

2. KESELAMATAN PESAKIT

Taklimat Pengurusan Risiko & Keselamatan Pesakit HQE II 2023

Dr Ahmad Humaizi

18/9/2023

Outline

- MPSG 2.0
- WHO PATIENT SAFETY SOLUTIONS
- E-IR 2.0: DETAILS ON LIST SELECTION

MPSG 2.0



Easy guide on implementation
& monitoring of

MALAYSIAN PATIENT SAFETY GOALS 2.0



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INTRODUCTION



MPSG 2.0 was launched on 17 September 2021 during World Patient Safety Day by the Director General of Health Malaysia

The new goals were developed based on feedbacks from stakeholders and experience gained from 7 years implementation of MPSG

It is more practical and consolidated. MPSG 2.0 consist of 7 goals and 9 indicators.





GOALS IN MALAYSIAN PATIENT SAFETY GOALS 2.0

MALAYSIAN PATIENT SAFETY GOALS 2.0



MINISTRY OF HEALTH MALAYSIA

GOAL 1	INFECTION PREVENTION AND CONTROL <i>Applicable to Hospital / Medical Institution</i>	GOAL 4	TRANSFUSION SAFETY <i>Applicable to Hospital / Medical Institution</i>
 <p>KPI 1 : Hand Hygiene Compliance Rate Target : $\geq 75\%$ <i>6 monthly audit</i></p>	<p>KPI 2 : Rate of Catheter Associated Blood Stream Infection Target : ≤ 0.5 per 100 admissions <i>Once / year (point prevalence survey)</i></p>		<p>KPI 6 : Number of Incorrect Blood Component Transfused (IBCT) Target : Zero Cases <i>Monthly data collection</i></p>
GOAL 2	SAFE SURGERY SAVES LIVES <i>Applicable to Hospital / Medical Institution with OT</i>	GOAL 5	FALL PREVENTION <i>Applicable to Hospital / Medical Institution / Clinics</i>
 <p>KPI 3 : No. of "Wrong Surgery Performed" Target : Zero Cases <i>Monthly data collection</i></p>	<p>KPI 4 : No. Of "Unintended retained surgical item" (URSI) Target Zero Cases of Category 2 & 3 <i>Monthly data collection</i></p>		<p>KPI 7 : Rate of Patient Fall Target : Inpatient : ≤ 5 per 1000 patient-days Outpatient & Primary Healthcare Facilities : $\leq 5\%$ <i>Monthly data collection</i></p>
GOAL 3	MEDICATION SAFETY <i>Applicable to Hospital / Medical Institution / Clinics</i>	GOAL 6	PATIENT IDENTIFICATION <i>Applicable to Hospital / Medical Institution / Clinics</i>
 <p>KPI 5 : Number of Medication Error Leading To Severe Harm Or Death Target : Zero Cases <i>Monthly data collection</i></p>			<p>KPI 8 : Number of Patient Safety Incidents Caused by Wrong Patient Identification (Detected by incident reporting & investigation) Target : Zero Cases <i>Monthly data collection</i></p>
GOAL 7	INCIDENT REPORT AND LEARNING SYSTEM <i>Applicable to Hospital / Medical Institution / Clinics</i>	 <p>KPI 9 : Implementation of Patient Safety Incident Report and Learning System Target : System Implemented <i>Compiled monthly (No. of reports for additional information)</i></p>	

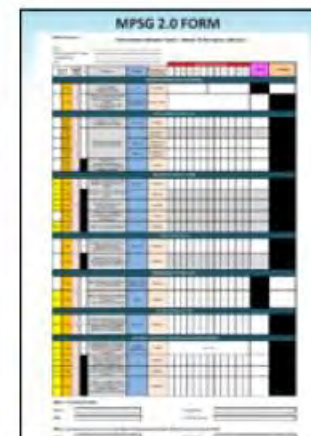
PREREQUISITE TO IMPLEMENTATION

**1**

Identify type of facility and is your performance should be reported individually or under a parent organization.

**2**

Make sure your facility had already established a Patient Safety Committee to implement and monitor the program.

**3**

Make sure Guideline and forms required for implementation of MPSG 2.0 is available and implemented accordingly.

JK Keselamatan Pesakit HQE II

PUNCA KUASA

Pemantapan JK
Keselamatan
Pesakit di Fasiliti
Kesihatan



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: 03-8883 2545
Faks: 03-8889 5542
Email: anhisham@moh.gov.my

Ruj Tuan:
Ruj kami: KKM600-28/2/12Jld 2 (28)
Tarikh: 17 Januari 2020

SEPERTI DI SENARAI EDARAN

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

**PEKELILING KETUA PENGARAH KESIHATAN MALAYSIA BIL | TAHUN 2020:
KESELAMATAN PESAKIT AGENDA UTAMA PERKHIDMATAN KESIHATAN**

1. TUJUAN PEKELILING

Pekeliling ini bertujuan untuk memaklumkan berkenaan menjadikan keselamatan pesakit agenda utama dalam perkhidmatan kesihatan di Malaysia selari dengan resolusi Mesyuarat Pertubuhan Kesihatan Sedunia Ke- 72 berkenaan *Global Action on Patient Safety*.

FUNGSI JK KESELAMATAN PESAKIT

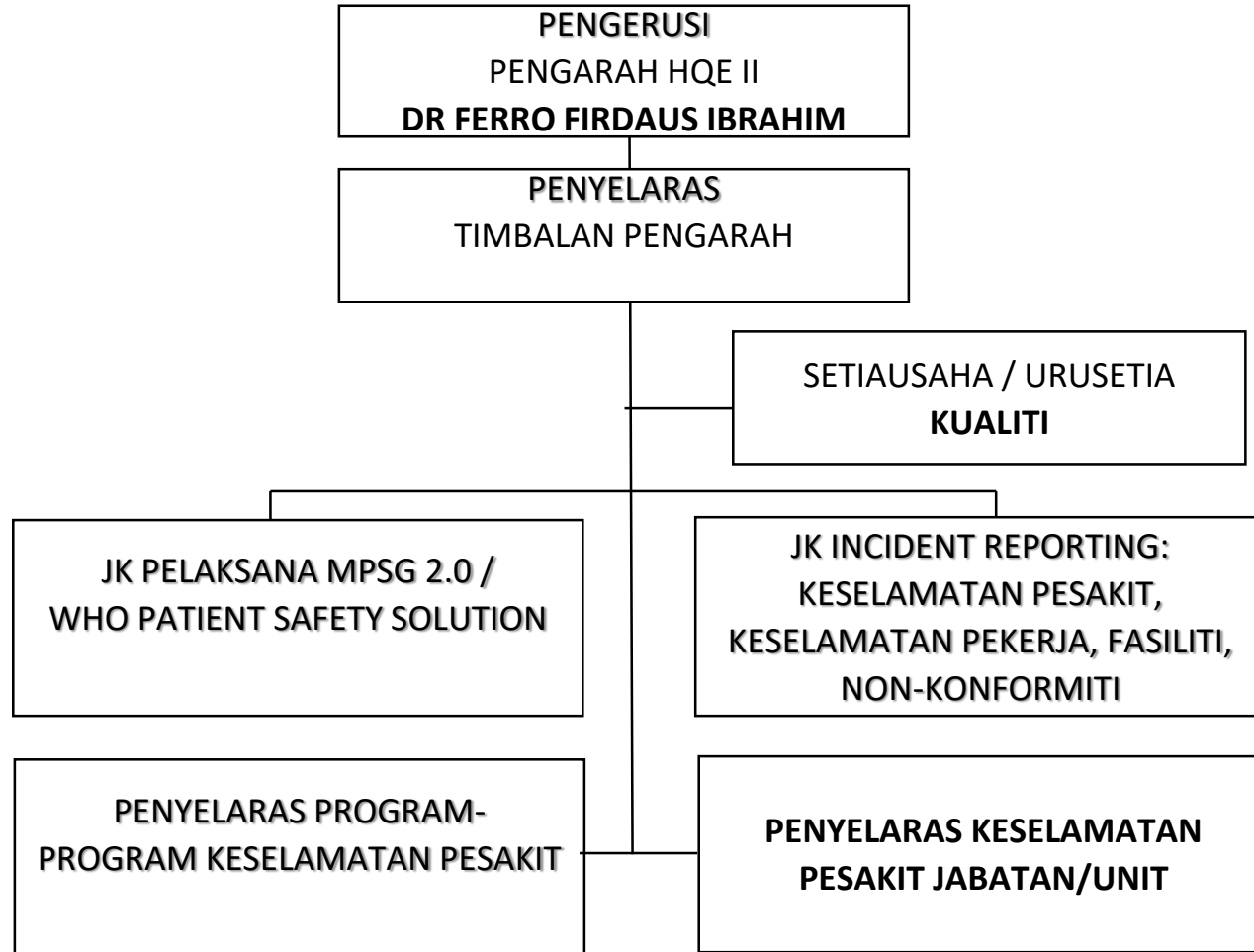
- a) Menjadi pemimpin dan penggerak utama dalam meningkatkan aspek keselamatan pesakit di fasiliti kesihatan atau di negeri tersebut
- b) Merancang dan mewujudkan kaedah, sistem kerja dan program bagi memastikan keselamatan rawatan pesakit.
- c) Memastikan pelaksanaan *Malaysian Patient Safety Goals* serta lain-lain program keselamatan pesakit yang perlu dilaksanakan berdasarkan arahan Ketua Pengarah Kesihatan Malaysia dijalankan secara efektif.
- d) Memantau dan menilai status keselamatan pesakit di fasiliti kesihatan melalui pelaksanaan *Malaysian Patient Safety Goals, Incident Reporting and Learning System* dan lain-lain.
- e) Membincangkan insiden, aduan dan isu-isu keselamatan pesakit di fasiliti serta tindakan penambahbaikan (*risk reduction strategies*) yang efektif.
- f) Memantau keberkesanan tindakan penambahbaikan yang diambil dalam menangani isu-isu keselamatan pesakit.
- g) Mengambil tindakan secara proaktif, kreatif dan inovatif bagi mengelakkan daripada berlakunya kemudaratan kepada pesakit.
- h) Merancang dan menjalankan aktiviti promosi, kesedaran dan pendidikan berkenaan keselamatan pesakit.

