Patient Safety Unit
Quality in Medical Care Section
Medical Development Division
Ministry of Health
&
Patient Safety Council of Malaysia

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  - YBhg. Dato' Sri Dr. Hasan bin Abdul Rahman

- Members of the Patient Safety Council of Malaysia

- Technical Coordinators of the Patient Safety Council of Malaysia: Patient Safety Unit, Quality in Medical Care Section, Medical Development Division, MOH.

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Technical Coordinators of the Patient Safety Council of Malaysia
Patient Safety Unit
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Ministry of Health Malaysia
2013

FOREWORD

BY THE DIRECTOR-GENERAL OF HEALTH, MALAYSIA
CHAIRMAN OF THE PATIENT SAFETY COUNCIL OF MALAYSIA

The Ministry of Health has a *"Vision for Health"* which mandates the development of a safe healthcare system that is attained through the coordinated efforts of all the major stakeholders, which is why the Patient Safety Council was set up in 2003 by decree of the Malaysian Cabinet. This Council is entrusted with the very challenging responsibility of leading national efforts in ensuring a safe Malaysian health care system.

However, in our noble quest and zest to attain patient safety, we must be mindful of the fact that patient safety is a very tough problem. Prof. Charles Vincent, an international expert in patient safety once said, *"In health care, we are beginning to understand how difficult the safety problem is, in cultural, technical, clinical and psychological terms NOT TO MENTION its massive scale and heterogeneity"*. This is because its scope is enormous as health care is extraordinarily diverse in terms of activities involved and the way it is delivered, from the hospitals to primary care, dental services, laboratory services etc.

Patient Safety can be defined as the avoidance, prevention, detection and amelioration of adverse outcomes or injuries stemming from the process of health care. In addition, it also refers to the amelioration of adverse outcomes or injuries, i.e. the need for rapid medical intervention to deal with the immediate medical mishap. It also includes the need to care for injured patients and to support the unfortunate staff involved (often termed as the "second victim of medical errors") in the serious incident.

In this electronic age of quick solutions, the sad reality is that there are no "magic bullets" or easy solutions for this very serious problem, which has the potential to undermine the trust that the public has for the medical professions, as the champions and the guardians of the patient safety. Prof. Vincent demonstrated this by saying that: *"One of the greatest obstacles to progress on patient safety is, paradoxically, the attraction of "neat solutions, whether political, organisational or clinical"*.

The Safety Council has been promulgating the adoption of a "systems approach" to patient safety i.e. errors are more commonly caused by faulty systems, processes, and conditions that cause people to make mistakes or fail to prevent them. This is because, the reality in medicine

is that there is much uncertainty and complexity .....in history-taking, diagnosis, investigations and finally treatment. However, this does not absolve the health care professional from individual accountability for the demonstration of a high level of professional competence, which has always been the key to professionalism, a value much honoured by the medical profession.

Developing a safe Malaysian health care system necessitates the institutionalization of a culture of quality and safety. One of the ways that this can be achieved is through the implementation of Patient Safety Goals, which focus our attention to key areas for patient safety. While these goals "do not tell the whole picture", in view of the enormity of the issue of patient safety, they are useful as a baseline to further improve patient safety in Malaysia. Needless to say, these Safety Goals will be further refined upon or expanded as we progress in this vital field of Clinical Risk Management and Patient safety.

A safe culture can only BEGIN TO BE engineered into our healthcare system or organisations, when we adopt a "just and non-blaming culture". One of the important products of a non-blaming culture is a mandatory "Incident Reporting and Learning System" where national data can be obtained regarding "Clinical Incidents" and "Root Cause Analyses" are conducted to investigate the incidents in order to determine the contributory factors for certain high priority incidents. In fact, an Incident Reporting System is one of the Patient Safety Goals for Malaysia. The MOH believes that *"A clever person learns from his or her mistakes while a wise person learns from the mistakes of others".*

A National Report Card on patient safety is the outcome of this ambitious endeavor by the Patient Safety Council. The patient safety KPIs that accompany these Safety Goals 2013 indicators will provide a strong impetus for the measurement and improvement of patient safety in all Malaysian health care institutions.

"Safety is everyone's business! Let us all work together in the spirit of teamwork and learning to make our health care system a safer one in 2013 and beyond! "Success does not consist in never making mistakes but in never making the same one a second time".

Datuk Dr. Noor Hisham bin Abdullah
Director-General of Health Malaysia

MESSAGE

BY THE DEPUTY DIRECTOR-GENERAL OF HEALTH (MEDICAL)

Rapid scientific development in the field of clinical research and clinical practice leading to new modalities of treatment , makes it necessary for healthcare providers to ensure that the safety of patients is guaranteed at all times. Patients must be protected from unethical practices and harmful treatment or procedures.

Medicine is viewed as a noble profession and patients come to us seeking treatment in the belief that we will provide them with the best possible solution or cure for their ailment. As such, it is our moral and professional responsibility to ensure that this trust in the profession is upheld at all times.

Patient safety is an integral part of Clinical Governance; as such, all practitioners of clinical governance will automatically be advocates of patient safety. The term "clinical governance" is a combination of several activities which have and are being practised in most Ministry of Health hospitals. For years we have, been carrying out various activities which measure the quality of the delivery of healthcare by activities such as such as NIA and quality assurance.

The Ministry of Health has and will always promote patient safety, for example in 2005, we conducted the first local study on the prevalence of adverse events and we had a rate of 3% which is comparable if not better that many developed nations.

In an effort to ensure that staff are up-to-date with the current medical advances, we have implemented various activities that ensure continuous professional development such as CME and CPD and in some centers we also carry out research.

To ensure patient complaints and other grievances are dealt with in an effective manner, we have various mechanisms to deal with these complaints such as in-hospital reviews with root cause analysis and when indicated, independent investigations.

Collectively, all these above-mentioned activities constitute clinical governance.
WHO places great emphasis on patient safety, so much so in October 2004 , they launched the World Alliance for Patient Safety. Malaysia ratified this alliance in May 2006 becoming one of the pioneering members of this global effort to enhance patient safety.

Today's patients are educated and empowered persons, who demand a lot from the healthcare system. They have access to a wide variety of information from the media and as such, it is our duty to ensure that they acquire the right knowledge. Once that is done, then, we can empower them to take a certain amount of responsibility of their own health.

Based on the number and types complaints that are received from patients or the care-givers, a vast majority can be attributed to human factors. They can be categorized as being due to lack of adequate communication, either between the care provider and the patient or their relatives resulting misunderstanding leading to undue worry.

We must move to an era where there has to be adequate communication between all parties involved in the care of the patient. It has been shown in hospitals where this is practised, there has been improvement in patient safety and improved patient satisfaction.

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Introduction

"Malaysian Patient Safety Goals: Guidelines on Implementation and Surveillance" explains the details of the Goals as well as the implementation and surveillance for their associated Key Performance Indicators.

It describes the 13 Patient Safety Goals, the technical specification of the associated 19 KPIs, i.e. definitions, criteria, indicators, numerators, denominators and targets as well as the data collection format. It is hoped that these guidelines will assist healthcare facilities in the implementation and surveillance of Patient Safety Goals so that objective evaluation on the status of patient safety in Malaysia can be made.

Background

The Patient Safety Council of Malaysia is committed to establishing a safe Malaysian healthcare system. Hence, the Malaysian Patient Safety Goals were developed by the Patient Safety Council of Malaysia to encourage and challenge our healthcare organizations to improve some of the most significant, challenging and enduring patient safety issues in Malaysia. These goals are applicable to both public and private healthcare facilities in Malaysia.

The Malaysian Patient Safety Goals will allow systematic monitoring and evaluation of patient safety status in Malaysia. The first version of these goals was prepared by Dr. PAA Mohamed Nazir bin Abdul Rahman and included 15 goals and 59 KPIs. Subsequently, Dr. Nazir and Dr. Nor'Aishah, through a series of consultative meetings with the key stakeholders, reduced them to a more implementable 13 safety goals and 19KPIs.

The goals, strategies, key performance indicators and targets are based on the WHO's as well as international goals for patient safety as well as national issues. They were developed as a result of discussions with various stakeholders including the MSQH, University Hospitals, the Malaysian Medical Association, other associations, hospital directors and clinicians as well as discussions with Sir Liam Donaldson (Advisor to WHO Director-General on strategic issues in patient safety and former Principal Advisor to National Health Services, United Kingdom).

Intent of The Malaysian Patient Safety Goals

1. To stimulate healthcare organizations to improve key patient safety areas as well as patient safety in general
2. To outline important patient safety areas that need to be focused on and improved upon
3. To provide a measurable (and improvable) "bird's eye view" or "dashboard" of the status of patient safety in public as well as private health care facilities in Malaysia
4. Their associated KPIs will act as "Performance Measurement Tools" in areas that are critical to a safe healthcare system
5. An objective means for the Patient Safety Council of Malaysia to monitor and evaluate as well as improve the status of patient safety in the country

Philosophy of The Malaysian Patient Safety Goals

"Patient safety is a key dimension of quality in health care and should be given prime importance by the healthcare fraternity. If possible, preventable adverse events should be avoided, at all costs"

Strategic Directions of The Malaysian Patient Safety Goals

1. Ensure a systematic framework for healthcare sectors by integrating quality, safety and risk management
2. Manage major and significant aspects of safety risk to patients receiving healthcare
3. Implement evidence-based best practices, safety measures and solutions
4. Assess and understanding issues of unsafe care

Each strategy underpins the goal/ goals and performance indicator/s.

