SERVICE STANDARD 07: HEALTH INFORMATION MANAGEMENT SYSTEM (HIMS)

PREAMBLE

Patient care services are highly dependent on the communication and transfer of information among healthcare professionals to patients and their families and community. Health information is a resource that shall be managed effectively through:

a) identifying information needs;
b) developing an information management system;
c) defining and capturing data and information;
d) analysing data and transforming it into information;
e) transmitting and reporting data and information;
f) utilisation of information in management decisions.

Principles of good information management apply to all methods both paper based or electronic.

TOPIC 7.1:
ORGANISATION AND MANAGEMENT

STANDARD 7.1.1

The Health Information Management System (HIMS) Services shall be organized and administered to facilitate the collation, aggregation, and analysis of Facility demographic data through an established system, which includes confidentiality*, safekeeping, and retrieval of medical records and documents, both paper-based and electronic, related to patient care.

*Personal Data Protection Act (PDPA) 2013.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
7.1.1.1	Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Health Information Management System Services are clearly documented and measurable. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required accordingly and communicated to all staff.	NA			NA	
	EVIDENCE OF COMPLIANCE					
	1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body. — NA					

	2.	Goals and objectives of the Health Information Management System Services in line with the Facility statements are available, endorsed and dated.	NA				
	3.	Evidence of planned reviews of the above statements.	NA				
	4.	These statements are communicated to all staff (orientation programme, minutes of meeting, etc.)	NA				
	5.	Achievement of goals and objectives are monitored, reviewed and revised accordingly.	NA				
7.1.1.2 CORE	There is an organisation chart which: a) provides a clear representation of the structure, functions and reporting relationships between the Person In Change (PIC), Head and the staff of the HIMS Services; b) is accessible to all staff and clients; c) is revised when there is a major change in any of the following: i) organisation; ii) functions; iii) reporting relationships; iv) staffing patterns.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the HIMS Services and staff of the HIMS Services.	NA				
	2.	Organisation chart of the service is endorsed, dated and accessible.	NA				
	3.	The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv).	NA				
7.1.1.3	Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the HIMS Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Minutes are accessible, disseminated and acknowledged by the staff.	NA				
	2.	Attendance list of members with adequate representative of the service.	NA				

	3.	Frequency of meetings as scheduled.	NA				
	4.	Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved).	NA				
7.1.1.4	The Head of HIMS Services is involved in the planning, justification and management of the budget and resource utilisation of the services.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Minutes of Facility-wide management meeting	NA				
	2.	Documented evidence on request for allocation of budget and resources (staffing, equipment, etc.) for the service.	NA				
	3.	Approved budget and resources.	NA				
7.1.1.5	The Head of HIMS Services is involved in the appointment and/OR assignment of staff.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Records on staff interview (if applicable)	NA				
	2.	Appointment/assignment letter of Head of Service	NA				
	3.	Job description of Head of Service	NA				
	4.	Records on staff deployment	NA				
	5.	Duty roster	NA				
7.1.1.6	The HIMS Services plan and design information management processes to meet internal and external information needs.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policies and procedures are available to plan and design information management processes.	NA				
7.1.1.7 CORE	Statistical information is available from the HIMS Services or elsewhere as determined by the Facility and distributed to appropriate committees and relevant staff. The type and amount of information maintained shall meet the statutory requirements and may include information about major clinical services but not limited to: a) number of admissions and discharges; b) bed occupancy; c) percentage of critical beds occupied; d) patient days;			NA			NA	