JK KESELAMATAN PESAKIT

KEANGGOTAAN	
Pengerusi	Pengarah Hospital
Penyelaras	Timb Pengarah
Urusetia	Kualiti
Ahli	Kardiologi / Perubatan Am
	Pediatrik Kardio
	Anest ICU / KAP
	CTS / Orto / Neurosurg / Pembedahan
	Kecemasan
	Ortodontik / Radio / JPT / Pato
	KPJH / KPPPP / Pengurusan Klinikal
	Penjagaan Luka / Hemodialisis / JRP
	UPCK / Fisio / UDS / Psikologi / JKSP
	Pengurusan / Kejuruteraan / Promosi
	Kawalan Infeksi
	SSSL
	Medication Safety
	Transfusion Safety
	Fall Prevention
Incident Reporting	
Mortality Review	
Wakil pesakit / keluarga	

HQE II	
DR FERRO FIRDAUS IBRAHIM	
DR AHMAD HUMAIZI	
DR LIEW HOUNG BANG, DR GIRI SHAN	
DR SIVA RAO	
DR LIM CHEE HUI, DR CHUA CHEN CHEN	
DR DAVID TANG, DR CHAN KL, DR MOHD SOFAN, DR SITI ZUBAIDAH	
DR GRACE YONG	
DR LYNNORA, DR WAN NAJWA, DR SHAHNAZ, DR ERIC KHOO	
PJ HIKMAH SAVITRI, EN ANDREW SUALI, DR NAZIF	
DR ANANTHA, EN RASNIN, PN DAYANG FAUZIAH	
PN VOO SIEW CHING, PN MARINA MAH, EN LOH	
PN SITI FADILAH, IR THOMSON, PN NURSAFWANAH	
DR VIVY, KJ ROZAWANY	
DR SITI ZUBAIDAH, PJ IDA	
PN SIEW LEN	
DR SHAHNAZ	
PJ HIKMAH, JK JENET	
DR AHMAD HUMAIZI, KJ NORMI	
DR WAN MOHD RASHID, PJ MURIKAH, PJ AINAH, DR SIVA	

CARTA ORGANISASI JK KESELAMATAN PESAKIT HQE II 2023





Clinic	Hosp	7	Total no. of patient safety incident reporting done (for year of reporting).	-	Monthly													
Clinic	Hosp		Total no. of patient safety incident with severe or death outcome.	-	Monthly													
Clinic	Hosp		Total no. of patient safety incident with severe or death outcome that were investigated and action taken.	-	Monthly													

Officer compiling the data

Name:

Designation:

Date:

HP./Fax/ E-mail:

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

Name:

Designation:

Date:

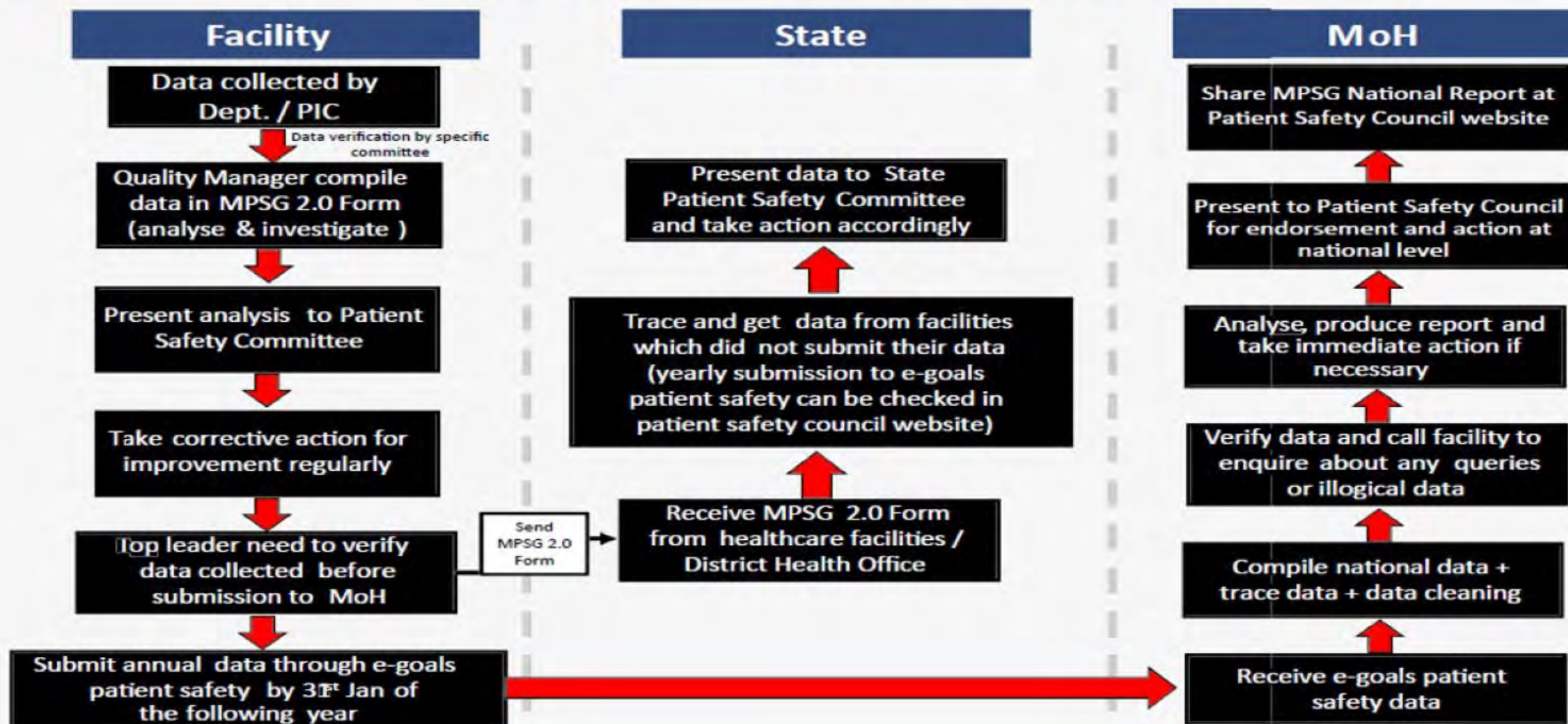
HP./Fax/ E-mail:

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.



MPSG 2.0 FLOW CHART





GOAL I (KPI : I)
HAND HYGIENE
COMPLIANCE RATE

PREREQUISITE TO IMPLEMENTATION

5 moments for HAND HYGIENE

**1**

Implement & conduct promotion, awareness, training, orientation and monitoring program for Hand Hygiene in your facility.

**2**

Having a trained Infection Control Nurse (ICN) or Link Nurse to conduct the audit

**3**

Make sure Guideline and forms required for the audit is available.

World Health Organization Patient Safety SAVE LIVES

Observation Form

Facility: _____ Patient Number: _____ Session: _____

Service: _____ Date: _____ Observer: _____

Unit: _____ Ward/Bed No.: _____ Page No.: _____

Department: _____ Referral Authority: _____ Date: _____

Country: _____

Ref No.	Ref No.	Ref No.	Ref No.	Ref No.	Ref No.
1	2	3	4	5	6
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
25	26	27	28	29	30
31	32	33	34	35	36
37	38	39	40	41	42
43	44	45	46	47	48
49	50	51	52	53	54
55	56	57	58	59	60
61	62	63	64	65	66
67	68	69	70	71	72
73	74	75	76	77	78
79	80	81	82	83	84
85	86	87	88	89	90
91	92	93	94	95	96
97	98	99	100	101	102

DETAILS ON KPI 1 : HAND HYGIENE COMPLIANCE RATE

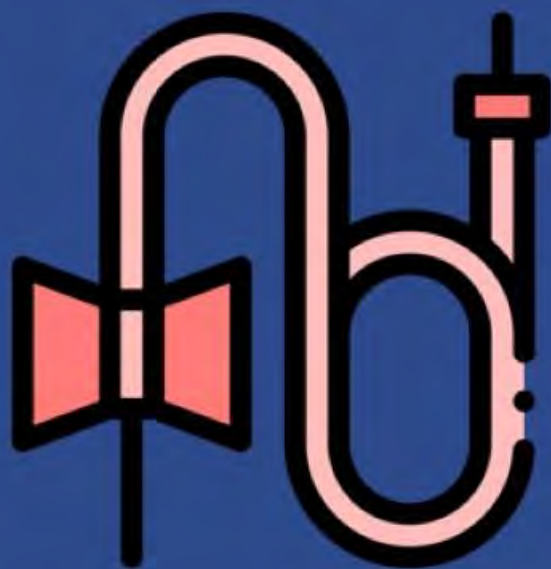


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KPI NO. 1	HAND HYGIENE COMPLIANCE RATE
NUMERATOR (N)	Number of hand hygiene actions (wash or rub) performed
DENOMINATOR (D)	Number of opportunities observed
FORMULA	$(N/D) \times 100$
TARGET	$\geq 75\%$ compliance rate at each audit
DATA COLLECTION AT FACILITY LEVEL	6-monthly (twice a year)
APPLICABLE FOR	All hospitals and medical institutions that treat patient.



GOAL 1 (KPI : 2)
RATE OF CATHETER
ASSOCIATED BLOOD
STREAM INFECTION
(CABSI)



PREREQUISITE TO IMPLEMENTATION

**1**

Implement & conduct promotion, awareness, training, orientation and monitoring program for Prevention of CABS I in your facility.

**2**

Having a trained Healthcare Personnel / Nurse to conduct the audit
(Understand the definition and audit process)

**3**

Make sure Guideline and forms required for the audit is available.

DETAILS ON KPI 2 : RATE OF CATHETER ASSOCIATED BLOOD STREAM INFECTION

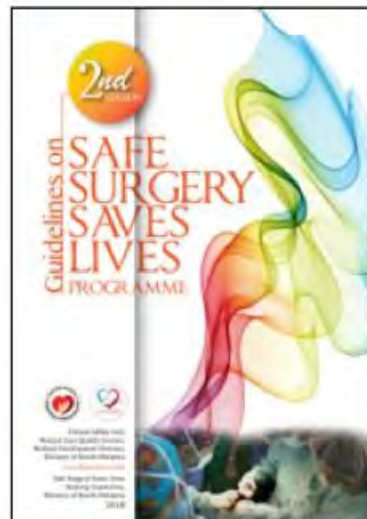
KPI NO. 2	RATE OF CATHETER ASSOCIATED BLOOD STREAM INFECTION (CABSI) - NO. OF CABSI PER 100 ADMISSIONS
NUMERATOR (N)	Total number of CABSI cases
DENOMINATOR (D)	Total number of patient admissions to the hospital
FORMULA	$(N/D) \times 100$
TARGET	≤0.5 PER 100 ADMISSIONS
DATA COLLECTION AT FACILITY LEVEL	Once a year, over a period of 2 weeks
MONITORING METHODS	It is a hospital-wide cross sectional, point prevalence survey conducted once a year. Population under surveillance: All in-patients during the survey period
APPLICABLE FOR	All hospitals and medical institutions that treat patient.