Table 1: Summary of Strategic Directions, Goals, Key Performance Indicator (KPI), Target and Frequency of Data Collection

Key Areas for Safety Goals	Goal No.	Patient Safety Goals	KPI	Target	Frequency of Data Collection
#1: Implementing a systematic framework for the health care sector by integrating quality, safety and risk management through Clinical Governance	*1	To implement Clinical Governance	1. Implementation of Clinical Governance (CG) in all relevant health care facilities	All elements of CG implemented by all relevant health care facilities	Yearly
#2: Managing major and significant aspect of safety risk to patients receiving health care	2	To implement the WHO's 1st Global Patient Safety Challenge: " Clean Care is Safer Care"	2. National Hand hygiene compliance rate	≥ 75% at each audit	Quarterly
	3	To implement the WHO's 2nd Global Patient Safety Challenge: "Safe Surgery Saves Lives"	3. Number of "wrong surgeries" performed	Zero (0)	Monthly
			4. Number of cases of unintended "retained foreign body"	Zero (0)	
	4	To implement the WHO's 3rd Global Patient Safety Challenge: "Tackling Antimicrobial Resistance"	5. Incidence rate of MRSA infection	≤ 0.4%	Monthly
			6. Incidence rate of ESBL – Klebsiella pneumoniae infection	≤ 0.3%	Monthly
			7. Incidence rate of ESBL – E.coli infection	≤ 0.2%	Monthly
#3: Implementing evidence-based "best practice" and safety measures	5	To improve the accuracy of patient identification	8. Compliance rate for "At least 2 identifiers implemented"	100%	6 monthly
	6	To ensure the safety of transfusions of blood and blood products	9. Number of transfusion errors ("Actual")	Zero (0)	Monthly
			10. Number of transfusion errors ("Near Misses")	To be determined later pending national data analysis and trending	Monthly

Strategic Directions	Goal No.	Goals	KPI	Target	Frequency of Data Collection
	*7	To ensure medication safety	11. Number of Medication errors ("Actual")	Zero (0)	Monthly
			12. Number of Medication errors ("Near Misses")	To be determined later pending national data analysis and trending	
#3: Implementing evidence-based "best practice" and safety measures	8	To improve clinical communication by implementing a critical value programme	13. % of critical values notified within 30 minutes	100%	Monthly
	*9	To reduce patient falls	14. Percentage reduction in the number of falls (adult patients)	A 10% reduction each year based on the previous year's data as a baseline	Monthly
			15. Percentage reduction in the number of falls (pediatric patients)	A 10% reduction each year based on the previous year's data as a baseline	
	10	To reduce the incidence of healthcare-associated pressure ulcers	16. Incidence rate of pressure ulcers	≤ 3%	Quarterly
	**11	To reduce Catheter-Related-Blood-stream Infection (CRBSI)	17. Rate of CRBSI	<5 per 1000 catheter days	Monthly
	**12	To reduce Ventilator Associated Pneumonia (VAP)	18. Rate of VAP	<10 per 1000 ventilator days	Monthly

Strategic Directions	Goal No.	Goals	KPI	Target	Frequency of Data Collection
#4: Assessing and understanding issues of unsafe care	*13	To implement an Incident Reporting and Learning System	19. Implementation of a facility-wide Incident Reporting system (including Root Cause Analysis) or other methods to investigate incidents (e.g. clinical audit, enquiries etc.)	System implemented	Yearly

Remark

- All goals are applicaple to hospitals except ** Goals No. 11, 12 - applicable to hospitals with ICU only
- *Goals No. 1, 7, 9, 13 - applicable to clinics

Target Setting

The targets are based on:

- Current MOH standards
- Statistics on previous performance of Malaysian healthcare facilities
- Consensus amongst clinical experts
- National and international standards or data (where available, from literature search)
- Discussion with Sir Liam Donaldson (Advisor to WHO Director-General on strategic issues in patient safety and former Principal Advisor to National Health Services, United Kingdom) - 19th September 2012

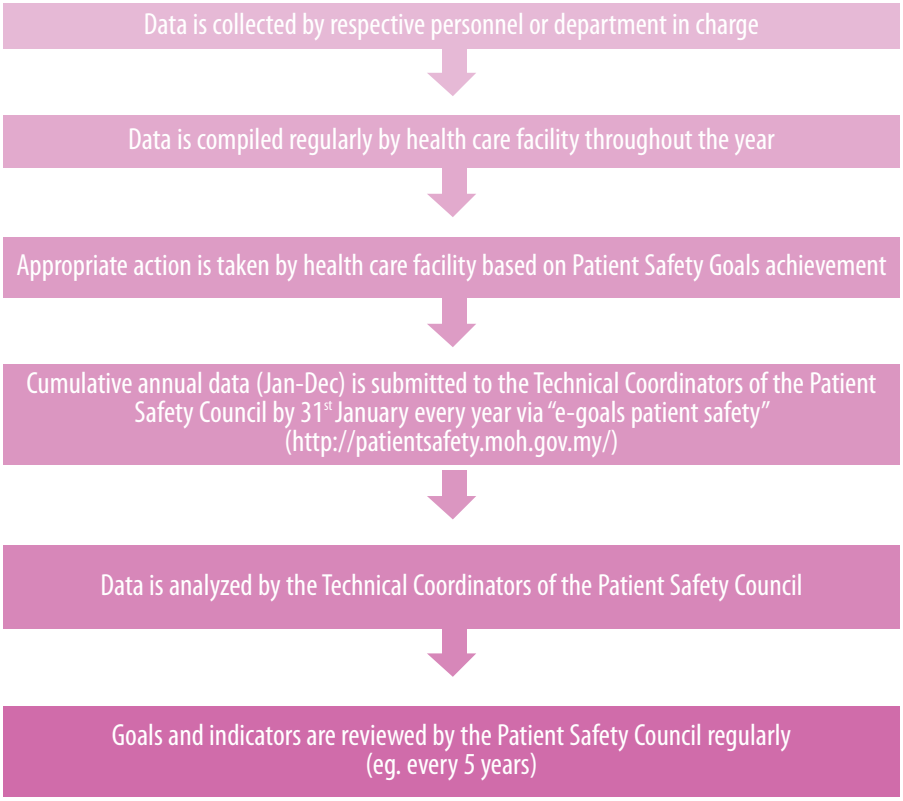
Evaluation of Malaysian Patient Safety Goals & Indicators

The usefulness of the goals, indicators and targets will be reviewed by the Patient Safety Council regularly (eg: every 5 years).

Data Collection System

- At facility level, each healthcare facility is required to collect the data based on the data collection format **(PSG Form 1).** (Page 36 and 37)
- The data shall be analyzed by the facility at regular intervals (e.g. every month or 3 months).
- The facility shall then take pro-active measures to improve performance or prevent recurrence of similar "incident" at the facility.
- The data shall be submitted to the Technical Coordinators of the Patient Safety Council, Quality in Medical Care Section, MOH **once a year only (by 31st January of the next year).**
- The Technical Coordinators of the Patient Safety Council will then analyze the data and present it to the Patient Safety Council. The data will be used to plan and prioritize actions to further improve patient safety at the national level.

Diagram 1: Summary of Patient Safety Goals Data Collection Process



Technical Specifications of Malaysian Patient Safety Goals & KPIs

Patient Safety Goal No. 1	**To implement Clinical Governance**
Rationale	**Clinical Governance** is the systematic framework of accountability for the health care sector that integrates quality, safety and risk management. It is also known as corporate responsibility for safe care and encompasses executive management being accountable for patient safety. The objectives of clinical governance are: • To ensure that there is a systematic framework for the healthcare sector to support and drive the provision of safe health care • To drive core programmes for quality, safety and risk management • To ensure that the appropriate accountability, leadership and oversight arrangements are in place to institutionalize and internalize quality and safety
Strategies & Implementation	Set up organizational structure/ accountability arrangements. Six (6) essential underpinning requirements need to be implemented for Clinical Governance to function in an organization and they are: 1. Communication and consultation with key stakeholders 2. Clear accountability arrangements 3. Adequate capacity and accountability 4. Standardised policies, procedures, protocols and guidelines 5. Monitoring and review arrangements 6. Assurance arrangements
KPI No. 1	**Implementation of Clinical Governance**
Definition of Terms	**Clinical governance** Clinical governance is a framework of accountability through which organizations are accountable for continually improving the quality of their health services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish. It is also defined as corporate accountability for clinical performance.
Indicator	Implementation of Clinical Governance (i.e. good clinical governance will be manifested as compliance to the patient safety goals)
Reference	Information on Clinical Governance is available in "Achieving Excellence In Clinical Governance", produced by the Patient Safety Council of Malaysia & Ministry of Health Malaysia (http://patientsafety.moh.gov.my/)

Patient Safety Goal No. 2	To implement the WHO's 1st Global Patient Safety Challenge:" Clean Care is Safer Care"
Rationale	Infection control is acknowledged universally as a key patient safety issue as nosocomial (healthcare –associated) infections are a major cause of morbidity and mortality in healthcare facilities world-wide. The 1st Global Patient Safety Challenge was initiated by the WHO in late 2004 and mandates signatory countries to work diligently towards the reduction of healthcare-associated infections and their consequences. Malaysia became one of the earliest signatories in the world, in early 2005, to the promotion and implementation of hand hygiene in its health care facilities.
Strategies & Implementation	Hand Hygiene Campaigns and Training Programmes are regularly conducted.
KPI No. 2	**Hand Hygiene Compliance Rate** (refer page 57)
Definitions	**Hand hygiene:** Any action of hygienic hand antisepsis in order to reduce transient microbial flora (generally performed either by hand rubbing with an alcohol-based formulation or hand washing with plain or antimicrobial soap and water) **The opportunity:** is an accounting unit for the action; it determines the need to perform hand hygiene action, whether the reason (the indication that leads to the action) be single or multiple
Inclusion Criteria	Any health care worker involved in direct or indirect patient care
Numerator (N)	Number of hand hygiene actions (wash or rub) performed
Denominator (D)	Number of opportunities observed
Formula	(N/D) x 100
Target	≥ 75% compliance rate at each audit (quarterly audit)
Data collection at facility level	Quarterly (Every 3 months)
Remarks	5 indications have been adopted for the assessment of hand hygiene performance 'My 5 Moments for Hand Hygiene': • Before patient contact • Before aseptic task • After body fluid exposure risk • After patient contact • After contact with patient's surroundings

Patient Safety Goal No. 3	**To implement the WHO's 2nd Global Patient Safety Challenge: "Safe Surgery Saves Lives"**
Rationale	The regular use of Surgical Checklists can increase adherence to safety standards and prevent errors during surgery. It can also reduce the rate of complications and mortality associated with surgical care.
Strategies & Implementation	As per the WHO "Safe Surgery Saves Lives" implementation guidelines. Each healthcare facility is required to establish the relevant committees and to either adopt the WHO check-list or develop their own local check-list to suit their local conditions.
KPI No. 3	**Number of "Wrong Surgeries" Performed**
Target	Zero (0) cases
KPI No. 4	**Number of Cases of "Unintended Retained Foreign Body"**
Target	Zero (0) cases
Definitions of Terms	• **Wrong surgeries performed:** surgery which involved wrong-procedure, wrong-person or wrong-site surgery. Risks can be reduced with compliance to Surgical Safety Peri-operative Checklist, pre-operative verification process, surgical site marking and conducting a time-out. • **Unintended retained foreign body in patients:** surgical instruments, gauze, abdominal packs or any unintended objects that were left in the patients' body peri-operatively. • **Surgical Safety Checklist:** This is a check list developed by World Health Organization to ensure surgical safety. This check list was adapted, modified and standardized for the used in MOH hospitals and known as the 'Peri-operative Check List'.
Inclusion Criteria	Surgery involving general or regional anesthesia.
Data collection at facility level	Data (numbers of cases) to be collected on a monthly basis.