	e) births and deaths; f) procedures performed; g) diagnosis in accordance to current ICD (International Classification of Diseases); h) length of stay in days; i) autopsies; j) number of new registrations; k) number of follow up.					
	EVIDENCE OF COMPLIANCE					
	1.	The type and amount of information maintained to meet the statutory requirements include information about major clinical services but not limited to as (a) to (k) should be made available.	NA				
7.1.1.8	Appropriate statistics and records shall be maintained in relation to the provision of HIMS Services and used for managing the services and patient care purposes.		NA			NA	
	EVIDENCE OF COMPLIANCE					
	1.	Records are available but not limited to the following:				
	a)	staffing number and staff profile;	NA			
	b)	staff training records;	NA			
	c)	number of medical reports produced;	NA			
	d)	incident reports;	NA			
	e)	other records to be made available, such as:-				
	i)	medical reports;	NA			
	ii)	data from the Social Security Organisation (SOCSO) /Board;	NA			
	iii)	data from Employee Provident Fund (EPF) Board;	NA			
	iv)	data from Medical Board;	NA			
	v)	medicolegal inquiries;	NA			
	vi)	post mortem reports;	NA			
	f)	data on performance improvement activities, including performance indicators;	NA			
	g)	copy of signatures/signature bank of healthcare providers.	NA			
7.1.1.9 CORE	A Medical Records Committee chaired by a medical practitioner shall be responsible to: a) determine standards and policies for the HIMS Services;		NA			NA	

	b) introduce new medical record forms or amendments to existing forms; c) recommend actions to be taken to resolve problems related to medical records and the HIMS Services; d) review regularly the contents of medical records to ensure that the recorded clinical information is complete and sufficient for the purpose of providing and evaluating patient care; e) formulate a medical abbreviations list which shall be approved by the Person In Charge (PIC) of the Facility; f) improve HIMS Services. Notes/Explanations *Membership of the Medical Records Committee shall be chaired by a medical practitioner and include the Head of HIMS Services, medical and nursing staff representatives, and other healthcare personnel who could contribute substantially to the HIMS Services.* EVIDENCE OF COMPLIANCE 1. Appointment letters for Chairman and committee members. NA 2. Terms of Reference NA 3. Minutes of meeting NA 4. Medical records audit report NA 5. Current and approved abbreviations list NA					
7.1.1.10	There is evidence that the Medical Records Committee meets regularly and keeps adequate minutes which are submitted to the Medical and Dental Advisory Committee (MDAC). EVIDENCE OF COMPLIANCE 1. Minutes of meeting of Medical Records Committee NA	NA			NA	

TOPIC 7.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD 7.2.1
The HIMS Services shall be directed by and staffed with suitably qualified and trained personnel to achieve the goals and objectives of the services.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
7.2.1.1 CORE	The Head and staff of the HIMS Services shall be individuals qualified by education, training, experience and certification to commensurate with the requirements of the various positions.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Records on credentials of Head of Service and staff required to fill up the posts within the service (to match the complexity of the Facility and services)	NA				
	2.	Appointment/assignment letters	NA				
	3.	Certification	NA				
	4.	Training and competency records	NA				
7.2.1.2	The authority, responsibilities and accountabilities of the Head of HIMS Services are clearly delineated and documented.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Appointment/assignment letter for Head of Service.	NA				
	2.	Description of duties and responsibilities	NA				
7.2.1.3	Sufficient numbers of personnel and support staff with appropriate qualifications are employed to meet the need of the services.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Number of staff and qualification should commensurate with workload.	NA				
	2.	Staffing pattern	NA				
	3.	Duty roster	NA				
	4.	Census and statistics	NA				

7.2.1.4	There are written and dated specific job descriptions for all categories of staff that include: a) qualifications, training, experience and certification required for the position; b) lines of authority; c) accountability, functions and responsibilities; d) reviewed when required and when there is a major change in any of the following: i) nature and scope of work; ii) duties and responsibilities; iii) general and specific accountabilities; iv) qualifications required and privileges granted; v) staffing patterns; vi) Statutory Regulations.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (d).	NA				
	2.	Job description includes specialisation skills	NA				
	3.	Relevant privileges granted where applicable	NA				
	4.	The job description is acknowledged by the staff and signed by the Head of Service and dated.	NA				
7.2.1.5	Personnel records on training, staff development, leave and others are maintained for every staff. Note: Staff personal record may be kept in Human Resource Department as per Facility policy.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Staff personal records include:					
	a)	staff biodata;	NA				
	b)	qualification and experience;	NA				
	c)	training record;	NA				
	d)	competency record and privileging;	NA				
	e)	leave record;	NA				
	f)	confidentiality agreement.	NA				

