PUTRA MEDICAL CENTRE
PUSAT PAKAR PERUBATAN PUTRA

ANNUAL REPORT

PUTRA MEDICAL CENTRE

PROFFESSIONAL METICULOUS CARING

2021 - 2022

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VISION

To be a leading healthcare service provider of choice with a passion for the community.

MISSION

PMC is committed to deliver quality healthcare services comprehensively and consistently through continuous development in human resources and updating of technology.

VALUES

PMC is committed and practice its work on the principle of

Professionalism, ***M***eticulous and ***C***aring

ABOUT US

Putra Medical Centre (PMC) started as a 24-hours 20 bedded maternity and Polyclinic operating from a double storey bungalow house at Jalan Lumpur in Alor Setar under the name of Pusat Lim & Yu. The centre was the brainchild of Dr Lim Kim Huat and Dr Yu Ching Hsiu.

Putra Medical Centre was registered on 19th April 1991 primarily to participate in the growth of private hospitals in Malaysia and commenced operation on 2nd July 1995. The Centre started with only a handful of Specialists and 3 Medical Officers. Today PMC is supported by a team of 27 Residents Consultants, 16 Visiting Consultants and 5 Medical Officers. Putra Medical Centre has now grown into a 162 bedded, acute care & general medical/surgical hospital. We aim to provide high quality, cost effective standard healthcare which will meet the needs and expectations of our patients through comprehensive primary, secondary and selected tertiary care services on an inpatient, outpatient, and referral basis.

Putra Medical Centre strives to ensure that all of our patients are treated with respect and dignity and their needs and complaints are attended efficiently and promptly. Putra Medical Centre is now in its 29th year of operation. It has a total workforce of 450 employees, ranging from senior management down to its auxiliary staffs. The Centre is 100% owned by Unique Luxury Sdn. Bhd. (Company No. 215791-U). Putra Medical Centre is continuously upgrading its facilities to provide better, affordable and quality medical healthcare to the community.

WELCOMING NOTES

First and foremost we are proud to present the first Key Performance Indicator Annual Report by the Quality and Accreditation Unit in collaboration with all related Departments and Units.

This report is in line with recommendations by MSQH to improve our year to year achievement and to compare the hospital performance. Accurate and concise data and can be used to improve our services provided.

The main focus of Putra Medical Center is our patients / customers and also employees who carry out their duties through their respective capacities to maintain the safety and quality of the various services provided.

The Key Performance Indicators measured are in compliance with the Malaysian Patient Safety Goals (KKM) and MSQH regulations and ISO Standards. Most of the targets set for 2021 and 2022 were achieved. Although the achievement of the target is the main measure, the process of continuous improvement to achieve the outlined objectives is also important.

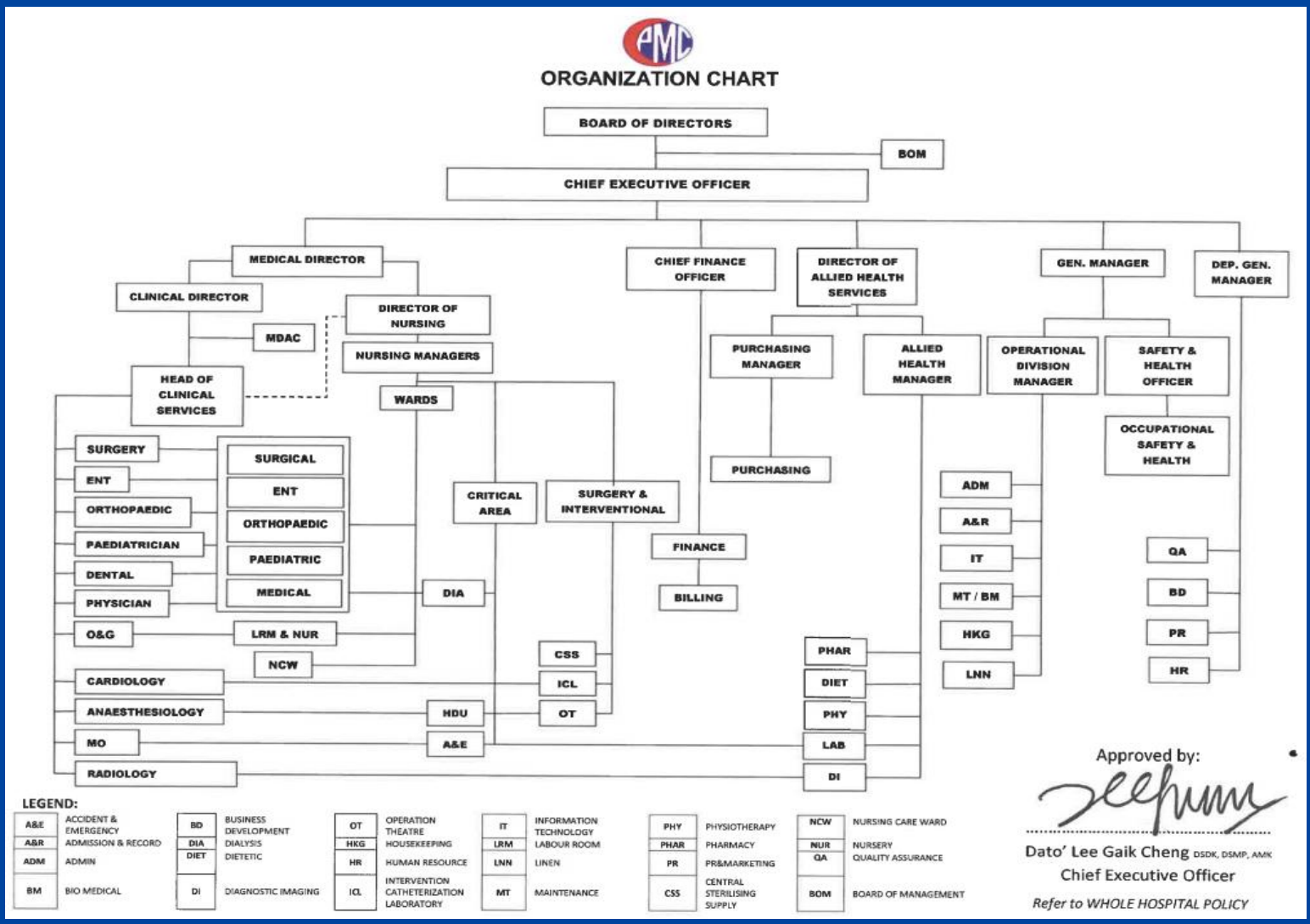
We believe that a well-prepared report (in collaboration with the Head of Department/Unit) and expanded through various discussion platforms with top management can be the backbone in efforts to improve the quality of Putra Medical Center services.

We hope this report will benefit the reader in better understanding Putra Medical Centre's strive for higher achievements and improvement.

ABU BAKAR BIN MADZLIPAH
Quality Assurance Manager

ORGANIZATION CHART

PUTRA MEDICAL CENTRE



THE DIRECTORS & TEAM

PUTRA MEDICAL CENTRE

BOARD OF DIRECTORS

Dato' Dr. Lim Kim Huat J.P
Person In Charge / Director

Dato' Lee Gaik Cheng *D.S.D.K, D.S.M.P, A.M.K*
Managing Director

Dato' Dr. Lim Tze Chou *D.I.M.P, A.M.K, B.K.M*
Executive / Clinical Director

Dr. Lim Tze Chwen *A.M.K, B.K.M*
Executive Director

Dr. Lim Tze Shi
Executive Director

MANAGEMENT TEAM

Founder & Advisor
Dato' Dr. Lim Kim Huat *J.P*

Managing Director
Dato' Lee Gaik Cheng *D.S.D.K, D.S.M.P, A.M.K*

Medical Director
Datin Dr. Lim Hui Ling *A.M.K, B.K.M*

Clinical Director
Dato' Dr. Lim Tze Chou *D.I.M.P, A.M.K, B.K.M.*

Executive Directors
Dato' Dr. Lim Tze Chou *D.I.M.P, A.M.K, B.K.M.*
Dr. Lim Tze Chwen *A.M.K, B.K.M*
Dr. Lim Tze Shi

Nursing Director
Madam Punida A/P Sathivheil

Director of Allied Health Services/Purchasing Manager
Ms. Lee Geik Peng *B.K.M*

General Manager/Operational Manager
Ms. Lee Ling Hui

Deputy General Manager/Marketing
Madam Shanti Manimegalai Karuppiah

Allied Health Manager
Mr. Abu Bakar Bin Madzlipah

Human Resources Manager
Madam Gan Guat Ghor

Admission & Records Manager
Mr. Anuar Bin Md Isa

Nursing Managers
Madam Norazean Binti Saari
Madam Wan Adzlin Binti Wan Hashim
Madam Normazila Binti Ahmad