Patient Safety Goal No. 4	To implement the WHO's 3rd Global Patient Safety Challenges- "Tackling Antimicrobial Resistance"
Rationale	Antimicrobial resistance poses a growing threat to the treatment and control of infections.
Strategies & Implementation	1. The Malaysian National Antibiotic Guidelines are implemented. 2. National and State Campaign on Containment of Antimicrobial Resistance 3. Antibiotic Stewardship Programme
KPI No. 5	**Incidence Rate of MRSA Infection**
Numerator (N)	Number of patients with MRSA infection in the hospital
Denominator (D)	Total number of hospital admissions
Formula	(N/D) x 100
Target	≤ 0.4%
KPI No. 6	**Incidence Rate of ESBL- Klebsiella pneumonia Infection**
Numerator (N)	Number of patients with ESBL- Klebsiella pneumoniae infection in the hospital
Denominator (D)	Total number of hospital admissions
Formula	(N/D) x 100
Target	≤ 0.3%
KPI No. 7	**Incidence Rate of ESBL- E.coli Infection**
Numerator (N)	Number of patients with ESBL- E.coli infection in the hospital
Denominator (D)	Total number of hospital admissions
Formula	(N/D) x 100
Target	≤ 0.2%
Definition of Terms	**Case definitions:** MDRO (Multi-Drug Resistent Organism) case definition must fulfill ALL of the following criteria: 1) Isolation of an MDRO from any body sites 2) The patient must be admitted to the ward 3) The case must be "Newly Identified"

	"Newly Identified" include: I. MDRO identified for the first time during current hospital admission II. Cases that have been identified at your site but acquired "new infection" (infection with organism having different antibiogram or defined as new infection by the attending clinician) **Population under surveillance is all in-patients except:** 1) Cases from Emergency department, clinic or other outpatient services 2) Cases previously identified at other acute care facilities/hospitals 3) Cases re-admitted with same alert organisms within one year 4) Cases with insufficient information on healthcare exposure 5) Cases from screening culture 6) Coloniser
Data collection at facility level	Monthly
Reference	Alert Organism Surveillance Manual, Ministry Of Health 2012

Patient Safety Goal No. 5	To improve the accuracy of patient identification
Rationale	Patient identification is essential step in ensuring that the correct treatment is being given to the correct patient.
Strategies & implementation	To implement the use of at least two identifiers for a patient at point of providing care, treatment or health services.
KPI No. 8	**Compliance Rate For "At least 2 identifiers Implemented"** (refer page 41)
Definition of Terms	• **Patient identifier:** person-specific information, not the medium on which that information resides • **The opportunity:** is an accounting unit for the action; it determines the need to perform or observe process of patient identification at point of providing care, treatment or health services **"Acceptable method of Identification":** Patient's name, patient's tag, registration number (RN), NRIC and date of birth **"Unacceptable method of Identification":** Patient's room number or patient's bed number
Examples of processes /procedures requiring patient identification	• upon admission or transfer/ transport to another hospital or other health care setting • administration of all medicines • X- ray or imaging procedures • Surgical intervention or procedures • Blood transfusion or blood products • Collecting of patient's bodily fluid samples • Confirmation of death
Numerator (N)	Number of process whereby at least 2 identifiers are being used
Denominator (D)	Number of opportunities observed
Formula	(N/D) x 100
Target	100% compliance rate at each audit
Data collection at facility level	6 monthly

Patient Safety Goal No. 6	To ensure the safety of transfusion of blood and blood products
Rationale	The need to ensure the provision of universal access to safe, quality and efficacious blood and blood products for transfusion, their safe and appropriate use and also ensuring blood donor and patient safety are key elements of a safe and high quality transfusion programme
Strategies & Implementation	1. To ensure that the use of blood and blood products adhere to the National Transfusion Guidelines 2. A local hemo-vigilance programme is developed
Definitions	**Transfusion Error ("Actual") :** Wrong pack of blood or its product for the intended patient is given **Transfusion Error ("Near misses") :** Transfusion error that almost occurs but was prevented/ intervened resulting in no harm
KPI No. 9	**Number of Transfusion Errors ("Actual")**
Target	Zero (0) cases
KPI No. 10	**Number of Transfusion Errors ("Near Misses")**
Target	To be determined later pending national data analysis and trending
Data collection at facility level	Monthly

Patient Safety Goal No. 7	To ensure medication safety
Rationale	Medication errors may occur at various points of care and often go undetected. Some error may lead to serious morbidity and even mortality. Hence, ensuring medication safety is vital.
Strategies & Implementation	1. Implement information technology to support prescribing, dispensing and administering medicine – example: Computerised Prescribers' Order Entry (CPOE) 2. Report medication errors through the Medication Error Reporting System (MERS) to enable sharing of lesson learnt 3. Implement safety solutions for "Look Alike Sound Alike (LASA) medication" 4. Control of concentrated electrolyte solutions 5. Application of 6Rs and verbalization when administering injectable medication
KPI No. 11	**Number of Medication Errors ("Actual")**
Target	Zero (0) cases
KPI No. 12	**Number of Medication Errors ("Near Misses")**
Target	To be determined later pending national data analysis and trending
Definition of Terms	• **Medication Error ("Actual") :** An error occurred and reached the patient • **Medication Error ("Near Misses") :** Any medication error that does not reach patient • **Concentrated Electrolyte Solution :** examples include Sodium Chloride more than 0.9%, Potassium Chloride or Phosphate • **6Rs:** During administering any medication; it is proposed that the healthcare providers check whether it is the RIGHT patient, medication, time, dose and route (per oral, sublingual, patch, etc), documentation
Types of medication error	Prescribing error, Omission error, Wrong time error, Unauthorized drug error, Dose error, Dosage form error, Drug preparation error , Route of administration error, Administration Technique error, Deteriorated drug error, Monitoring error, Compliance error (from MERS, Pharmaceutical Service Division, MOH)
Data collection	Monthly

Patient Safety Goal No. 8	To improve clinical communication by implementing critical value programme
Rationale	Failure of timely communication and follow-up of critical laboratory values (results) can lead to errors, increased morbidity and mortality.
Strategies & Implementation	1. Identify and maintain the list of critical values for the laboratory (Ref: ISO 15189:2008: Medical Laboratories – the particular requirements for quality and competence in clause 5.8.8 "In order that local clinical needs can be served, the laboratory shall determine the critical properties and their 'alert/critical' intervals, in agreement with the clinicians using the laboratory") 2. Establish procedures for immediate notification of critical laboratory values and establish records of turnaround time for the notification (ISO 15189:2007 clause 5.8.7) 3. Analysis of specimen (routine/urgent/stat) and if the results are within critical limits:- a) Verify the results and check for common analytical interferences or pre-analytical, analytical and post-analytical factors that can affect the test result. b) Notify the results immediately to the requestor or any authorized personnel through suitable mechanism. What to inform : - Informer name and designation - Patient ID (name and RN/IC) - Sample date & time - Test name and result c) Ask the recipient to read back the results which was notified. d) Maintain records of the notification and the relevant information such as :- • Informer name and designation • Patient destination (location) • Patient ID (name and RN/IC) • Test name and result • Sample date & time • Name of recipient 4. Dispatch the original report to the requestor

KPI No. 13	Percentage Of Critical Values Notified Within 30 Minutes or Less
Definition of Terms	**1) Critical laboratory value (results)** Test result or value that falls outside the critical limits or the presence of any unexpected abnormal findings, cells or organisms which may cause imminent danger to the patient, and/or require immediate medical attention. **2) Critical limits** Boundaries of low and high laboratory test values beyond which may cause imminent danger to the patient and/or require immediate medical attention.
Inclusion Criteria	Critical laboratory value (results) for the identified Chemical Pathology and Hematology tests for the laboratory.
Numerator (N)	Total number of critical laboratory values (results) notified within 30 minutes or less
Denominator (D)	Total number of critical laboratory values (results) identified and notified for the month
Formula	(N/D) x 100
Target	100%
Data collection at facility level	Monthly
References	1. Lily M, Sararaks S, Norita TTY, Noor Aishah MD, Low LL, Ainul NMH, Keah KC, Mohdsadek, Maimunah AH, Habibah B, Irdayu H &Suria J. 2010. Improving Notification Of Critical Results In MOH Hospitals. A Project for Improving Patient Safety [Lab 7; PS 21/2010 (41)] Institute for Health Systems Research, Kuala Lumpur, Malaysia. 2. Massachusetts Coalition for the Prevention of Medical http://www.macoalition.org/Initiatives/docs/CTRgriswold.pdf

Patient Safety Goal No. 9	To reduce patient fall
Rationale	Patient falls are a potentially serious form of incident and are considered largely preventable
Strategies & Implementation	To implement a patient fall prevention program
KPI No. 14	**Percentage reduction in the Number of falls (adults)**
Formula	No. of falls this year –(minus) no. of falls last year x 100 No. of falls last year
Target	10% reduction or more * Negative value means reduction in the number of falls whereas positive value means increment in the number of falls
KPI No. 15	**Percentage reduction in the Number of falls (pediatric patients)**
Formula	No. of falls this year –(minus) no. of falls last year x 100 No. of falls last year
Target	10% reduction or more * Negative value means reduction in the number of falls whereas positive value means increment in the number of falls
Definition of Terms	Fall: fall that happens at the facility's premises Pediatric fall: fall amongst patients aged 12 years old and below
Exclusion Criteria	Exclusion criteria for pediatric fall: non injurious developmental fall for infants/ toddlers as they are learning to walk
Data collection at facility level	Monthly