7.2.1.6	There is a structured orientation programme where new staff are briefed on their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities. EVIDENCE OF COMPLIANCE 1. Policy requiring all new staff to attend a structured orientation programme. — NA 2. Records on structured orientation programme — NA 3. Orientation module — NA 4. List of attendance — NA	NA			NA	
7.2.1.7	Staff receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility. EVIDENCE OF COMPLIANCE 1. Performance appraisal for staff is completed upon probationary period and as an annual exercise. — NA	NA			NA	
7.2.1.8	There is evidence of training needs assessment and staff development plan which provide the knowledge and skills required for staff to maintain competency in their current positions and future advancement. EVIDENCE OF COMPLIANCE 1. Training needs assessment is carried out and gaps identified. — NA 2. A staff development plan based on training needs assessment is available — NA 3. Training schedule/calendar is in place — NA 4. Training module — NA	NA			NA	
7.2.1.9	There are continuing education activities for staff to pursue professional interests and to prepare for current and future changes in practice. EVIDENCE OF COMPLIANCE 1. Training records on continuing education activities are kept and maintained for each staff. — NA 2. Contents of training programme — NA 3. Training records on continuing education activities are kept and maintained for each staff — NA	NA			NA	

	4.	Certificate of attendance/degree/post basic training .	NA					

TOPIC 7.3:
POLICIES AND PROCEDURES

STANDARD 7.3.1

Written policies and procedures shall reflect current standards of practice for HIMS Services, and they serve as standard operating procedures to meet the information needs of all those providing clinical services, management and external sources that may require data and information from the Facility.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
7.3.1.1 CORE	There are written policies and procedures for the HIMS Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years. EVIDENCE OF COMPLIANCE 1. Documented policies and procedures for the service. — NA 2. Policies and procedures are consistent with regulatory requirements and current standard practices. — NA 3. Evidence of periodic review of policies and procedures. — NA 4. The policies and procedures are endorsed and dated. — NA	NA			NA	
7.3.1.2 CORE	Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved. This includes but not limited to: a) information security including data integrity; b) retention time of records, data and information; c) use of standardized diagnosis codes, procedure codes, symbols, abbreviations and definitions; d) contain sufficient information to identify patients, support diagnosis and treatment, document allergies and the course and outcome of treatment and continuity ofcare; e) identification of those authorized to make entries in the patient's medical record, with date and time of entry. Cross departmental collaboration is practiced in developing relevant policies and procedures where applicable.	NA			NA	

	EVIDENCE OF COMPLIANCE						
	1.	Minutes of committee meetings on development and revision on policies and procedures.	NA				
	2.	Minutes of meeting with evidence of cross reference with other departments	NA				
	3.	Documented cross departmental policies	NA				
	4.	Reference to relevant policies, procedures, protocols, manuals and guidelines, such as Guidelines for Management of Medical Records, Ministry of Health.	NA				
	5.	Policies and procedures which include but not limited to (a) to (e).	NA				
	6.	Electronic information system security policies	NA				
7.3.1.3	Current policies and procedures are communicated to all staff.			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	Training and briefing on the current policies and procedures/Minutes of meetings	NA				
	2.	Circulation list and acknowledgement	NA				
7.3.1.4 CORE	There is evidence of compliance with policies and procedures.			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	Compliance with policies and procedures through:					
	a)	interview of staff on practices;	NA				
	b)	verify with observation on practices;	NA				
	c)	results of medical records audit on practices;	NA				
	d)	practices in line with established policies and procedures.	NA				
	e)	Audit report on user access for EMR (Reference : GHOP_JCT 2016 Page 50 5.9.3.2 General Condition for Access of EMR in facility)	NA				
7.3.1.5	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible to staff.			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference.	NA				