Operation Theatre Sister
SR Norsyakila Binti Shariff

Dialysis (Person In-Charge)
Datin Dr. Lim Hui Ling

Pharmacists
Mr. Ng Li Xiang
Mr. Alwi Mulyadi

Bio-Medical Engineers
Ms. Nurul Ashikin Binti Hassan

Information Technology Manager
Mr. Mohd Khairul bin Mustafa

LIST OF SERVICES AND CONSULTANT

NO.	SPECIALTIES	RESIDENT CONSULTANT	VISITING CONSULTANT
1	PHYSICIAN	Dato' Dr Chan Jit Wooi	
		Dr. Hasmannizar bin Abdul Manap	
		Dr. Anuar bin Waid	
		Dr. Cheng Hee Song	
2	ORTHOPAEDIC	Dato' Dr. Suresh Ramasamy	Dr. Muhammad Azhar bin Abdullah
		Dato' Dr. Suresh Chopra	
		Dr. Abdul Samad bin Lazim	
		Dr. Muhammad Suhairi bin Juhari	
3	ENT	Dr. Mahamad Yusop bin Saad	Dr. Izny Hafiz bin Zainon
		Dr. Ahmad Hafiz bin Ali	
4	GENERAL SURGEON	Dr. Syed Johaidy bin Syed Arifin	
		Dr. Ng Kok Joo	
		Dr. Tan Boon Lee	
		Dr. Oon Min Jeh	
5	OBSTETRIC & GYNAECOLOGY	Dato' Dr. Lim Tze Chou	Dato' Dr. Bavanandam Naidu Gopal
		Dr. Yeoh Gim Hooi	Dr. Aw Lin Da
		Dr. Kumar Ramasamy	
		Dr. Tan Yi Pin	
6	UROLOGY	Dr. Lim Eng Kian	
		Dr. Cyril Natarajan	
7	ANAESTHESIOLOGY	Dr. Tan Kheng Huat	Dr. Abdul Malik bin Mokhtar
		Dr. Lim Wei Keong	
		Dr. Yong Chen Fei	
8	PAEDIATRICS	Dato' Dr. K. Gunasaegaram	Dr. Yeoh Guan Cheam
		Dr. Norhaila binti Mohamad Adenam	
		Dr. Lee Beng Suan	
9	RADIOLOGY	Dr. Mohd Rizal bin Abu Bakar	
		Dr. Farouk bin Hj. Jalil	
10	DENTIST	Dr. Sim Koshin	Prof. Dato' Dr. Shah Kamal bin Jamal Din
		Dr. Varman Vijayackumar	Dr. Soon Hooi Im Dr Mohd Ghazali bin Busseri Dr Ng Ie Seng
11	OPHTHAMOLOGY	Dr. Bashkaran Karuppannan	
12	CARDIOLOGIST	Dr. Hasmannizar bin Abdul Manap	Dr. Kantha Rao Narasamulo
13	NEPHROLOGIST		Dr. Eason Chang

MEDICAL OFFICERS

DATIN DR. LIM HUI LING
MBBS (MMMC)
Medical Officer @
Medical Director PMC

DR. SYARIZA BINTI SALLEH
MD (UKM)
Medical Officer

DR. FARID NAQIB ZAINI
MBBS (MMMC)
Medical Officer

DR. VIGNESVRAO A/L MALLNAIDU
MD (BALI ISLAND)
Medical Officer

DR. TAN GUAN HORNG
MD (UNAND, INDONESIA)
Medical Officer

DR. GAN CHEAT LOON
MD (KMU, TAIWAN)
Medical Officer

KEY PERFORMANCE INDICATOR (KPI) MSQH & ISO 2021-2022

HOSPITAL STATISTICS

CATEGORY	2021	2022
1. Total Admission	6943	8565
2. Total Discharged Patient	6892	8587
3. Bed Occupancy Rate (BOR)	48.48%	56.59%
4. Total Out Patient	109113	122605
5. Total No. of Births	1350	1113
6. No of Deaths (Adult)	57	51
7. Average Length of Stay (ALOS)	4.3	4.1
8. New Case (Out Patient)	17839	22960
9. Bed Occupancy Rate HDU	67.50%	78.80%

Diagram 1: PMC statistics according to classification from 2021 to 2022
*Source: Medical Records Department

DISCIPLINE / YEAR	2021	2022
1. MEDICAL	1571	2076
2. SURGICAL	1380	1382
3. ENT	143	223
4. O&G	1571	1418
5. ORTHOPAEDIC	1122	1214
6. PAEDIATRIC	1132	2214
7. DENTAL	3	5
8. OPHTHALMOLOGY	7	7
9. DERMATOLOGY	14	10
TOTAL CASES	6943	8549

Figure 3: The number of operation cases by discipline from 2021 to 2022.
*Source: Medical Records Department.

Based on the data obtained, Figure 3 shows the number of cases by discipline from 2021 to 2022. In 2021, the highest discipline was Medical & O&G cases which recorded 1571 cases. In 2022, the highest discipline was Paediatric which recorded 2214 cases.

TEN PRINCIPAL CAUSES OF HOSPITALISATION IN HOSPITALS (2021 & 2022)

		2021		2022	
NO.	CAUSES	NO. OF DISCHARGES	% TO TOTAL DISCHARGES	NO. OF DISCHARGES	% TO TOTAL DISCHARGES
1	CHAPTER XV : PREGNANCY, CHILDBIRTH AND THE PUERPERIUM (O00-O99)	1286	19.27	1422	20.2
2	CHAPTER XI : DISEASES OF THE DIGESTIVE SYSTEM (K00-K93)	1016	15.23	984	13.98
3	CHAPTER I : CERTAIN INFECTIOUS AND PARASITIC DISEASES (A00-B99)	683	10.24	916	13.02
4	CHAPTER XIII : DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE (M00-M99)	561	8.41	910	12.93
5	CHAPTER X : DISEASES OF THE RESPIRATORY SYSTEM (J00-J99)	522	7.82	574	8.16
6	CHAPTER XIX : INJURY, POISONING AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES (S00-T98)	491	7.36	485	6.89
7	CHAPTER IX : DISEASES OF THE CIRCULATORY SYSTEM (I00-I99)	482	7.22	422	6
8	CHAPTER XIV : DISEASES OF THE GENITOURINARY SYSTEM (N00-N99)	436	6.53	407	5.78
9	CHAPTER XII : DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE (L00-L99)	200	3	164	2.33
10	CHAPTER XVIII : SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS, NOT ELSEWHERE CLASSIFIED (R00-R99)	192	2.88	153	2.17
Sub Total		**5869**	**87.96**	**6437**	**91.46**
TOTAL ALL CAUSES		**6672**	**100**	7038	100

Diagram 2: 10 main reasons for patient admission to PMC from 2021 to 2022.
*Source: Medical Records Department.

Diagram 2 shows the 10 main reasons for patient admission to PMC. In 2021 & 2022, the main reason for patient admission was PREGNANCY, CHILDBIRTH AND THE PUERPERIUM (O00-O99) with a percentage of 19.27 % (2021) and 20.20% (2022).

ACHIEVEMENT STATUS KEY PERFORMANCE INDICATOR (ISO KPI) - 2021

PUTRA MEDICAL CENTRE
PUSAT PAKAR PERUBATAN PUTRA

Quality Objectives and Planning (Jan - Jun 2021)

List	Process	Performance indicator	Quality Objective	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1	Record control	To scanned discharge document within 72 hrs from the time discharge document received.	100%	100%	100%	100%	100%	100%	100%
2	Record control	Missing record.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
3	Admission registration	Average time to register admission within 10 minutes (only applicable to case where bed is available).	10 minutes	8.11mins	7.96mins	8.31mins	8.74mins	8.57mins	8.34mins
4	Front desk	Mistake in in-patient patient information caused by front desk.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
5	Accident & emergency	To attend (from time received call until depart from PMC) emergency ambulance call within 15 minutes.	100%	100%	100%	100%	100%	100%	100%
6	Accident & emergency	To attend patient within 10 minutes by nurses after outpatient registration for non emergency case.	95%	100%	100%	100%	100%	100%	100%
7	Accident & emergency	To attend patient by doctor within 25 minutes after outpatient registration for non emergency case.	95%	100%	100%	100%	100%	100%	100%
8	Nursing services	Call bell to be attended within 45s.	85%	93.65%	94.73%	96.79%	95.62%	94.03%	95.32%
9	Labour room	Swabbing within 1 hr after delivery for normal delivery.	100%	100%	100%	100%	100%	100%	100%
10	High Dependency Unit (HDU)	Maintain HDU patient free from phlebitis.	80%	100%	100%	100%	100%	100%	100%
11	Invasive Cardiac Catheterization Lab (ICCL)	Major complication during Percutaneous Coronary Intervention (Death, Acute Myocardial Infarction, Stroke).	0 case	0 case	0 case	0 case	0 case	0 case	0 case
12	Physiotherapy	To attend new referral cases within 30 minutes.	100%	100%	100%	100%	100%	100%	100%
13	Physiotherapy	Burn case from thermal modalities.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
14	Dialysis	Patients should have prescribed U.R.R > 65% in next follow up.	85%	-	85.3%	-	-	87.5%	-
15	Dialysis	Patient with hemoglobin of more than 10g/dl.	70%	-	73.5%	-	-	71.9%	-
16	Dialysis	Dialysis patient completed their 4 hours treatment without complication.	95%	98.3%	97.9%	98.3%	98.5%	98.5%	98.4%
17	Nursery	Baby released to wrong mother.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
18	Dietetics and food service	To attend Patient in critical condition within 1.5 hours.	100%	100%	100%	100%	100%	100%	100%
19	Dietetics and Food Service	To attend patient in non critical condition within 4 hours.	100%	100%	100%	100%	100%	100%	100%
20	Pharmacy	To dispense the medication to outpatient within 15 minutes.	100%	100%	100%	100%	100%	100%	100%
21	Pharmacy	To dispense the TTA to inpatient within 20 minutes.	100%	100%	100%	100%	100%	100%	100%
22	Pharmacy	Medication dispensing error.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
23	Purchasing	To response within 45 minutes to relevant HOD upon receiving the non stock draft PO.	100%	100%	100%	100%	100%	100%	100%
24	Billing	To attend 100% outpatient bill within 15 minutes.	100%	100%	100%	100%	100%	100%	100%
25	Billing	To prepare 100% inpatient bill within 10 minutes.	100%	100%	100%	100%	100%	100%	100%
26	Billing	Mistake in collection.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
27	Diagnostic Imaging	To 100% provide image & report for general X-ray, mammogram, ultrasound and dexa scan - within 1 hr; CT scan, MRI, and special procedure - within 2 hours during working hours of radiologist.	100%	100%	100%	100%	100%	100%	100%
28	Diagnostic Imaging	Wrong marker, wrong patient and wrong site.	0 case	0 case	0 case	1 case	0 case	0 case	0 case
29	Lab	Test report reliability based on valid complaint from Doctor.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
30	Lab	Error in sample handling for example wrong label, wrong blood type, wrong patient details etc.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
31	Business	Customer complaints should not be more than 10 cases per month.	<10 cases	0 case	0 case	0 case	0 case	0 case	0 case
32	Human resources	100% Minimum 4 manhours training per month for all Nursing Staffs.	100%	100%	100%	100%	100%	100%	100%
33	Human resources	100% Minimum 1 manhour training per month for all Non Nursing Staffs.	100%	100%	100%	100%	100%	100%	100%
34	Facility	Percentage of Planned Preventive Maintenance being done on scheduled.	≥ 98%	98.21%	98.81%	100%	99.62%	77.14%	97.36%
35	Facility	Percentage of work order completed on scheduled.	≥ 98%	98.47%	100%	100%	97.54%	99.07%	94.44%
36	Operation Theatre	0 case of cancellation of scheduled OT caused by PMC.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
37	CSSD	0 case of short of surgical instrument in set.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
38	Operation Theatre	0 case of air sampling result above 10CFU.	0 case	0 case	-	-	0 case	-	-
39	Housekeeping	Not more than 3% customer complaint on housekeeping.	<3%	0%	0%	0%	0%	0%	0%
40	Linen	Bed sheet rejection.	<5%	0.71%	0.66%	0.66%	0.00%	0.67%	0.00%

ality Assurance Unit.