GOAL 2 (KPI : 3)
NO. OF WRONG
SURGERY
PERFORMED



PREREQUISITE TO IMPLEMENTATION

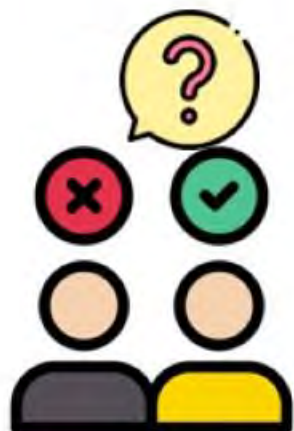
**1**

Make sure the relevant Guideline and forms on the implementation of Safe Surgery Saves Lives is available.

**2**

Implement & conduct promotion, awareness, training, orientation and monitoring program for Safe Surgery Saves Lives.

TYPES OF “WRONG SURGERY” INCLUDED IN THE MONITORING OF KPI 3



WRONG PATIENT

Mistakenly Doing
different
procedure then
what's intended

WRONG PROCEDURE



WRONG SIDE

Doing more than
what's consented

Doing less than
what's consented



WRONG SITE



E.g. : Wrong
Intraocular Lens
inserted

WRONG IMPLANT

DETAILS ON KPI 3 : NO. OF WRONG SURGERY PERFORMED



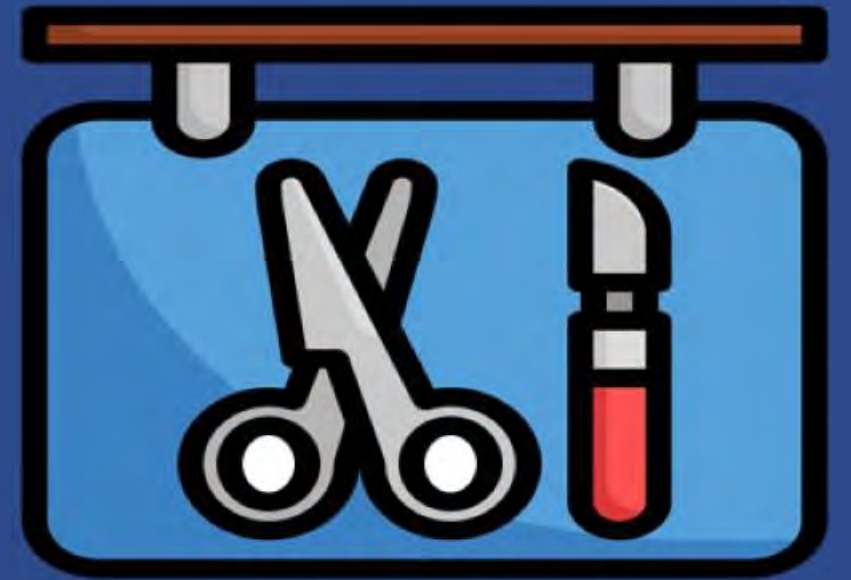
MINISTRY OF HEALTH MALAYSIA

KPI NO. 3	NUMBER OF “WRONG SURGERIES” PERFORMED
DATA TO BE REPORTED	<ol style="list-style-type: none">1. Total number of “Wrong Surgeries” performed2. Total number of operations/procedures performed in operation theatre in hospitals providing surgery services
TARGET	ZERO CASE OF WRONG SURGERY
DATA COLLECTION AT FACILITY LEVEL	<p><i>Cases can be detected through your facility Patient Safety Incident Report System</i></p> <p>Data (numbers of cases) to be collected on a monthly basis.</p>
APPLICABLE FOR	All hospitals and medical institutions with operation theatre

GOAL 2 (KPI : 4)

NO. OF

**“UNINTENDED
RETAINED SURGICAL
ITEM” (URSI)**



PREREQUISITE TO IMPLEMENTATION

**1**

Make sure the relevant Guideline and forms on the implementation of Safe Surgery Saves Lives and URSI is available.

2

Implement & conduct promotion, awareness, training, orientation and monitoring program for Safe Surgery Saves Lives.

DETAILS ON KPI 4 : UNINTENDED RETAINED SURGICAL ITEM (URSI)



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KPI NO. 4	NUMBER OF “UNINTENDED RETAINED SURGICAL ITEM”
DATA TO BE REPORTED	<ol style="list-style-type: none">1. Total number of Unintended Retained Surgical Item for Category 1, 2 and 32. Total no of operations/procedures performed in operation theatre in hospitals providing surgery services
TARGET	ZERO CASES OF CATEGORY 2 & 3 UN-INTENDED RETAINED SURGICAL ITEM
DATA COLLECTION AT FACILITY LEVEL	Data (numbers of cases) to be collected on a monthly basis.
APPLICABLE FOR	All hospitals and medical institutions with operation theatre



GOAL 3 (KPI : 5)

NUMBER OF

**MEDICATION ERROR
LEADING TO SEVERE
HARM OR DEATH**



PREREQUISITE TO IMPLEMENTATION



1

Make sure the relevant Guideline and forms on the implementation of Medication Safety programme is available.

5 Moments for Medication Safety



2

Implement & conduct promotion, awareness, training, orientation and monitoring program for Medication Safety.

DETAILS ON KPI 5 : NO. OF MEDICATION ERROR RELATED TO SEVERE HARM OR DEATH



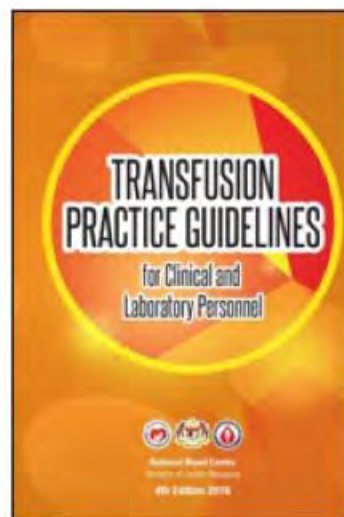
KPI NO. 5	NUMBER OF MEDICATION ERROR LEADING TO SEVERE HARM OR DEATH
DATA TO BE REPORTED	<ol style="list-style-type: none"> 1. Total number of Actual Medication Error leading to severe harm or death (ME category F to I) 2. Total number of Actual Medication Error (overall) 3. Total number of Near-Miss Medication Error 4. Total number of hospital admission and clinic visit
TARGET	ZERO CASES OF MEDICATION ERROR LEADING TO SEVERE HARM OR DEATH (ME CATEGORY F TO I)
DATA COLLECTION AT FACILITY LEVEL	Data (numbers of cases) to be collected on a monthly basis.
APPLICABLE FOR	All hospitals, medical institutions & clinics that treat patient



GOAL 4 (KPI : 6)
NO. OF ACTUAL
INCORRECT BLOOD
COMPONENT
TRANSFUSION (IBCT)
ERROR



PREREQUISITE TO IMPLEMENTATION

**1**

Make sure the relevant Guideline and forms on the implementation of Transfusion Safety programme is available.

2

Implement & conduct promotion, awareness, training, orientation and monitoring program for Transfusion Safety.

DETAILS ON KPI 6 : NO. OF INCORRECT BLOOD COMPONENT TRANSFUSED (IBCT)

KPI NO. 6	NUMBER OF ACTUAL INCORRECT BLOOD COMPONENT TRANSFUSION ERROR (IBCT)
DATA TO BE REPORTED	<ol style="list-style-type: none">1. Total number of Actual Incorrect Blood Component Transfusion Error (IBCT)2. Total number of Near Miss Incorrect Blood Component Transfusion Error (IBCT)
TARGET	ZERO CASES OF ACTUAL INCORRECT BLOOD COMPONENT TRANSFUSION ERROR (IBCT)
DATA COLLECTION AT FACILITY LEVEL	Data (numbers of cases) to be collected on a monthly basis.
APPLICABLE FOR	All hospitals and medical institutions that treat patient.



GOAL 5 (KPI : 7)

RATE OF PATIENT FALL

DETAILS ON KPI 7 : RATE OF PATIENT FALL



DEFINITION

Fall is an unintentional descent to a lower level, which may or may not result in injury. For the purpose of this document, falls include all witnessed and unwitnessed incidents occurring in all inpatient and outpatient healthcare facilities.

This does not include falls due to events such as seizures, loss of consciousness, paralysis or cardiac arrest and due to external forces.

CRITERIA

INCLUSION

Case of unintentional patient fall in health facility compound.

EXCLUSION

- Falls due to events such as seizures, loss of consciousness, paralysis or cardiac arrest and due to external forces.
- Intentional fall due to suicidal attempt.
- Non injurious developmental fall among infant / toddler.



KPI NO. 7

RATE OF PATIENT FALL

FORMULA

Inpatient

$\frac{\text{Total number of falls}}{\text{Total number of patient-days in the facility}} \times 1000$

Total number of patient-days in the facility

= Falls rate per 1000 patient-days

Note :
*Only for admitted patient.
Day-care patients are not included as inpatient.*

Outpatient and Primary Healthcare Facilities

$\frac{\text{Total number of falls}}{\text{Total number of clinic attendance}} \times 100$

Total number of clinic attendance

Including all other outpatient services attendance

= Falls rate

TARGET

Inpatient : ≤ 5 per 1000 patient-days

Outpatient and Primary Healthcare Facilities : ≤ 5 %

DATA COLLECTION
AT FACILITY LEVEL

Data (numbers of cases) to be collected on a monthly basis.

APPLICABLE FOR

All hospitals, medical institutions & clinics that treat patient



GOAL 6 (KPI : 8)

NO. OF PATIENT SAFETY
INCIDENTS CAUSED BY
WRONG PATIENT
IDENTIFICATION



DETAILS ON KPI 8 : NO. OF INCIDENTS CAUSED BY WRONG PATIENT IDENTIFICATION



INCLUSION CRITERIA

Patient safety incidents which wrong patient identification was found as one of the root cause or contributing factor.

Can be detected by using any method of Patient Safety Investigation in the facility such as Root Cause Analysis.