Patient Safety Goal No. 10	To reduce the incidence of Healthcare Associated Pressure Ulcers
Rationale	Pressure ulcers cause considerable harm to patients and can lead to morbidity, mortality. Moreover, it is largely preventable.
Strategies & Implementation	To implement healthcare-associated pressure ulcer prevention programmes
KPI No. 16	**Incidence Rate of Pressure Ulcers**
Definition of Terms	**Pressure ulcer:** an area of localised damage to the skin and underlying tissue caused by pressure, shear, friction and/or a combination of these **Immobilized patient:** patient who is unable to carry out activities of daily living (e.g. unable to feed or bathe by him/herself)
Criteria	**Inclusion criteria:** 1) Immobilized patient 2) Pressure ulcer developed 48 hours after admission 3) No sign of pressure ulcer during admission
Numerator (N)	Number of healthcare associated presure ulcer
Denominator (D)	Total number of immobilized patients
Formula	(N/D) x 100
Target	≤ 3%
Data collection at facility level	Quarterly

Patient Safety Goal No. 11	To reduce Catheter-Related Blood Stream Infections in the ICU*
Rationale	The occurrence of catheter-related bloodstream infections, particularly in intensive care patients, can be serious or even life threatening
Strategies & Implementation	To implement Central Venous Catheter Care Bundle (CVC-CB). It consists of five evidence-based procedures recommended by the CDC (Centers for Disease Control and Prevention): 1. Hand hygiene 2. Maximal barrier precautions upon insertion 3. Chlorhexidine skin antisepsis 4. Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters 5. Daily review of line necessity with prompt removal of unnecessary line
KPI No. 17	**Rate of CRBSI (number of CRBSI per 1000 catheter-days)**
Definition of Terms	**CRBSI Definition:** CRBSI is defined as "the presence of a short -term Central Venous Catheter (CVC) in a patient with clinical evidence of infection (fever, chills and/or hypotension) in the absence of other identifiable course of infection with concordant growth of the same organism from the peripheral blood and the catheter hub **CRBSI Diagnosis:** A definitive diagnosis of CRBSI requires the **same organism** growing from the blood cultures with either: 1. quantitative cultures of blood samples having a ratio of >3:1cfu/ml of blood (catheter: periphery) 2. Differential time to positivity (DTP) of at least 2 hours: growth from catheter hub of at least 2 hours earlier than the periphery However, the Malaysian Registry of Intensive Care (MRIC) diagnoses CRBSI by just having concordant growth of the same organism from the catheter hub and periphery only (because the current practice is unable to use either of the methods above to diagnose CRBSI)
Numerator (N)	Total number of CRBSI cases
Denominator (D)	Total number of catheter days for all patients with catheter
Formula	(N/D) X 1000 catheter-days
Target	<5 per 1000 catheter-days
Data collection at facility level	Monthly

*applicable to hospital with intensive care unit (which is under care of anesthesiology team)

Patient Safety Goal No. 12	To reduce Ventilator Associated Pneumonia In the ICU*
Rationale	The prevention of VAP can help reduce the time that the patient is on the ventilator, ICU and hospital stay as well as costs and mortality
Strategies & Implementation	To implement VAP Care Bundle: The ventilator care bundle has four key components: 1. Elevation of the head of the bed to between 30- 45 degrees 2. Daily "sedation vacation" 3. Peptic ulcer disease prophylaxis 4. Deep venous thrombosis prophylaxis (unless contraindicated)
KPI No. 18	**Rate of VAP (Number of VAP per 1000 ventilator days)**
Definition of Terms	Ventilator-Associated Pneumonia (VAP): Pneumonia that occurs after 48 hours of intubation
Numerator (N)	Total number of VAP cases
Denominator (D)	Total number of ventilator days for all ventilated patients
Formula	(N/D) x 1000 ventilator-days
Target	< 10 per 1000 ventilator days
Data collection at facility level	Monthly

*applicable to hospital with intensive care unit (which is under care of anesthesiology team)

Patient Safety Goal No. 13	To implement an Incident Reporting and Learning System
Rationale	The fundamental role of incident reporting systems is to enhance patient safety by learning from failures of the healthcare system through the investigation of incidents (e.g. through RCA). In this way, a "non-blaming and learning culture" will be nurtured.
Strategies & Implementation	1. An Incident Reporting and Learning System with a mandatory reporting list is implemented 2. Capability and capacity to perform incident investigation such as Root Cause Analysis (RCA) (or mini RCA) to support Incident Reporting is developed and strengthened
KPI No. 19	**Implementation of A Facility-Wide Incident Reporting System (Including Root Cause Analysis) Or Other Methods To Investigate Incidents (e.g. Clinical Audit, Enquiries Etc.)**
Target	System implemented
Data collection at facility level	Yearly
Reference	PAA Mohamed Nazir AR, Lily M & Kalsom M. 2013. Incident Reporting & Learning System From Information To Action Manual. Medical care Quality Section, Medical Development Division, Ministry of Health Malaysia

APPENDICES

APPENDIX I

PSG Form 1

Performance Indicator Matrix : Annual Performance (Jan-Dec)

State : _____

MOH/ University/ Private : _____

Hospital/ Clinic : _____

Year : _____

Type of facility		Goal No	PI	Indicator	Target	Frequency of monitoring
		Strategic Direction 1				
		Ensuring systematic framework for health care sectors by integrating quality, safety and risk management				
Clinic	Hosp	1	1	Implementation of CG	CG Implemented	Yearly
		Strategic Direction 2				
		Managing major and significant aspect of safety risk to patients receiving health care by implementing Global Patient Safety Challenges				
	Hosp	2	1	Hand hygiene compliance rate	≥ 75% at each audit	Quarterly
	Hosp	3	1	Number of "wrong surgery" performed	Zero (0)	Monthly
	Hosp		2	Number of cases of unintended "retained foreign body"	Zero (0)	Monthly
	Hosp	4	1	Incidence rate of MRSA infection	≤ 0.4%	Monthly
	Hosp		2	Incidence rate of ESBL - *Klebsiella pneumoniae* infection	≤ 0.3%	Monthly
	Hosp		3	Incidence rate of ESBL - *E.coli* infection	≤ 0.2%	Monthly
		Strategic Direction 3				
		Implementing evidence based best practice and safety measures				
	Hosp	5	1	Compliance rate for "at least 2 identifiers implemented"	100%	Bi-annually
	Hosp	6	1	Number of transfusion errors (actual)	Zero (0)	Monthly
	Hosp		2	Number of transfusion errors (near miss)	*	Monthly
Clinic	Hosp	7	1	Medication errors (actual)	Zero (0)	Monthly
Clinic	Hosp		2	Medication errors- (near miss)	*	Monthly
	Hosp	8	1	% of critical value notified within 30 minutes	100%	Monthly
Clinic	Hosp	9	1	% reduction in the number of falls (adult)	**	Monthly
Clinic	Hosp		2	% reduction in the number of falls (pediatric)	**	Monthly
	Hosp	10	1	Incidence rate of pressure ulcers	≤ 3%	Quarterly
	Hosp w ICU	11	1	#Rate of CRBSI	<5 per 1000 catheter days	Monthly
	Hosp w ICU	12	1	#Rate of VAP	<10 per 1000 ventilator days	Monthly
		Strategic Direction 4				
		Assessing and Understanding Problems of Unsafe Care				
Clinic	Hosp w ICU	13	1	Implementation of Incident Reporting or other methods to investigate incidents	System Implemented	Yearly

#Applicable to hospital with intensive care unit

Officer compiling the data

Name : _____

Date: _____

Officer reviewing and verifying the data (Head of Department / Quality officer / Hospital Director / CEO)

Name : _____

Date : _____

This form is to be used by health care facilities to quantify annual performance measurement at their level and it must be kept for their record of their hospital trending.
The health care facilities also need to fill in the **e-goals-patient safety** form which can be assessed at patient safety website.

Performance Indicator Matrix : Annual Performance (Jan-Dec)												Total	Average
J	F	M	A	M	J	J	A	S	O	N	D		
Yes / No												-	-
Yes / No												-	-

* to be determined later pending national data analysis and trending

** $\geq$ 10% reduction each year based on the previous year's data

Designation :

HP / Fax / E-mail :

Designation :

HP / Fax / E-mail :

APPENDIX II

Table 2: References and guidelines related to the Malaysian Patient Safety Goals

No	Guidelines related to patient safety goals	Soft Copy (can be downloaded in patient safety MOH/ WHO website)	Can be assessed via:
1	Clinical Governance in Patient Safety	√	http://patientsafety.moh.gov.my/modules/mastop_publish/?tac=Downloads
2	1st Global Patient Safety Challenge : "Clean Care is Safer Care"	√	www.who.int/gpsc/en/
3	2nd Global Patient Safety Challenge : "Clean Care is Safer Care"	√	http://patientsafety.moh.gov.my/modules/mastop_publish/?tac=Downloads
4	3rd Global Patient Safety Challenge : "Tackling Antimicrobial Resistance"	√	http://www.who.int/patientsafety/implementation/amr/en/index.html http://medicaldev.moh.gov.my/v2/uploads/ckpp/mdro_manual.pdf
5	Transfusion Practice Guidelines: Transfusion Practice Guidelines For Clinical And Laboratory Personnel	√	http://www.pdn.gov.my/index.php?option=com_weblinks&view=category&id=40%3Apanduan&Itemid=180&lang=en
6	Guidelines Transfusion: Guidelines For Transfusion Of Blood Products	√	http://www.pdn.gov.my/index.php?option=com_weblinks&view=category&id=40%3Apanduan&Itemid=180&lang=en
7	Guidelines Rational Use: Guidelines For The Rational Use Of Blood And Blood Product	√	http://www.pdn.gov.my/index.php?option=com_weblinks&view=category&id=40%3Apanduan&Itemid=180&lang=en
8	Garis Panduan Pengesanan dengan Alahan Ubat-ubatan	√	http://www.pharmacy.gov.my/newsmaster.cfm?&action=news&menuid=139&lang=EN
9	Guideline on Safe Use of High Alert Medications	√	http://www.pharmacy.gov.my/newsmaster.cfm?&action=news&menuid=139&lang=EN

No	Guidelines related to patient safety goals	Soft Copy (can be downloaded in patient safety MOH/ WHO website)	Can be assessed via:
10	Guideline on Medication Error Reporting	√	http://pharmacy.gov.my/index.cfm?menuid=112&parentid=107
11	National Antibiotic Guideline 2008	√	http://www.pharmacy.gov.my/newsmaster.cfm?&action=news&menuid=139&lang=EN
12	Catheter-Related Bloodstream Infections (CRBSI)	√	http://patientsafety.moh.gov.my/modules/mastop_publish/?tac=Downloads
13	Ventilator -Associated Pneumonia (VAP) Prevention	-	
14	Health Care-Associated Pressure Ulcers Prevention	-	
15	Incident Reporting and Learning System , Incident investigation, Root Cause Analysis	√	http://patientsafety.moh.gov.my/modules/mastop_publish/?tac=Publication

APPENDIX III

PATIENT IDENTIFICATION MANUAL

1. Introduction

The accuracy of patient identification remains a key focus of any healthcare organization. Failure to correctly identify patients constitutes one of the most serious risks to patient safety and can result in a range of adverse events such as medication errors, transfusion errors, procedures on the "wrong person" and the discharge of infants to the wrong families.

