### SERVICE STANDARD 17A: PHYSIOTHERAPY SERVICES

<table>
<thead>
<tr>
<th>Indicator 01</th>
<th>Incidence of Burns sustained during delivery of electrotherapeutic modalities or thermal agents (sentinel event)</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:

- Burns should not occur if a model of good care is followed. The emphasis is on prevention because safety of patients is of utmost importance during the delivery of heat therapy.
- This indicator reflects Safety and Clinical Effectiveness.

**Definition of Terms:**

1. **Burns**:
   Tissue damage following the application of electro-therapeutic modalities and thermal agents resulting in excessive/latent redness and pain or blistering of skin over the area treated

2. **Electro-therapeutic Modalities**:
   Short wave Diathermy, Microwave Diathermy, Infra Red Ray

3. **Thermal Agents**:
   Hot packs, Paraffin wax baths

**Inclusion Criteria**: All patients undergoing treatment with the use of electro therapeutic modalities or thermal agents

**Exclusion Criteria**: NA

**Type of Indicator**: Sentinel Event

**Numerator**: Number of incidences of burns sustained during delivery of electrotherapeutic modalities or thermal agents

**Target**: 0

**Data Collection**: Monthly

**Comments/Review**: 
## SERVICE STANDARD 17A: PHYSIOTHERAPY SERVICES

### Indicator 02: Percentage of inpatient referrals seen on time (≤ 24 hours) by the physiotherapist

**Rationale**: This indicator was selected:
- To enhance the effectiveness of physiotherapy treatment management.
- To improve patients and clients satisfaction.
- To prevent complications.

**Definition of Terms**:

1. **In-patients**: Patients who are admitted in the ward.

2. **Working Days**: Physiotherapy services are available on weekdays i.e. Mondays to Friday or Sunday to Thursday (according to individual states)

**Inclusion Criteria** : All in- patients referred during working days

**Exclusion Criteria** : All in- patients referred during weekends and public holidays

**Type of Indicator** : Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of in- patients receiving intervention by physiotherapist within 24 working hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of in- patients referred for Physiotherapy Services</td>
</tr>
</tbody>
</table>

**Target** : ≥ 85%

**Data Collection** : Monthly

**Comments/Review** :
## SERVICE STANDARD 17A: PHYSIOTHERAPY SERVICES

<table>
<thead>
<tr>
<th>Indicator 03</th>
<th>Rate of positive outcomes from cases referred for chest physiotherapy by Intensive Care Unit</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected:
- To enhance the effectiveness of physiotherapy treatment management.
- To provide prompt and efficient physiotherapy service and prevent complications

**Definition of Terms:**

1. **Chest Physiotherapy**
   Chest physiotherapy is the term for a group of designed treatments to improve respiratory efficiency, promote expansion of the lungs, strengthen respiratory muscles and eliminate secretions from the chest. The chest physiotherapy treatments are generally performed by physiotherapists. The purpose of *chest physiotherapy* is to help patients breathe more freely and to get more oxygen into the body. *Chest physiotherapy* includes postural drainage, chest percussion, chest vibration, positioning, breathing exercises, coughing and suctioning is necessary.

2. **Positive Outcome for chest physiotherapy**
   Clearance of secretions and improved respiratory efficiency is the goal of chest physiotherapy. Positive Outcome of cases refers to an improvement in respiratory function and cough ability. The patient is considered to be responding positively to chest physiotherapy if some, but not necessarily all of these changes occur:
   - decreased volume of secretions
   - changes in breath sounds
   - improved vital signs
   - increased oxygen in the blood as measured by arterial blood gas values
   - patient reports of eased breathing

Reference: The Free Dictionary By Farlex

**Inclusion Criteria**: All adult patients admitted to ICU and referred for chest physiotherapy

**Exclusion Criteria**: 1. Myocardial instability:
   a. Systolic BP (<90mmHg)
   b. Heart Rate (>140/min)
   c. Evidence of acute myocardial ischemic last 24 hours
   d. Dyshrhythmia requiring new anti-dyshrhythmic agents last 24 hours
   2. Increased ICP >20mmHg
   3. Aneurysm
   4. Un-stabilized head injury
   5. Recent spinal injury/surgery (less than 24 hours)
   6. Acute haemorrhage ie APO (Acute Pulmonary Oedema)
   7. Pulmonary Embolism before anti - coagulant drugs
   8. Active Pulmonary Tuberculosis before anti Tuberculosis drug

**Type of Indicator**: Rate Based Outcome Indicator
<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients achieve positive outcomes from physiotherapy intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of patients in ICU referred for Chest Physiotherapy X 100%</td>
</tr>
</tbody>
</table>

**Target:** 75%

**Data Collection:** Monthly

**Comments/Remarks:**

1. Chelsea Critical Care Physical Assessment Tool (CPax) 2010
2. MOH Early Mobility Programme 2013
3. KKM Care Protocol Critically Ill Adults 2003
4. Physiotherapy for Respiratory and Cardiac Problem 1995

References:

1. Chelsea Critical Care Physical Assessment Tool (CPax) 2010
2. MOH Early Mobility Programme 2013
3. KKM Care Protocol Critically Ill Adults 2003
4. Physiotherapy for Respiratory and Cardiac Problem 1995
### SERVICE STANDARD 17B: OCCUPATIONAL THERAPY SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of stroke patients with improvement of Activities of Daily Living (ADL) independence after ADL intervention</td>
<td>75%</td>
<td>6 Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of patients restored back to their capabilities to perform at least one meaningful occupation*</td>
<td>70%</td>
<td>6 Monthly</td>
</tr>
</tbody>
</table>

*Occupation may include activity of daily living tasks, work, play, leisure, household tasks etc.*
## SERVICE STANDARD 17B: OCCUPATIONAL THERAPY SERVICES

### Indicator 01: Percentage of stroke patients with improvement of Activities of Daily Living (ADL) independence after ADL Intervention

**Rationale**: This indicator was selected because:

- The rate at which independence level is achieved varies between hospitals. The rate needs to be standardized. There is strong evidence to show that there is significant improvement after ADL intervention among the stroke patients.
- This indicator reflects Clinical Effectiveness and Efficiency

**Definition of Terms:**

1. **Stroke**:  
   Stroke or cerebro-vascular accident (CVA) is the sudden onset of neurological deficit brought about by vascular injury to the brain. The most typical manifestation of CVA is hemiparesis or hemiplegia (mild weakness or complete paralysis respectively) of the body OPPOSITE to the side of CVA

2. **Activities of Daily Living (ADL)**:  
   Activities related to grooming, bathing, toilet, dressing, feeding, transfer/wheelchair, bowel control, urinary control, walking and climbing stairs.

3. **Modified Barthel ADL Index**:  
   The Modified Barthel ADL Index (MBI) is an international assessment instrument for ADL that is designed to record what a patient does; not what he could achieve and is aimed at recording the degree of independence. (Shah, S 1989). Modified Barthel ADL Index is an assessment of Personal hygiene, bathing self, feeding, toileting, climbing stairs, dressing, bowel control, bladder control, ambulation, wheelchair and transfer from chair/ bed.  
   Score of MBI from: The International standard of dependency level is shown as follow:  
   - 0 - 24 indicates total dependence on others in ADL.  
   - 25 - 49 indicates severe dependency  
   - 50 - 74 indicates moderate dependency  
   - 75 - 90 indicates mild dependency  
   - 91 - 99 indicate minimal dependency.  
   (Shah, S. and Cooper B. 1995)  
   One treatment session takes 30 minutes. It can be delivered in the ward or in the Occupational Therapy Department
### Inclusion Criteria

1. Stroke patients with score of less than 60% of MBI before intervention.
2. No age limit (Age was not criteria; there is not a significant attribute to ADL independence performance.)

### Exclusion Criteria

1. Stroke patients with score of more than 60% of MBI before intervention
2. Stroke occurring after brain injury or brain tumour
3. Defaulter
4. Patient without good social support

### Type of Indicator

**Rate Based Outcome Indicator**

### Numerator

The total number of STROKE patients who attained a score of 60% and above MBI within 6 months

### Denominator

The total number of STROKE patients referred to Occupational Therapy

\[
\text{Target} : 75\% \text{ of stroke patient improve in ADL function after occupational therapy intervention}
\]

### Data Collection

6 Monthly

### Comments/Review

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Target</th>
<th>Data Collection</th>
<th>Comments/Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke patients with score of less than 60% of MBI before intervention.</td>
<td>The total number of STROKE patients who attained a score of 60% and above MBI within 6 months</td>
<td>The total number of STROKE patients referred to Occupational Therapy</td>
<td>75% of stroke patient improve in ADL function after occupational therapy intervention</td>
<td>6 Monthly</td>
<td></td>
</tr>
</tbody>
</table>
**SERVICE STANDARD 17B: OCCUPATIONAL THERAPY SERVICES**

<table>
<thead>
<tr>
<th>Indicator 02:</th>
<th>Percentage of patients restored back to their capabilities to perform at least one meaningful occupation* after occupational therapy intervention</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:
- This indicator reflects the effectiveness and appropriateness of ADL intervention of patients based on the Modified Barthel Index (MBI).

**Definition of Terms:**

**Activities of Daily Living:**

Activities of daily living are activities related to grooming, bathing, dressing, feeding, transfer/wheelchair, bowel control, urinary control, walking and climbing stairs. Modified Barthel ADL Index is an assessment of feeding, grooming, dressing, bowel control, bladder control, transfer, toilet use, walking and climbing stairs. Score of MBI from: The International standard of dependency level is shown as follows:

- 0 - 24 indicates total dependence on others in ADL.
- 25 - 49 indicates severe dependency.
- 50 - 74 indicates moderate dependency.
- 75 - 90 indicates mild dependency.
- 91 - 99 indicate minimal dependency.

(Shah, S. and Cooper B. 1995)

*Meaningful occupation may include activities of daily living tasks, work, play, leisure, household tasks etc.*

**Inclusion Criteria**: All patients referred to the Occupational Therapist for rehabilitation with score of less than 60% of MBI before intervention.