EXCLUSION CRITERIA

Cases involving stolen identity / identity theft.

DETAILS ON KPI 8 : NO. OF PATIENT SAFETY INCIDENTS CAUSED BY WRONG PATIENT IDENTIFICATION



KPI NO. 8	NUMBER OF PATIENT SAFETY INCIDENTS CAUSED BY WRONG PATIENT IDENTIFICATION (DETECTED THROUGH INCIDENT REPORTING & INVESTIGATION)
DATA TO BE REPORTED	Number of Patient Safety Incidents which Wrong Patient Identification was found as one of the root cause or contributing factor.
TARGET	ZERO INCIDENT CAUSED BY WRONG PATIENT IDENTIFICATION
DATA COLLECTION AT FACILITY LEVEL	Data (numbers of cases) to be collected on a monthly basis.
APPLICABLE FOR	All hospitals, medical institutions & clinics that treat patient



GOAL 7 (KPI : 9)
IMPLEMENTATION OF
PATIENT SAFETY
INCIDENT REPORT
AND LEARNING
SYSTEM

DETAILS ON KPI 9 : IMPLEMENTATION OF PATIENT SAFETY INCIDENT REPORT AND LEARNING SYSTEM

KPI NO. 9	IMPLEMENTATION OF PATIENT SAFETY INCIDENT REPORT AND LEARNING SYSTEM
DATA TO BE REPORTED	<ul style="list-style-type: none">• Total number of patient safety incident reporting done (for year of reporting).• Total no. of patient safety incident with severe or death outcome.• Total no. of patient safety incident with severe or death outcome that were investigated and action taken.
TARGET	INCIDENT REPORTING AND LEARNING SYSTEM IMPLEMENTED
DATA COLLECTION AT FACILITY LEVEL	Data (numbers of cases) to be collected on a monthly basis.
APPLICABLE FOR	All hospitals, medical institutions & clinics that treat patient

MPSG 2.0 Indicator: 2022 & 2023

REDUCING HARM

PENCAPAIAN JAN-DIS 2022

NO	MPSG INDICATOR	STD	P1	P2			
1	Hand Hygiene Compliance Rate	≥ 75%	90.5	93.5	94%	Total no. of surgeries/procedures performed in the hospital's OT	4619
2	Rate of Catheter Associated Blood Stream Infection (CABSI) - No. of CABSI per 100 admissions	≤ 0.5 Per 100 Admissions			0.1%	Number of Actual Medication Error	3
3	Number of "Wrong Surgeries" performed	0	0	0	0	Number of Near Miss Medication Error	63
4	Number of Unintended Retained Surgical Item	0	0	0	0	Number of near miss Incorrect Blood Component Transfusion Error (IBCT)	0
5	Number of Medication Error leading to Severe Harm or Death	0	0	0	0	Total no. of hospital admission (exclude clinic attendance)	12255
6	Number of actual Incorrect Blood Component Transfusion Error (IBCT)	0	0	0	0	Total no. of clinic attendance	67888
7	Rate of patient fall (inpatient) - per 1000 bed-days	≤5 per 1000 pt-d			0.179%	Total no. of patient safety incident reporting done (for year of reporting)	70
	Rate of patient fall (outpatient or clinics) - per 100 clinics attendance	≤5 %			0.002%	Total no. of patient safety incident with severe or death outcome.	2
8	Number of Patient Safety incidents caused by wrong patient identification (detected through incident reporting & investigation)	0	0	0	0	Total no. of patient safety incident with severe or death outcome that were investigated and action taken.	2
9	Implementation of Incident Reporting System or other Methods To Investigate Incidents	System Implemented	Y	Y	Y		

REDUCING HARM

PENCAPAIAN JAN-JUN 2023

NO	MPSG INDICATOR	STD	P1	P2			
1	Hand Hygiene Compliance Rate	≥ 75%	86		86%	Total no. of surgeries/procedures performed in the hospital's OT	2279
2	Rate of Catheter Associated Blood Stream Infection (CABSI) - No. of CABSI per 100 admissions	≤ 0.5 Per 100 Admissions			0.11%	Number of Actual Medication Error	7
3	Number of "Wrong Surgeries" performed	0	0		0	Number of Near Miss Medication Error	32
4	Number of Unintended Retained Surgical Item	0	0		0	Number of near miss Incorrect Blood Component Transfusion Error (IBCT)	0
5	Number of Medication Error leading to Severe Harm or Death	0	0		0	Total no. of hospital admission (exclude clinic attendance)	6267
6	Number of actual Incorrect Blood Component Transfusion Error (IBCT)	0	0		0	Total no. of clinic attendance	54678
7	Rate of patient fall (inpatient) - per 1000 bed-days	≤5 per 1000 pt-d	0.1		0.1%	Total no. of patient safety incident reporting done (for year of reporting)	13
	Rate of patient fall (outpatient or clinics) - per 100 clinics attendance	≤5 %	0.004		0.004%	Total no. of patient safety incident with severe or death outcome.	0
8	Number of Patient Safety incidents caused by wrong patient identification (detected through incident reporting & investigation)	0	0		0	Total no. of patient safety incident with severe or death outcome that were investigated and action taken.	0
9	Implementation of Incident Reporting System or other Methods To Investigate Incidents	System Implemented	Y		Y		

