) Committee for the purpose of planning, implementing and maintaining a comprehensive workplace safety programme including monitoring and reporting on incidents and accidents related to workplace safety and health of staff, in compliance with the Occupational Safety and Health Act (OSHA) 1994.			
	EVIDENCE OF COMPLIANCE: 1. OSH Committee is established. ☐ 2. Organisation chart of OSH Committee ☐ 3. Terms of Reference of the OSH Committee ☐ 4. Schedule of meetings for the year ☐ 5. Minutes of meetings ☐			
	Facility Comments:			
2.6.1.2	The Occupational Safety and Health (OSH) Committee shall be headed by top Management and supported by a Safety and Health Officer (SHO) registered with Department of Occupational Safety and Health (DOSH). The composition of the committee shall follow Occupational Safety and Health Act (OSHA) 1994 requirements. The letter of appointments shall clearly define the authority, responsibilities and accountabilities for the committee members.			
	EVIDENCE OF COMPLIANCE: 1. Composition of the Committee is in accordance to the OSH Act 1994:			

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THANK YOU

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