7.3.1.6	A single record for every patient is maintained with integrated recording system by healthcare providers. A single record is a record that is a composite of all data on a given patient whether as an inpatient, ambulatory care or emergency patient. Their entire medical record is in one folder under one medical record reference number. The record of psychiatric patients shall be retained as according to statutory requirements. Integrated record is a system of joint recording by various healthcare providers who record information around the patient (patient based) according to sequence of events. Notes: For public hospital, option given for single record system: a) Single record (1 patient, 1 folder) include Inpatient, Outpatient (Emergency Department, Specialist Clinics, Xray Films and all related document) b) Merging of Inpatient Records from various discipline in One folder c) Merging of outpatient and inpatient records according to discipline in One folder d) Patient Medical Records that has been compiled using methods a or b or c kept in the Medical Records Department, However if there is constraint on storage space the record can be kept at location other than the Medical Records Department with the supervision of Medical Records Officer. Reference: Surat Arahan Kaedah Pemusatan Rekod Perubatan (1 patient 1 folder) 10 Jun 2019 EVIDENCE OF COMPLIANCE 1. A single record system is implemented for inpatient and outpatient. NA 2. Integrated records are practiced. NA	NA			NA	
7.3.1.7	There is a system for patient identification, cross referencing and a filing system that allows rapid retrieval of records. EVIDENCE OF COMPLIANCE 1. Policies and procedures for patient identification, cross referencing and a filing system that allows rapid retrieval of records. NA	NA			NA	
7.3.1.8	Provision shall be made for 24-hour availability of the patient's record to healthcare providers to ensure continuity of care. EVIDENCE OF COMPLIANCE 1. On-call roster is available for paper based system. NA 2. 24-hour access electronic system to authorised healthcare providers. NA	NA			NA	

7.3.1.9 CORE	There is a policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel. There are policies and procedures on information storage and recovery including procedures for data recovery in case of malfunctions or disaster. EVIDENCE OF COMPLIANCE 1. Policy for safeguarding the information in the record against breach of confidentiality, loss, damage, or use by unauthorised personnel is in place. — NA 2. Guidelines for management of medical records, electronic information system security and user access control policies (paper based and electronic information systems). — NA 3. Mechanisms are in place to support Facility-wide and HIMS functions even in case of unexpected failure or emergency. — NA	NA			NA	
7.3.1.10	Written consent of the patient or authorized next of kin is required for release of medical information to persons not otherwise authorized to receive this information. EVIDENCE OF COMPLIANCE 1. Consent form for medical records request is available. — NA 2. Signed consent forms — NA 3. Authorizations letters — NA	NA			NA	
7.3.1.11 CORE	The patient's medical record contains documentation of patients' valid consent for all procedures. Written informed consent shall be obtained from: a) the patient; b) the spouse, parent or next of kin where the patient is mentally disabled; c) the parent or guardian where the patient is unmarried and below eighteen years of age. Notes/Explanations A valid consent may be dispensed with if a surgeon believes that any delay caused in obtaining the consent would endanger the life of a patient, provided that a consensus of the surgeon and another registered medical practitioner is obtained and they jointly sign a statement stating that the delay would endanger the life of the patient. EVIDENCE OF COMPLIANCE 1. Written informed consent is taken in accordance with guidelines and regulatory requirements. — NA	NA			NA	