ACHIEVEMENT STATUS KEY PERFORMANCE INDICATOR (ISO KPI) - 2021

PUTRA MEDICAL CENTRE
PUSAT PAKAR PERUBATAN PUTRA

List	Process	Performance indicator	Quality Objectives and Planning (Jul - Dec 2021) Quality Objective	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1	Record control	To scanned discharge document within 72 hrs from the time discharge document received.	100%	100%	100%	100%	100%	100%	100%
2	Record control	Missing record.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
3	Admission registration	Averrage time to register admission within 10 minutes (only applicable to case where bed is available).	10 minutes	8.11mins	7.96mins	8.31mins	8.74mins	8.57mins	8.34mins
4	Front desk	Mistake in in-patient patient information caused by front desk.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
5	Accident & emergency	To attend (from time received call until depart from PMC) emergency ambulance call within 15 minutes.	100%	100%	100%	100%	100%	100%	100%
6	Accident & emergency	To attend patient within 10 minutes by nurses after outpatient registration for non emergency case.	95%	100%	100%	100%	100%	100%	100%
7	Accident & emergency	To attend patient by doctor within 25 minutes after outpatient registration for non emergency case.	95%	100%	100%	100%	100%	100%	100%
8	Nursing services	Call bell to be attended within 45s.	85%	93.65%	94.73%	96.79%	95.62%	94.03%	95.32%
9	Labour room	Swabbing within 1 hr after delivery for normal delivery.	100%	100%	100%	100%	100%	100%	100%
10	High Dependency Unit (HDU)	Maintain HDU patient free from phlebitis.	80%	100%	100%	100%	100%	100%	100%
11	Invasive Cardiac Catheterization Lab (ICCL)	Major complication during Percutaneous Coronary Intervention (Death, Acute Myocardial Infarction, Stroke).	0 case	0 case	0 case	0 case	0 case	0 case	0 case
12	Physiotherapy	To attend new referral cases within 30 minutes.	100%	100%	100%	100%	100%	100%	100%
13	Physiotherapy	Burn case from thermal modalities.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
14	Dialysis	Patients should have prescribed U.R.R > 65% in next follow up.	85%	-	85.3%	-	-	87.5%	-
15	Dialysis	Patient with hemoglobin of more than 10g/dl.	70%	-	73.5%	-	-	71.9%	-
16	Dialysis	Dialysis patient completed their 4 hours treatment without complication.	95%	98.3%	97.9%	98.3%	98.5%	98.5%	98.4%
17	Nursery	Baby released to wrong mother.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
18	Dietetics and food service	To attend Patient in critical condition within 1.5 hours.	100%	100%	100%	100%	100%	100%	100%
19	Dietetics and Food Service	To attend patient in non critical condition within 4 hours.	100%	100%	100%	100%	100%	100%	100%
20	Pharmacy	To dispense the medication to outpatient within 15 minutes.	100%	100%	100%	100%	100%	100%	100%
21	Pharmacy	To dispense the TTA to inpatient within 20 minutes.	100%	100%	100%	100%	100%	100%	100%
22	Pharmacy	Medication dispensing error.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
23	Purchasing	To response within 45 minutes to relevant HOD upon receiving the non stock draft PO.	100%	100%	100%	100%	100%	100%	100%
24	Billing	To attend 100% outpatient bill within 15 minutes.	100%	100%	100%	100%	100%	100%	100%
25	Billing	To prepare 100% inpatient bill within 10 minutes.	100%	100%	100%	100%	100%	100%	100%
26	Billing	Mistake in collection.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
27	Diagnostic Imaging	To 100% provide image & report for general X-ray, mammogram, ultrasound and dexa scan - within 1 hr; CT scan, MRI, and special procedure - within 2 hours during working hours of radiologist.	100%	100%	100%	100%	100%	100%	100%
28	Diagnostic Imaging	Wrong marker, wrong patient and wrong site.	0 case	0 case	0 case	1 case	0 case	0 case	0 case
29	Lab	Test report reliability based on valid complaint from Doctor.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
30	Lab	Error in sample handling for example wrong label, wrong blood type, wrong patient details etc.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
31	Business	Customer complaints should not be more than 10 cases per month.	<10 cases	0 case	0 case	0 case	0 case	0 case	0 case
32	Human resources	100% Minimum 4 manhours training per month for all Nursing Staffs.	100%	100%	100%	100%	100%	100%	100%
33	Human resources	100% Minimum 1 manhour training per month for all Non Nursing Staffs.	100%	100%	100%	100%	100%	100%	100%
34	Facility	Percentage of Planned Preventive Maintenance being done on scheduled.	≥ 98%	98.21%	98.81%	100%	99.62%	77.14%	97.36%
35	Facility	Percentage of work order completed on scheduled.	≥ 98%	98.47%	100%	100%	97.54%	99.07%	94.44%
36	Operation Theatre	0 case of cancellation of scheduled OT caused by PMC.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
37	CSSD	0 case of short of surgical instrument in set.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
38	Operation Theatre	0 case of air sampling result above 10CFU.	0 case	0 case	-	-	0 case	-	-
39	Housekeeping	Not more than 3% customer complaint on housekeeping.	<3%	0%	0%	0%	0%	0%	0%
40	Linen	Bed sheet rejection.	<5%	0.71%	0.66%	0.66%	0.00%	0.67%	0.00%

*Source: Quality Assurance Unit.

ACHIEVEMENT STATUS KEY PERFORMANCE INDICATOR (ISO KPI) - 2022

PUTRA MEDICAL CENTRE PUSAT PAKAR PERUBATAN PUTRA			Quality Objectives and Planning (Jan - Jun 2022)						
List	**Process**	**Performance indicator**	**Quality Objective**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**
1	Record control	To scanned discharge document within 48 hrs from the time discharge document received.	90%	100%	100%	100%	100%	100%	100%
2	Record control	Missing record.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
3	Admission registration	Average time to register admission within 9 minutes (only applicable for case where bed is available).	9 minutes	7.84min	7.82min	7.72min	7.64min	7.84min	7.31min
4	Front desk	Mistake in in-patient patient information caused by front desk.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
5	Accident & emergency	To attend (from time received call until depart from PMC) emergency ambulance call within 15 minutes.	100%	100%	100%	100%	100%	100%	100%
6	Accident & emergency	To attend patient within 8 minutes by nurses after outpatient registration for non emergency case.	95%	99.90%	99.93%	100%	99.90%	100%	100%
7	Accident & emergency	To attend patient by doctor within 25 minutes after outpatient registration for non emergency case.	95%	99.90%	98.25%	99.53%	99.18%	99.88%	99.85%
8	Nursing services	Call bell to be attended within 45s.	90%	93.78%	93.05%	93.16%	93.32%	96.94%	94.30%
9	Labour room	Swabbing within 1 hr after delivery for normal delivery.	100%	100%	100%	100%	100%	100%	100%
10	High Dependency Unit (HDU)	Maintain HDU patient free from phlebitis.	90%	100%	94.44%	93.75%	93.55%	96.97%	97.87%
11	Invasive Cardiac Catheterization Lab (ICCL)	Major complication during Percutaneous Coronary Intervention (Death, Acute Myocardial Infarction, Stroke).	0 case	0 case	0 case	0 case	0 case	0 case	0 case
12	Physiotherapy	To attend new referral cases (Inpatient) within 20 minutes.	100%	100%	100%	100%	100%	100%	100%
13	Physiotherapy	Burn case from thermal modalities.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
14	Dialysis	Patients should have prescribed U.R.R > 65% in next follow up.	85%	-	55.2%	-	-	55.2%	-
15	Dialysis	Patient with hemoglobin of more than 10g/dl.	70%	-	72.4%	-	-	62.1%	-
16	Dialysis	Dialysis patient completed their 4 hours treatment without complication.	95%	98.5%	98.8%	98.0%	99.4%	98.9%	99.2%
17	Nursery	Baby released to wrong mother.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
18	Dietetics and food service	To attend Patient in critical condition within 1 hour.	80%	100%	100%	100%	100%	100%	100%
19	Dietetics and Food Service	To attend patient in non critical condition within 3 hours.	80%	100%	100%	100%	100%	100%	100%
20	Pharmacy	To dispense the medication to outpatient within 15 minutes.	100%	100%	100%	100%	100%	100%	99.91%
21	Pharmacy	To dispense the TTA to inpatient within 20 minutes.	100%	100%	100%	100%	100%	100%	100%
22	Pharmacy	Medication dispensing error.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
23	Purchasing	To response within 30 minutes to relevant HOD upon receiving the non stock draft PO.	100%	100%	100%	100%	100%	100%	100%
24	Billing	To attend 100% outpatient bill within 12 minutes.	100%	100%	100%	100%	100%	100%	100%
25	Billing	To prepare 100% inpatient bill within 10 minutes.	100%	100%	100%	100%	100%	100%	100%
26	Billing	Mistake in collection.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
27	Diagnostic Imaging	To 100% provide image & report for general X-ray, mammogram and ultrasound - within 1 hr; CT scan, MRI, and special procedure - within 2 hours during working hours of radiologist.	100%	100%	100%	100%	100%	100%	100%
28	Diagnostic Imaging	Wrong marker.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
29	Diagnostic Imaging	To attend mobile radiography case within 15 minutes.	70%	100%	100%	100%	100%	100%	100%
30	Lab	Test report reliability based on valid complaint from Doctor.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
31	Lab	Error in sample handling for example wrong label, wrong blood type, wrong patient details etc.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
32	Lab	Turnaround time (TAT) for urgent Full Blood Count less that 45 minutes.	>90%	99.3%	100.0%	100.0%	99.0%	100%	100%
33	Business	Customer complaints should not be more than 10 cases per month.	<10 cases	0 case	0 case	2 cases	1 case	0 case	1 case
34	Human resources	100% Minimum 4 manhours training per month for all Nursing Staffs.	100%	100%	100%	100%	100%	100%	100%
35	Human resources	100% Minimum 2 manhours training per month for all Non Nursing Staffs.	100%	100%	100%	100%	100%	100%	100%
36	Facility	Percentage of Planned Preventive Maintenance being done on scheduled.	≥ 98%	98.61%	98.57%	100%	98.35%	94.49%	96.02%
37	Facility	Percentage of work order completed on scheduled.	≥ 98%	100%	99.48%	99.56%	99.58%	99.42%	98.57%
38	Operation Theatre	Percentage of elective operation cancellation rate.	<10%	5.60%	7.18%	6.61%	4.74%	5.74%	4.86%
39	Operation Theatre	0 case of air sampling result above 10CFU.	0 case	0 case	-	-	0 case	-	-
40	CSSD	0 case of short of surgical instrument in set.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
41	Housekeeping	Not more than 2% customer complaint on housekeeping.	<2%	0%	0%	0%	0%	0%	0%
42	Linen	Bed sheet rejection.	<2%	0%	0%	0%	0%	0.90%	1.81%