The failure is not isolated to one area of a hospital but can easily occur in the emergency department, ICU, general wards or in any other department that interacts with patients. It can even go unnoticed and may involve a medication, specimen or procedure. Moreover, it has been cited in more than 100 individual root cause analyses by the US Department in of Veteran Affairs (VA) National Center for Patient Safety from January 2000 to March 2003.

In response to this major problem and in an effort to reduce harm from misidentification, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recommended using at least two identifiers when taking blood samples, administering medications or blood products (JCAHO, Patient Safety Goals 2003).

2. Aims & Objectives

- To ensure patient safety at all times
- To provide and ensure general mechanisms to verify correct patient identification
- To raise awareness among medical personnel of the importance of correctly identifying patient at all time and before undertaking any procedure or intervention
- To help in reminding all heath care providers to verify that the person they attend to is the one for whom the treatment or procedure is intended and match the treatment or procedure to that person
- To educate them on how to monitor the compliance rate of using at least two identifiers for a patient at point of providing care, treatment or health services

3. Definition

Patient identifier: Person-specific information, not the medium on which that information resides.

The opportunity: is an accounting unit for the action; it determines the need to perform or observe process of patient identification at point of providing care, treatment or health services.

4. The Procedure for Patient Identification Accuracy

4.1 Who must wear the identity wristband:

- All patients in the Emergency Department
- All patients in hospital departments
- All day case patients, excluding dialysis out-patients except when they are to receive blood transfusions or any other intravenous therapy or medication, when a patient identity wristband must be applied
- All out-patients undergoing diagnostic or invasive procedures and/or treatment that impair their conscious levels during the appointment excluding dialysis out-patients as mentioned above
- Any out-patient who is cognitively compromised and/or impaired

4.2 Initial identification

Upon initial admission or seeing the patient, it is crucial to identify his or her identification correctly.

Steps identifying the patient include:

a) Ask the patient to tell you;

- Name (full name includes surname)
- Identification card number
- Date of birth
- Address

DO NOT state their name first and then ask to confirm or deny by a yes/ no response

b) Ask their caregiver or relative if the patient is unable to tell you their name (in unconscious patient, babies, children, mental disability and patient with dysphasia).

c) Do cross referencing with the patient's previous health record (if available at hand or if he/she has previous admission).

d) Use a translator if communication breakdown occur.

e) The inability to identify patient accurately by using methods given above, must be documented properly in the patient's health care record.

f) Once the patient is suspected to be admitted; a written (black)/ printed wristband which consists of the name of the patient, IC or registration number must be placed on the patient's wrist.

4.3 Identity wristband

a) The information or identifiers to be recorded on it; (at least 4 identifiers) include:

- Full name of the patient
- Date of admission
- Date of birth and/or ID number (last four digit)
- Hospital registration number
- Name of the ward

b) The information on the wristband must only be in black and this may be written by pen or printed directly on the wristband with certain printers.

c) Patients who have been admitted to a ward following initial treatment in the Emergency Department (ED) must use the hospital registration number instead of their ED number.

4.4 Applying the identity wristband

a) Before putting it on the patient's wrist, the patient should be asked to read back the information written on the wristband and confirm its correctness (authenticity).

b) Where: on dominant limb/ do not apply to the hand with arterio-venous shunt fistula (renal failure patient who is on dialysis).

c) How to apply it: tight enough to avoid it from sliding off, but loose enough to allow blood circulation.

d) The identity wristband must be applied on admission to the hospital or once the patient has entered a department for a treatment.

e) There are few occasions where patients may refuse to wear the wristband. Where appropriate, they must be explained about the risk of not wearing the wristband. The discussion and reasons why the patients do not want to wear it must be properly documented in the patients' health record.

f) No alteration must be made on the wristband after it has been attached to the patient. If alteration is required, a new ID wristband must be printed and attached by the health care worker who made or recognized the error.

4.5 Procedures requiring patient identification

a) The procedures include:

- upon admission or transfer/ transport to another hospital or other care setting
- administration of all medicines
- X- ray or imaging procedures
- Surgical intervention or procedures
- Blood transfusion/ blood products
- Collecting of patient bodily fluid samples
- Confirmation of death

b) Prior to any procedure, the clinician/ staff nurse must confirm the identification of correct patient by asking (where possible) the patient to state their name and hospital registration number and checking these details against the identity wristband and their medical record. DO NOT state their name and ask them to deny or confirm by a yes or no reply.

c) If the patient is unable to tell his or her name, refer to the identity wristband or verify the details with a relative or caretaker. If the relative is not available, two (2) clinical staffs have to check and confirm the patient identification and document it in the patient's clinical record.

d) DO NOT proceed any procedure if the patient is not wearing his or her identity wristband. If any clinician or staff nurse found a patient with a missing identity wristband, he or she must immediately inform the in-charge staff nurse of the ward or department.

e) The identity wristband must remain on during the whole admission and to be removed only on the day of discharge.

Technical Specification of the 5th Malaysian Patient Safety Goals

Patient Safety Goal No. 5	**To improve the accuracy of patient identification**
Rationale	Patient identification is essential step in ensuring that the correct treatment is being given to the correct patient.
Strategies & implementation	To implement the use of at least two identifiers for a patient at point of providing care, treatment or health services.
KPI No. 8	**Compliance Rate For "At Least 2 Identifiers Implemented"**
Definition of Terms	• **Patient identifier:** person-specific information, not the medium on which that information resides • **The opportunity:** is an accounting unit for the action; it determines the need to perform or observe process of patient identification at point of providing care, treatment or health services **"Acceptable method of Identification":** Patient's name, patient's tag, registration number (RN), NRIC and date of birth **"Unacceptable method of Identification":** Patient's room number or patient's bed number
Examples of processes /procedures requiring patient identification	• upon admission or transfer/ transport to another hospital or other care setting • administration of all medicines • X- ray or imaging procedures • Surgical intervention or procedures • Blood transfusion or blood products • Collecting of patient's bodily fluid samples • Confirmation of death
Numerator (N)	Number of process whereby at least 2 identifiers are being used
Denominator (D)	Number of opportunities observed
Formula	(N/D) x 100
Target	100% compliance rate at each audit
Data collection at facility level	6 monthly

5. Monitoring Compliance

Compliance audit of using two (2) identifiers need to be conducted six (6) monthly. The objective is to ensure two (2) identifiers are used when giving medication, transfusion or performing important procedures. The process of conducting compliance audit is as follows:

5.1 How to conduct the audit

5.1.1. Select auditor

5.1.2. Train the auditors and health care workers

5.1.3. Decide when to do the audit (twice a year) and how many opportunities need for each session

5.1.3 (a) Number of opportunities (sampling) to be observed based on allocated bed per year

No. of hospital beds	Total no. of opportunities
< 350	100
351- 600	125
601- 800	150
351- 600	200
>1000	250

5.1.4. Auditor performs the audit;

5.1.4 (a) He/ she introduces and explains the purpose of the audit to the healthcare workers and patients

5.1.4 (b) Observe the healthcare workers during the delivery of healthcare activities to the patients

5.1.4 (c) Record the audit findings in the audit form A (Appendix i)

How to use the form A (Appendix i)

- Each column of the grid to identify indication of using 2 identifiers is intended to be dedicated to a specific category of staff. Therefore, numerous healthcare workers may be included during one session in the column dedicated to their category.
- Observe the opportunities requiring using 2 identifiers.

- If the healthcare worker uses 2 identifiers for any indication, count an opportunity in the appropriate box ☐ ,tick square corresponding to the indication you have detected and then tick at Yes ☐ box next to indication column
- Each opportunity refers to one line in each column; each line is independent from one column to another

5.1.5. After completing the audit, the auditor needs to analyze and calculate the compliance rate of using 2 identifiers by filling up form B (Appendix ii). Follow the instruction given on how to use the form.

5.1.6. Form C (Appendix iii) is an optional form to be filled up by the auditor if they want to see the indication related compliance with using 2 identifiers.

5.1.7. Submit the bi-annual compliance rate data by using the Patient Safety Goal Form (PSG Form 1) to the Patient Safety Council Secretariat once a year only (by 31st January every year).

5.1.8. The process flowchart of conducting the audit is shown in Appendix iv.

APPENDIX i

Patient Identification Compliance Audit Form (Form A)

Hospital/ Clinic:	Session number:
Ward (if applicable):	Date:
Department (if applicabale):	Time: to
Name of observer:	

CATEGORY OF STAFF BEING AUDITED: Doctor/ Nursing Staff/Assistant MO/Allied Health Professionals

*Please tick √ which is relevant in the box

Cat			Cat			Cat			Cat		
No			No			No			No		
Opp	Indication	2 identifier	Opp	Indication	2 identifier	Opp	Indication	2 identifier	Opp	Indication	2 identifier
1.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	1.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	1.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	1.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No
2.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion	☐ Yes ☐ No	2.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion	☐ Yes ☐ No	2.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion	☐ Yes ☐ No	2.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion	☐ Yes ☐ No

Cat			Cat			Cat			Cat		
No			No			No			No		
Opp	Indication	2 identifier	Opp	Indication	2 identifier	Opp	Indication	2 identifier	Opp	Indication	2 identifier
	☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No		☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No		☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No		☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No
3.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	3.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	3.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	3.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No
4.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	4.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	4.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No	4.	☐ Administration of Medication ☐ X-Ray & Imaging Procedure ☐ Invasive Procedure ☐ Blood Transfusion ☐ Collecting of Patient Body Fluid, Blood sample ☐ Transfer of Patient ☐ Confirmation of Death ☐ Others_____	☐ Yes ☐ No

* To be completed by the data manager.