	2.	On-site observation on completeness of consent form.	NA					
7.3.1.12	Medical records not be removed from the jurisdiction and safekeeping of the Facility unless in accordance with a court order, or statute and this shall be properly recorded. Medical Records can be moved base on cluster framework. A copy of the record shall be retained by the Facility until the original records be returned to the Facility at the end of the proceedings. Notes : Reference : Framework Cluster Hospital 2015			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policies and procedures on tracing and retrieving of medical records.	NA					
	2.	Medical records movement documentation.	NA					
	3.	Copy of court order and authorised letter (if applicable).	NA					
7.3.1.13	There is a system for recording and monitoring movement of medical records within the Facility for easy retrieval.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Standard operating procedures for recording and monitoring movement of medical records.	NA					
	2.	Movement of medical records is documented.	NA					
7.3.1.14	The medical practitioners, nurses, and allied health professionals are responsible for the completeness and timely completion of medical records by ensuring the following procedures as stated in the policy manuals: a) clinical history and examination are available within 24 hours of admission and prior to surgical procedures; b) reports of operations or procedures are recorded immediately after completion of the procedure, dated and signed; c) all medical reports shall be completed by medical practitioners within the Facility's stipulated period. Exceptions may occur when test and autopsy reports are not available; d) all records are indexed and coded within one month of the patient's discharge.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Policies and procedures to include (a) to (d).	NA					
	2.	Sampling of patient medical records (BHT)	NA					
	3.	Monitoring of timeliness of medical report preparation.	NA					

7.3.1.15	There is a policy on the retention of medical records and there are guidelines on the appropriate storage of active and inactive records. Records shall be preserved at least for the period as specified under the written law pertaining to limitation period (e.g. Statute of Limitation, National Archives Policy). EVIDENCE OF COMPLIANCE 1. Policy and guidelines on the retention of medical records. NA 2. Records on medical records disposal NA 3. On-site observation on storage of medical records NA		NA			NA	
7.3.1.16	There are written policies and procedures to aggregate data and determine what data and information are to be regularly aggregated to meet the needs of clinical and managerial staff in the Facility and agencies outside the Facility. EVIDENCE OF COMPLIANCE 1. Policies, procedures and guidelines on data and information to be collected, analyzed and utilized by the Management. NA		NA			NA	

TOPIC 7.4:
FACILITIES AND EQUIPMENT

STANDARD 7.4.1
Adequate physical facilities and equipment are available for the efficient operations of the HIMS Services.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
7.4.1.1 CORE	The facility for the HIMS Services is designed to facilitate safe and adequate storage, prompt retrieval, distribution and accessibility of medical records.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	On-site inspection of storage areas ensures records are stored safely.	NA				
	2.	Preventive measures for possible destruction of records by fire, water and pest.	NA				
	3.	Access control for authorised personnel.	NA				
	4.	Policy on distribution of medical records addresses the issues of confidentiality and security.	NA				
7.4.1.2	There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, administrative functions and for other medical personnel to read and work with reference to medical records, including records on microfilm or other storage media.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Adequate and proper utilisation of space for staff functions and medical records storage.	NA				
	2.	Appropriate type of equipment/system to match the complexity of services including types of storage media, i.e.microfilm.	NA				
	3.	Easy access and clear exit routes	NA				
7.4.1.3	There is sufficient space for storage needs. a) The active storage area has sufficient space to keep all medical records currently in use at the Facility. b) Inactive records may be stored separately.		NA			NA	
	EVIDENCE OF COMPLIANCE						

	1.	Paper based system On-site observation of the active and inactive medical records storage.	NA				
	2.	Electronic system					
	a)	Adequate storage space in the server(s)	NA				
	b)	Adequate and appropriate space for server.	NA				
	c)	Off-site back-up system is available	NA				
7.4.1.4	Areas for active and inactive medical records storage are sufficiently secured to protect records against loss, damage or use by unauthorised personnel.			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	Access control to areas for active and inactive medical records storage	NA				
	2.	Records on medical records movement from the storage areas.	NA				
	3.	Appropriate fire suppression system is in place.	NA				
7.4.1.5	There shall be a system to control the access to the HIMS Services facility.			NA			NA
	EVIDENCE OF COMPLIANCE						
	1.	Security system to control the access to HIMS Services facility, e.g. closed-circuit television (CCTV), security guard, electronic access system, etc.	NA				