*Source: Quality Assurance Unit.

ACHIEVEMENT STATUS KEY PERFORMANCE INDICATOR (ISO KPI) - 2022

PUTRA MEDICAL CENTRE PUSAT PAKAR PERUBATAN PUTRA			Quality Objectives and Planning (Jul - Dec 2022)						
List	**Process**	**Performance indicator**	**Quality Objective**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
1	Record control	To scanned discharge document within 48 hrs from the time discharge document received.	90%	100%	100%	100%	100%	100%	100%
2	Record control	Missing record.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
3	Admission registration	Average time to register admission within 9 minutes (only applicable for case where bed is available).	9 minutes	7.05min	6.74min	6.88min	6.60min	6.57min	6.93min
4	Front desk	Mistake in in-patient patient information caused by front desk.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
5	Accident & emergency	To attend (from time received call until depart from PMC) emergency ambulance call within 15 minutes.	100%	100%	100%	100%	100%	100%	100%
6	Accident & emergency	To attend patient within 8 minutes by nurses after outpatient registration for non emergency case.	95%	100%	100%	100%	99.95%	100%	100%
7	Accident & emergency	To attend patient by doctor within 25 minutes after outpatient registration for non emergency case.	95%	100%	99.84%	99.02%	99.73%	99.58%	99.43%
8	Nursing services	Call bell to be attended within 45s.	90%	91.58%	90.62%	92.19%	92.68%	92.00%	92.41%
9	Labour room	Swabbing within 1 hr after delivery for normal delivery.	100%	100%	100%	100%	100%	100%	100%
10	High Dependency Unit (HDU)	Maintain HDU patient free from phlebitis.	90%	100%	100%	100%	100%	100%	100%
11	Invasive Cardiac Catheterization Lab (ICCL)	Major complication during Percutaneous Coronary Intervention (Death, Acute Myocardial Infarction, Stroke).	0 case	0 case	0 case	0 case	0 case	0 case	0 case
12	Physiotherapy	To attend new referral cases (Inpatient) within 20 minutes.	100%	100%	100%	100%	100%	100%	100%
13	Physiotherapy	Burn case from thermal modalities.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
14	Dialysis	Patients should have prescribed U.R.R > 65% in next follow up.	85%	-	88.5%	-	-	85.7%	-
15	Dialysis	Patient with hemoglobin of more than 10g/dl.	70%	-	61.5%	-	-	71.4%	-
16	Dialysis	Dialysis patient completed their 4 hours treatment without complication.	95%	99.1%	99.2%	99.2%	98.9%	97.8%	97.4%
17	Nursery	Baby released to wrong mother.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
18	Dietetics and food service	To attend Patient in critical condition within 1 hour.	80%	100%	100%	100%	100%	100%	100%
19	Dietetics and Food Service	To attend patient in non critical condition within 3 hours.	80%	100%	100%	100%	100%	100%	100%
20	Pharmacy	To dispense the medication to outpatient within 15 minutes.	100%	99.90%	100%	100%	100%	100%	100%
21	Pharmacy	To dispense the TTA to inpatient within 20 minutes.	100%	99.69%	100%	100%	100%	100%	100%
22	Pharmacy	Medication dispensing error.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
23	Purchasing	To response within 30 minutes to relevant HOD upon receiving the non stock draft PO.	100%	100%	100%	100%	100%	100%	100%
24	Billing	To attend 100% outpatient bill within 12 minutes.	100%	100%	100%	100%	100%	100%	100%
25	Billing	To prepare 100% inpatient bill within 10 minutes.	100%	100%	100%	100%	100%	100%	100%
26	Billing	Mistake in collection.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
27	Diagnostic Imaging	To 100% provide image & report for general X-ray, mammogram and ultrasound - within 1 hr; CT scan, MRI, and special procedure - within 2 hours during working hours of radiologist.	100%	100%	100%	100%	100%	100%	100%
28	Diagnostic Imaging	Wrong marker.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
29	Diagnostic Imaging	To attend mobile radiography case within 15 minutes.	70%	100%	100%	94.74%	100%	100%	100%
30	Lab	Test report reliability based on valid complaint from Doctor.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
31	Lab	Error in sample handling for example wrong label, wrong blood type, wrong patient details etc.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
32	Lab	Turnaround time (TAT) for urgent Full Blood Count less that 45 minutes.	>90%	99.2%	99.1%	99.5%	99.5%	100%	98.2%
33	Business	Customer complaints should not be more than 10 cases per month.	<10 cases	0 case	0 case	0 case	0 case	2 cases	0 case
34	Human resources	100% Minimum 4 manhours training per month for all Nursing Staffs.	100%	100%	100%	100%	100%	100%	100%
35	Human resources	100% Minimum 2 manhours training per month for all Non Nursing Staffs.	100%	100%	100%	100%	100%	100%	100%
36	Facility	Percentage of Planned Preventive Maintenance being done on scheduled.	≥ 98%	99.09%	96.00%	100%	98.90%	97.37%	98.47%
37	Facility	Percentage of work order completed on scheduled.	≥ 98%	95.52%	97.47%	98.86%	99.58%	99.26%	99.54%
38	Operation Theatre	Percentage of elective operation cancellation rate.	<10%	6.14%	3.78%	2.70%	1.91%	1.97%	2.33%
39	Operation Theatre	0 case of air sampling result above 10CFU.	0 case	0 case	-	-	0 case	-	-
40	CSSD	0 case of short of surgical instrument in set.	0 case	0 case	0 case	0 case	0 case	0 case	0 case
41	Housekeeping	Not more than 2% customer complaint on housekeeping.	<2%	0%	0%	0%	0%	0%	0%
42	Linen	Bed sheet rejection.	<2%	0%	1.94%	0%	0%	0%	0.52%

*Source: Quality Assurance Unit.

ACHIEVEMENT STATUS KEY PERFORMANCE INDICATOR (MSQH KPI) - 2021

PUTRA MEDICAL CENTRE
PUSAT PAKAR PERUBATAN PUTRA

Quality Objectives and Planning (Jan - Jun 2021)

List	Service Standard	Performance indicator	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1	01: Governance, Leadership and Direction	Percentage of patients leaving hospital against medical advice relative to all patients hospitalised wihin a specified period	Downward trends	4.19%	3.05%	3.10%	4.18%	4.64%	3.25%
		Percentage of incidents/accidents during hospitalisation of patients as percentage of all admitted patients	<5%	0.00%	0.22%	0.16%	0.00%	0.00%	0.00%
		Hospital wide patient satisfaction survey (six monthly basis)	>80%	100%	100%	100%	100%	100%	100%
		Average number of training hours per employee (Full Time Equivalent) had attended in a year		4.69%	4.24%	4.62%	4.96%	4.37%	4.27%
		Average time to register admission within 10 minutes (only applicable to case where bed is available)	10 minutes	8.11mins	7.96mins	8.31mins	8.74mins	8.57mins	8.34mins
2	02: Environmental and Safety Services	Percentage of new staff (includes all on-site outsourced service providers) given orientation on Environmental, Safety and Health Policy and Programmed	80%	0%					
		Percentage of staff given continuous training in specific aspects of Environmental, Safety and Health	80%	91.88%			92.37%		
		Percentage of workplace hazards identified and risk managed	100%	100%	100%	100%	100%	100%	100%
3	03: Facility and Biomedical Equipment Management & Safety	Percentage of Planned Preventive Maintenance being done on schedule	98%	98.21%	98.81%	100%	99.62%	77.14%	97.36%
		Percentage of work orders completed on schedule	98%	98.47%	100%	100%	97.54%	99.07%	94.44%
4	04: Nursing Services	Percentage of intravenous (I/V) line complications (needles out, redness of skin, infection sites, extravasation)	≤0.5%	0%	0.16%	0.12%	0.28%	0%	0%
		Percentage of pressure sore among bed ridden patients	Downward trends	0%	0%	0%	0%	0%	0%
		Rate of patient falls - adult		0%	0%	0%	0%	0%	0%
		Rate of patient falls - paeds		0%	2.27%	0%	0%	0%	0%
5	05: Prevention and Control of Infection	Percentage of staff trained in Prevention and Control of Infection Practices	100% new staff	0%	0%	0%	100%	100%	100%
			85% existing staff	90.17%	85.71%	93.37%	93.50%	98.48%	95.96%
		Percentage of Healthcare Associated Infections (HCAI)	<5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Number of Resistant Organisms to Antibiotics within a specified period of time	<0.3%	0.00%	0.00%	0.00%	0.32%	0.19%	0.18%
6	07: Health Information Management System	Percentage of Medical Reports prepared within the stipulated period (2-4 weeks)	100%	87.00%	67.80%	79.80%	79.80%	76.90%	85.60%
		Percentage of Case Summaries that were completed within 72 working hours of discharge	100%	98.20%	98.70%	98.60%	98.40%	96.70%	99.30%
7	08: Emergency Services	Percentage of inappropriate triaging (under triaging): Category Green patients who should have been triaged as Category Red	≤0.5%	0%	0%	0%	0%	0%	0%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Red seen immediately	100%	100%	100%	100%	100%	100%	100%
7	08: Emergency Services	Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Yellow seen within 30 minutes	≥85%	100%	100%	100%	100%	100%	100%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Green seen within 90 minutes	>70%	100%	100%	100%	100%	100%	100%
		Unplanned return of patient seen at Emergency Department within 24 hours for similar complaint	3%	0%	0%	0%	0%	0%	0%
8	09A: Clinical Services (Medical Related Services)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0.83%	0%	0%	0%	0%
		Dengue Case Fatality Rate	0%	0%	0%	0%	0%	0%	0%
9	09B: Clinical Services (Surgical Related Services)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Unplanned return to Operating Theatre within the same hospital admission following surgery	0%	0%	0%	0%	0%	0%	0%