Short description of items (for Form A)

Hospital/ clinic	To complete to the local nomenclature
Ward (if applicable)	To complete to the local nomenclature
Department (if applicable)	To complete to the local nomenclature
Session number	Attributed at the moment of data entry for analysis
Date	Day/ month/ year
Time	Hour/ minute
Name of observer	Observer's initials (observer is responsible for the data collection and for checking their accuracy before submitting the form for analysis)
Cat(egory)	Category of staff 1. Doctor 2. Nursing staff 3. Assistant MO 4. Allied Health Professionals
Nu(mber)	Number of observed healthcare workers belonging to the same category as they enter the field of observation and you detect opportunities
Opp(ortunity)	Defined by one indication at least
Indication	Reason that motivate to use at least 2 identifiers during delivery of care to the patients • Transfer of patient • administration of medication • X- ray or imaging procedures • Surgical intervention or invasive procedures • Blood transfusion • Collecting of patient bodily fluid samples • Confirmation of death
2 identifiers	Person- specific information, not the medium on which that information resides. Acceptable identifiers include; • Patient's name • Patient's date of birth • NRIC • Hospital registration number

Patient Identification Compliance Audit Form- Basic Compliance Calculation (Form B)

APPENDIX ii

	Hosp:						Period:								
	Cat:			Cat:			Cat:			Cat:			Total Per Session:		
Session No	Opp (n)	Yes (n)	No (n)	Opp (n)	Yes (n)	No (n)	Opp (n)	Yes (n)	No (n)	Opp (n)	Yes (n)	No (n)	Opp (n)	Yes (n)	No (n)
1															
2															
3															
4															
5															
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11															
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13															
14															
15															
16															
17															
18															
19															
20															
Total															
Calculation	Opp (n)= / No of Y (n)=			Opp (n)= / No of Y(n)=			Opp (n)= / No of Y(n)=			Opp (n)= / No of Y(n)=			Opp (n)= / No of Y(n)=		
Compliance															

$$\text{Compliance of using 2 identifiers (\%)} = \frac{\text{No. of "Yes"}}{\text{Total Number of Opportunities}} \times 100$$

Instructions for use:

1. Check data in the audit compliance form (form A).

2. Report the session number and the related observation data in the same line. This attribution of session number validates the fact that the data has been taken into count for compliance calculation

3. Results per category of staff and per session (vertical):
   a. Sum up recorded opportunities (opp) in the case report for per staff category: report the sum in the corresponding cell in the calculation form
   b. Sum up the no. of yes using 2 identifiers related to the total of opportunities above: report the sum in corresponding cell in the calculation form
   c. Proceed in the same way for each session
   d. Add up all sums per each category of staff and put the calculation to calculate the compliance rate (given in percent)

4. The addition of results of each line permits to get global compliance at the end of last right column

Patient Identification Compliance Audit Form - Optional Calculation Form (Form C)

(Indication-related compliance with using at least 2 identifiers)

APPENDIX iii

	Hosp:															
	Administration of medication		X-ray/ imaging Procedure		Invasive Procedure		Blood transfusion/ blood products		Collecting patient body fluid/ blood sample		Transfer of patient		Confirmation of death		Others	
Session No	Ind (n)	Y (n)	Ind (n)	Y (n)	Ind (n)	Y (n)	Ind (n)	Y (n)	Ind (n)	Y (n)	Ind (n)	Y (n)	Ind (n)	Y (n)	Ind (n)	Y (n)
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2																
3																
4																
5																
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7																
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12																
13																
14																
15																
16																
17																
18																
19																
20																
Total																
Calculation	Y (n)= Ind (n)=		Y (n)= Ind (n)=		Y (n)= Ind (n)=		Y (n)= Ind (n)=		Y (n)= Ind (n)=		Y (n)= Ind (n)=		Y (n)= Ind (n)=		Y (n)= Ind (n)=	
Ratio Y/ ind																

Instructions for use:

1. Check data in the audit compliance form (Form A and B)

2. If several indications occur within the same opportunity, each one of the indication should be considered separately

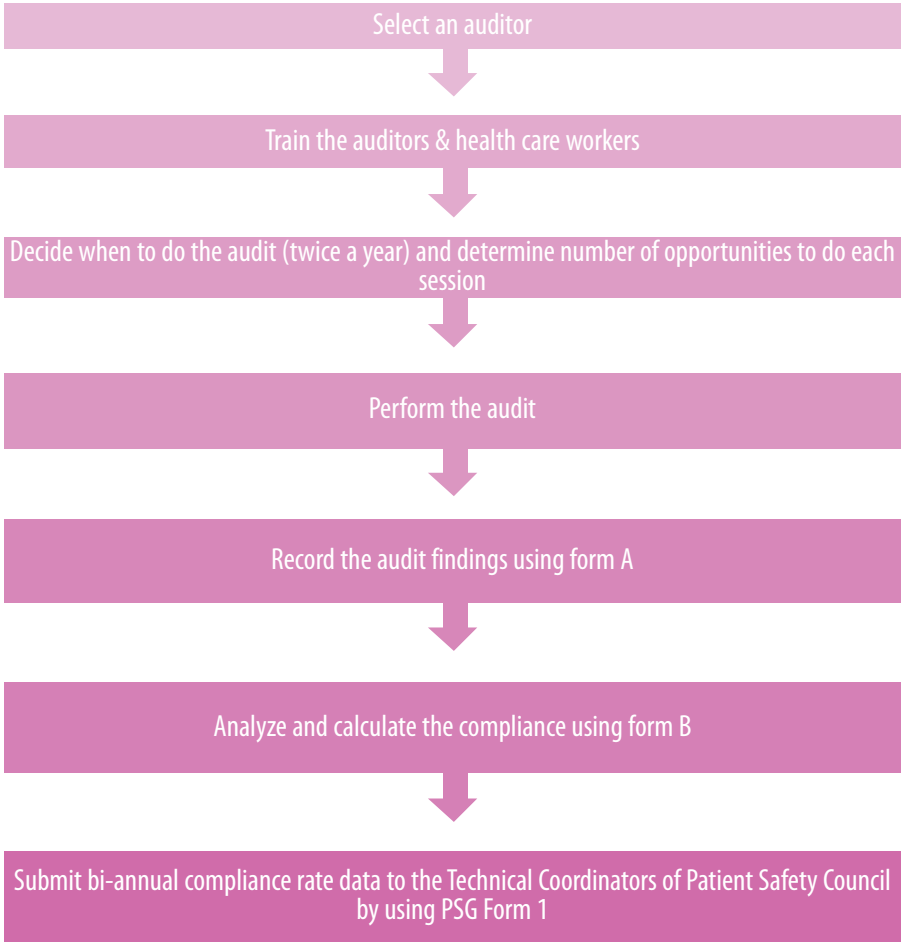
3. Report the session number and the related observation data in the same line. This attribution of session number validates the fact that the data has been taken into count for compliance calculation

4. Results per indication (ind) and per session (vertical):
   a. Sum up indications per indication in the observation form: report the sum in the corresponding cell in the calculation form
   b. Sum up the no. of yes (Y) using at least 2 identifiers related to the total of indications above: report the sum in corresponding cell in the calculation form
   c. Proceed in the same way for each session
   d. Add up all sums per each indication and put the calculation to calculate the ratio (given in percent)

Note: This calculation is not exactly a compliance result, as the denominator of the calculation is an indication instead of an opportunity. However, it gives overall picture of healthcare worker's behavior towards each type of indication

APPENDIX iv

Process Flowchart of Conducting An Audit



APPENDIX IV

HAND HYGIENE AUDIT TOOLS & OBSERVATION FORM

Hand Hygiene Audit Tool & Observation Form

Observation Form

Facility :		Period Number*:		Session Number*:	
Service:		Date: (dd/mm/yy)	/ /	Observer: (initials)	
Ward:		Start/End time: (hh:mm)	: / :	Page No:	
Department:		Session duration: (mm)		City**:	
Country**:					

Prof.cat.		Prof.cat.		Prof.cat.		Prof.cat.	
Code		Code		Code		Code	
N°		N°		N°		N°	

Opp.	Indication	HH Action	Opp.	Indication	HH Action	Opp.	Indication	HH Action	Opp.	Indication	HH Action
1	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	1	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	1	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	1	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves
2	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	2	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	2	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	2	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves

3	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	3	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	3	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	3	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves
4	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	4	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	4	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	4	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves
5	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	5	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	5	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	5	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves
6	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	6	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	6	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	6	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves
7	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	7	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	7	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	7	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves
8	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	8	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	8	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves	8	☐ bef-pat. ☐ bef-asept. ☐ aft-b.f. ☐ aft-pat. ☐ aft.p.surr.	☐ HR ☐ HW ○ missed ○ gloves

* To be completed by the data manager

General Recommendations

(refer to the Hand Hygiene Technical Reference Manual)

1. In the context of open and direct observations, the observer introduces him/ herself to the health-care worker and to the patient when appropriate, explains his/her task and proposes immediate informal feed back.
2. The health-care worker, belonging to one of the main four following professional categories (see below),is observed during the delivery of health-care activities to patients.
3. Detected and observed data should be recorded with a pencil in order to be immediately corrected if needed.
4. The top of the form (header) is completed before starting data collection (excepted end time and session duration).
5. The session should last no more than 20 minutes (± 10 minutes according to the observed activity); the end time and the session duration are to be completed at the end of the observation session.
6. The observer may observe up to three health-care workers simultaneously, if the density of hand hygiene opportunities permits.
7. Each column of the grid to record hand hygiene practices is intended to be dedicated to a specific professional category. Therefore numerous health-care workers may be sequentially included during one session in the column dedicated to their category. Alternatively each column may be dedicated to a single health-care worker only of whom the professionall category should be indicated.
8. As soon as you detect an indication for hand hygiene, count an opportunity in the appropriate column and cross the square corresponding to the indication(s) you detected. Then complete all the indications that apply and the related hand hygiene actions observed or missed.
9. Each opportunity refers to one line in each column; each line is independent from one column to another.
10. Cross items in squares (several may apply for one opportunity) or circles (only a single item may apply at one moment).
11. When several indications fall in one opportunity, each one must be recorded by crossing the squares.
12. Performed or missed actions must always be registered within the context of an opportunity.
13. Glove use may be recorded only when the hand hygiene action is missed while the health-care worker is wearing gloves.

Short description of items

Facility:	to complete according to the local nomenclature	
Service:	to complete according to the local nomenclature	
Ward:	to complete according to the local nomenclature	
Department:	to complete according to the following standardized nomenclature:	
	medical, including dermatology, neurology, haematology, oncology, etc.	surgery, including neurosurgery, urology, ENT, ophthalmology, etc.
	mixed (medical & surgical), including gynaecology	obstetrics, including related surgery
	paediatrics, including related surgery	intensive care & resuscitation
	emergency unit	long term care & rehabilitation
	ambulatory care, including related surgery	other (to specify)
Period N°:	1) pre- / 2) post-intervention; and then according to the institutional counter.	
Date:	day (dd) / month (mm) / year (yy)	
Start/end time:	hour (hh) / minute (mm).	