**Exclusion Criteria**: i) Patients attained less than 20 sessions of ADL intervention ii) Stroke patients

**Type of Indicator** : Rate Based Outcome Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients who improved in ability to perform at least one meaningful occupation after occupational therapy intervention X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of patients referred to Occupational Therapist for intervention</td>
</tr>
</tbody>
</table>

**Target**: 70% of patients improved in ability to perform at least one Meaningful occupation

**Data Collection**: 6 Monthly

**Comments/Review**: 
**SERVICE STANDARD 17C: DIETETIC SERVICES**

There are tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of in-patient referrals seen on time (24 hours) by the Dietician</td>
<td>≥ 85%</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of out-patient referrals seen by the Dietician within the stipulated time by the Dietetic Services and approved by the Facility</td>
<td>≥ 85%</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Energy intake at least 70% of recommendation within 5 days of enteral nutrition initiation among patients in the ward</td>
<td>≥ 80%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
SERVICE STANDARD 17C: DIETETIC SERVICES

Indicator 01 : Percentage of in-patient referrals seen on time (24 hours) by the Dietician

Rationale : This indicator was selected because:

- Dietary consultation and nutrition support services are an integral part of total patient care. The high rate of referrals and limited manpower pose a challenge to the dietician in striving to deliver the services within acceptable time frame; to ensure the provision of appropriate nutrition intervention.

- This indicator reflects Timely Access and Patient Centeredness

Definition of Terms:

Seen on Time/Timely Response:

In-patient referrals should be seen within the same day of receiving of referral cases on working days, and for cases referred after 1.00 pm, the patient should be seen before 1.00 pm the following working day.

Inclusion Criteria : Patient requiring nutritional intervention:
- Tube feeding
- Combination of tube feeding and parenteral
- Oral liquid Diet only
- Combination of oral and parenteral nutrition
- Patient with poor oral intake (intake less than half of food served)

Exclusion Criteria : - Patient referred for dietician consultation only
- Patient referred but discharged without being seen by dietician
- Patient referred but passed away before being seen by dietician

Type of Indicator : Rate Based Process Indicator

Numerator : Number of in-patients requiring intervention and seen by dietician within 24 hours of referral

Denominator : Total number of in-patients requiring intervention and seen by dietician X 100%

Target : ≥ 85%

Data Collection : Monthly

Comments/Review :
## SERVICE STANDARD 17C: DIETETIC SERVICES

### Indicator 02: Percentage of out-patient referrals seen by the Dietician within the stipulated time by the Dietetic Services and approved by the Facility

**Rationale:** This indicator was selected because:

- Dietary consultation and nutrition support services are an integral part of total patient care. The high rate of referrals and limited manpower pose a challenge to the dietician in striving to deliver the services within acceptable time frame; to ensure the provision of appropriate nutrition intervention.

- This indicator reflects Timely Access and Patient Centeredness

### Definition of Terms:

1. **Seen within the stipulated Time:**
   Out-patient cases referred for intervention by Dietician should be seen within the stipulated time upon receiving of referrals on working days.

2. **Stipulated time:**
   Refers to the agreed time/duration as specified by the Facility within which appointments are given for out-patient referrals to the dietician.

### Inclusion Criteria:
- All patients requiring dietary consultation

### Exclusion Criteria:
- Patient referred for urgent dietary intervention
- Patient referred but discharged without being seen by dietician
- Patient referred but passed away before being seen by dietician

### Type of Indicator:
- Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of out-patient referrals seen by the Dietician within the stipulated time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of out-patients referred to the dietician</td>
</tr>
<tr>
<td>Target</td>
<td>≥ 85%</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Monthly</td>
</tr>
<tr>
<td>Comments/Review</td>
<td></td>
</tr>
</tbody>
</table>

X 100%
### SERVICE STANDARD 17C: DIETETIC SERVICES

**Indicator 03**: Energy intake at least 70% of recommendation within 5 days of enteral nutrition initiation among patients in the ward

**Rationale**: This indicator was selected because:

- Nutritional support is an integral part of total patient care. Patients requiring enteral nutrition are ill patients who are unable to take oral feedings due to their health status or provided as a temporary measure in post-surgery to ensure the provision of appropriate nutritional intervention.

- This indicator reflects Clinical Efficiency and Patient Centeredness.

**Definition of Terms**:

1. **Enteral Nutrition**:

   Enteral nutrition is provided where a patient is fed via an enteral tube. There are several different methods of enteral tube feeding, but most short term tube fed enteral nutrition should be given via a nasogastric tube. Patients for enteral feeding include those with swallowing disorders, such as motor neurone disease, multiple sclerosis, those with physical obstruction to swallowing, such as oesophageal tumours, those unable to ingest food, such as head injury or stroke patients among others.

2. **Energy Intake**:

   Energy intake is the total number of calories taken in daily whether ingested or by parenteral routes. Energy is provided by food and drink. It comes from the fat, carbohydrate and protein the diet contains. Energy requirements vary from one individual to the next, depending on factors such as age, sex, body composition and physical activity level.

**Inclusion Criteria**: All patients in the Facility /Hospital requiring parental nutrition

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients receiving parental nutrition having achieved 70% of the recommended energy intake within 5 days of initiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of patients on parental nutrition during the specified period</td>
</tr>
</tbody>
</table>

**Target**: ≥ 80%

**Data Collection**: Monthly

**Comments/Review**: 

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### SERVICE STANDARD 17D: SPEECH-LANGUAGE THERAPY SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of new cases outpatient referrals given appointment within 90 days (waiting time between the date patient presents to request for appointment and the initial appointment given within 90 days)</td>
<td>≥85%</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of inpatient referrals of swallowing and feeding difficulties responded within 3 working days.</td>
<td>≥85%</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of patient satisfaction towards patient education in therapy</td>
<td>≥80%</td>
<td>6 Monthly</td>
</tr>
<tr>
<td>SERVICE STANDARD 17D: SPEECH- LANGUAGE THERAPY SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 01 : Percentage of new cases outpatient referrals given appointment within 90 days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rationale** : This indicator was selected because:

- Speech-Language Pathology Services consultation and support services are an integral part of total rehabilitative care. The provision of appropriate intervention should be within the acceptable time frame.

- Patient–centred services must give priority to prompt attention to patient needs by reducing the waiting times for consultation. This indicator reflects Timely Access and Patient Centredness.

**Definition of Terms:**

**Waiting Time for new appointment:**

Waiting time between the date patient presents to request for appointment and the initial appointment given within 90 days of referral. Time of receiving referral documentation to time of initial appointment given on working days.

**Inclusion Criteria** : All new outpatients referred to Speech Pathologist for consultation or management

**Exclusion Criteria** : NA

**Type of Indicator** : Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new outpatient cases given appointment to the Speech – Language Therapist within 90 days of referral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of new outpatient referrals received by Speech- Language Therapist for initial appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 85%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments/Review</th>
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<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>


SERVICE STANDARD 17D: SPEECH-LANGUAGE THERAPY SERVICES

Indicator 02: Percentage of inpatient referrals of swallowing and feeding difficulties responded within 3 working days

Rationale: This indicator was selected because:
- Speech-Language Therapy Services consultation and support services are an integral part of total rehabilitative care and the treatment plan is usually a long term process. The provision of appropriate intervention should be within the acceptable time frame.
- Patients with swallowing and feeding difficulties must be given priority to prompt attention to meet patient’s nutritional needs and general wellbeing.
- This indicator reflects Timely Access and Patient Centredness.

Definition of Terms:
1. Swallowing and Feeding Difficulties:
Eating and swallowing problems, known as dysphagia, occur in many medical conditions and can occur both in adults and children. The main risks associated with swallowing problems are:
- Choking or asphyxiation: When food blocks the airway, preventing breathing. Also when food or liquid enter the airway below the level of the vocal cords.
- Aspiration pneumonia: If food or liquid enter the lungs it can cause a lung infection.
- Dehydration: Not drinking enough fluids is bad for health and can lead to problems such as constipation.
- Malnutrition: Lack of nourishment leads to poor health and harms the body’s ability to fight infection.

Feeding disorders in children include problems gathering food and getting ready to suck, chew, or swallow it. For example, a child who cannot pick up food and get it to her mouth or cannot completely close her lips to keep food from falling out of her mouth may have a feeding disorder.

2. Waiting Time for Speech Therapist Response:
Time between the date the inpatient is referred to the Speech Language Therapist to initial contact/examination within 3 working days.

Inclusion Criteria: All in-patients referred to Speech – Language Therapist for management of swallowing and feeding difficulties.

Exclusion Criteria: NA

Type of Indicator: Rate Based Process Indicator

Numerator: Number of in-patients referred and responded within 3 days by Speech Therapist for swallowing & feeding difficulties

Denominator: Total number of in-patients referred to Speech Therapist for swallowing & feeding difficulties X 100 %

Target: ≥ 85%

Data Collection: Monthly

Comments/Review:
<table>
<thead>
<tr>
<th>SERVICE STANDARD 17D: SPEECH- LANGUAGE THERAPY SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 03 : Percentage of patient satisfaction towards patient education in therapy</td>
</tr>
</tbody>
</table>

**Rationale** : This indicator was selected because:

- Speech- Language Pathology Services consultation and support services are an integral part of total rehabilitative care.
- As proxy to measurement of patient- centred services and level of client satisfaction to meeting patient needs from registration for out-patient care to care and treatment.

**Definition of Terms :**

1. **Patient Satisfaction Survey** :

   Patient satisfaction is a measure of the extent to which a patient is content with the health care which they received from their health care provider.

2. **Patient Education Therapy**:

   Patient education is an individualized, systematic, structured process to assess and impart knowledge or develop a skill in order to effect a change in behavior. The goal is to increase comprehension and participation in the self-management of health care needs. The patient/family/significant others play an active part in the process. Patient education is an important component of care in both inpatient and ambulatory settings. Patient/family education is an interdisciplinary and collaborative process designed to meet the needs of the individual patient throughout the continuum of care.

   Ref: UTMB Handbook of Operating Procedures : Policy 9.3.4 Patient/Family Education

**Inclusion Criteria** : All out-patients attending patient education therapy

**Exclusion Criteria** : In- patient satisfaction survey

**Type of Indicator** : Patient Satisfaction Survey

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of outpatients given patient education therapy with ≥ 80% satisfaction level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of outpatients given patient education therapy</td>
</tr>
</tbody>
</table>

**Target** : ≥ 80% patient satisfaction level

**Data Collection** : 6 Monthly

**Comments/Review** :
## SERVICE STANDARD 17E: AUDIOLOGY SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of new cases given appointment in audiology clinic following a referral within 45 days</td>
<td>≥ 85%</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of patients given hearing aid on trial after diagnosis of hearing loss within (≤) 8 weeks</td>
<td>≥ 80%</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of ear impression taking without complications</td>
<td>≥ 90%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
### SERVICE STANDARD 17E: AUDIOLOGY SERVICES

**Indicator 01**: Percentage of new cases given appointment in audiology clinic following a referral within 45 days

**Rationale**: This indicator was selected because:

- Audiology Services consultation and support services are an integral part of total rehabilitative care. The high rate of referrals poses a challenge to the audiologist in striving to deliver the appropriate intervention within the acceptable time frame.
- Patient–centred services must give priority to prompt attention to patient needs by reducing the waiting times for consultation. This indicator reflects Timely Access and Patient-Centredness.