TOPIC 7.5:
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD 7.5.1
The Head of HIMS Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the HIMS Services.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
7.5.1.1	There are planned and systematic safety and performance improvement activities to monitor and evaluate the performance of the HIMS Services. The process includes: a) Planned activities b) Data collection c) Monitoring and evaluation of the performance d) Action plan for improvement e) Implementation of action plan f) Re-evaluation for improvement Innovation is advocated. **EVIDENCE OF COMPLIANCE** 1. Planned performance improvement activities include (a) to (f) — NA 2. Records on performance improvement activities. — NA 3. Minutes of performance improvement meetings — NA 4. Performance improvement studies — NA 5. Records on innovation if available — NA	NA			NA	
7.5.1.2	The Head of HIMS Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate individual/personnel within the respective services. **EVIDENCE OF COMPLIANCE** 1. Minutes of meetings — NA 2. Letter of assignment of responsibilities — NA 3. Job description — NA	NA			NA	
7.5.1.3	The Head of HIMS Services shall ensure that the staff are trained and complete incident reports which are promptly reported, investigated, discussed by the staff with learning objectives and forwarded to the Person In Charge (PIC) of the Facility.	NA			NA	

	Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence. EVIDENCE OF COMPLIANCE 1. System for incident reporting is in place, which include: a) Training of staff — NA b) Policy on incident reporting — NA c) Methodology of incident reporting — NA d) Register/records of incidents — NA 2. Completed incident reports — NA 3. Root Cause Analysis — NA 4. Corrective and preventive action plans — NA 5. Remedial measure — NA 6. Minutes of meetings — NA 7. Acknowledgment by Head of Service and PIC/Hospital Director — NA 8. Feedback given to staff regarding incident reporting. — NA					
7.5.1.4 CORE	There is tracking and trending of specific performance indicators not limited to but at least two (2) of the following: a) percentage of medical reports prepared within the stipulated period: Target: 90% Reference: Technical Specifications Of Hospital Performance Indicators For Accountability (HPIA) & Specific Indicators Version 7.1 2019 Secondary and Tertiary Care (Public & Private) Facility: ≤ 4 weeks Primary Care Facility: ≤ 2 weeks) b) Percentage of case summaries that were dispatched within 72 hours of discharge Target: 95% Reference: National Indicator Approach Version 5.0 EVIDENCE OF COMPLIANCE 1. Specific performance indicators monitored. — NA 2. Records on tracking and trending analysis. — NA 3. Remedial measures taken where appropriate — NA	NA			NA	
7.5.1.5	Feedback on results of safety and performance improvement activities are regularly communicated to the staff. EVIDENCE OF COMPLIANCE	NA			NA	

	1.	Results on safety and performance improvement activities are accessible to staff	NA					
	2.	Evidence of feedback via communication on results of performance improvement activities through continuing education activities / meetings.	NA					
	3.	Minutes of service/committee meetings	NA					
7.5.1.6	Appropriate documentation of safety and performance improvement activities is kept and confidentiality of medical practitioners, staff and patients is preserved.			NA			NA	
	EVIDENCE OF COMPLIANCE							
	1.	Documentation on performance improvement activities and performance indicators.	NA					
	2.	Policy statement on anonymity on patients and providers involved in performance improvement activities.	NA					

TOPIC 7.6:
SPECIAL REQUIREMENTS

STANDARD 7.6.1
An accurate patient's medical record is maintained to facilitate optimal patient care and allow for evaluation of the care provided.

CRITERION NO.	CRITERIA FOR COMPLIANCE		SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
					AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
7.6.1.1	The patient's medical record contains sufficient details to enable: a) the patient to receive effective continuing care; b) effective communication among the members of the healthcare team; c) medical practitioners to have access to the information required for further consultation and treatment; d) another medical practitioner or other healthcare personnel to assume the care of the patient; e) carrying out concurrent or retrospective evaluation of patient care.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Sampling of medical records to ensure (a) to (e) are evidenced in medical records.	NA				
	2.	Audit on quality medical record documentation - sampling is scheduled for at least once in 2 years (Reference: Manual Audit Rekod KKM Terbitan 2018)	NA				
7.6.1.2 CORE	Entries into the records are made only by healthcare professionals of the Facility. Each entry is dated with time and signed by the care provider with name and designation written down.		NA			NA	
	EVIDENCE OF COMPLIANCE						
	1.	Sampling of medical records to validate:					
	a)	Only healthcare professionals made entries to the records.	NA				
	b)	Each entry is dated with time and signed by the care provider with name and designation written down.	NA				
7.6.1.3	All entries in the record including alterations to the record shall be legibly written in ink or typewritten or recorded on a computer terminal which is designed to receive such information and if recorded and stored in computer, it may be stored on in any device suitable for the storage of data.		NA			NA	