Session duration:	difference between start and end time, resulting in minutes of observation.	
Session N°:	attributed at the moment of data entry for analysis.	
Observer:	observer's initials (the observer is responsible for the data collection and for checking their accuracy before submitting the form for analysis.	
Page N°:	to write only when more than one form is used for one session.	
Prof.cat:	according to the following classification:	
	1. nurse / midwife	1.1 nurse, 1.2 midwife, 1.3 student.
	2. auxiliary	
	3. medical doctor	3.1 in internal medicine, 3.2 surgeon, 3.3 anaesthetist/ resuscitator/ emergency physician, 3.4 paediatrician, 3.5 gynaecologist, 3.6 consultant, 3.7 medical student.
	4. other health-care worker	4.1 therapist (physiotherapist, occupational therapist, audiologist, speech therapist), 4.2 technician (radiologist, cardiology technician, operating room technician, laboratory technician, etc), 4.3 other (dietician, dentist, social worker and any other health-related professional involved in patient care), 4.4 student.
Number:	number of observed health-care workers belonging to the same professional category (same code) as they enter the field of observation and you detect opportunities.	
Opp(ortunity):	defined by one indication at least	
Indication:	reason(s) that motivate(s) hand hygiene action; all indications that apply at one moment must be recorded	
	bef.pat: before touching a patient	aft.b.f: after body fluid exposure risk
	bef.asept: before clean/aseptic procedure	aft.pat: after touching a patient
		aft.p.surr: after touching patient surroundings
HH action:	response to the hand hygiene indication(s); it can be either a positive action by performing handrub or handwash, or a negative action by missing handrub or handwash	
	HR: hand hygiene action by handrubbing with an alcohol-based formula	Missed: no hand hygiene action performed
	HW: hand hygiene action by handwashing with soap and water	

Observation Form – Basic Compliance Calculation

	Facility:						Period:			Setting:					
	Prof.cat.			Prof.cat.			Prof.cat.			Prof.cat.			Total Per Session:		
Session No	Opp (n)	HW (n)	HR (n)	Opp (n)	HW (n)	HR (n)	Opp (n)	HW (n)	HR (n)	Opp (n)	HW (n)	HR (n)	Opp (n)	HW (n)	HR (n)
1															
2															
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13															
14															
15															
16															
17															
18															
19															
20															
Total															
Calculation	Act (n) = / Opp (n)=			Act (n) = / Opp (n)=			Act (n) = / Opp (n)=			Act (n) = / Opp (n)=			Act (n) = / Opp (n)=		
Compliance															

$$\text{Compliance (\%)} = \frac{\text{Actions}}{\text{Opportunities}} \times 100$$

Instructions for use

1. Define the setting outlining the scope for analysis and report related data according to the chosen setting.

2. Check data in the observation form. Hand hygiene actions not related to an indication should not be taken into account and vice versa.

3. Report the session number and the related observation data in the same line. This attribution of session number validates the fact that data has been taken into count for compliance calculation.

4. Results per professional category and per session (vertical):
   - 4.1 Sum up recorded opportunities (opp) in the case report form per professional category: report the sum in the corresponding cell in the calculation form.
   - 4.2 Sum up the positive hand hygiene actions related to the total of opportunities above, making difference between handwash (HW) and handrub (HR): report the sum in the corresponding cell in the calculation form.
   - 4.3 Proceed in the same way for each session (data record form).
   - 4.4 Add up all sums per each professional category and put the calculation to calculate the compliance rate (given in percent)

5. The addition of results of each line permits to get the global compliance at the end of the last right column.

Observation Form – Optional Calculation Form

(Indication-related compliance with hand hygiene)

	Facility:						Period:			Setting:					
	Before touching a patient			Before clean/ aseptic procedure			After body fluid exposure risk			After touching a patient			After touching patient surroundings		
Session No	Indic (n)	HW (n)	HR (n)	Indic (n)	HW (n)	HR (n)	Indic (n)	HW (n)	HR (n)	Indic (n)	HW (n)	HR (n)	Indic (n)	HW (n)	HR (n)
1															
2															
3															
4															
5															
6															
7															
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14															
15															
16															
17															
18															
19															
20															
Total															
Calculation	Act (n) = / Indic1 (n) =			Act (n) = / Indic2 (n) =			Act (n) = / Indic3 (n) =			Act (n) = / Indic4 (n) =			Act (n) = / Indic5 (n) =		
Ratio act/ indic*															

Instructions for use

1. Define the setting outlining the scope for analysis and report related data according to the chosen setting.

2. Check data in the observation form. Hand hygiene actions not related to an indication should not be taken into account and vice versa.

3. If several indications occur within the same opportunity, each one should be considered separately as well as the related action.

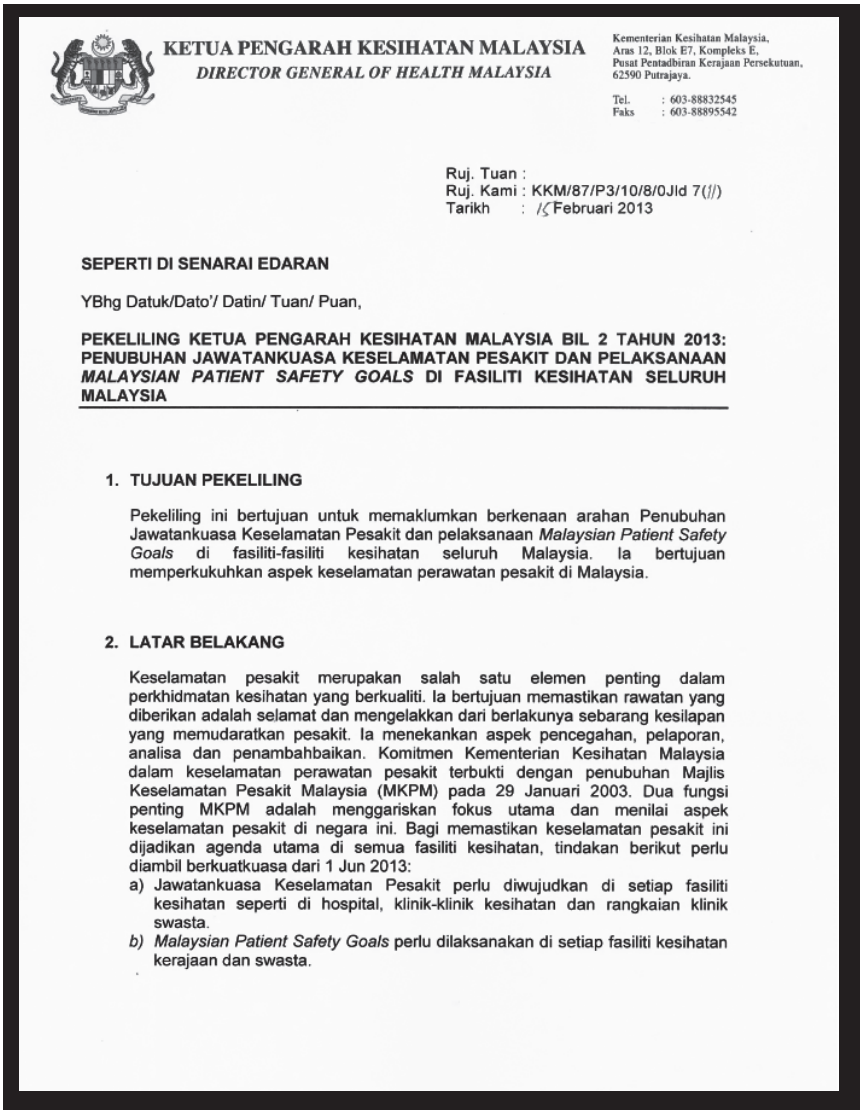
4. Report the session number and the related observation data in the same line. This attribution of session number validates the fact that data has been taken into count for compliance calculation.

5. Results per indication (indic) and per session (vertical):
   - 4.1 Sum up indications per indication in the observation form: report the sum in the corresponding cell in the calculation form.
   - 4.2 Sum up positive hand hygiene actions related to the total of indications above, making the difference between handwash (HW) and handrub (HR): report the sum in the corresponding cell in the calculation form.
   - 4.3 Proceed in the same way for each session (observation form).
   - 4.4 Add up all sums per each indication and put the calculation to calculate the ratio (given in percent)

*Note: This calculation is not exactly a compliance result, as the denominator of the calculation is an indication instead of an opportunity. Action is artificially overestimated according to each indication. However, the result gives an overall idea of health-care worker's behaviour towards each type of indication.

APPENDIX V

CIRCULAR OF THE DIRECTOR GENERAL OF HEALTH MALAYSIA No. 2/ 2013 ON THE ESTABLISHMENT OF PATIENT SAFETY COMMITTEE IN ALL HEALTH CARE FACILITIES AND THE IMPLEMENTATION OF MALAYSIAN PATIENT SAFETY GOALS



KETUA PENGARAH KESIHATAN MALAYSIA
DIRECTOR GENERAL OF HEALTH MALAYSIA

Kementerian Kesihatan Malaysia,
Aras 12, Blok E7, Kompleks E,
Pusat Pentadbiran Kerajaan Persekutuan,
62590 Putrajaya.

Tel. : 603-88832545
Faks : 603-88895542

Ruj. Tuan :
Ruj. Kami : KKM/87/P3/10/8/0Jld 7(//)
Tarikh : /5 Februari 2013

SEPERTI DI SENARAI EDARAN

YBhg Datuk/Dato'/ Datin/ Tuan/ Puan,

PEKELILING KETUA PENGARAH KESIHATAN MALAYSIA BIL 2 TAHUN 2013: PENUBUHAN JAWATANKUASA KESELAMATAN PESAKIT DAN PELAKSANAAN *MALAYSIAN PATIENT SAFETY GOALS* DI FASILITI KESIHATAN SELURUH MALAYSIA

1. TUJUAN PEKELILING

Pekeliling ini bertujuan untuk memaklumkan berkenaan arahan Penubuhan Jawatankuasa Keselamatan Pesakit dan pelaksanaan *Malaysian Patient Safety Goals* di fasiliti-fasiliti kesihatan seluruh Malaysia. Ia bertujuan memperkukuhkan aspek keselamatan perawatan pesakit di Malaysia.