10	09C: Clinical Services (Obstetrics & Gynaecology Services)	Emergency Caesarean Rates	<30%	10.96%	13.58%	13.83%	10.00%	13.45%	7.41%
		Elective Caesarean Rates	<30%	24.66%	27.16%	28.72%	30.00%	31.93%	42.22%
		Maternal Mortality Ratio (sentinel event)	0%	0%	0%	0%	0%	0%	0%
11	09D: Clinical Services (Paediatric Services)	Number of Mortality/Morbidity audits/meetings being conducted in the department with documentation of cases discussed	0	0	0	0	0	0	0
		Percentage of paediatric patients with unplanned re-admission for the same condition within 48 hours of discharge	≤2%	0%	0%	0%	0%	0%	0%
		Community acquired pneumonia death rate in previously healthy children aged between one (1) month and five (5) years	≤1%	0%	0%	0%	0%	0%	0%
12	09E: Clinical Services (Cardiology)	Percentage of "Normal" Diagnostic Angiogram	<5%	0%	66.67%	0%	0%	100%	66.67%
		Major complication rate during Diagnostic Coronary Angiogram (Death, acute myocardial infarction, stroke)	<1%	0%	0%	0%	0%	0%	0%
		Major complication rate during Percutaneous Coronary Intervention (Death, acute myocardial infarction, stroke)	<1%	0%	0%	0%	0%	0%	0%
		Percutaneous Coronary Intervention (PCI) within 90 minutes after diagnosed as acute myocardial infarction "Door to Balloon" Time	0%	0%	0%	0%	0%	0%	0%
13	09: Clinical Services (Oral Maxillofacial Surgery/Dental)	Patient seen by Dentist within 90 minutes	95%	100%	100%	100%	100%	100%	100%
		Less than 5% of Customer Complaint for Dental treatment	<5%	0%	0%	0%	0%	0%	0%
14	09: Clinical Services (Orthopaedic)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Number of Mortality/Morbidity audits/meetings being conducted in the department with documentation of cases discussed		1	0	0	0	0	0
15	09: Clinical Services (Otorhinolaryngology (ENT)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Unplanned return to Operating Theatre within the same hospital admission following surgery	0%	0%	0%	0%	0%	0%	0%
16	13C: Chronic Dialysis Treatment	Catheter Related Blood Stream Infection (CRBSI) should not be more frequent than 3:1000	0%	0%	0%	0%	0%	0%	0%
		Annual mortality rate for dialysis patient taking of all factors should not be more than 15%	<15%	0%	0%	0%	0%	0%	0%
		Dialysis patients achieved their Transferrin Saturation (Tsats) > 20%	80%	-	82.4%	-	-	81.3%	-
		Dialysis patients achieved their Hemoglobin level 10-12gm	70%	-	73.5%	-	-	71.9%	-
		Patient achieved their U.R.R. >65%	>85%	-	85.3%	-	-	65.6%	-
17	10: Anaesthetic Services	Pain score on discharge from recovery room should be less than four (4)	100%	100%	100%	100%	100%	100%	100%
		Number of patients having prolonged stay in recovery room for more than (2) hours (sentinel event)	0	0	0	0	0	0	0
18	11: Operating Suite Services	Rate of compliance to Safe Surgery Saves Lives (SSSL) practice	100%	100%	100%	100%	100%	100%	100%
		Percentage of Elective Operation Cancellation Rate	<10%	3.29%	1.33%	1.20%	2.22%	3.59%	0.00%
		Percentage of patients awaiting emergency surgery for more than 24 hours due to lack of OT time	<1%	0%	0%	0%	0%	0%	0%
19	13: Critical Care (ICU/CCU/CICU/CRW/ HDU/BURNS CARE UNIT	Rate of pressure ulcers	<3%	0%	0%	0%	2.78%	0%	10.64%
		Rate of unplanned extubation	<5%	0%	0%	0%	0%	0%	0%
		Rate of Catheter Related Blood Stream Infection	>5per 1000 catheter days	0%	0%	0%	0%	0%	0%
20	13B: Critical Care Services (Labour Delivery Services)	Incident of massive Post-Partum Haemorrhage (PPH) of total deliveries should be less than 1% (exclusion criteria: placenta previa and adherence placenta)	<1%	0%	0%	0%	0%	0%	0%
		Complication rate from instrumental/vaginal deliveries: incidence of 3rd and 4th degree tears	<10%	0%	0%	0%	0%	0%	0%
21	14: Radiology/ Diagnostic Imaging Services (Facility with Radiologist)	Percentage of Plain Films/Images reported by Radiologists	90%	100%	100%	100%	100%	100%	100%
		Percentage of Normal: Magnetic Resonance Imaging (MRI)		10.45%	12.50%	10.00%	8.53%	17.39%	13.70%
		Percentage of Normal: Computed Axial Tomography (CT) Scans reported by Radiologist		22.44%	22.04%	22.39%	25.11%	21.74%	25.76%
		Percentage of Radiological Examination Errors: wrong marker	0%	0%	0%	0.09%	0%	0%	0%
		Percentage of Radiological Examination Errors: use of primary markers	0%	0%	0%	0%	0%	0%	0%

		Percentage of Radiological Examination Errors: wrong site X-rayed	0%	0%	0%	0%	0%	0%	0%
		Percentage of Radiological Examination Errors: wrong patient X-rayed	0%	0%	0%	0%	0%	0%	0%
22	15: Pathology Services	Laboratory Turnaround Time (TAT) for urgent Full Blood Count within 45 minutes	>90%	100%	100%	100%	100%	100%	100%
		Notification of Neonatal Serum Bilirubin Result >300 umo/L within 30 minutes	≥95%	100%	100%	100%	100%	100%	100%
		Rejection Rate of specimens	<1%	0.18%	0.19%	0.16%	0.35%	0.11%	0.17%
23	16: Blood Transfusion Services	Cross-Match Transfusion Ratio	≤2.0	1.2%	1.0%	1.1%	1.1%	1.2%	1.1%
		Expiry rates of different blood components: red cell	≤2.5%	0%	0%	6.1%	8.1%	4.9%	4.9%
		Expiry rates of different blood components: platelet concentrates	≤15%	-	-	-	-	-	-
23	16: Blood Transfusion Services	Expiry rates of different blood components: apheresis (platelet or plasma)	0%	-	-	-	-	-	-
		Number of Adverse Events in patients (near misses, transfusion errors (incorrect blood component transfused), transfusion reactions, transfusion transmitted infections)	0	0	0	0	0	0	0
24	17A: Physiotherapy Services	Incident of Burns sustained during delivery of Electrotherapeutic Modalities or Thermal Agents	Sentinel Event	0	0	0	0	0	0
		Percentage of inpatient referrals seen on time (≤24 hours) by the physiotherapist	≥85%	100%	100%	100%	100%	100%	100%
25	17C: Dietetic Services	Percentage of in-patient referrals seen on time (4 hours) by the Dietitian	≥85%	100%	100%	100%	100%	100%	100%
		Percentage of out-patient referrals seen by the Dietitian within the stipulated time by the Dietetic Services and approved by the Facility	≥85%	100%	100%	100%	100%	100%	100%
26	18: Pharmacy Services	Percentage of Dispensing Error (inpatient)	0%	0%	0%	0%	0%	0%	0%
		Average time for a prescription to be dispensed from time received at counter to time medication given to patient	100%	100%	100%	100%	100%	100%	100%
		Number and value of expired drugs at end of month over a specified period	RM	3059.34	1061.66	2979.44	2093.60	677.05	4192.20
27	19: Central Sterile Supply Services (CSSS)	Percentage of sterile instrument sets rejected	<5%	0%	0%	0%	0%	0%	0%
		Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence	0%	0%	0%	0%	0%	0%	0%
28	20: Housekeeping Services	Trend of performance score during in-house inspection/joint inspection	80%	84.00%	86.11%	84.21%	86.84%	84.21%	89.47%
		Customer satisfaction feedback survey	80%	100%	100%	100%	100%	100%	100%
29	21: Linen Services	Percentage of Linen Shortfall - Blanket	2%	0%	0%	0%	0%	0%	0%
		Percentage of Linen Shortfall - Bedsheet	2%	0%	0%	0%	0%	0%	0%
		Linen Rejection Rate - Blanket	<2%	0%	0.71%	0%	0%	0.72%	0%
		Linen Rejection Rate - Bedsheet	<2%	0.71%	0.66%	0.66%	0.00%	0.67%	0.00%
		Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence	100%	100%	100%	100%	100%	100%	100%
		Internal customer satisfaction survey	80%	100%	100%	100%	100%	100%	100%
30	22: Food Services	Percentage of ready to serve food tested negative for pathogenic microorganism as per schedule	100%	-	100%	.-	-	100%	-
		Occurrence of physical contamination of food served to patients	≤1%	0%	0%	0%	0%	0%	0%
31	23A: Mortuary Services	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	75%	100%	100%	100%	100%	100%	100%
		Percentage of correct bodies released to the right next of kin/claimant	100%	100%	100%	100%	100%	100%	100%

*Source: Quality Assurance Unit.