		EVIDENCE OF COMPLIANCE					
	1.	Sampling of medical records (paper based/electronic system) to be provided by the medical records staff for surveyor's validation.	NA				
7.6.1.4 CORE	Only the abbreviations and symbols which have been approved by the Medical Records Committee are used.		NA			NA	
		EVIDENCE OF COMPLIANCE					
	1.	Abbreviations and symbols list which have been approved by the Medical Records Committee.	NA				
	2.	Sampling of medical records on-site to validate compliance to the abbreviations list.	NA				
7.6.1.5	All original or copies of reports by medical, nursing and allied health professionals from whatever source of origin are filed in the patient's medical record.		NA			NA	
		EVIDENCE OF COMPLIANCE					
	1.	Completeness of documents in medical records, e.g. laboratory report, reference letter, etc.	NA				
7.6.1.6	Entries to the medical record shall be timely and made in a way that prevent unauthorised alteration.		NA			NA	
		EVIDENCE OF COMPLIANCE					
	1.	Sampling of medical records on validation of timeliness of entries.	NA				
	2.	On-site observation on practices.	NA				
7.6.1.7	Corrections which are dated and initialed by the author are only made to the medical record by the use of a single line through the incorrect entry. The correction is also put as close to the 'struck out' incorrect entry as possible, indicating that the correction is the intended and correct information. 'White out' or other types of correction materials or erasure of entries shall not be used to correct incorrect entries.		NA			NA	
		EVIDENCE OF COMPLIANCE					
	1.	Policy on correction of wrong entries in medical records	NA				
	2.	Sampling of medical records to ensure compliance with the above policy.	NA				

	3.	Adequate sampling on the healthcare professional	NA					

STANDARD 7.6.2

Each patient's medical record shall contain appropriate information on the patient and treatment provided.

CRITERION NO.	CRITERIA FOR COMPLIANCE	SELF RATING	FACILITY COMMENTS	SURVEYOR FINDINGS		
				AREAS FOR IMPROVEMENT / RECOMMENDATIONS	SURVEYOR RATING	RISK
7.6.2.1	There are adequate particulars to identify the patients: a) a unique medical record number or reference; b) IC or passport number; c) name in full; d) address; e) date of birth; f) gender; g) person and contact details to notify in an emergency. **EVIDENCE OF COMPLIANCE** 1. Sampling of medical records addressing items (a) to (g). NA	NA			NA	
7.6.2.2	The admission form is completed at the time of admission or when the relevant information is available. **EVIDENCE OF COMPLIANCE** 1. Sampling of filled admission form NA	NA			NA	
7.6.2.3 CORE	An "alert" notation for conditions such as allergic responses and drug reactions shall be documented by the examining doctor and prominently displayed in the medical records and in the appointment card. **EVIDENCE OF COMPLIANCE** 1. Sampling of medical records to validate entry of alert notation. NA	NA			NA	
7.6.2.4	The patient's medical record contains on admission a written provisional diagnosis by the admitting medical practitioner. **EVIDENCE OF COMPLIANCE** 1. Sampling of medical records for entry of provisional diagnosis where applicable. NA	NA			NA	
7.6.2.5	The patient's medical record contains patient's history pertinent to the condition being treated, including relevant details of: a) present and past medical history;	NA			NA	