Track & Trending

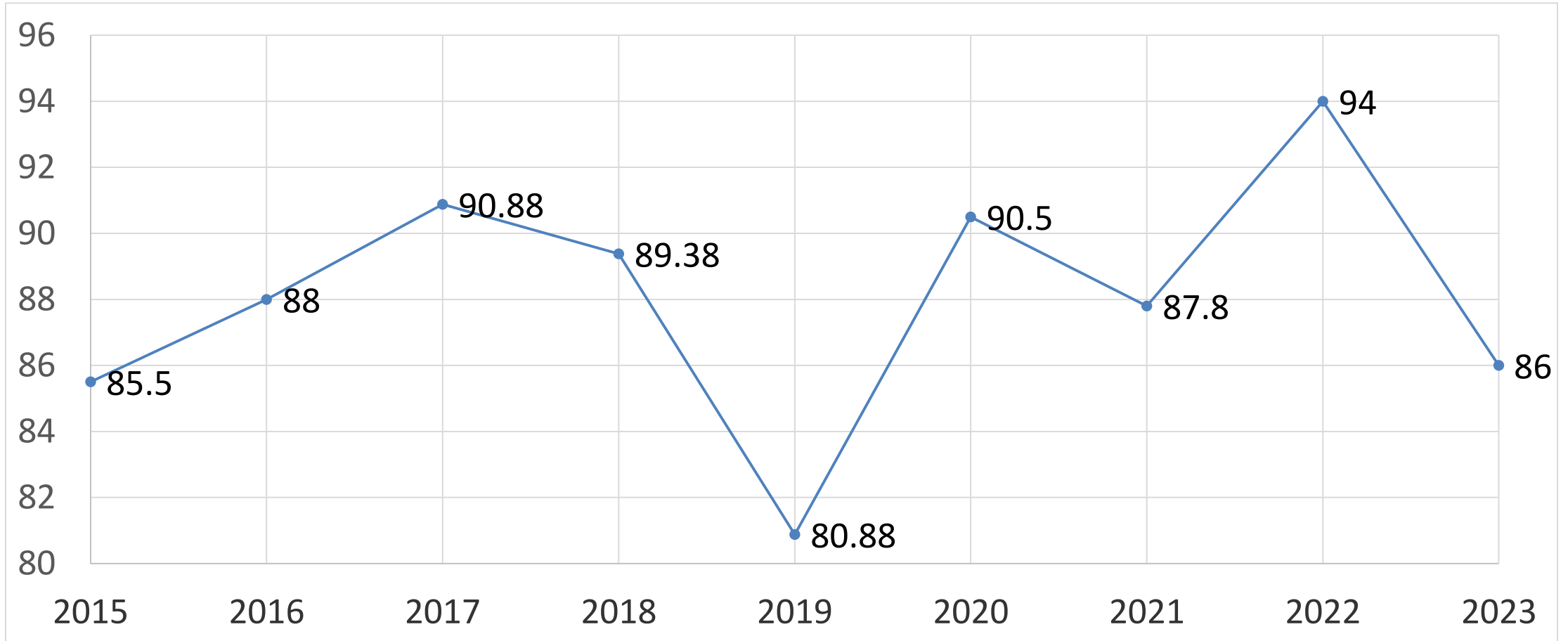
MPSG 2015 – Jan-Jun 2023

PI MSQH Service Standard 01

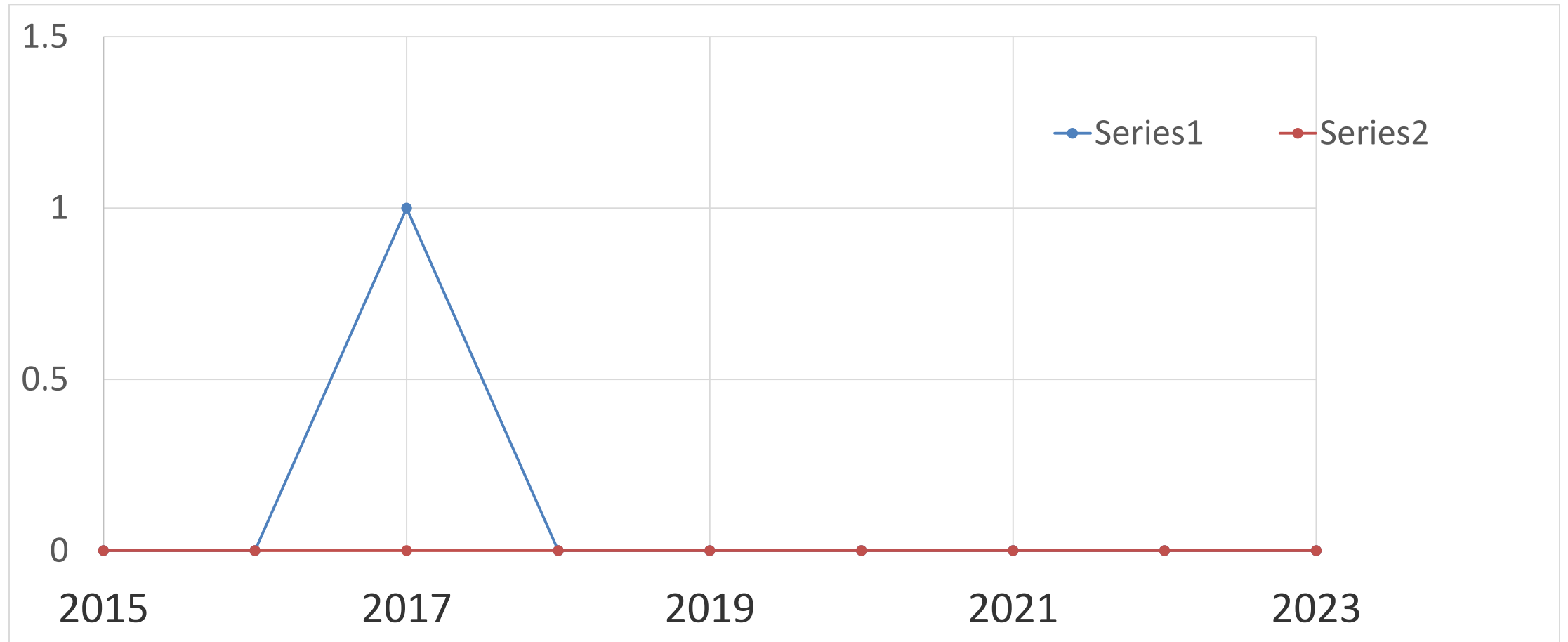
MPSG

- Hand Hygiene Compliance Rate
- No. of Wrong Surgery & No. of URSI
- Incidence Rate of MRSA, ESBL - Klebsiella pneumoniae, ESBL - E.coli Infection
- Compliance Rate for "at least 2 identifiers implemented"
- No. of Transfusion Error (Actual) & (Near Miss)
- No. of Medication Errors (Actual) & (Near Miss)
- % of Critical value Notified within 30 minutes & % of Action towards critical value Results that have been notified within 30 minutes
- No. of Fall (Adult) & (Pediatric)

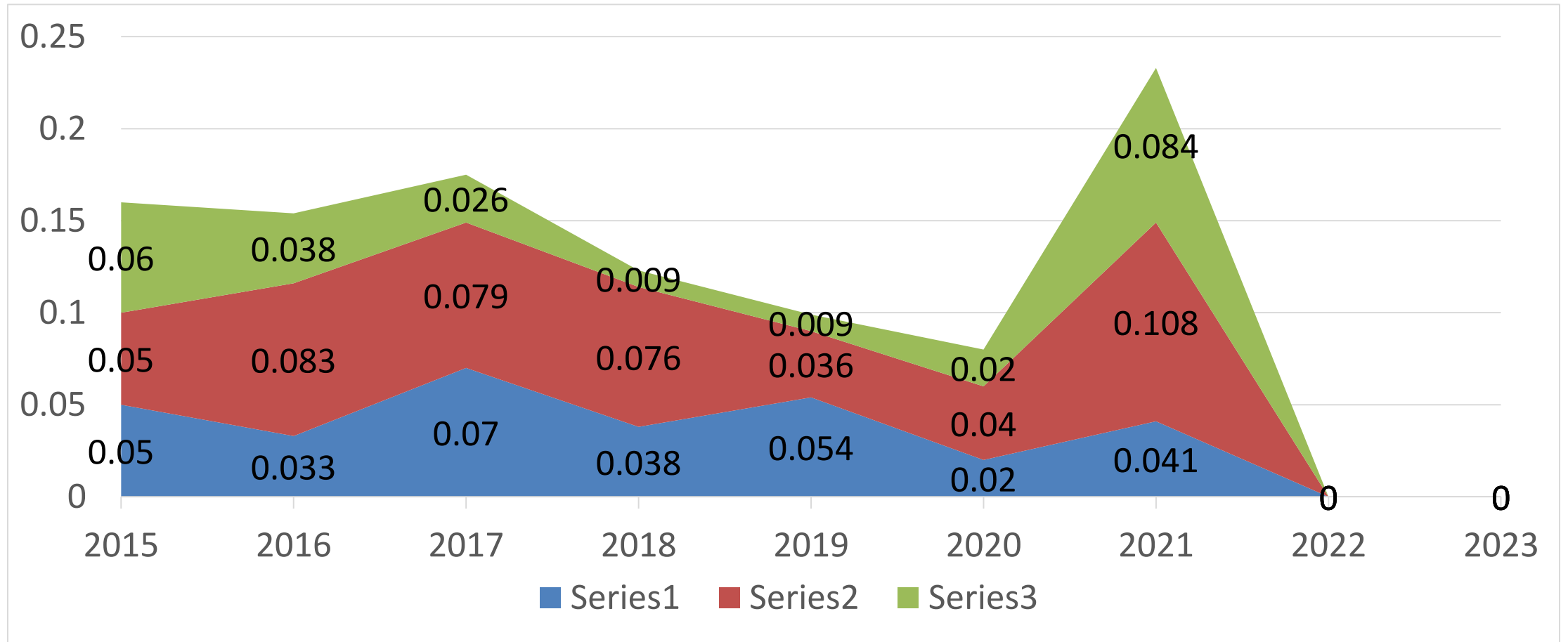
Hand Hygiene Compliance Rate



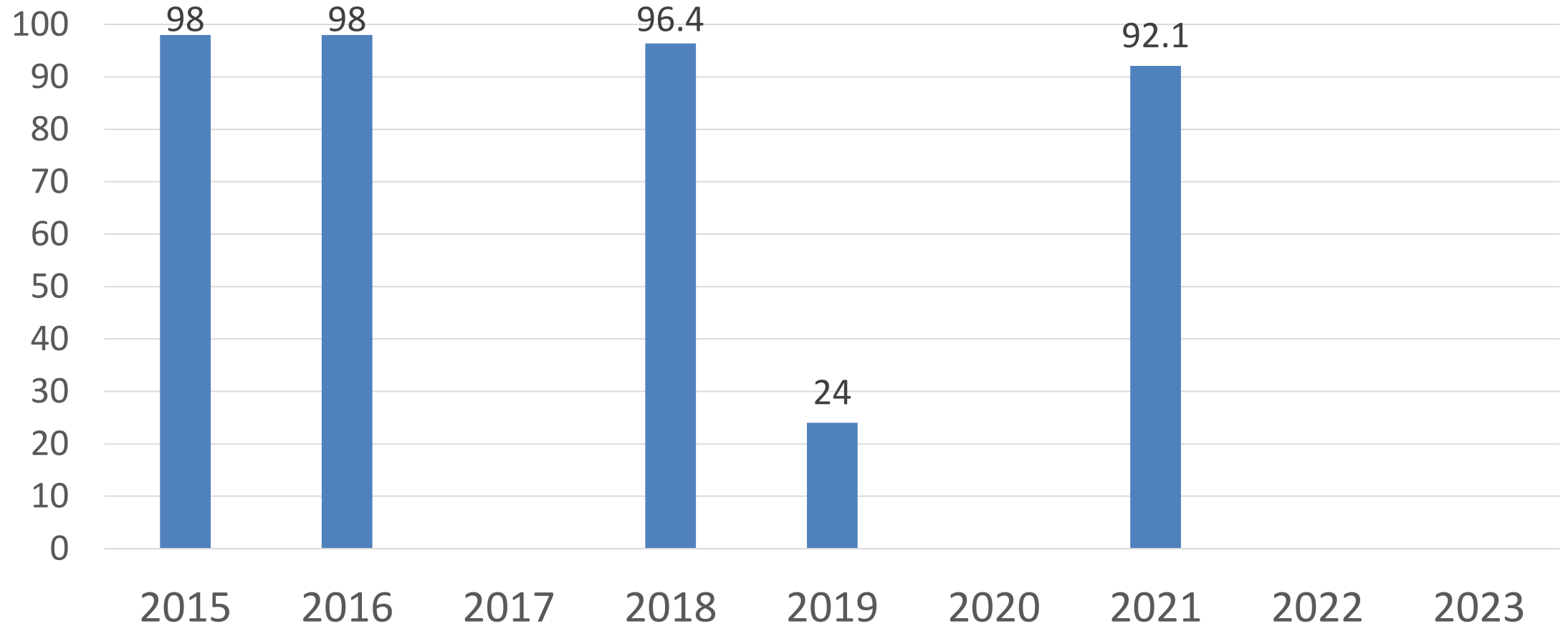
No. of Wrong Surgery & No. of URSI



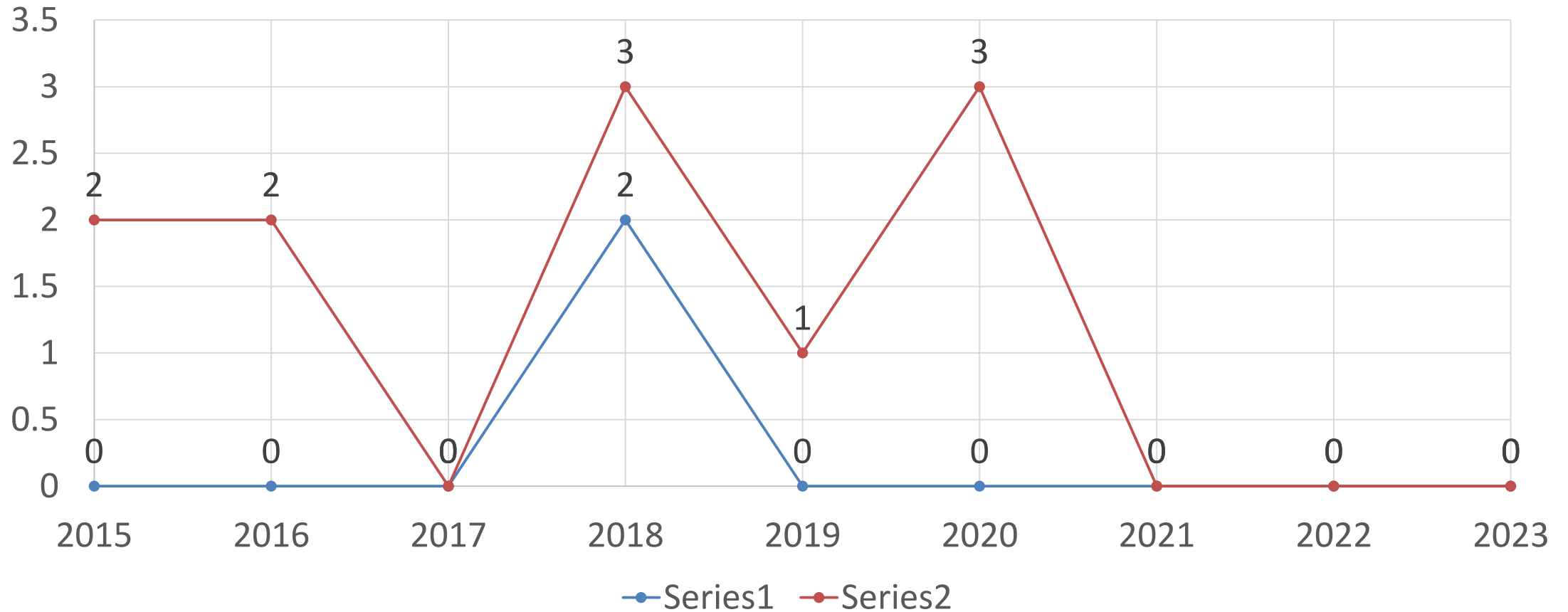
Incidence Rate of MRSA, ESBL - Klebsiella pneumoniae, ESBL - E.coli Infection