**Definition of Terms**:

**Waiting Time for new appointment**: Waiting time between the date patient presents to request for appointment following a referral and the initial appointment given within 45 days. Time of receiving referral documentation to time of initial appointment given on working days.

**Inclusion Criteria**: All new cases referred to the audiologist for screening and intervention.

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of new cases given initial appointment to the Audiology Clinic within 45 days of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of new referrals received for initial appointment to Audiology Clinic</td>
</tr>
</tbody>
</table>

**Target**: ≥ 85%

**Data Collection**: Monthly

**Comments/Review**: 
SERVICE STANDARD 17E: AUDIOLOGY SERVICES

Indicator 02 : Percentage of patients given hearing aid on trial after diagnosis of hearing loss within (≤) 8 weeks

Rationale : This indicator was selected because:

- Audiology Services consultation and support services are an integral part of total rehabilitative care. The provision of appropriate intervention should be within the acceptable time frame.
- Patient-centred services must give priority to prompt attention to patient needs by reducing the waiting times for consultation. This indicator reflects Timely Access and Patient Centredness.

Definition of Terms:

1. Hearing loss:
   Deafness, hearing impairment or hearing loss is a partial or total inability to hear.

2. Hearing aid:
   A hearing aid is a device designed to improve hearing. Hearing aids are classified as medical devices in most countries, and regulated by the respective regulations. Hearing aid can amplify sound waves in order to help a deaf or hard-of-hearing person hear sounds more clearly and can help a person hear better, but it won’t return hearing to normal levels.

3. Time taken between a diagnosis of hearing loss and the initiation of rehabilitation:
   Intervention with hearing aid given within (≤) 8 weeks following diagnosis of hearing loss.

4. Rehabilitation Intervention:
   Intervention program designed to initiate solutions to listening and communication problems among hearing-impaired individuals. Different steps are taken towards improving the situation; including acquiring hearing aids.

Inclusion Criteria : All patients referred to the Audiologist for screening and initiation of intervention

Exclusion Criteria : NA

Type of Indicator : Waiting Time

Numerator : Number of patients given hearing aids on trial within 8 weeks after diagnosis of hearing loss

Denominator : Total number of patients referred for hearing aid after diagnosis of hearing loss x 100%

Target : ≥ 80%

Data Collection : Monthly

Comments/Review : 
### SERVICE STANDARD 17E: AUDIOLOGY SERVICES

**Indicator 03**: Percentage of ear impression taking without complications

**Rationale**: This indicator was selected because:

- Audiology Services consultation and support services are an integral part of total rehabilitative care. The provision of appropriate intervention should be made safe for the patients
- This indicator reflects clinical effectiveness and patient safety.

**Definition of Terms:**

1. **Ear impression**: Ear Impressions are required for any custom fitted product. They will ensure a perfect and therefore comfortable fit, giving the largest amount of ambient attenuation possible but more importantly allowing the person to enjoy a better quality of sound at lower volumes. Any person taking ear impressions must be qualified. They will then perform the procedure correctly and more importantly safely.

2. **Complications on taking ear impression**: Possible complications that may arise when taking an ear impression (Dillon, H., 2001)
   - i. Cerumen impaction
   - ii. Hematoma of the ear canal or tympanic membrane
   - iii. Perforation of the tympanic membrane.
   - iv. Traumatic perforation with perilymph fistula
   - v. Impact on existing or previous surgical procedures
   - vi. Exacerbation of certain conditions (e.g. Ménière's disease, skin irritations or conditions within the external ear or canal)
   - vii. Filling middle ear with impression material

**Inclusion Criteria**: All patients referred to the Audiology Clinic for taking ear impressions.

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Outcome Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients/clients taken ear impressions at the Audiology Clinic without complications</td>
<td>Total number of patients/clients referred to the Audiology Clinic for taking ear impressions. x 100%</td>
</tr>
</tbody>
</table>

**Target**: ≥ 90%

**Data Collection**: Monthly

**Comments/Review**: 
### SERVICE STANDARD 17F: OPTOMETRY SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of patients with Waiting Time within 90 minutes to see Optometrist after Registration (within 90 minutes)</td>
<td>80%</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of new patients for specialised procedure either low vision or contact lens or binocular assessment that were given appointment for the first consultation within six (6) weeks at optometry clinic.</td>
<td>≥ 80%</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of contact lens related corneal ulcer</td>
<td>≤ 0.2%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
**SERVICE STANDARD 17F: OPTOMETRY SERVICES**

**Indicator 01 :** Percentage of patients with Waiting Time within 90 minutes to see Optometrist after Registration

*Rationale*: This indicator was selected because:

- Patient-centered services must give priority to prompt attention to patient needs by reducing waiting times for consultation.

**Definition of Terms:**

**Waiting Time:**

Time of registration/appointment (whichever is later) to the time the patient is first seen by the optometrist. 80% to be seen within 90 minutes after registration.

**Inclusion Criteria**: All out-patients registered at the Optometry/Ophthalmology Clinic and waiting to see the Optometrist.

**Exclusion Criteria**: Patients who came without appointment to the Optometry/Ophthalmology Clinic for consultation with Ophthalmologist.

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients with waiting time of ≤ 90 minutes to see the optometrist at Optometry/Ophthalmology Clinic after registration x 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of patients seen by the optometrist at Optometry/Ophthalmology Clinic</td>
</tr>
</tbody>
</table>

**Target**: 80%

**Data Collection**: Monthly

**Comments/Review**: 
## SERVICE STANDARD 17F: OPTOMETRY SERVICES

### Indicator 02: Percentage of new patients for specialised procedure either low vision or contact lens or binocular assessment that were given appointment for the first consultation within six (6) weeks at optometry clinic.

**Rationale:** This indicator was selected because:

- Optometry Services consultation and support services are an integral part of total rehabilitative care and generally to assist vision correction/promote good vision in the individual.
- Patient-centered services must give priority to prompt attention to patient needs by reducing waiting times for consultation.

**Definition of Terms:**

1. **New appointment:**
   
   New Appointment refers to the initial appointment for new cases referred to the optometrist (first time consultation).

2. **Waiting Time:**
   
   The waiting time refers to time between the date patient presents to request for appointment following a referral and the initial appointment given within six (6) weeks.

**Inclusion Criteria:** All patients referred to optometrist for specialized procedures (low vision, Contact lens & binocular vision) assessment.

**Exclusion Criteria:** NA

**Type of:** Rate Based Process Indicator

**Numerator:** Number of patients referred to Optometrist for specialised procedures and given appointment for consultation within 6 weeks x 100%

**Denominator:** Total number of patients referred to optometrist for specialized procedures

**Target:** ≥ 80%

**Data Collection:** Monthly

**Comments/Review:**
## SERVICE STANDARD 17F: OPTOMETRY SERVICES

### Indicator 03: Percentage of contact lens related corneal ulcer

**Rationale**: This indicator was selected because:

- While contact lenses are safely used by millions of people every day, they do carry a risk of eye infection. The most common infection related to contact lens use is infection of the cornea - Keratitis is the most serious complication of contact lens wear. In severe cases, it can lead to corneal scarring that impairs vision, and may lead to the need for a cornea transplant.
- This indicator reflects safe care as even a small percentage of complications can constitute a major public health problem.

### Definition of Terms:

1. **Contact lens-related infection/complications** - range from self-limiting to sight-threatening, which require rapid diagnosis and treatment to prevent vision loss. Factors that contribute to a contact lens-related infection include:
   - Use of extended-wear lenses
   - Sleeping in your contact lenses
   - Reduced tear exchange under the lens
   - Environmental factors
   - Poor hygiene, including poor maintenance of contact lens cases or reusing or topping off contact lens solution

2. **Contact lens related Corneal Ulcer**

   Corneal ulcer, also known as ulcerative keratitis and infectious keratitis, is most often associated with contact lens use or misuse. Corneal ulcer is essentially an open wound to the eye. It is characterized by disruption of the corneal epithelium and stroma and can be either inflammatory or infectious. Corneal ulcers are debilitating and potentially sight-threatening. A major risk factor for developing a corneal ulcer is overnight use of soft contact lenses, and the risk increases with each consecutive night of continuous wear.

Ref: Contact Lens-Related Corneal Ulcer: A Teaching Case Report: Trinh Khuu, OD, FAAO

Aurora Denial, OD, FAAO

**Inclusion Criteria**: All cases of contact lens related Corneal Ulcer seen and reported at the Optometrist/Ophthalmology clinic

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Outcome Indicator

### Numerator

Number of patients with contact lens related corneal ulcer detected by Optometrist X 100%

### Denominator

Total number of patients (using contact lens) examined by the Optometrist

**Target**: ≤ 0.2%

**Data Collection**: Monthly

**Comments/Review**: 
## SERVICE STANDARD 17G: HEALTH EDUCATION SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Number of patients received behavioural needs assessment (cognitive, affective &amp; psychomotor) prior to health education intervention for any specific chronic Diseases</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of patients who Quit Smoking after six (6) months of receiving quit smoking services</td>
<td>20%</td>
<td>6 Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of patient referrals seen within two (2) weeks</td>
<td>80%</td>
<td>Monthly</td>
</tr>
<tr>
<td>4.</td>
<td>Number of in-house health education materials (printed &amp; electronic) production which have been pre-tested accordingly</td>
<td>100%</td>
<td>6 monthly</td>
</tr>
<tr>
<td>SERVICE STANDARD 17G: HEALTH EDUCATION SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 01: Number of patients received behavoural needs assessment (cognitive, affective &amp; psychomotor) prior to health education intervention for any specific Chronic Diseases</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rationale**: This indicator was selected because:

- Behavioural needs assessment prior to Health Education Intervention should be conducted to assess the change in the cognitive, affective and psychomotor behaviour of the clients after Health Education intervention which also measures the effectiveness of Health Education especially for specific chronic diseases.

- Health Education is aimed to educate and encourage patients and community to comply with the treatment regime offered in controlling their diseases and maintaining their wellbeing.