ACHIEVEMENT STATUS KEY PERFORMANCE INDICATOR (MSQH KPI) - 2021

PUTRA MEDICAL CENTRE
PUSAT PAKAR PERUBATAN PUTRA

Quality Objectives and Planning (Jul - Dec 2021)

List	Service Standard	Performance indicator	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
1	01: Governance, Leadership and Direction	Percentage of patients leaving hospital against medical advice relative to all patients hospitalised wihin a specified period	Downward trends	3.19%	4.01%	5.83%	4.39%	3.86%	5.66%
		Percentage of incidents/accidents during hospitalisation of patients as percentage of all admitted patients	<5%	0.00%	0.00%	0.17%	0.00%	0.00%	0.15%
		Hospital wide patient satisfaction survey (six monthly basis)	>80%	100%	100%	100%	100%	100%	100%
		Average number of training hours per employee (Full Time Equivalent) had attended in a year		4.36%	4.17%	4.18%	4.31%	5.39%	5.16%
		Average time to register admission within 10 minutes (only applicable to case where bed is available)	10 minutes	8.23mins	8.71mins	8.50mins	8.46mins	8.8mins	8.27 mins
2	02: Environmental and Safety Services	Percentage of new staff (includes all on-site outsourced service providers) given orientation on Environmental, Safety and Health Policy and Programmed	80%	89.90%					
		Percentage of staff given continuous training in specific aspects of Environmental, Safety and Health	80%	89.20%			91.30%		
		Percentage of workplace hazards identified and risk managed	100%	100%	100%	100%	100%	100%	100%
3	03: Facility and Biomedical Equipment Management & Safety	Percentage of Planned Preventive Maintenance being done on schedule	98%	89.31%	93.75%	100%	98.85%	100%	99.50%
		Percentage of work orders completed on schedule	98%	97.33%	98.90%	99.00%	96.47%	99.16%	98.64%
4	04: Nursing Services	Percentage of intravenous (I/V) line complications (needles out, redness of skin, infection sites, extravasation)	≤0.5%	0%	0%	0%	0%	0%	0%
		Percentage of pressure sore among bed ridden patients	Downward trends	0%	0%	0%	0%	0%	0%
		Rate of patient falls - adult		0%	0%	0%	0%	0%	0%
		Rate of patient falls - paeds		0%	0%	1.89%	0%	0.70%	0.00%
5	05: Prevention and Control of Infection	Percentage of staff trained in Prevention and Control of Infection Practices	100% new staff	0%	0%	100%	100%	100%	0%
			85% existing staff	94.20%	96.14%	94.12%	93.30%	96.26%	97.41%
		Percentage of Healthcare Associated Infections (HCAI)	<5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Number of Resistant Organisms to Antibiotics within a specified period of time	<0.3%	0.34%	0.17%	0.33%	0.98%	0.16%	0.00%
6	07: Health Information Management System	Percentage of Medical Reports prepared within the stipulated period (2-4 weeks)	100%	75.40%	67.10%	67.10%	76.20%	78.90%	
		Percentage of Case Summaries that were completed within 72 working hours of discharge	100%	98.80%	98.30%	98.50%	97.70%	97.60%	97.30%
7	08: Emergency Services	Percentage of inappropriate triaging (under triaging): Category Green patients who should have been triaged as Category Red	≤0.5%	0%	0%	0%	0%	0%	0%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Red seen immediately	100%	100%	100%	100%	100%	100%	100%
7	08: Emergency Services	Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Yellow seen within 30 minutes	≥85%	100%	100%	100%	100%	100%	100%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Green seen within 90 minutes	>70%	100%	100%	100%	100%	100%	100%
		Unplanned return of patient seen at Emergency Department within 24 hours for similar complaint	3%	0%	0%	0%	0%	0%	0%
8	09A: Clinical Services (Medical Related Services)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Dengue Case Fatality Rate	0%	0%	0%	0%	0%	0%	0%
9	09B: Clinical Services (Surgical Related Services)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Unplanned return to Operating Theatre within the same hospital admission following surgery	0%	0%	0%	0%	0%	0%	0%

10	09C: Clinical Services (Obstetrics & Gynaecology Services)	Emergency Caesarean Rates	<30%	19.01%	15.45%	16.67%	11.36%	18.35%	12.93%
		Elective Caesarean Rates	<30%	27.27%	31.71%	24.64%	18.94%	22.02%	25.86%
		Maternal Mortality Ratio (sentinel event)	0%	0%	0%	0%	0%	0%	0%
11	09D: Clinical Services (Paediatric Services)	Number of Mortality/Morbidity audits/meetings being conducted in the department with documentation of cases discussed	0	0	0	0	0	0	0
		Percentage of paediatric patients with unplanned re-admission for the same condition within 48 hours of discharge	≤2%	0%	0%	0%	0%	0%	0%
		Community acquired pneumonia death rate in previously healthy children aged between one (1) month and five (5) years	≤1%	0%	0%	0%	0%	0%	0%
12	09E: Clinical Services (Cardiology)	Percentage of "Normal" Diagnostic Angiogram	<5%	50.00%	75.00%	0%	0%	50.00%	50.00%
		Major complication rate during Diagnostic Coronary Angiogram (Death, acute myocardial infarction, stroke)	<1%	0%	0%	0%	0%	0%	0%
		Major complication rate during Percutaneous Coronary Intervention (Death, acute myocardial infarction, stroke)	<1%	0%	0%	0%	0%	0%	0%
		Percutaneous Coronary Intervention (PCI) within 90 minutes after diagnosed as acute myocardial infarction "Door to Balloon" Time	0%	0%	0%	0%	0%	0%	0%
13	09: Clinical Services (Oral Maxillofacial Surgery/Dental)	Patient seen by Dentist within 90 minutes	95%	100%	100%	100%	100%	100%	100%
		Less than 5% of Customer Complaint for Dental treatment	<5%	0%	0%	0%	0%	0%	0%
14	09: Clinical Services (Orthopaedic)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Number of Mortality/Morbidity audits/meetings being conducted in the department with documentation of cases discussed		0	0	0	0	0	0
15	09: Clinical Services (Otorhinolaryngology (ENT)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Unplanned return to Operating Theatre within the same hospital admission following surgery	0%	0%	0%	0%	0%	0%	0%
16	13C: Chronic Dialysis Treatment	Catheter Related Blood Stream Infection (CRBSI) should not be more frequent than 3:1000	0%	0%	0%	0%	0%	0%	0%
		Annual mortality rate for dialysis patient taking of all factors should not be more than 15%	<15%	0%	0%	0%	0%	0%	0%
		Dialysis patients achieved their Transferrin Saturation (Tsats) > 20%	80%	-	81.8%	-	-	-	-
		Dialysis patients achieved their Hemoglobin level 10-12gm	70%	-	72.7%	-	-	70.0%	-
		Patient achieved their U.R.R. >65%	>85%	-	87.9%	-	-	86.7%	-
17	10: Anaesthetic Services	Pain score on discharge from recovery room should be less than four (4)	100%	100%	100%	100%	100%	100%	100%
		Number of patients having prolonged stay in recovery room for more than (2) hours (sentinel event)	0	0	0	0	0	0	0
18	11: Operating Suite Services	Rate of compliance to Safe Surgery Saves Lives (SSSL) practice	100%	100%	100%	100%	100%	100%	100%
		Percentage of Elective Operation Cancellation Rate	<10%	1.79%	3.50%	3.03%	2.44%	2.92%	7.64%
		Percentage of patients awaiting emergency surgery for more than 24 hours due to lack of OT time	<1%	0%	0%	0%	0%	0%	0%
19	13: Critical Care (ICU/CCU/CICU/CRW/ HDU/BURNS CARE UNIT	Rate of pressure ulcers	<3%	6.52%	19.23%	0%	14.29%	0%	0%
		Rate of unplanned extubation	<5%	0%	0%	0%	0%	0%	0%
		Rate of Catheter Related Blood Stream Infection	>5per 1000 catheter days	0%	0%	0%	0%	0%	0%
20	13B: Critical Care Services (Labour Delivery Services)	Incident of massive Post-Partum Haemorrhage (PPH) of total deliveries should be less than 1% (exclusion criteria: placenta previa and adherence placenta)	<1%	0.83%	0%	0.72%	0%	0%	0%
		Complication rate from instrumental/vaginal deliveries: incidence of 3rd and 4th degree tears	<10%	0%	0%	0%	0%	0%	0%
21	14: Radiology/ Diagnostic Imaging Services (Facility with Radiologist)	Percentage of Plain Films/Images reported by Radiologists	90%	100%	100%	100%	100%	100%	100%
		Percentage of Normal: Magnetic Resonance Imaging (MRI)		12.50%	15.85%	18.27%	4.84%	7.75%	13.22%
		Percentage of Normal: Computed Axial Tomography (CT) Scans reported by Radiologist		20.57%	23.08%	21.79%	21.93%	23.41%	25.83%
		Percentage of Radiological Examination Errors: wrong marker	0%	0%	0%	0%	0%	0%	0%
		Percentage of Radiological Examination Errors: use of primary markers	0%	0%	0%	0%	0%	0%	0%