	b) family history; c) social history and considerations; d) examination; e) assessment including results of investigations; f) observation; g) treatment. EVIDENCE OF COMPLIANCE 1. Sampling of medical records to ensure (a) to (g) are documented in the medical records. NA					
7.6.2.6	Drug orders are written directly in the drug prescription form in the patient's medical record by medical practitioners. EVIDENCE OF COMPLIANCE 1. Drug prescription written by medical practitioner. NA 2. Sampling of medical records to verify the above. NA	NA			NA	
7.6.2.7	Therapeutic orders and orders for special diagnostic tests are documented in the patient's medical record. EVIDENCE OF COMPLIANCE 1. Sampling of medical records to verify entry of therapeutic orders and orders for special diagnostic tests. NA	NA			NA	
7.6.2.8	There is evidence that the care plans are documented in the patient's medical record. EVIDENCE OF COMPLIANCE 1. Sampling of medical records for entry of care plan NA	NA			NA	
7.6.2.9	Progress notes, observations and consultation reports are written by medical, nursing, and paramedical staff to record all significant events such as changes in the patient's condition and responses to treatment. These are written as events occur with date and time and give a pertinent chronological report of the patient's progress. EVIDENCE OF COMPLIANCE 1. Chronological integrated notes from medical, nursing and paramedical staff noted in samples of medical records. NA	NA			NA	
7.6.2.10	The medical practitioner records the preoperative diagnosis and there is an operative report immediately after surgery, including:	NA			NA	

	a) date, time and duration; b) description of the findings; c) the procedure performed; d) tissue removed; e) tissue sent for pathological examination; f) preoperative and postoperative diagnosis; g) postoperative instructions; h) surgeon's name and signature including name of assistant where applicable. EVIDENCE OF COMPLIANCE 1. Sampling of medical records to verify operative report addressing items (a) to (h). NA					
7.6.2.11	The patient's medical record contains information particularly relating to anaesthesia including: a) date, time and duration; b) informed consent of anesthesia; c) evidence of a preoperative assessment by an anesthetist, preferably by the attending anaesthetist; d) drugs and doses given during anaesthesia and route of administration; e) monitoring data; f) intravenous fluid therapy, if given; g) post anaesthetic instructions, where appropriate; h) name and signature of attending anaesthetist. EVIDENCE OF COMPLIANCE 1. Samplings of medical records and verify the notes containing anaesthetic report addressing items (a) to (h). NA	NA			NA	
7.6.2.12	All diagnoses and procedures are recorded using relevant terminology of a current revision of the International Classification of Diseases (ICD). EVIDENCE OF COMPLIANCE 1. Sampling of medical records indicating current ICD. NA	NA			NA	
7.6.2.13	There is a discharge summary that is completed within 72 hours of the patient's discharge; a copy of which is filed in the patient's medical record. The discharge summary or discharge letter contains at least the following information: a) discharge diagnosis; b) procedures performed; c) follow up arrangements; d) therapeutic orders;	NA			NA	

	e) patient's condition on discharge; f) brief summary of significant findings, results of laboratory tests and events during the patient's hospitalization. Notes/Explanations *The referral letter shall accompany the patient being transferred to another facility with a copy filed in the medical record.* *For public hospital, only discharge note allowed to be given to patient upon discharge.* *(Reference: Surat Arahan Bil KKM 87/P1/11/(29) Jld 7 bertarikh 12 Nov 2010)* EVIDENCE OF COMPLIANCE 1. Sampling of medical records containing discharge summary that address items (a) to (f). NA					
7.6.2.14	When an autopsy is performed, a provisional anatomical diagnosis is documented in the patient's medical record within 72 hours and the medical record is completed within one month following the autopsy. A copy of the autopsy report is filed in the medical record. EVIDENCE OF COMPLIANCE 1. Sampling of medical records to verify provisional anatomical diagnosis within 72 hours and completed autopsy report within one month period. Changed to 8 weeks (Refer Surat Pekeliling KPK Bil 17/2008 – Garispanduan Bedah-Siasat Mayat di Hospital-Hospital KKM) NA	NA			NA	

SERVICE SUMMARY	
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OVERALL RATING :	NA
OVERALL RISK :	-