**Definition of Terms**:

1. **Behavioural Needs Assessment**

The practice of health education involves three major program-planning activities: needs assessment, program development, and evaluation. Behavioral needs assessment is a method used in the field of psychology to observe, describe, explain, predict and sometimes correct behavior. Behavioral needs assessment can be useful in clinical, educational and corporate settings. Clients receiving behavioral health education are assessed on their knowledge, attitude and practices on specific chronic diseases i.e. diabetes before intervention to gauge changes in behavior after the health education intervention.

2. **Health Education Intervention**:

Various techniques/activities aimed at change in the cognitive, affective and psychomotor behaviour of the clients/patients in reference to specific chronic disease i.e. diabetes.

**Inclusion Criteria**: Patients receiving health education intervention i.e. patient education for chronic diseases eg. diabetes

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients received behavioural needs assessment prior to Health Education Intervention for specific chronic disease e.g. diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
</tr>
<tr>
<td>Data Collection</td>
<td>Monthly</td>
</tr>
<tr>
<td>Comments/Review</td>
<td></td>
</tr>
</tbody>
</table>
### SERVICE STANDARD 17G: HEALTH EDUCATION SERVICES

#### Indicator 02 : Percentage of patients who Quit Smoking after six (6) months of receiving Quit Smoking Services

**Rationale**: This indicator was selected because:

- Smoking has been shown to be hazardous to health, and is a risk for many diseases such as cancers and cardiovascular diseases. In the *National Health and Morbidity Survey (NHMS)* conducted in 2006, it was found that 22.5% of Malaysians aged 18 and over were smokers. Therefore, the Ministry of Health has taken the initiative to continue the Say No to Smoking Campaign that was held on a large scale nationally, initiated in 2004.

- This is in line with the commitments that have been affirmed by the Ministry of Health Malaysia in the 64th World Health Assembly in May 2011 that is by targeting 60% of patients with cardiovascular disease or at high risk of developing the disease to quit smoking within 6 months of enrolling in a Quit Smoking Clinic organized by the Ministry of Health.

**Definition of Terms:**

1. **Quit Smoking intervention:**
   Patients admitted to Ministry of Health Hospitals that have Quit Smoking Clinic Service and have enrolled in the Quit Smoking Program.

2. **Post Intervention:**
   Patients enrolled in the Quit Smoking Program and have ceased smoking.

**Inclusion Criteria** : Patients enrolled in the Quit Smoking Program in Ministry of Health Hospitals that have Quit Smoking Clinic Service.

**Exclusion Criteria** : NA

**Type of Indicator** : Rate Based Outcome Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of persons who quit smoking within 6 months of enrolling in the Quit Smoking Clinic X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of persons who smoke who attended the Quit Smoking Clinic</td>
</tr>
</tbody>
</table>

**Target** : 20%

**Data Collection** : 6 monthly

**Comments/Review** :
### SERVICE STANDARD 17G: HEALTH EDUCATION SERVICES

<table>
<thead>
<tr>
<th>Indicator 03</th>
<th>Percentage of patient referrals seen within two (2) weeks</th>
</tr>
</thead>
</table>

**Rationale**

This indicator was selected because:

- Patient Centered services must give priority to prompt attention to patient needs by reducing waiting times for consultation.
- This indicator reflects the effectiveness of the service.

**Definition of Terms:**

**Patient Referrals:**

Time taken from the date of referral received to the date seen by the Health Education Officer within two (2) weeks.

**Inclusion Criteria**

All patients referred to the Health Education Officer for consultation/health education

**Exclusion Criteria**

NA

**Type of Indicator**

Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients seen by the Health Education Officer within 2 weeks of referral X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of patients referred to the Health Officer</td>
</tr>
</tbody>
</table>

**Target**

80 %

**Data Collection**

Monthly

**Comments/Review**


## SERVICE STANDARD 17G: HEALTH EDUCATION SERVICES

### Indicator 04
Percentage of in-house health education materials (printed & electronic) production which have been pre-tested accordingly

**Rationale:**
This indicator was selected because:

- The production of printed materials is useful tools in health education intervention activities. Behavior change is more likely to occur for those who received tailored materials and those who had higher self-efficacy.

- Printed materials are widely used by healthcare providers as a tool for providing health information.

**Definition of Terms:**

**Health Education Materials:**
Printed health education materials (HEMs) are widely used to increase awareness and knowledge, change attitudes and beliefs, and help individuals adopt and maintain healthy lifestyle behaviors.

**Inclusion Criteria:**
All in-house health education materials (printed & electronic) produced every 6 months

**Exclusion Criteria:**
NA

**Type of Indicator:**
Rate Based Outcome Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of in-house health education materials (printed &amp; electronic) produced which have been pre-tested</th>
<th>X 100 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of in-house health education materials (printed &amp; electronic) produced</td>
<td></td>
</tr>
</tbody>
</table>

**Target:**
100 %

**Data Collection:**
6 Monthly

**Comments/Review:**
## SERVICE STANDARD 17H: MEDICAL SOCIAL SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of patients registered who have received assistance</td>
<td>100%</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of in-patients seen within 48 hours of referral</td>
<td>90%</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of Out-patients seen within the same day of referral (subject to Medical Social Officers are available)</td>
<td>90%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
**SERVICE STANDARD 17H: MEDICAL SOCIAL SERVICES**

| Indicator 01 : Percentage of patients registered who have received assistance |

**Rationale** : This indicator was selected because:

- Patient Centered services must give priority to prompt attention to patient needs for Medical Social Services assistance.
- This indicator reflects the effectiveness of the service.

**Definition of Terms:**

1. **Registered with Medical Social Services**
   Registration at the Hospital’s Medical Social Services Clinic for assistance.

2. **Types of Medical Social Assistance:**
   - Monetary
   - Transport
   - Prosthetics
   - Counselling
   - Temporary Lodging
   - etc

**Inclusion Criteria** : All patients registered at the Medical Social Services for assistance (all types of assistance)

**Exclusion Criteria** : NA

**Type of Indicator** : Rate Based Process Indicator

| Numerator : Number of patients registered with Medical Social Services Clinic and received assistance |
| Denominator : Total number of patients registered with Medical Social Services for assistance |

Target : 100%

Data Collection : Monthly

Comments/Review :
### SERVICE STANDARD 17H: MEDICAL SOCIAL SERVICES

**Indicator 02 :** Percentage of inpatients seen within 48 hours of referral

**Rationale :** This indicator was selected because:

- Patient Centered services must give priority to prompt attention to patient needs by reducing waiting times for consultation/assistance.
- This indicator reflects the effectiveness of the service.

**Definition of Terms:**

**In- Patient Referral**

A patient who is admitted to a hospital bed and who receives lodging and food as well as treatment; including referral to the Medical Social Officer for assistance/counseling.

**Inclusion Criteria :** All in-patients referred to the Medical Social Officer for assistance/counseling

**Exclusion Criteria :** NA

**Type of Indicator :** Rate Based Process Indicator

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th>Number of in-patients seen by the Social Medical Officer within 48 hours of referral X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>Total number of in-patients referred to the Social Medical Officer</td>
</tr>
</tbody>
</table>

**Target**

90%

**Data Collection**

Monthly

**Comments/Review**
SERVICE STANDARD 17H: MEDICAL SOCIAL SERVICES

**Indicator 03 :** Percentage of Out-patients seen within the same day of referral (subject to Medical Social Officers’ availability)

**Rationale :** This indicator was selected because:

- This indicator measures the respond time taken for the outpatient to be seen by the Medical Social Officer for intervention. Patient Centered services must give priority to prompt attention to patient needs by reducing waiting times for consultation/assistance.

- This indicator reflects the effectiveness of the service and poses a challenge to the Social Medical Officer to deliver the services within the acceptable time frame.

**Definition of Terms:**

1. **Outpatient:**
   
   A patient who is not hospitalized but who received treatment at the hospital/clinic/associated facility for diagnosis or treatment. This includes all out-patients referred to the Medical Social Officer for assistance/counseling.

2. **Same day of referral:**
   
   Refers to the consultation carried out or taking place on the same day as a preliminary action e.g. the patient is seen on the same day of referral from the doctor to the Medical Social Officer.

**Inclusion Criteria :** All out-patients referred to the Medical Social Officer for assistance/counseling (subject to the availability of the medical officer on the same day of referral)

**Exclusion Criteria :** NA

**Type of Indicator :** Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of out-patients seen by the Social Medical Officer within the same day of referral</td>
<td>Total number of out-patients referred to the Social Medical Officer X 100%</td>
</tr>
</tbody>
</table>

**Target :** 90 %

**Data Collection :** Monthly

**Comments/Remarks :**
STANDARD 17I: PSYCHOLOGY COUNSELLING SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of patients registered for counselling and discharged from the programme</td>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of patients requiring referral for further management</td>
<td></td>
<td>Monthly</td>
</tr>
</tbody>
</table>
### SERVICE STANDARD 17I: PSYCHOLOGY COUNSELLING SERVICES

<table>
<thead>
<tr>
<th>Indicator 01</th>
<th>Percentage of patients registered for counselling and discharged from the programme</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:
- This indicator reflects access to Psychology Counseling Services and being effectively discharged from the programme, which poses a challenge to the Psychology Counsellor to deliver the services effectively.

**Definition of Terms:**

1. **Psychology Counselling**:

   Counseling psychology is defined as the study of the mental health of individuals engaged in developmental processes. Counseling psychologists are employed in a variety of settings depending on the services they provide and the client populations they serve. Some are employed in colleges and universities as teachers, supervisors, researchers, and service providers. Others are employed in independent practice providing counseling, psychotherapy, assessment, and consultation services to individuals, couples/families, groups, and organizations.

2. **Psychology Counselling Services**

   Psychology Counselling form an integral part of rehabilitation services. The scope of counselling practice shall be provided by qualified and licensed counsellor registered with Counselling Board Malaysia (Act 580).

3. **Discharged from the Psychology Counselling programme**:

   Cessation of participation from the programme having successfully completed the counseling/rehabilitation sessions.

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>All patients referred to the Psychology Counselling Officer for consultation and counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>NA</td>
</tr>
<tr>
<td>Type of Indicator</td>
<td>Rate Based Outcome Indicator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients registered for Psychology Counselling sessions and discharged from the programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of patients registered for Psychology Counselling Services X 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection</td>
<td>Monthly</td>
</tr>
<tr>
<td>Comments/Review</td>
<td></td>
</tr>
</tbody>
</table>
### SERVICE STANDARD 17I: PSYCHOLOGY COUNSELLING SERVICES

<table>
<thead>
<tr>
<th>Indicator 02</th>
<th>Percentage of patients requiring referral for further management</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:

- This indicator reflects access to care for further management and effectiveness of the service which poses a challenge to the Psychology Counsellor to make prompt and timely referrals.