		Percentage of Radiological Examination Errors: wrong site X-rayed	0%	0%	0%	0%	0%	0%	0%
		Percentage of Radiological Examination Errors: wrong patient X-rayed	0%	0%	0%	0%	0%	0%	0%
22	15: Pathology Services	Laboratory Turnaround Time (TAT) for urgent Full Blood Count within 45 minutes	>90%	98.40%	100%	100%	100%	99.30%	100%
		Notification of Neonatal Serum Bilirubin Result >300 umo/L within 30 minutes	≥95%	100%	100%	100%	100%	100%	100%
		Rejection Rate of specimens	<1%	0.12%	0.10%	0.23%	0.27%	0.41%	0.21%
23	16: Blood Transfusion Services	Cross-Match Transfusion Ratio	≤2.0	1.2%	1.1%	1.1%	1.1%	1.2%	1.0%
		Expiry rates of different blood components: red cell	≤2.5%	4.7%	6.7%	0%	0%	0%	0.0%
		Expiry rates of different blood components: platelet concentrates	≤15%	-	-	-	-	-	-
23	16: Blood Transfusion Services	Expiry rates of different blood components: apheresis (platelet or plasma)	0%	-	-	-	-	-	-
		Number of Adverse Events in patients (near misses, transfusion errors (incorrect blood component transfused), transfusion reactions, transfusion transmitted infections)	0	0	0	0	0	0	0
24	17A: Physiotherapy Services	Incident of Burns sustained during delivery of Electrotherapeutic Modalities or Thermal Agents	Sentinel Event	0	0	0	0	0	0
		Percentage of inpatient referrals seen on time (≤24 hours) by the physiotherapist	≥85%	100%	100%	100%	100%	100%	100%
25	17C: Dietetic Services	Percentage of in-patient referrals seen on time (4 hours) by the Dietitian	≥85%	100%	100%	100%	100%	100%	100%
		Percentage of out-patient referrals seen by the Dietitian within the stipulated time by the Dietetic Services and approved by the Facility	≥85%	100%	100%	100%	100%	100%	100%
26	18: Pharmacy Services	Percentage of Dispensing Error (inpatient)	0%	0%	0%	0%	0%	0%	0%
		Average time for a prescription to be dispensed from time received at counter to time medication given to patient	100%	100%	100%	100%	100%	100%	100%
		Number and value of expired drugs at end of month over a specified period	RM	164.60	2336.67	4703.30	2816.50	747.58	11932.98
27	19: Central Sterile Supply Services (CSSS)	Percentage of sterile instrument sets rejected	<5%	0%	0%	0%	0%	0%	0%
		Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence	0%	0%	0%	0%	0%	0%	0%
28	20: Housekeeping Services	Trend of performance score during in-house inspection/joint inspection	80%	84.21%	85.53%	90.79%	86.84%	81.58%	85.53%
		Customer satisfaction feedback survey	80%	100%	100%	100%	100%	100%	100%
29	21: Linen Services	Percentage of Linen Shortfall - Blanket	2%	0%	0%	0%	0%	0%	0%
		Percentage of Linen Shortfall - Bedsheet	2%	0%	0%	0%	0%	0%	0%
		Linen Rejection Rate - Blanket	<2%	0%	0%	0%	0%	0%	0%
		Linen Rejection Rate - Bedsheet	<2%	0.00%	0.00%	0.00%	3.23%	0.00%	0.00%
		Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence	100%	100%	0%	0%	0%	0%	0%
		Internal customer satisfaction survey	80%	100%	100%	100%	100%	100%	100%
30	22: Food Services	Percentage of ready to serve food tested negative for pathogenic microorganism as per schedule	100%	-	100%	-	-	100%	-
		Occurrence of physical contamination of food served to patients	≤1%	0%	0%	0%	0%	0%	0%
31	23A: Mortuary Services	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	75%	100%	100%	100%	100%	100%	100%
		Percentage of correct bodies released to the right next of kin/claimant	100%	100%	100%	100%	100%	100%	100%

*Source: Quality Assurance Unit.

ACHIEVEMENT STATUS KEY PERFORMANCE INDICATOR (MSQH KPI) - 2022

PUTRA MEDICAL CENTRE
PUSAT PAKAR PERUBATAN PUTRA

Quality Objectives and Planning (Jan - Jun 2022)

List	Service Standard	Performance indicator	Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
1	01: Governance, Leadership and Direction	Percentage of patients leaving hospital against medical advice relative to all patients hospitalised wihin a specified period	Downward trends	3.49%	3.29%	2.77%	5.10%	4.47%	4.65%
		Percentage of incidents/accidents during hospitalisation of patients as percentage of all admitted patients	<5%	0.15%	0.00%	0.00%	0.18%	0.00%	0.36%
		Hospital wide patient satisfaction survey (six monthly basis)	>80%	99.91%	99.68%	99.59%	99.93%	99.64%	99.76%
		Average number of training hours per employee (Full Time Equivalent) had attended in a year	-	4.82hrs	4.68hrs	4.71hrs	5.19hrs	5.00hrs	4.68hrs
		Average time to register admission within 9 minutes (only applicable to case where bed is available)	9 minutes	7.84mins	7.82min	7.72min	7.64min	7.84min	7.31min
2	02: Environmental and Safety Services	Percentage of new staff (includes all on-site outsourced service providers) given orientation on Environmental, Safety and Health Policy and Programmed	80%	86.54%					
		Percentage of staff given continuous training in specific aspects of Environmental, Safety and Health	80%	92.51% (JAN - MAR)			94.35% (APR - JUN)		
		Percentage of workplace hazards identified and risk managed	100%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3	03: Facility and Biomedical Equipment Management & Safety	Percentage of Planned Preventive Maintenance being done on schedule	98%	98.61%	98.57%	100%	98.35%	94.49%	96.02%
		Percentage of work orders completed on schedule	98%	100%	99.48%	99.56%	99.58%	99.42%	98.57%
4	04: Nursing Services	Percentage of intravenous (I/V) line complications (needles out, redness of skin, infection sites, extravasation)	≤0.5%	0.28%	1.18%	0.44%	0.60%	0.49%	0.00%
		Percentage of pressure sore among bed ridden patients	Downward trends	0%	0%	0%	2.56%	0%	0%
		Rate of patient falls - adult		0%	0%	0%	0%	0%	0.68%
		Rate of patient falls - paeds		0.61%	0%	0%	0.85%	0.00%	0.00%
5	05: Prevention and Control of Infection	Percentage of staff trained in Prevention and Control of Infection Practices	100% new staff	100%	100%	100%	100%	100%	100%
			85% existing staff	92.82%	92.67%	96.07%	92.14%	97.24%	97.54%
		Percentage of Healthcare Associated Infections (HCAI)	<5%	0%	0%	0%	0%	0%	0%
		Number of Resistant Organisms to Antibiotics within a specified period of time	MRSA 0.3%	0%	0%	0.35%	0%	0.14%	0%
			ESBL 0.3%	0%	0%	0.17%	0%	0.14%	0%
6	07: Health Information Management System	Percentage of Medical Reports prepared within the stipulated period (2-4 weeks)	100%	80.4% (DEC 21)	72.2% (JAN 2022)	73.8% (FEB 2022)	67.3% (MAR 2022)	69.9% (APR 2022)	61.6% (MAY 2022)
		Percentage of Case Summaries that were completed within 72 working hours of discharge	100%	96.9%	97.7%	97.5%	97.1%	97.8%	98.1%
7	08: Emergency Services	Percentage of inappropriate triaging (under triaging): Category Green patients who should have been triaged as Category Red	≤0.5%	0%	0%	0%	0%	0%	0%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Red seen immediately	100%	100%	100%	100%	100%	100%	100%
7	08: Emergency Services	Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Yellow seen within 30 minutes	≥85%	100%	100%	100%	100%	100%	100%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Green seen within 90 minutes	>70%	99.90%	99.93%	100%	99.90%	99.88%	99.85%
		Unplanned return of patient seen at Emergency Department within 24 hours for similar complaint	3%	0%	0%	0%	0%	0%	0%
8	09A: Clinical Services (Medical Related Services)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Dengue Case Fatality Rate	0%	0%	0%	0%	0%	0%	0%
9	09B: Clinical Services (Surgical Related Services)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Unplanned return to Operating Theatre within the same hospital admission following surgery	0%	0%	0%	0%	0%	0%	0%