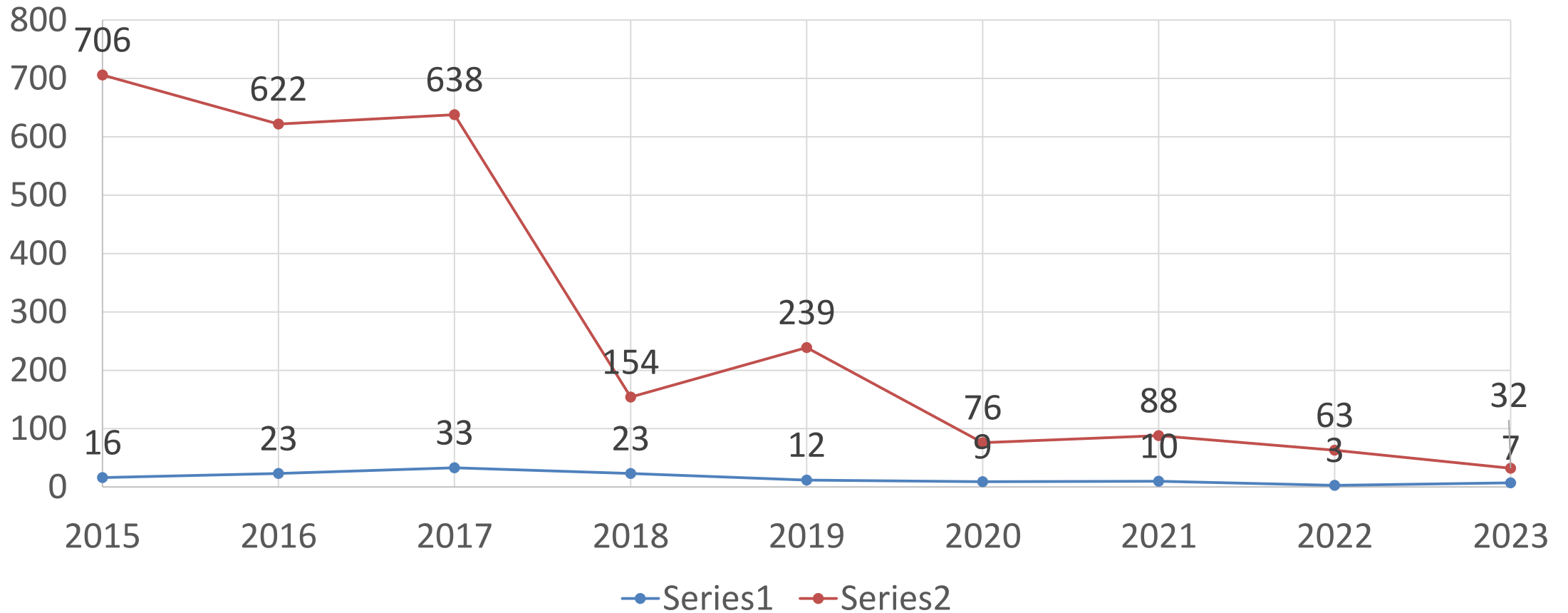
Compliance Rate for "at least 2 identifiers implemented"



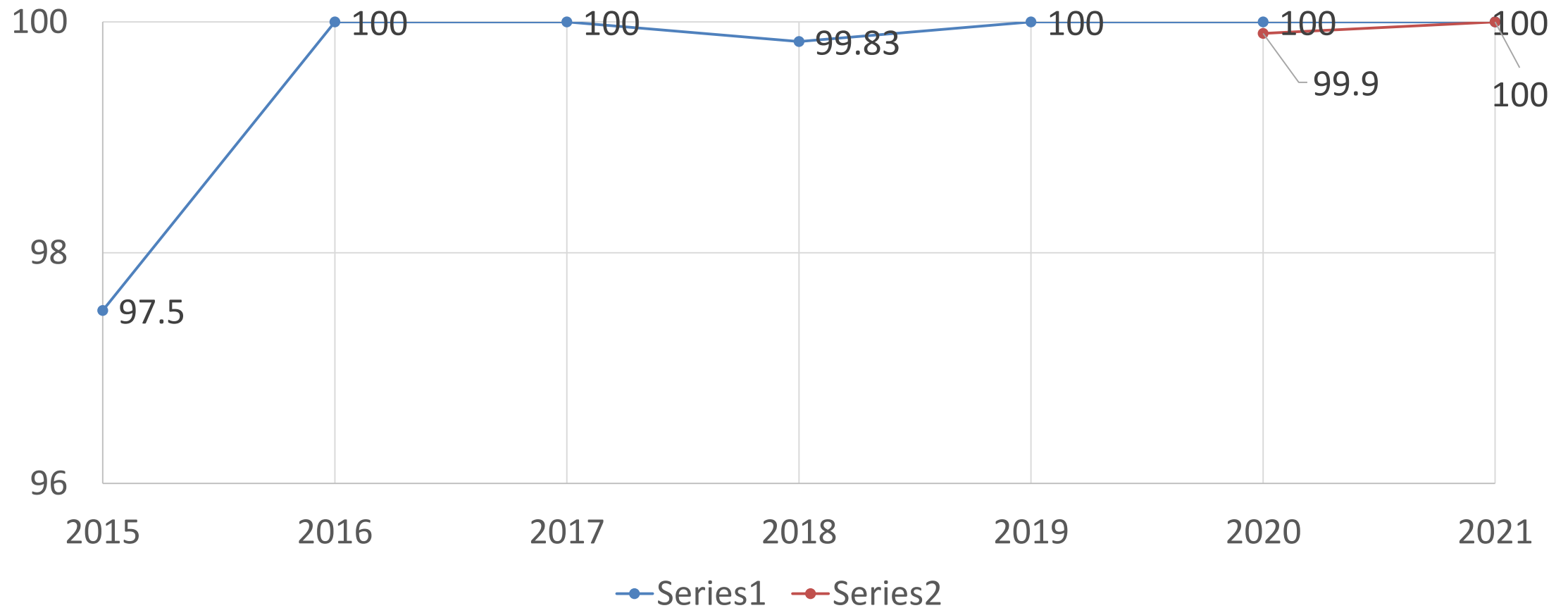
No. of Transfusion Error (Actual) & (Near Miss)



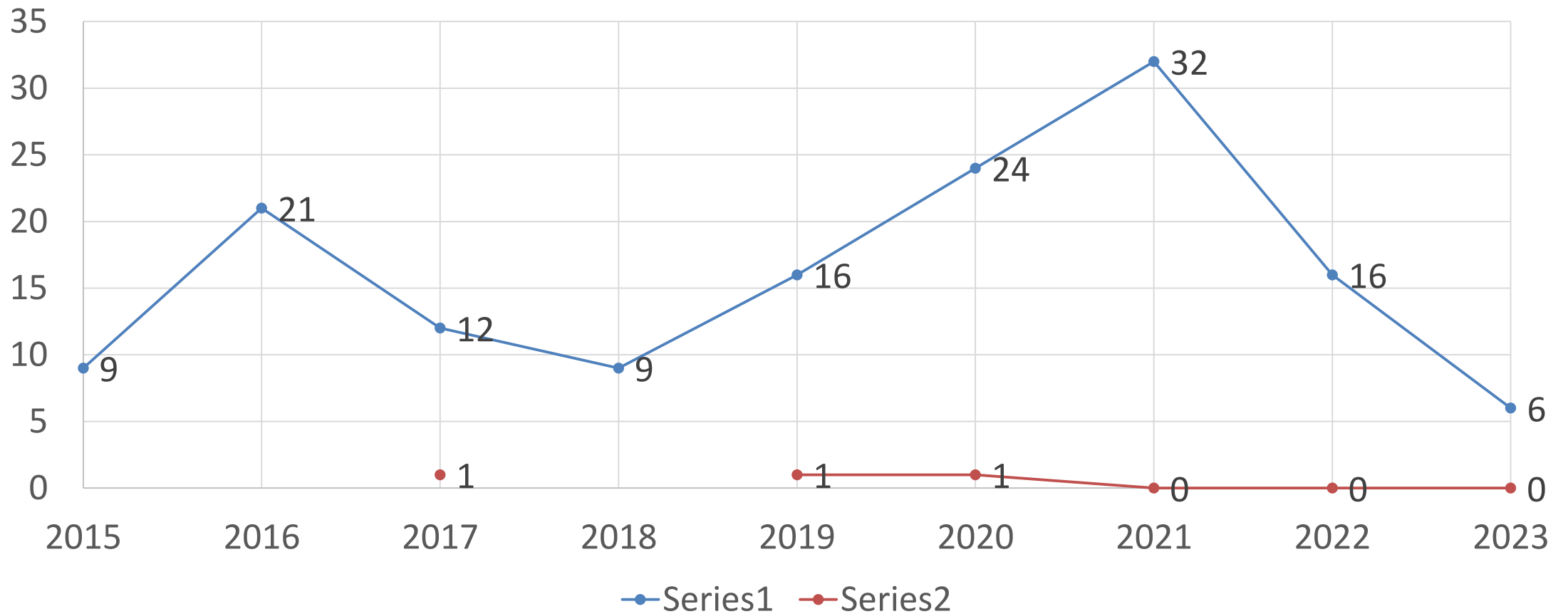
No. of Medication Errors (Actual) & (Near Miss)



% of **Critical value** notified within 30 minutes &
% of **Action** towards critical value results that have been notified within 30 minutes