**Definition of Terms:**

1. **Psychology Counselling Services**:

Psychology Counselling Services form an integral part of rehabilitation services. The scope of counselling practice shall be provided by qualified and licensed counsellor registered with the Counselling Board (Act 580).

2. **Patients requiring further management**:

Refers to patients who having gone through the counseling sessions and needing further management by specialists i.e. psychiatrist.

**Inclusion Criteria**: All patients referred to the Psychology Counsellor for consultation and counseling

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients attending psychology counselling sessions and requiring referral for further management</th>
<th>X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of patients attending psychology counselling</td>
<td></td>
</tr>
</tbody>
</table>

**Target**

**Data Collection**: Monthly

**Comments/Review**: 

**SERVICE STANDARD 17J: CLINICAL PSYCHOLOGY SERVICES**

There is safety tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of Relapse Cases</td>
<td>Sentinel event</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of Psychological Assessment Completed within 30 working days</td>
<td>85%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
**SERVICE STANDARD 17J: CLINICAL PSYCHOLOGY SERVICES**

<table>
<thead>
<tr>
<th>Indicator 01</th>
<th>Percentage of Relapse Cases</th>
</tr>
</thead>
</table>

**Rationale** : This indicator was selected because:

- The Clinical Psychology Services shall be provided only by trained and qualified Clinical Psychologists to outpatients, inpatients in an efficient and effective and caring manner and shall be coordinated with other relevant clinical services in accordance with accepted standards of practice.

- This indicator reflects clinical effectiveness and poses a challenge to the Clinical Psychologist in striving to deliver the services effectively.

**Definition of Terms:**

1. **Clinical Psychology Services**:

Clinical Psychology Services offer psychotherapy to reduce psychological distress (mental illness), augment and promote psychological well-being and quality of life. The services are part of a multidisciplinary team for psychological readjustment and restoration to psychological fitness.

2. **Relapse of Case**:

Clinical Psychology Services require extended case monitoring of the status of clients, providing support, and accelerating re-entry into treatment in the event of impending or actual relapse. This is accomplished through the efforts with contacts with the client and significant other members of the family and health care providers.

**Inclusion Criteria** : All patients successfully discharged from the Clinical Psychology Services having achieved restoration of psychological fitness.

**Exclusion Criteria** : NA

**Type of Indicator** : Sentinel Event

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients having acquired psychological fitness and successfully discharged from the Clinical Psychology Services and relapsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of patients having acquired psychological fitness and successfully discharged from the Clinical Psychology Services</td>
</tr>
</tbody>
</table>

\[ \text{Target} = 0 \]

**Data Collection** : Monthly

**Comments/Review** :
**SERVICE STANDARD 17J: CLINICAL PSYCHOLOGY SERVICES**

**Indicator 02 : Percentage of Psychological Assessment Completed within 30 working days**

**Rationale** : This indicator was selected because:

- Psychological Assessment is the basis for clinical psychology service delivery.
- The use of psychological assessment requires a documented plan for subsequent audit of clinical effectiveness of service delivery.

**Definition of Terms:**

1. **Psychological Assessment**:

Psychological assessment is a process of testing that uses a combination of techniques to help arrive at some hypotheses about a person and their behavior, personality and capabilities. Psychological assessment is the extensive purview of psychologists who use assessment tools to better understand what may be causing behavioral, emotional, or cognitive symptoms. Simply by observing a person’s behavior during various structured and unstructured tasks, having them and those who know them answer questions on psychological tests, and/or meeting with the person directly, a psychologist can help identify underlying causes and develop a plan for assisting them.

2. **Psychological Assessment Completed within 30 working days**:

Time taken from the date of referral to the Clinical Psychologist for consultation and treatment to the date of completion of the psychological assessment of the same patient. The waiting time refers to time between the dates the patient is seen by the Clinical Psychologist to the date of completion of the psychological assessment within 30 working days.

**Inclusion Criteria** : All patients referred to the Clinical Psychologist for consultation and treatment.

**Exclusion Criteria** : NA

**Type of Indicator** : Rate Based Outcome Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients who had Psychological Assessment completed within 30 working days</td>
<td>Total number of patients referred to the Clinical Psychologist for consultation X 100%</td>
</tr>
</tbody>
</table>

**Target** : 85%

**Data Collection** : Monthly

**Comments/Review** :
There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of Prescription Error</td>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of Dispensing Error</td>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Average time for a prescription to be dispensed from time received at counter to time medication given to patient</td>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td>4.</td>
<td>Number and value of expired drugs at end of month over a specified period</td>
<td></td>
<td>Monthly</td>
</tr>
</tbody>
</table>
SERVICE STANDARD 18: PHARMACY SERVICES

Indicator 01: Percentage of Prescription Error

**Rationale**: This indicator was selected because:

- Medication Error is a significant problem in hospitals and has an impact on the safety of patients. The large amount of medications used as well as the availability of new and potent medicines requires further enhancement on the awareness on medication safety. It is a serious adverse event where there is much pain and suffering or temporary/permanent disability.
- It is an indicator of the delivery of safe patient care in the hospital.

**Definition of Terms**:

1. **Medication Error**: A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. Such an event may be related to professional practices, healthcare products, procedures and systems including prescribing, order communication, product labelling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use. Medication errors may be committed by both inexperienced and experienced personnel like doctors, pharmacists, dentists and other healthcare provider, patients, manufacturers, caregivers and others.

2. **Prescribing Error**: Incorrect drug product selection (based on indications, contraindications, known allergies, existing drug therapy, and other factors), dose, dosage form, quantity, route of administration, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by physician (or other legitimate prescriber); illegible prescriptions or medication orders that lead to errors. (Reference: Guideline on Medication Error Reporting Ministry of Health Malaysia)

**Inclusion Criteria**: All prescriptions made out for patients (in-Patient and Out-Patients)

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Outcome Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of prescription errors (out-patients and in-patients) X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of prescriptions (outpatients and Inpatients) written by doctors</td>
</tr>
</tbody>
</table>

**Target**

**Data Collection**: Monthly

**Comments/Review**: 
SERVICE STANDARD 18: PHARMACY SERVICES

Indicator 02 : Percentage of Dispensing Error

Rationale:
This indicator was selected because:

- Medication Error is a significant problem in hospitals and has an impact on the safety of
  patients. The large amount of medications used as well as the availability of new and potent
  medicines requires further enhancement on the awareness on medication safety. It is a
  serious adverse event where there is much pain and suffering or temporary/permanent
disability.

- It is an indicator of the delivery of safe patient care in the hospital.

Definition of Terms:

1. Medication Error:
A medication error is any preventable event that may cause or lead to inappropriate medication
use or patient harm while the medication is in the control of the healthcare professional, patient
or consumer. Such an event may be related to professional practices, healthcare products,
procedures and systems including prescribing, order communication, product labelling,
packaging and nomenclature, compounding, dispensing, distribution, administration, education,
monitoring and use. Medication errors may be committed by both inexperienced and
experienced personnel like doctors, pharmacists, dentists and other healthcare provider,
patients, manufacturers, caregivers and others.

2. Dispensing Error:
- Dispensing or administration to the patient of medication not authorised by a
  legitimate prescriber.
- Dispensing or administration to the patient of a dose that is greater than or less than
  the amount ordered by the prescriber or administration of multiple doses to the
  patient, i.e. one or more dosage units in addition to those that were ordered.
- Dispensing or administration to the patient of a drug product in a different dosage
  form than that ordered by the prescriber.
- Dispensing or administration of a drug that has expired or for which the physical or
  chemical dosage-form integrity has been compromised.
  (Reference: Guideline on Medication Error Reporting Ministry of Health Malaysia)

Inclusion Criteria:
- All prescriptions made for patients (in-Patient and Out-Patients)

Exclusion Criteria:
- NA

Type of Indicator:
- Rate Based Outcome Indicator

Numerator:
- Number of dispensing errors (out-patients and in-patients)

Denominator:
- Total number of prescriptions dispensed (outpatients and Inpatients) X 100%

Target:

Data Collection:
- Monthly

Comments/Review:
## SERVICE STANDARD 18: PHARMACY SERVICES

**Indicator 03**: Average time for a prescription to be dispensed from time received at counter to time medication given to patient

**Rationale**: This indicator was selected because:

- Promptness of service is one criteria of quality care. Patient centred service must give priority to reducing waiting time for dispensing. This indicator reflects access and patient centeredness.

- Long waiting time can adversely affect patient satisfaction

**Definition of Term**:

1. **Waiting Time**:
   Time when a prescription is received at the pharmacy counter to the time the medication(s) is dispensed to the patient.

2. **Dispense**: Process of delivering medication to the patient

**Inclusion Criteria**: All prescriptions received from the Out Patient Pharmacy Department/Specialist Clinic/Follow up Clinic

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Total cumulative time taken to dispense all prescriptions received for the day from the time of receiving the first prescription to the time of the last dispensing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of prescriptions (outpatients) received for the day</td>
</tr>
</tbody>
</table>

**Target**

**Data Collection**: Monthly

**Comments/Review**: 
## SERVICE STANDARD 18: PHARMACY SERVICES

### Indicator 04: Number and value of expired drugs at end of month over a specified period

**Rationale:**
- To ensure good quality and safe medicines are available and accessible in a system that uses resources effectively for enhancement of the pharmaceutical services with better use of medicines and reduced wastage.
- To reflect the efficiency of the pharmaceutical services.

**Definition of Term:**

**Value of Expired Drugs:**

The cost of the drugs at the time of purchase.

**Inclusion Criteria:**

All expired drugs in stock at the end of the month over a specified period.

**Exclusion Criteria:**

NA

**Type of Indicator:**

Number and Value (cost)

**Numerator:**

Total number and value (cost) of expired drugs (all types of medications- oral, parental etc.) at the end of each month over a specified period.

**Target**

**Data Collection:** Monthly

**Comments/Review:**
### SERVICE STANDARD 19: CENTRAL STERILE SUPPLY SERVICES (CSSS)

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of sterile instrument sets rejected</td>
<td>&lt; 5%</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence</td>
<td></td>
<td>Monthly</td>
</tr>
</tbody>
</table>
**SERVICE STANDARD 19: CENTRAL STERILE SUPPLY SERVICES (CSSS)**

Indicator 01: Percentage of sterile instrument sets rejected

**Rationale**: This indicator was selected because:

- The Central Sterile Supply Services responsibility is to provide centralized sterilizing services and sterile supplies for all areas within the Facility that use sterile instruments, dressings, linen and other items to effectively prevent and control the incidence of Healthcare Acquired Infection (HAI).