2. LATAR BELAKANG

Keselamatan pesakit merupakan salah satu elemen penting dalam perkhidmatan kesihatan yang berkualiti. Ia bertujuan memastikan rawatan yang diberikan adalah selamat dan mengelakkan dari berlakunya sebarang kesilapan yang memudaratkan pesakit. Ia menekankan aspek pencegahan, pelaporan, analisa dan penambahbaikan. Komitmen Kementerian Kesihatan Malaysia dalam keselamatan perawatan pesakit terbukti dengan penubuhan Majlis Keselamatan Pesakit Malaysia (MKPM) pada 29 Januari 2003. Dua fungsi penting MKPM adalah menggariskan fokus utama dan menilai aspek keselamatan pesakit di negara ini. Bagi memastikan keselamatan pesakit ini dijadikan agenda utama di semua fasiliti kesihatan, tindakan berikut perlu diambil berkuatkuasa dari 1 Jun 2013:

a) Jawatankuasa Keselamatan Pesakit perlu diwujudkan di setiap fasiliti kesihatan seperti di hospital, klinik-klinik kesihatan dan rangkaian klinik swasta.
b) *Malaysian Patient Safety Goals* perlu dilaksanakan di setiap fasiliti kesihatan kerajaan dan swasta.

3. JAWATANKUASA KESELAMATAN PESAKIT

3.1 Tanggungjawab Pelaksanaan

Pihak pengurusan tertinggi fasiliti kesihatan adalah bertanggungjawab mewujudkan jawatankuasa ini serta memastikan ianya berfungsi.

3.2 Fungsi Jawatankuasa Keselamatan Pesakit adalah seperti berikut:

a) Menjadi penggerak utama dalam aspek keselamatan rawatan pesakit di fasiliti kesihatan tersebut.

b) Merancang dan mewujudkan kaedah, sistem kerja dan program bagi memastikan keselamatan rawatan pesakit

c) Memastikan pelaksanaan "*Malaysian Patient Safety Goals*"

d) Memantau dan menilai status keselamatan rawatan pesakit melalui pelaksanaan sistem pemantauan "*e-goals: patient safety*"

e) Membincangkan insiden, aduan serta isu-isu melibatkan keselamatan rawatan pesakit, tindakan penambahbaikan dan keberkesanan tindakan.

f) Merancang dan menjalankan aktiviti promosi dan pendidikan berkenaan keselamatan rawatan pesakit.

g) Lain-lain perkara berkaitan keselamatan rawatan pesakit yang dirasakan perlu.

3.3 Keanggotaan jawatankuasa adalah seperti di ***Lampiran 1.***

3.4 Fasiliti kesihatan yang mempunyai bilangan anggota yang kecil tidak perlu mewujudkan Jawatankuasa Keselamatan Pesakit. Namun begitu adalah menjadi tanggungjawab pemilik fasiliti kesihatan tersebut memastikan aspek keselamatan rawatan pesakit diberi keutamaan dalam Mesyuarat Pengurusan yang dilakukan secara tetap dan berjadual.

4. MALAYSIAN PATIENT SAFETY GOALS

4.1 Tanggungjawab Pelaksanaan

a) Sekretariat Majlis Keselamatan Pesakit Malaysia bertanggungjawab dalam pewujudan polisi, garis panduan serta sistem berkaitan; penilaian pencapaian, penghasilan laporan dan pembentangan kepada Majlis Keselamatan Pesakit Malaysia. *Patient Safety Goals* ini juga akan disemak dari semasa ke semasa.

b) Setiap pihak pengurusan tertinggi fasiliti kesihatan bertanggungjawab untuk melaksanakan, memantau pencapaian *Malaysian Patient Safety Goals* dan mengambil tindakan sewajarnya serta proaktif bagi mempertingkatkan keselamatan rawatan pesakit di fasiliti kesihatan tersebut.

4.2 Objektif *Malaysian Patient Safety Goals* adalah seperti berikut:

a) Mempertingkatkan keselamatan rawatan pesakit di Malaysia

b) Menggariskan aspek keselamatan rawatan pesakit yang perlu diberi keutamaan

c) Memantau dan menilai status keselamatan rawatan pesakit secara lebih sistematik.

d) Merancang tindakan khusus sama ada di peringkat fasiliti kesihatan tersebut, negeri dan kebangsaan.

4.3 Buku Garis Panduan Pelaksanaan

Pekeliling ini harus dibaca bersekali dengan *Malaysian Patient Safety Goals – Implementation & Surveillance Guidelines*. Ia menerangkan dengan terperinci mengenai kaedah pelaksanaan dan tindakan yang perlu diambil bagi melaksanakan dasar ini serta format yang perlu digunakan.

4.4 Pengumpulan Data Melalui "*e-goals-patient safety*"

Bagi memudahkan pemantauan pencapaian *Malaysia Patient Safety Goals* di seluruh negara, satu web-based program dikenali sebagai ***"e-goals-patient safety"*** telah diwujudkan. Pencapaian perlu dihantar sekali setahun selewat-lewatnya sebelum atau pada **31 Januari** tahun berikutnya secara *online*. Sila layari laman sesawang *http://patientsafety.moh.gov.my/* dan tekan pada pautan *Patient Safety Goals* untuk menghantar pencapaian kepada Sekretariat Majlis Keselamatan Pesakit Malaysia.

5. SKOP PELAKSANAAN & TARIKH BERKUATKUASA

5.1 Pekeliling ini berkuatkuasa mulai dari **1 Jun 2013**

5.2 Pekeliling ini melibatkan semua fasiliti kesihatan di sektor awam dan swasta di seluruh Malaysia.

6. PELAKSANAAN ARAHAN PEKELILING

6.1 Setiap pihak pengurusan tertinggi fasiliti kesihatan bertanggungjawab mematuhi dan melaksanakan pekeliling ini

6.2 Setiap Jabatan Kesihatan Negeri adalah bertanggungjawab sepenuhnya bagi memastikan Pekeliling ini dilaksanakan dan dipantau secara berkala.

6.3 Bahagian Farmasi, Bahagian Pergigian, Bahagian Kejururawatan,

Bahagian Perkembangan Perubatan, Bahagian Amalan Perubatan dan Bahagian Sains Kesihatan Bersekutu turut bertanggungjawab untuk membantu pelaksanaan Pekeliling ini.

7. PERTANYAAN

Sebarang pertanyaan boleh dikemukakan kepada:

Sekretariat Majlis Keselamatan Pesakit Malaysia
Cawangan Kualiti Penjagaan Perubatan
Bahagian Perkembangan Perubatan
Kementerian Kesihatan Malaysia
Aras 4, Blok E1, Parcel E,
Pusat Pentadbiran Kerajaan Persekutuan
62590 Putrajaya
No. Telefon : 03-88831180, No. Fax: 03-8883 1176

Sekian, terima kasih.

"BERKHIDMAT UNTUK NEGARA"

Saya yang menurut perintah,

(DATUK DR. NOOR HISHAM ABDULLAH)
b/p Ketua Pengarah Kesihatan Malaysia
Merangkap Pengerusi Majlis Keselamatan
Pesakit Malaysia

s.k. - Ketua Setiausaha Kementerian Kesihatan Malaysia
- Timbalan Ketua Setiausaha (Kewangan)
- Timbalan Ketua Setiausaha (Pengurusan)
- Timbalan Ketua Pengarah Kesihatan (Kesihatan Awam)
- Timbalan Ketua Pengarah Kesihatan (Perubatan)
- Timbalan Ketua Pengarah Kesihatan (Penyelidikan & Sokongan Teknikal)
- Pengarah Kanan Pergigian
- Pengarah Kanan Farmasi
- Pengarah Kanan Kualiti Makanan
- Pengarah Bahagian Perkembangan Perubatan
- Pengarah Bahagian Amalan Perubatan
- Pengarah Bahagian Kejururawatan
- Sekretariat Majlis Keselamatan Pesakit Malaysia

Lampiran 1

Cadangan Keanggotaan Jawatankuasa Keselamatan Pesakit

a) Jawatankuasa Keselamatan Pesakit dipengerusikan oleh pihak pengurusan tertinggi fasiliti kesihatan. Sebagai contoh:
- Bagi hospital – Pengarah atau CEO hospital
- Bagi klinik-klinik kesihatan/klinik pergigian – Pegawai Kesihatan Daerah/Pegawai Pergigian Daerah bertanggungjawab terhadap klinik-klinik tersebut
- Bagi rangkaian klinik swasta – Pemilik klinik atau Pegawai atasan yang dipertanggungjawabkan.

b) Berikut merupakan **cadangan** keahlian Jawatankuasa. Namun begitu, setiap fasiliti berhak menentukan keahlian jawatankuasa mengikut kesesuaian fasiliti masing-masing.

i) Bagi hospital – Wakil dari Jabatan berikut:
- Unit Kualiti atau unit yang bertanggungjawab dalam *Incident Reporting*
- Jabatan Kecemasan & Trauma
- Jabatan Perubatan
- Jabatan Paediatrik Jabatan Surgeri/Orthopedik/O & G dan lain-lain disiplin pembedahan
- Jabatan Anaestesiologi (ICU)
- Jabatan Patologi dan Unit Tabung Darah
- Jabatan Farmasi
- Penyelia Jururawat atau Pengarah Jururawat
- Ketua Penolong Pegawai Perubatan
- Unit Kawalan Infeksi
- Lain-lain yang dirasakan sesuai

ii) Bagi hospital/institusi yang tidak mempunyai kesemua jabatan di atas, memadai dengan keanggotaan dari Jabatan yang ada sahaja.

iii) Bagi klinik-klinik kesihatan/pergigian - Jawatankuasa turut dianggotai oleh:
- Pegawai Perubatan/Pergigian Yang Menjaga klinik
- Wakil Pakar Perubatan Keluarga *(Family Medicine Specialist)*
- Wakil Penyelia Jururawat
- Wakil Penyelia Penolong Pegawai Perubatan
- Lain-lain yang dirasakan sesuai

iv) Bagi rangkaian klinik swasta - Jawatankuasa turut dianggotai oleh:
- Wakil pegawai perubatan
- Wakil paramedik dan *allied health professional*
- Wakil pembantu klinik
- Lain-lain yang dirasakan sesuai

c) Ahli Lembaga Pelawat juga boleh dipertimbangkan sebagai Ahli Jawatankuasa.