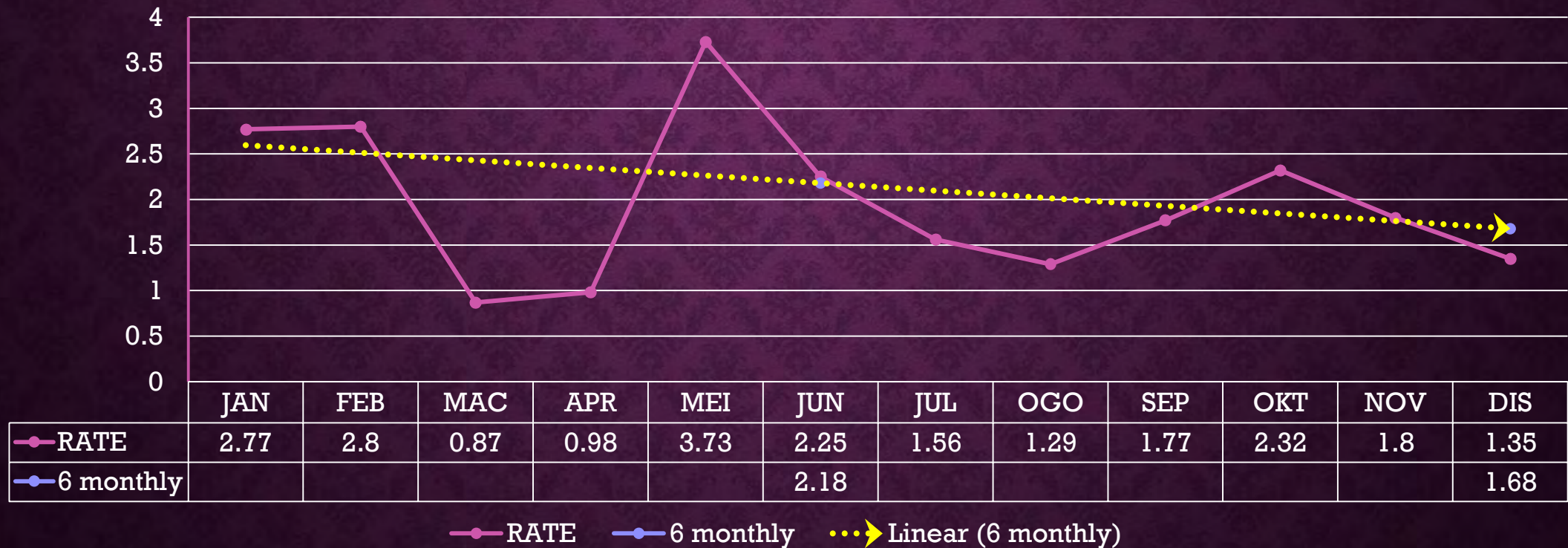


No. of Fall (Adult) & (Pediatric)



Performance Indicator MSQH: Service Standard 1 (2022)

1.1 PERCENTAGE OF PATIENTS LEAVING HOSPITAL AGAINST MEDICAL ADVICE RELATIVE TO ALL PATIENTS HOSPITALISED WITHIN A SPECIFIED PERIOD



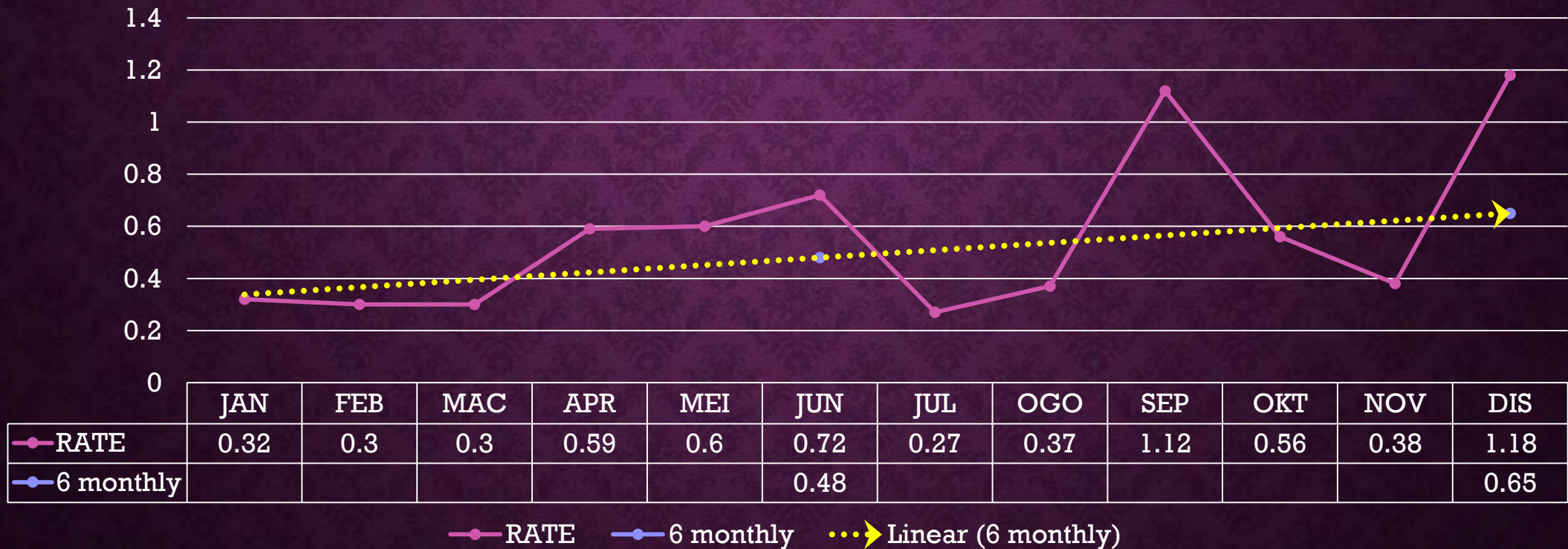
Target : Downward Trend

Achievement : ✓

Peluang Penambahbaikan

- PI 1.1 Percentage of patients leaving hospital against medical advice relative to all patients hospitalised within a specified period
 - Tambahbaik borang KKM – tambah info sebab balik ke rumah:
 - sosial,
 - kewangan,
 - logistik,
 - kepercayaan

1.2 PERCENTAGE OF INCIDENTS/ACCIDENTS DURING HOSPITALISATION OF PATIENTS AS PERCENTAGE OF ALL ADMITTED PATIENTS



Target : Downward Trend

Achievement : ✘

SIQ : ✔

NO	MAIN CONTRIBUTING FACTORS	SUB-FACTORS	REMEDIAL ACTIONS		PRIORITY	STATUS
			ACTIONS	RESPONSIBLE PERSON		
1	Task & Technology	Many cases that doesn't fulfil the criteria as "incident" reporting under MOH IR 2.0 guidelines are being recorded, which contributed to the target not being achieved.	Procedural changes- Only cases pertaining to patient safety are to be reported and recorded for performance indicator analysis purpose	Head, Quality Unit		

Peluang Penambahbaikan

- PI 1.2 incident
 - E-IR 2.0

List of Incidents in e-IR

1. Wrong surgery / Procedure
2. Unintended retained surgical item in patient after an operation
3. Unintended retained foreign body in patient after a procedure (procedure other than operation/ surgery in OT)
4. Error in transfusion of blood / blood products
5. Medication Error
6. Patient Fall in facility
7. Obstetric related incidents
8. Adverse outcome of clinical procedure
9. Pre-hospital care and ambulance service related incident
10. Radiology related incident (Radiotherapy / Imaging)

List of Incidents in e-IR

11. Patient suicide / attempted suicide / self-harm
12. Patient discharged to wrong family members / next-of-kin
13. Assault/ battery of patient
14. Unanticipated Fire – Fire, flame, or unanticipated smoke, heat, or flashes occurring in the facility
15. Clinical management error (Investigation error –includes lab error , diagnostic error, suboptimal treatment / management)
16. Other physical injury to patient (excluding assault / battery) relating to patient safety
17. Dislodgement of catheter / tube
18. Death of patient by unexplained cause or under suspicious circumstances that are required to be reported to police
19. Missing patient / abduction (NOT ABSCONDED)
20. Food Contamination / Poisoning (not to include patient admitted due to food poisoning)

e-IR 2.0: Details on List Selection

To improve reporting system

To reduce numbers of reporting of “others category”

List of Incidents in e-IR

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Example of Selection for each type of incident

Type of Incident

- Wrong surgery / Procedure

Type of wrong surgery / procedure

- Wrong Procedure
- Wrong Patient
- Wrong Site
- Wrong Side
- Wrong Implant

Main Factors / Root Cause

- Consent
- Patient Identification
- Documentation
- Imaging
- Lab Related
- OT Administration (OT list mismatch)
- Other non-compliance to SSSL Procedure
- Others

Type of Incident

- URSI

Situation

- Cat.1 (retained but decide to leave)
- Cat.2 (retained but not found after SOP search)
- Cat.3 (incidentally found due to sx. or on follow-up)

Main Factors / Root Cause

- Swab count/instrument count documentation
- Swab count/instrument count communication
- Swab count/instrument count procedure
- Equipment failure / durability
- Skill / experience
- Others

Item

- Soft goods (gauze , sponge , tampon , swab and etc.)
- Sharps (needles)
- Instruments (Clamp / Scissors / Retractor / Depressor / etc.)
- Guidewire / Catheters
- Small misc. items (broken part needles / instruments / others)

Sub-item

- Gauze
- Tampon
- Abdominal pack
- Instrument / instrument part
- Guide wire
- Catheters
- Needles
- Others

Example of Selection for each type of incident

Type of Incident

- URFB (Procedure)

Type of URFB

- Cat.1 (retained but decide to leave)
- Cat.2 (retained but not found after SOP search)
- Cat.3 (incidentally found due to sx. or on follow-up)

Main Factors / Root Cause

- Swab count/instrument count documentation
- Swab count/instrument count communication
- Swab count/instrument count procedure
- Equipment failure / durability
- Skill / experience
- Others

Item

- Soft goods (gauze , sponge , tampon , swab and etc.)
- Sharps (needles)
- Instruments (Clamp / Scissors / Retractor / Depressor / etc.)
- Guidewire / Catheters
- Small misc. items (broken part needles / instruments / others)

Sub-item

- Gauze
- Tampon
- Abdominal pack
- Instrument / instrument part
- Guide wire
- Catheters
- Needles
- Others

Procedure (specify)