- This indicator reflects the efficiency of the Central Sterile Supply Services.

**Definition of Term:**

**Reject of sterile instruments:**

The major role of the CSSS is disinfection, sterilization and reprocessing service and thermal decontamination for products not able to be sterilized. Occasions of reject sterile instrument sets could cause disruptions in surgical procedures and cost for the facility due to:

- Breech in the integrity of sterility
- Incomplete sets
- Use of poor packaging material
- etc.

**Inclusion Criteria**: Reject instrument sets per batch from all areas (OT, wards, clinics) of the facility at the end of the day over a specified period.

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Output Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Total number of reject sterile instrument sets in a month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of instrument sets sterilized in a month</td>
</tr>
</tbody>
</table>

**Target**: Data Collection: Monthly

**Comments/Review**: 

---
## SERVICE STANDARD 19: CENTRAL STERILE SUPPLY SERVICES (CSSS)

### Indicator 02

Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence.

### Rationale

This indicator was selected because:

- The Central Sterile Supply Services responsibility is to provide centralized sterilizing services and sterile supplies for all areas within the Facility that use sterile instruments, dressings, linen and other items to effectively prevent and control the incidence of Healthcare Acquired Infection (HAI).

- Knowledge of how to prevent harm to patients and staff during care is the most important knowledge in the field of patient safety. One of the best practices for patient safety is to establish a “No Blame, Reporting Culture by initiating an Incident Reporting and Learning System.

### Definition of Terms:

1. **Incidents:**
   
   Mishaps, near misses and hazards that have a likely hood of recurring if risk management strategies are not institutionalised. Example: incomplete sets, breach of sterility, staff injury, mechanical failure/malfunction of autoclaves etc.

2. **Root Cause Analysis (RCA)**

   Root Cause Analysis is a structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it. (Bjorn Andersen and Tom Fagerhaug. Root Cause Analysis: Simplified Tools and Techniques. McGraw- Hill, 2000)

### Inclusion Criteria

- All types of incidents needing RCA reported and documented

### Exclusion Criteria

- NA

### Type of Indicator

- Rate Based Outcome Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of incidents reported and where Root Cause Analysis is done and actions taken in the month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of incidents reported in the month X 100%</td>
</tr>
</tbody>
</table>

### Target

Data Collection: Monthly

Comments/Review:
## SERVICE STANDARD 20: HOUSEKEEPING SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Trend of performance score during in-house inspection/joint inspection</td>
<td>80% with minimum score of 3</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Customer satisfaction feedback survey</td>
<td>80% satisfaction</td>
<td>6 Monthly</td>
</tr>
</tbody>
</table>
Indicator 01: Trend of performance score during in-house inspection/joint inspection

Rationale: This indicator was selected because:

- The Housekeeping Services are an integral part of the hospital support services to ensure a clean environment in the hospital and is crucial in the prevention and control of Healthcare Acquired Infection (HAI).
- This indicator measures the quality of the performance of Housekeeping Services. Regular trending of the performance of the service examines the weakness and shortfalls in the overall improvement of the Housekeeping Services.

Definition of Terms:

1. Trending of Performance Score:

During the periodic in-house/joint inspection of the performance of the housekeeping services, staff of the hospital/outsource services contractor conducts an objective assessment using set criteria and scoring on the performance of the cleansing service for each area of the facility. These scores are to be trended as per achievement for each area of the facility for a specific period.

2. Performance Score:

   - 1 = Poor
   - 2 = Fair
   - 3 = Good
   - 4 = Excellent
   - 5 = Non-Applicable

(Source: Technical Requirements Performance Indicators, Ministry of Health Hospital Support Services)

Inclusion Criteria: All the areas in the facility to be included i.e. wards, critical care areas, operating theatre, Emergency Department etc.

Exclusion Criteria: NA

Type of Indicator: Process Based Indicator

Numerator: Performance trend showing 80% with minimum score of 3 for cleansing service in all areas of the Facility

Target: 80% with minimum score of 3

Data Collection: Monthly

Comments/Review:
## SERVICE STANDARD 20: HOUSEKEEPING SERVICES

<table>
<thead>
<tr>
<th>Indicator 02: Customer satisfaction feedback survey</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected:

- The Housekeeping Services are an integral part of the hospital support services to ensure a clean environment in the hospital and is crucial in the prevention and control of Healthcare Acquired Infection (HAI) and mishaps may occur in the cleansing service.

- As proxy to measurement of patient-centred services and level of client satisfaction to meet patient needs on cleanliness of the environment and comfort of the patient.

**Definition of Terms**: Patient Satisfaction Survey

Patient satisfaction survey is a measure of the extent to which a patient (inpatient and outpatient) is content with the cleanliness of the environment/facilities of the Healthcare Facility and the level of patient comfort.

**Inclusion Criteria**: All out-patients and in-patients

**Exclusion Criteria**: NA

**Type of Indicator**: Patient Satisfaction Survey

**Numerator**: Number of patient satisfaction surveys done every six (6) months with 80% satisfaction level

**Target**: 80% satisfaction level

**Data Collection**: 6 Monthly

**Comments/Review**: –
## SERVICE STANDARD 21: LINEN SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of Linen Shortfall</td>
<td>2 %</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Linen Rejection Rate</td>
<td>&lt; 2 %</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence</td>
<td>100 %</td>
<td>Monthly</td>
</tr>
<tr>
<td>4.</td>
<td>Internal customer satisfaction survey</td>
<td>80% satisfaction</td>
<td>6 monthly</td>
</tr>
</tbody>
</table>
SERVICE STANDARD 21: LINEN SERVICES

Indicator 01 : Percentage of Linen Shortfall

**Rationale** : This indicator was selected because:

- A reliable laundry service is of utmost importance to healthcare facilities. In healthcare facilities, patients expect linen to be changed daily. An adequate supply of clean linen that is sufficient for the comfort and safety of the patient thus becomes essential.
- The Linen Service is an integral part of the hospital support services to ensure clean Linen and Laundry Services in hospitals and is crucial in the prevention and control of Healthcare Acquired Infection (HAI).
- Laundry and linen service plays a very important role in maintaining and safeguarding the health and hygiene of both the inpatient and medical staff.

**Definition of Terms:**

1. **Hospital Linen**
The term ‘hospital linen’ includes all textiles used in the hospital including mattress, pillow covers, blankets, bed sheets, towels, screens, curtains, doctors/staff coats, theatre cloth etc. The hospital uses these materials in different areas like Operation Theatre, wards, outpatient departments and office areas.

2. **Linen Services**
Linen Services include the supply and delivery of clean linen and the collection and washing of dirty and soiled linen which may be provided from within the Facility or outsourced where linen shortfalls are likely to occur.

3. **Shortfall in Linen Services:**
Target per bed weight (e.g. 5.34 kg) versus Actual Received (4.85 kg/Bed) or par level as is the current practice in hospitals.

**Inclusion Criteria** : All types of linen used in the Healthcare Facility i.e. patient’s linen, bed covers, linen for drapes and procedures etc.

**Exclusion Criteria** : NA

**Type of Indicator** : Rate Based Outcome Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Total quantity of Linen by types (bed sheet, patients pyjamas, bedcovers etc) and par levels actually supplied to the Facility in a month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total quantity of Linen by types (bed sheet, patients pyjamas, bedcovers, etc.) and par levels agreed to be supplied to the Facility in a month X 100%</td>
</tr>
</tbody>
</table>

**Target** : 2%

**Data Collection** : Monthly

**Comments/Review** :
**SERVICE STANDARD 21: LINEN SERVICES**

<table>
<thead>
<tr>
<th>Indicator 02</th>
<th>Linen Rejection Rate</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:

- A reliable laundry service is of utmost importance to healthcare facilities. In healthcare facilities, patients expect linen to be changed daily. An adequate supply of clean linen that is sufficient for the comfort and safety of the patient thus becomes essential.

- The Linen Service is an integral part of the hospital support services to ensure clean Linen and Laundry Services in hospitals and is crucial in the prevention and control of Healthcare Acquired Infection (HAI).

- Laundry and linen service plays a very important role in maintaining and safeguarding the health and hygiene of both the patients and medical staff.

**Definition of Terms:**

1. **Hospital Linen**:
   The term ‘hospital linen’ includes all textiles used in the hospital including mattress, pillow covers, blankets, bed sheets, towels, screens, curtains, doctors/staff coats, theatre cloth etc. The hospital uses these materials in different areas like Operation Theatre, wards, outpatient departments and office areas.

2. **Linen Rejection**:
   Washed linen upon delivery maybe rejected by the facility for various reasons i.e. odour, torn, stained, torn etc.

**Inclusion Criteria**: All types of washed hospital linen upon delivery that does not comply with the set standards of clean linen

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Output Indicator

**Numerator**: Total quantity of Linen by weight and types (bed sheet, patients pyjamas, bed covers etc.) rejected by the Facility in a month

**Denominator**: Total quantity of Linen by weight and types (bed sheet, patients pyjamas, bedcovers etc.) supplied to the Facility in a month \[ \times 100\% \]

**Target**: < 2%

**Data Collection**: Monthly

**Comments/Review**: 

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*Malaysian Society for Quality in Health 2017*

*Performance Indicators - MSQH Hospital Accreditation Standards 5th Edition*
## SERVICE STANDARD 21: LINEN SERVICES

**Indicator 03**: Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence.

### Rationale
This indicator was selected because:

- Knowledge of how to prevent harm to patients and staff during care is the most important knowledge in the field of patient safety. One of the best practices for patient safety is to establish a “No Blame, Reporting Culture by initiating an Incident Reporting and Learning System.

- The Linen Service is an integral part of the hospital support services to ensure clean linen and laundry services in hospitals and is crucial in the prevention and control of Healthcare Acquired Infection (HAI).

### Definition of Terms:

1. **Linen Services**: 
   Linen Services include the supply and delivery of clean linen and the collection and washing of dirty and soiled linen which may be provided from within the Facility or outsourced where incidents of mishaps i.e. injury, linen shortfalls etc are likely to occur.

2. **Incidents**: 
   Mishaps, near misses and hazards i.e. injury due to unclear Standard Operating Procedures that have a likely hood of recurring if risk management strategies are not institutionalised.

3. **Root Cause Analysis (RCA)**: 
   Root Cause Analysis is a structured investigation that aims to identify the true cause of a problem and the actions necessary to eliminate it? (Bjorn Andersen and Tom Fagerhaug. Root Cause Analysis: Simplified Tools and Techniques. McGraw- Hill, 2000)

### Inclusion Criteria
All types of incidents needing RCA reported and documented within a specified period

### Exclusion Criteria
NA

### Type of Indicator
Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Total number of incidents reported for which Root Causes Analysis is done and actions taken in a month. X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of incidents reported in a month</td>
</tr>
<tr>
<td>Target</td>
<td>100%</td>
</tr>
<tr>
<td>Data Collection</td>
<td>Monthly</td>
</tr>
<tr>
<td>Comments/Review</td>
<td></td>
</tr>
</tbody>
</table>

---

**Malaysian Society for Quality in Health**

**Performance Indicators - MSQH Hospital Accreditation Standards 5th Edition**

Page 194
## SERVICE STANDARD 21: LINEN SERVICES

### Indicator 04: Internal Customer satisfaction survey

**Rationale**: This indicator was selected:

- The Linen Service is an integral part of the hospital support services to ensure clean linen and laundry services in hospitals and is crucial in the prevention and control of Healthcare Acquired Infection (HAI).

- Customer satisfaction survey is one of the tools that can be used in recognizing areas for improvement in the linen services provided.

**Definition of Terms**:

1. **Facility’s Internal Customer**:
   
   Internal Customer refers to the Facility’s staff involved in the handling of Linen and Laundry Services including representatives of the Facility’s Management i.e. liaison staff, ward staff etc.

2. **Satisfaction Survey**:
   
   Internal customer satisfaction survey is a measure of the extent to which the Facility’s management/staff is satisfied with the Linen and Laundry Services in particular the cleanliness and adequacy of patients’ garments, linen used for beddings, towels etc. The survey is referring to a Customer Satisfaction Survey Questionnaire.

**Inclusion Criteria**: All staff/clients handling the Facility’s Linen and Laundry Services and participates in the Internal Customer Satisfaction Survey

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th>Number of participating Internal Customers indicating they were “satisfied” in the customer satisfaction survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>Total number of Internal Customers who participated in the Customer Satisfaction Survey X 100 %</td>
</tr>
</tbody>
</table>

**Target**: 80% satisfaction level

**Data Collection**: 6 Monthly

**Comments/Review**: –
## SERVICE STANDARD 22: FOOD SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of ready to serve food tested negative for pathogenic microorganism as per schedule</td>
<td>100%</td>
<td>3 Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Occurrence of physical contamination of food served to patients</td>
<td>≤ 1% cases</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Client Food Satisfaction survey</td>
<td>&gt; 80% satisfaction</td>
<td>6 Monthly</td>
</tr>
</tbody>
</table>
## SERVICE STANDARD 22: FOOD SERVICES

### Indicator 01: Percentage of ready to serve food tested negative for pathogenic microorganism as per schedule

**Rationale**: This indicator was selected because:

- This indicator reflects the safety of the Healthcare Facility’s Food Services for in-patients’ consumption.
- There should be no occurrences of samples of ready to serve food being tested positive for pathogenic micro-organism if high quality food preparation, handling and transport are implemented or adhered to.

**Definition of Terms:**

1. **Ready to serve food**: Ready to eat/serve food means food (cooked and freshly cut) that is in a form that is edible without additional preparation to achieve food safety. Foods which are ready to be taken for sampling under strict sanitary and food quality standards and tested for pathogenic microorganism.

2. **Food testing for microorganism**: Microbiology testing is a crucial requirement across many food industries worldwide where products, processes and human health are at risk of being negatively affected by the presence and breeding of micro-organisms such as specific pathogens, bacteria, yeast and moulds. Food testing for microorganism is important to determine the safety and quality of food.

3. **As per schedule**: Samples (6-10) of ready to be served food (cooked and freshly cut) for in-patients taken for testing for microorganism over every three (3) months

<table>
<thead>
<tr>
<th><strong>Inclusion Criteria</strong></th>
<th>Samples (6-10) of ready to be served food (cooked and freshly cut) for In-Patient Food Services (that include outsourced or in-house kitchen) are taken for sampling every three (3) months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Type of Indicator</strong></td>
<td>Rate Based Process Indicator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th>Number of samples of ready to serve food (cooked and freshly cut) for in-patients tested negative for pathogenic micro-organism</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>Total number of samples (6-10) of ready to serve food (cooked and freshly cut) for in-patients tested for pathogenic micro-organism</td>
</tr>
</tbody>
</table>

**Target**: 100%

**Data Collection**: 3 monthly

**Comments/Review**: 
### SERVICE STANDARD 22: FOOD SERVICES

<table>
<thead>
<tr>
<th>Indicator 02</th>
<th>Occurrence of physical contamination of food served to patients</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:

- This indicator reflects the safety of the Food and Dietary Services for patient's consumption.
- There should be no occurrences of food contamination if high quality food preparation, handling and transport are implemented or adhered to.

**Definition of Terms:**

**Contaminated Food:**

Presence of materials that are not normally found in food served/prepared for inpatients (that include outsourced and in-house kitchen)

**Inclusion Criteria**: Food prepared for all inpatients/on call staff

**Exclusion Criteria**: Micro-organisms and toxic chemicals.

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of Occurrences of Physical Contamination of Food during the study period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of food plating prepared during the study period</td>
</tr>
</tbody>
</table>

**Target**: ≤ 1% cases

**Data Collection**: Monthly

**Comments/Review**: 

---

*Malaysian Society for Quality in Health 2017*
## SERVICE STANDARD 22: FOOD SERVICES

<table>
<thead>
<tr>
<th>Indicator 03 : Client Food Satisfaction survey</th>
</tr>
</thead>
</table>

**Rationale:** This indicator was selected because:

- It is the hospital’s responsibility to provide high quality food services for the patients to support in the treatment and recovery of the patient’s health during admission at the hospital. Hence standards of food quality should be implemented and adhered to.

- This survey is a proxy measurement of Patient- Centred Services and Client Satisfaction level on the Food Services.

- Client satisfaction survey is one of the tools that can be used in recognizing areas for improvement in the Food Services.

### Definition of Terms:

1. **Hospital Client:**

   Refers to all in-patients provided Food Services during their course of admission in the Hospital

2. **Food Satisfaction Survey**

   Client food satisfaction survey is a measure of the extent to which an in-patient is content with the Food Services in particular in meeting the patient’s nutritional requirements and dietary needs. The survey is referring to a Customer Satisfaction Survey Questionnaire.

**Inclusion Criteria:** All in-patients in all wards/ units of the Facility

**Exclusion Criteria:** NA

**Type of Indicator:** Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Numbers of Client Food Satisfaction Survey Feedback with 80% satisfaction level X 100 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of clients that participated in the Client Food Satisfaction Survey</td>
</tr>
</tbody>
</table>

**Target:** > 80% satisfaction level

**Data Collection:** 6 Monthly

**Comments/Review:** –
### SERVICE STANDARD 23: FORENSIC SERVICES

There are including tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of bodies released to next of kin/claimant (non-medico-legal cases) within three (3) hours from time bodies are received in the mortuary</td>
<td>75%</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of correct bodies released to the right next of kin/claimant</td>
<td>100%</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of post-mortem for non-complicated cases performed within 24 hours from the time the Polis 61 Order is received</td>
<td>80%</td>
<td>Monthly</td>
</tr>
<tr>
<td>4.</td>
<td>Percentage of completion of post-mortem report for non-complicated cases from the date of post-mortem within eight (8) weeks</td>
<td>80%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Note:**
Non-complicated cases refer to accidents, suicides and natural deaths which are routine police cases subjected to forensic post-mortem examination.
### SERVICE STANDARD 23: FORENSIC SERVICES

<table>
<thead>
<tr>
<th>Indicator 01</th>
<th>Percentage of bodies released to next of kin/claimant (non-medico-legal cases) within three (3) hours from the time bodies are received in the mortuary</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:
- This indicator reflects the timeliness for the release of bodies for non-medico-legal cases and client centeredness of care in the Mortuary Service. There is a need to hasten the release of bodies of non-medico-legal cases for cultural and religious reasons.

**Definition of Terms:**

**Non-Medico-legal cases:**
There is no issue of Polis 61 order for post mortem.

**Inclusion Criteria**: Bodies of all cases requiring no post mortem

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of bodies released (non-medico-legal cases) to next of kin/claimant within 3 hours from the time bodies were received in the mortuary</th>
<th>X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of bodies received (non-medico-legal cases) in the mortuary during the month</td>
<td></td>
</tr>
</tbody>
</table>

**Target**: 75%

**Data Collection**: Monthly

**Comments/Review**:  

### SERVICE STANDARD 23: FORENSIC SERVICES

<table>
<thead>
<tr>
<th>Indicator 02</th>
<th>Percentage of correct bodies released to the right next of kin/claimant</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:

- This indicator reflects the efficiency of the Mortuary Service. The release of wrong bodies to the next of kin/claimant can turn out to be traumatic for the family as well as a medico-legal issue and an embarrassment to the facility.

**Definition of Term:**

**Release of Correct Bodies:**

Refers to the release of correct bodies (correct identity of the deceased) or to the correct party.

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>All bodies received at the mortuary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Criteria</td>
<td>NA</td>
</tr>
<tr>
<td>Type of Indicator</td>
<td>Rate Based Process Indicator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of correct bodies released to the next of kin/claimant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of bodies received in the mortuary during the month</td>
</tr>
</tbody>
</table>

**Target**: 100%

**Data Collection**: Monthly

**Comment/Review**: 
### SERVICE STANDARD 23: FORENSIC SERVICES

**Indicator 03**: Percentage of post-mortem for non-complicated cases performed within 24 hours from the time the Polis 61 Order is received

**Rationale**: This indicator was selected because:

- This indicator reflects the timeliness of post mortems for non-complicated cases and client centeredness of care in the Mortuary Service.
- It also shows the clinical effectiveness of care and efficiency of the Forensic Services

**Definition of Terms:***

1. **Post-mortem Examination**: An autopsy also known as a post-mortem examination is a highly specialized surgical procedure that consists of a thorough examination of a corpse by dissection to determine the cause and manner of death and to evaluate any disease or injury that may be present.

2. **Non-Complicated Cases**: Non-complicated cases refer to accidents, suicides and natural deaths which are routine police cases subjected to forensic post-mortem examination.