- Shortline/ longline insertion (IJC , CVC and etc.)
- Vaginal Examination / SVD
- Wound dressing
- Amputation (small)
- Incision and excision of lump and bump
- Venepuncture / Arterial / Branula
- Tubes / drains / catheters
- Others

Example of Selection for each type of incident

Type of Incident

- Error in transfusion of blood / blood products

Type of error

- Sampling / labelling error
- ABO discrepancy from previous record
- Wrong type of blood product transfused
- Improper storage & transportation
- Incorrect blood product issued
- Incorrect blood product provided
- Delayed or prolonged transfusion
- Others

Main Factors / Root Cause

- Patient Identification
- Non compliance to blood taking SOP
- Documentation Error
- Laboratory Technical Error
- Others

Type of Incident

- Medication Error

Main process for error

- Prescription
- Dispensing
- Administration
- Omission
- Monitoring
- Storage and disposal

Type of error

- Wrong Medication
- Wrong Patient
- Wrong Dose
- Wrong Time
- Wrong Route
- Wrong Indication
- Wrong Documentation

Example of Selection for each type of incident

Type of Incident

- Patient Fall in facility

Location

- Corridor / hallway
- Nursing station
- Toilet / near-toilet
- Bed / Bed-side / baby cot
- Pantry / Dining area / Common area
- Treatment room
- OT area
- Stairs
- High floor edge / ledge

Situation

- Chair / Wheelchair
- Transferring patient / stretcher / trolley
- While holding / breastfeeding
- During therapy
- Manoeuvring walking aid
- Reaching out
- Slipped
- Loss of balance
- Others

Main Factors / Root Cause

- Medical condition
- Wet floor
- Wheel not secure / moving parts not secure
- Railing malfunction or absent or not used
- Tired / sleepy / lapse of concentration
- Others

Example of Selection for each type of incident

Type of Incident

- Obstetric related incidents

Incidents involving

- Mother
- Baby
- Both

Type of Obs. incident

- PPH / Uterine atony
- Perineal tear (3rd degree tear and above only)
- Cervical tear
- Vaginal and surrounding area haematoma
- Shoulder dystocia
- Laceration wound on baby
- Neonatal bone fracture
- SAH
- HIE
- Nerve injury
- Delivery other than labour room
- Placenta abruptio
- Cord prolapse
- Others (specify)

Type of Incident

- Adverse outcome of clinical procedure

Type of adverse outcome

- Extravasation of fluid / medication / contrast
- Thrombophlebitis
- Pneumothorax / Haemothorax
- Perforation of organs
- Oral injury (Intubation related complication & etc.)
- Nerve and blood vessels injury
- High spinal anaesthesia
- Aspiration
- Others

Procedure

- Venepuncture / Arterial line
- Tubes / catheter / drain insertion
- Intravenous fluid / medication / contrast
- Intubation
- LSCS
- Scope procedure
- Anaesthesia
- Others

Example of Selection for each type of incident

Type of Incident

- Pre-hospital care and ambulance service related incident

Level of care

- Before transfer
- During transfer
- Receiving case

Situation

- Inadequate assessment / stabilization
- Inadequate / improper monitoring
- Inadequate preparation of medication and equipment
- Road traffic accident
- Physical injury (bumps / lacerations / etc.)
- Vehicle problem
- Wrong identification / documentation
- Wrong destination
- Others

Type of Incident

- Radiology related incident (Radiotherapy / Imaging)

Type of incident

- Wrong imaging
- Wrong labelling
- Wrong patient
- Wrong side / site
- Wrong report
- Delayed imaging
- Delayed report
- Incomplete imaging
- Pregnant patient (not known)
- Exposed to other patient
- Repeated imaging in close interval
- Unnecessary imaging
- Others

Example of Selection for each type of incident

Type of Incident

- Patient suicide / attempted suicide / self-harm

Type of suicide incident

- Hanging
- Strangulation
- Jump from height
- Poison / Medication
- Self inflicted physical injury using sharp / blunt object / wall

Type of Incident

- Patient discharged to wrong family members / next-of-kin

Sub-Type

- Adult
- Paediatric (<12)

Main Factors / Root Cause

- Wrong identification
- Wrong documentation
- Abduction /Criminal intention
- Others

Example of Selection for each type of incident

Type of Incident

- Assault/ battery of patient

Location

- Inpatient
- Out patient

Situation

- Patient to Patient
- Staff to Patient
- Relative or Others to Patient

Type of Incident

- Unanticipated Fire – Fire, flame, or unanticipated smoke, heat, or flashes occurring in the facility

Location

- Ward
- Emergency
- High dependency ward / ICU / PICU or similar
- Store near patients area
- Clinics / outpatient services area
- Pantry / Dining area / Common area
- Treatment room

Types

- Actual fire
- Explosion
- Spark
- Flash
- Smoke
- Heat

Situation

- Wire trip
- Equipment related
- Lightings / fan / plug / switch / other inbuild electrical components
- Oxygen outlet
- Cigarette / vape related
- Intentional
- Patient related appliance / equipment

Type of Incident

- Clinical management error (Investigation error – includes lab error , diagnostic error, suboptimal treatment / management)

Process involved in error (most significant or likely)

- Patient Assessment and Examination
- Investigation
- Diagnosis
- Treatment & Management

Situation

- Unplanned readmission to A&E / OT / ICU
- Unplanned cessation of treatment / support
- Wrong management (investigation, diagnosis, treatment , referral and etc.)
- Delay in management (investigation, diagnosis, treatment , referral and etc.)

Main Factors / Root Cause

- Laboratory Related Error
- Equipment malfunction / misuse
- Documentation error
- Identification error
- Miscommunication
- Skill / experience / competency
- Others

Factor

- Lab Related Error

Sub-classification

- Delay in processing sample
- Delay result and critical value
- Labelling and sampling
- Lab Result Error
- Documentation Error
- Sample Rejection / Sample Missing

Example of Selection for each type of incident

Type of Incident

- Other physical injury related to patient safety

Sub-classification

- Thermal Burn injury (Diathermy / Hot Packing)
- Chemical Burn Injury (Chemical leak / spillage)
- Radiation Burn Injury
- Electric Shock / Burn
- Physical injury due to structure / building
- Sharp injury
- Others

Type of Incident

- Dislodgement of catheter / tube

Types of dislodgement

- ETT (including self extubation)
- Chest Tube
- Epidural catheter
- Venous / Arterial Cannula
- Tracheostomy tube
- Haemodialysis cath. tube
- T-connector
- Long / Short Line
- Ryle's tube
- Urinary catheter
- Others

Example of Selection for each type of incident

Type of Incident

- Death of patient by unexplained cause or under suspicious circumstances that are required to be reported to police

Type of Incident

- Missing patient / abduction (NOT ABSCONDED)

Type of Incident

- Food Contamination / Poisoning

WHO Global Patient Safety
Challenges
& WHO Patient Safety Solutions

Appendix 1.a: World Health Organization (WHO) Global Patient Safety Initiatives

No	World Health Organization (WHO) Global Patient Safety Challenges
1	Identify patient correctly
2	Improve effective communication
3	Improve the safety of high-alert medications
4	Ensure correct-site, correct-procedure, correct-patient surgery
5	Reduce the risk of healthcare associated infections
6	Reduce the risk of patient harm resulting from fall

No	World Health Organization (WHO) Patient Safety Solutions
1	Look-Alike, Sound-Alike Medication Names
2	Patient Identification
3	Communication During Patient Hand-Overs
4	Performance of Correct Procedure at Correct Body Site
5	Control of Concentrated Electrolyte Solutions
6	Assuring Medication Accuracy at Transitions in Care
7	Avoiding Catheter and Tubing Misconnections
8	Single Use of Injection Devices
9	Improved Hand Hygiene to Prevent Healthcare Associated Infections

REDUCING HARM

NO	MPSG 2.0 GOALS	PENYELARAS	WHO PS SOLUTIONS	
1	Patient Identification	WHO PS CHALLENGE 1. Identify patient correctly		
		Kualiti	Patient Identification	
		WHO PS CHALLENGE 2. Improve effective communication		
		Kejururawatan	Communication during Patient Hand-Overs	
	<i>(Previously improve clinical communication through critical value notification)</i>	<i>(Previously under pathology & ward-nursing)</i>		
2	Medication without Harm	WHO PS CHALLENGE 3. Improve the safety of high-alert medications		
		Farmasi	LASA Medication Names	
			Control of Concentrated Electrolyte Solutions	
			Assuring Medication Accuracy at Transitions in Care	
		Kejururawatan	Avoiding Catheter & Tubing Mis-Connections	

REDUCING HARM

NO	MPSG 2.0 GOALS	PENYELARAS	WHO PS SOLUTIONS	
3	Safe Surgery Saves Lives	WHO PS CHALLENGE 4. Ensure correct-site, correct procedure, correct patient surgery		
		SSSL/OT	Performance of Correct Procedure at Correct Body Site	
4	Infection Prevention and Control	WHO PS CHALLENGE 5. Reduce the risk of HCAI		
		Kawalan Infeksi	Improved Hand Hygiene to Prevent HCAI	
			Single Use of Injection Devices	
5	Prevention of Patient Fall	WHO PS CHALLENGE 6. Reduce the risk of patient harm resulting from fall		
		Kejururawatan		
6	Transfusion Safety	JPT		
7	Implementing Incident Report and Learning System	Kualiti		

WHO Patient Safety Solutions

WHO Patient Safety Solutions

Look-Alike, Sound-Alike Medication Names

Patient Safety Solutions
| volume 1, solution 1 | May 2007



Patient Identification

Patient Safety Solutions
| volume 1, solution 2 | May 2007



Communication During Patient Hand-Over

Patient Safety Solutions
| volume 1, solution 3 | May 2007



Performance of Correct Procedure at Correct Body Site

Patient Safety Solutions
| volume 1, solution 4 | May 2007



Control of Concentrated Electrolyte Solutions

Patient Safety Solutions
| volume 1, solution 5 | May 2007



Assuring Medication Accuracy at Transitions in Care

Patient Safety Solutions
| volume 1, solution 6 | May 2007



Improved Hand Hygiene to Prevent Health Care-Associated Infections

Patient Safety Solutions
| volume 1, solution 9 | May 2007



Single Use of Injection Devices

Patient Safety Solutions
| volume 1, solution 8 | May 2007



Avoiding Catheter and Tubing Mis-Connections

Patient Safety Solutions
| volume 1, solution 7 | May 2007