  **Inclusion Criteria**: All non-complicated cases requiring post mortem

  **Exclusion Criteria**: NA

  **Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of post-mortems for non-complicated cases performed within 24 hours from the time Polis 61 Order is received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of post-mortems for non-complicated cases performed with Polis Order 61 received in a month</td>
</tr>
</tbody>
</table>

**Target**: 80%

**Data Collection**: Monthly

**Comments/Review**:  

---
## SERVICE STANDARD 23: FORENSIC SERVICES

### Indicator 04 : Percentage of completion of post-mortem report for non-complicated cases from the date of post-mortem within eight (8) weeks

**Rationale** : This indicator was selected because:

- This indicator reflects the efficiency of the Forensic Services and timeliness for post-mortem reports for non-complicated cases.

**Definition of Terms:**

1. **Post-mortem Report:**
   A detailed clinical report of a postmortem examination of a cadaver. An autopsy also known as a post-mortem examination is a highly specialized surgical procedure that consists of a thorough examination of a corpse by dissection to determine the cause and manner of death and to evaluate any disease or injury that may be present.

2. **Non-Complicated Cases:**
   Non-complicated cases refer to accidents, suicides and natural deaths which are routine police cases subjected to forensic post-mortem examination.

**Inclusion Criteria** : All non-complicated cases requiring post mortem

**Exclusion Criteria** : NA

**Type of Indicator** : Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of post-mortem reports completed within eight (8) weeks from date of post-mortem for non-complicated cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of post-mortems performed for non-complicated cases within the month X 100%</td>
</tr>
</tbody>
</table>

**Target** : 80%

**Data Collection** : Monthly

**Comments/Review** :
### SERVICE STANDARD 23A: MORTUARY SERVICES

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of bodies released to next of kin/claimant (non-medico-legal cases) within three (3) hours from time bodies are received in the mortuary</td>
<td>75%</td>
<td>Monthly</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of correct bodies released to the right next of kin/claimant</td>
<td>100%</td>
<td>Monthly</td>
</tr>
<tr>
<td>3.</td>
<td>Percentage of post-mortem for non-complicated cases performed within 24 hours from the time the Polis 61 Order is received (where applicable)</td>
<td>80%</td>
<td>Monthly</td>
</tr>
<tr>
<td>4.</td>
<td>Percentage of completion of post-mortem report for non-complicated cases from the date of post-mortem within eight (8) weeks</td>
<td>80%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Note:**
Non-complicated cases refer to accidents, suicides and natural deaths which are routine police cases subjected to forensic post-mortem examination.
**SERVICE STANDARD 23A: MORTUARY SERVICES**

**Indicator 01:** Percentage of bodies released to next of kin/claimant (non-medico-legal cases) within three (3) hours from the time bodies are received in the mortuary

**Rationale:** This indicator was selected because:

- This indicator reflects the timeliness for the release of bodies for non-medico-legal cases and client centeredness of care in the Mortuary Service. There is a need to hasten the release of bodies of non-medico-legal cases for cultural and religious reasons.

**Definition of Terms:**

**Non-Medico-legal cases:**

There is no issue of Polis 61 order for post mortem.

**Inclusion Criteria:** Bodies of all cases requiring no post mortem

**Exclusion Criteria:** NA

**Type of Indicator:** Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of bodies released (non-medico-legal cases) to next of kin/claimant within 3 hours from the time bodies were received in the mortuary</th>
<th>X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of bodies received (non-medico-legal cases) in the mortuary during the month</td>
<td></td>
</tr>
</tbody>
</table>

**Target:** 75%

**Data Collection:** Monthly

**Comments/Review:**
## SERVICE STANDARD 23A: MORTUARY SERVICES

<table>
<thead>
<tr>
<th>Indicator 02</th>
<th>Percentage of correct bodies released to the right next of kin/claimant</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:

- This indicator reflects the efficiency of the Mortuary Service. The release of wrong bodies to the next of kin/claimant can turn out to be traumatic for the family as well as a medico-legal issue and an embarrassment to the facility.

**Definition of Term:**

**Release of Correct Bodies**: Refers to the release of correct bodies (correct identity of the deceased) or to the correct party.

**Inclusion Criteria**: All bodies received at the mortuary

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of correct bodies released to the next of kin/claimant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of bodies received in the mortuary during the month</td>
</tr>
</tbody>
</table>

Target: 100%

Data Collection: Monthly

Comment/Review:
## SERVICE STANDARD 23A: MORTUARY SERVICES

<table>
<thead>
<tr>
<th>Indicator 03: Percentage of post-mortem for non-complicated cases performed within 24 hours from the time the Polis 61 Order is received</th>
</tr>
</thead>
</table>

**Rationale**: This indicator was selected because:

- This indicator reflects the timeliness of post mortems for non-complicated cases and client centeredness of care in the Mortuary Service.
- It also shows the clinical effectiveness of care and efficiency of the Forensic Services.

**Definition of Terms:**

1. **Post-mortem Examination**: An autopsy also known as a post-mortem examination is a highly specialized surgical procedure that consists of a thorough examination of a corpse by dissection to determine the cause and manner of death and to evaluate any disease or injury that may be present.

2. **Non-Complicated Cases**: Non-complicated cases refer to accidents, suicides and natural deaths which are routine police cases subjected to forensic post-mortem examination.

**Inclusion Criteria**: All non-complicated cases requiring post mortem (where applicable)

**Exclusion Criteria**: NA

**Type of Indicator**: Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of post-mortems for non-complicated cases performed within 24 hours from the time Polis 61 Order is received X 100 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of post-mortems for non-complicated cases performed with Polis Order 61 received in a month</td>
</tr>
</tbody>
</table>

**Target**: 80%

**Data Collection**: Monthly

**Comment/Review**: 

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Performance Indicators - MSQH Hospital Accreditation Standards 5th Edition Page 208
## SERVICE STANDARD 23A: MORTUARY SERVICES

**Indicator 04**: Percentage of completion of post-mortem report for non-complicated cases from the date of post-mortem within eight (8) weeks

### Rationale
This indicator was selected because:

- This indicator reflects the efficiency of the Forensic Services and timeliness for post-mortem reports for non-complicated cases.

### Definition of Terms:

1. **Post-mortem Report**:
   
   A detailed clinical report of a postmortem examination of a cadaver. An autopsy also known as a post-mortem examination is a highly specialized surgical procedure that consists of a thorough examination of a corpse by dissection to determine the cause and manner of death and to evaluate any disease or injury that may be present.

2. **Non-Complicated Cases**:
   
   Non-complicated cases refer to accidents, suicides and natural deaths which are routine police cases subjected to forensic post-mortem examination.

### Inclusion Criteria
All non-complicated cases requiring post mortem

### Exclusion Criteria
NA

### Type of Indicator
Rate Based Process Indicator

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of post-mortem reports completed within eight (8) weeks from date of post mortem for non-complicated cases X 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of post-mortems performed for non-complicated cases within the month</td>
</tr>
</tbody>
</table>

### Target
80%

### Data Collection
Monthly

### Comments/Review

**SERVICE STANDARD 24A: CLINICAL RESEARCH CENTRE SERVICES**

There is tracking and trending of specific performance indicators which include but not limited to at least two (2) of the following indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>INDICATOR</th>
<th>TARGET</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Number of training conducted per year</td>
<td>Minimum 2 per year</td>
<td>Yearly</td>
</tr>
<tr>
<td>2.</td>
<td>Number of publications per year</td>
<td>Minimum 2 per year</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
SERVICE STANDARD 24A: CLINICAL RESEARCH CENTRE

Indicator 01: Number of training conducted per year

Rationale: This indicator was selected as a generic indicator because:

- Staff knowledge, competency and skills acquired to conduct studies related to clinical practices enable the Health Facility to share on best practices in the industry. Training in Clinical Research is an important element in continuing education for staff development in clinical research and practices.

- The Hospital’s Clinical Research Centre must undertake the responsibility to conduct Clinical Research Training for its own staff and for the Ministry of Health where required.

- Training in Clinical Research will be an early exposure and encouragement for staff to be involved in research

Definition of Terms:

Training in Clinical Research:

Refers to continuing education/training program designed to educate an individual and give him or her further skills or knowledge on Clinical Research to be applied in his or her line of work. These programs are intended to educate persons on new advancements, or to build upon a person’s expertise in a given field.

Inclusion Criteria: All training conducted in the Facility in relation to Clinical Research in a year

Exclusion Criteria: NA

Type of Indicator: Clinical Effectiveness and Quality Improvement

Numerator: Total number of training courses on Clinical Research conducted in the Facility in a year

Target: Minimum 2 per year

Data Collection: Yearly

Comments/Review:
## SERVICE STANDARD 24A: CLINICAL RESEARCH CENTRE SERVICES

### Indicator 02: Number of publications per year

**Rationale**: This indicator was selected because:

- The Hospital’s Clinical Research Centre must undertake the responsibility to publish Clinical Research studies conducted by the staff to share on their experiences and best practices in the industry. Publication on Clinical Research is an important element in continuing education for staff development.

- Publications on Clinical Research will be an early exposure and encouragement for staff to be involved in research

**Definition of Terms**:

**Publications on Clinical Research**: Studies with significant results more likely to lead to a greater number of publications and presentations and to be published in journals with a high citation impact factor.

**Inclusion Criteria**: All publications on Clinical Research studies undertaken by the Facility’s Clinical Research Centre

**Exclusion Criteria**: NA

**Type of Indicator**: Clinical Effectiveness and Quality Improvement

**Numerator**: Number of publications on Clinical Research undertaken the Facility’s Clinical Research Centre in a year

**Target**: Minimum 2 per year

**Data Collection**: Yearly

**Comments/Review**: 

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
<td>This indicator was selected because:</td>
</tr>
<tr>
<td><strong>Definition of Terms</strong></td>
<td>Publications on Clinical Research:</td>
</tr>
<tr>
<td><strong>Inclusion Criteria</strong></td>
<td>All publications on Clinical Research studies undertaken by the Facility’s Clinical Research Centre</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Type of Indicator</strong></td>
<td>Clinical Effectiveness and Quality Improvement</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of publications on Clinical Research undertaken the Facility’s Clinical Research Centre in a year</td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td>Minimum 2 per year</td>
</tr>
<tr>
<td><strong>Data Collection</strong></td>
<td>Yearly</td>
</tr>
<tr>
<td><strong>Comments/Review</strong></td>
<td></td>
</tr>
</tbody>
</table>