10	09C: Clinical Services (Obstetrics & Gynaecology Services)	Emergency Caesarean Rates	<30%	22.12%	17.53%	12.36%	17.19%	19.74%	12.22%
		Elective Caesarean Rates	<30%	23.01%	17.53%	21.35%	17.19%	19.74%	27.78%
		Maternal Mortality Ratio (sentinel event)	0%	0%	0%	0%	0%	0%	0%
11	09D: Clinical Services (Paediatric Services)	Number of Mortality/Morbidity audits/meetings being conducted in the department with documentation of cases discussed	-	1	0	0	0	0	0
		Percentage of paediatric patients with unplanned re-admission for the same condition within 48 hours of discharge	≤2%	0%	0%	0%	0%	0%	0%
		Community acquired pneumonia death rate in previously healthy children aged between one (1) month and five (5) years	≤1%	0%	0%	0%	0%	0%	0%
12	09E: Clinical Services (Cardiology)	Percentage of "Normal" Diagnostic Angiogram	<5%	0%	66.67%	50.00%	0%	0%	0%
		Major complication rate during Diagnostic Coronary Angiogram (Death, acute myocardial infarction, stroke)	<1%	0%	0%	0%	0%	0%	0%
		Major complication rate during Percutaneous Coronary Intervention (Death, acute myocardial infarction, stroke)	<1%	0%	0%	0%	0%	0%	0%
		Percutaneous Coronary Intervention (PCI) within 90 minutes after diagnosed as acute myocardial infarction "Door to Balloon" Time	0%	0%	0%	0%	0%	0%	0%
13	09: Clinical Services (Oral Maxillofacial Surgery/Dental)	Patient seen by Dentist within 90 minutes	95%	100%	100%	100%	100%	100%	100%
		Less than 5% of Customer Complaint for Dental treatment	<5%	0%	0%	0%	0%	0%	0%
14	09: Clinical Services (Orthopaedic)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Number of Mortality/Morbidity audits/meetings being conducted in the department with documentation of cases discussed	-	0	0	0	0	0	0
15	09: Clinical Services (Otorhinolaryngology (ENT)	Percentage of unplanned re-admission within 72 hours of discharge	0%	0%	0%	0%	0%	0%	0%
		Unplanned return to Operating Theatre within the same hospital admission following surgery	0%	0%	0%	0%	0%	0%	0%
16	13C: Chronic Dialysis Treatment	Catheter Related Blood Stream Infection (CRBSI) should not be more frequent than 3:1000	0%	0%	0%	0%	0%	0%	0%
		Annual mortality rate for dialysis patient taking of all factors should not be more than 15%	<15%	0%	0%	0%	0%	0%	0%
		Dialysis patients achieved their Transferrin Saturation (Tsats) > 20%	80%	-	69.0%	-	-	-	-
		Dialysis patients achieved their Hemoglobin level 10-12gm	70%	-	72.4%	-	-	62.1%	-
		Patient achieved their U.R.R. >65%	>85%	-	55.2%	-	-	55.2%	-
17	10: Anaesthetic Services	Pain score on discharge from recovery room should be less than four (4)	100%	100%	100%	100%	100%	100%	100%
		Number of patients having prolonged stay in recovery room for more than (2) hours (sentinel event)	0	0	0	0	0	0	0
18	11: Operating Suite Services	Rate of compliance to Safe Surgery Saves Lives (SSSL) practice	100%	100%	100%	100%	100%	100%	100%
		Percentage of Elective Operation Cancellation Rate	<10%	5.60%	7.18%	6.61%	4.74%	5.74%	4.86%
		Percentage of patients awaiting emergency surgery for more than 24 hours due to lack of OT time	<1%	0%	0%	0%	0%	0%	0%
19	13: Critical Care (ICU/CCU/CICU/CRW/ HDU/BURNS CARE UNIT	Rate of pressure ulcers	<3%	0%	0%	0%	3.85%	0.00%	2.13%
		Rate of unplanned extubation	<5%	0%	0%	0%	0%	0%	0%
		Rate of Catheter Related Blood Stream Infection	>5per 1000 catheter days	0%	0%	0%	0%	0%	0%
20	13B: Critical Care Services (Labour Delivery Services)	Incident of massive Post-Partum Haemorrhage (PPH) of total deliveries should be less than 1% (exclusion criteria: placenta previa and adherence placenta)	<1%	0%	0%	0%	0%	0%	0%
		Complication rate from instrumental/vaginal deliveries: incidence of 3rd and 4th degree tears	<10%	0%	0%	0%	0%	0%	0%
		Percentage of Plain Films/Images reported by Radiologists	90%	100%	100%	100%	100%	100%	100%

21	14: Radiology/ Diagnostic Imaging Services (Facility with Radiologist)	Percentage of Normal: Magnetic Resonance Imaging (MRI)	-	33.04%	13.54%	7.29%	12.18%	8.74%	11.92%
		Percentage of Normal: Computed Axial Tomography (CT) Scans reported by Radiologist	-	19.83%	17.35%	23.63%	17.39%	20.16%	17.95%
		Percentage of Radiological Examination Errors: wrong marker	0%	0%	0%	0%	0%	0%	0%
		Percentage of Radiological Examination Errors: use of primary markers	0%	0%	0%	0%	0%	0%	0%
		Percentage of Radiological Examination Errors: wrong site X-rayed	0%	0%	0%	0%	0%	0%	0%
		Percentage of Radiological Examination Errors: wrong patient X-rayed	0%	0%	0%	0%	0%	0%	0%
22	15: Pathology Services	Laboratory Turnaround Time (TAT) for urgent Full Blood Count within 45 minutes	>90%	99.30%	100%	100%	99.00%	100%	100%
		Notification of Neonatal Serum Bilirubin Result >300 umo/L within 30 minutes	≥95%	100%	100%	100%	100%	100%	100%
		Rejection Rate of specimens	<1%	0.12%	0.09%	0.34%	0.15%	0.24%	0.72%
23	16: Blood Transfusion Services	Cross-Match Transfusion Ratio	≤2.0	1.1	1.1	1.1	1.1	1.0	1.0
		Expiry rates of different blood components: red cell	≤2.5%	6.1%	10.0%	0.0%	3.7%	5.6%	6.9%
		Expiry rates of different blood components: platelet concentrates	≤15%	-	-	-	-	-	-
23	16: Blood Transfusion Services	Expiry rates of different blood components: apheresis (platelet or plasma)	0%	-	-	-	-	-	-
		Number of Adverse Events in patients (near misses, transfusion errors (incorrect blood component transfused), transfusion reactions, transfusion transmitted infections)	0	0	0	0	0	0	0
24	17A: Physiotherapy Services	Incident of Burns sustained during delivery of Electrotherapeutic Modalities or Thermal Agents	Sentinel Event	0 case	0 case	0 case	0 case	0 case	0 case
		Percentage of inpatient referrals seen on time (≤24 hours) by the physiotherapist	≥85%	100%	100%	100%	100%	100%	100%
25	17C: Dietetic Services	Percentage of in-patient referrals seen on time (4 hours) by the Dietitian	≥85%	100%	100%	100%	100%	100%	100%
		Percentage of out-patient referrals seen by the Dietitian within the stipulated time by the Dietetic Services and approved by the Facility	≥85%	100%	100%	100%	100%	100%	100%
26	18: Pharmacy Services	Percentage of Dispensing Error	0%	0%	0%	0%	0%	0%	0%
		Average time for a prescription to be dispensed from time received at counter to time medication given to patient	100%	100%	100%	100%	100%	100%	99.91%
		Number and value of expired drugs at end of month over a specified period	RM	RM3438.20	RM1026.90	RM1294.85	RM2812.12	RM3279.79	RM2753.56
27	19: Central Sterile Supply Services (CSSS)	Percentage of sterile instrument sets rejected	<5%	0%	0%	0%	0%	0%	0%
		Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence	0%	0%	0%	0%	0%	0%	0%
28	20: Housekeeping Services	Trend of performance score during in-house inspection/joint inspection	80%	84.21%	85.53%	85.53%	82.89%	84.21%	85.53%
		Customer satisfaction feedback survey	80%	100%	100%	100%	100%	100%	100%
29	21: Linen Services	Percentage of Linen Shortfall - Blanket	2%	0%	0%	0%	0%	0%	0%
		Percentage of Linen Shortfall - Bedsheet	2%	0%	0%	0%	0%	0%	0%
		Linen Rejection Rate - Blanket	<2%	0%	0.00%	0.00%	0.00%	0.29%	0.00%
		Linen Rejection Rate - Bedsheet	<2%	0.00%	0.00%	0.00%	0.00%	0.90%	1.81%
		Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence	100%	0%	0%	0%	0%	100%	100%
		Internal customer satisfaction survey	80%	100%	100%	100%	100%	100%	100%
30	22: Food Services	Percentage of ready to serve food tested negative for pathogenic microorganism as per schedule	100%	-	100%	100%	100%	100%	100%
		Occurrence of physical contamination of food served to patients	≤1%	0%	0%	0%	0%	0%	0%
31	23A: Mortuary Services	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	75%	100%	100%	100%	100%	100%	100%
		Percentage of correct bodies released to the right next of kin/claimant	100%	100%	100%	100%	100%	100%	100%

*Source: Quality Assurance Unit.

ACHIEVEMENT STATUS KEY PERFORMANCE INDICATOR (MSQH KPI) - 2022

PUTRA MEDICAL CENTRE
PUSAT PAKAR PERUBATAN PUTRA

Quality Objectives and Planning (Jul - Dec 2022)

List	Service Standard	Performance indicator	Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
1	01: Governance, Leadership and Direction	Percentage of patients leaving hospital against medical advice relative to all patients hospitalised within a specified period	Downward Trends	4.71%	3.73%	3.27%	4.99%	6.30%	3.83%
		Percentage of incidents/accidents during hospitalisation of patients as percentage of all admitted patients	Downward Trends	0.00%	0.27%	0.00%	0.12%	0.14%	0.00%
		Hospital wide patient satisfaction survey (six monthly basis)	> 80% patient satisfaction level	99.83%	99.63%	98.31%	99.14%	99.65%	99.25%
		Average number of training for nursing & non-nursing per employee for full time equivalent had attended a year	-	4.69hrs	4.63hrs	5.21hrs	4.87hrs	4.97hrs	5.09hrs
		Average time to register admission within 9 minutes (only applicable to case where bed is available)	9 minutes	7.05min	6.74min	6.88min	6.60min	6.57min	6.93min
2	02: Environmental and Safety Services	Percentage of issues identified during Environmental and Safety Audit are closed or followed through.	> 50%	100%				100%	
		Percentage of internal and external planned drills are carried out and documented including recommendations and followed through activities	100%	100%					
		Percentage of workplace hazards identified and risk managed	100%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3	03: Facility and Biomedical Equipment Management & Safety	Percentage of Planned Preventive Maintenance being done on schedule	98%	99.09%	96.00%	100%	98.90%	97.37%	98.47%
		Percentage of system/service uptime	92%	99.24%	99.24%	92.16%	98.74%	98.86%	99.24%
		Repair Time - Percentage of Repair /Work Orders completed within 7 working days)	7 working days	87.45%	99.06%	100%	100%	99.82%	99.08%
4	04: Nursing Services	Percentage of intravenous (I/V) line complications (needles out, redness of skin, infection sites, extravasation)	≤0.5%	0.00%	0.00%	0.14%	0.00%	0.00%	0.13%
5	05: Prevention and Control of Infection	Percentage of staff trained in Prevention and Control of Infection Practices	100% new staff	100%	100%	100%	100%	100%	100%
			85% existing staff	93.40%	94.03%	94.71%	93.55%	94.69%	96.33%
			100% Infection Control Nurse	100%	100%	100%	100%	100%	100%
		Percentage of Healthcare Associated Infections (HCAI)	<5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Number of Resistant Organisms to Antibiotics within a specified period of time	MRSA 0.3%	0.12%	0.00%	0.00%	0.00%	0.00%	0.00%
			ESBL- E.coli 0.2%	0.12%	0.27%	0.14%	0.37%	0.14%	0.00%
			ESBL - Klebsiellap pneumonia < 0.3%	0.00%	0.00%	0.00%	0.12%	0.00%	0.00%
			CRE < 0.1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
6	07: Health Information Management System	Percentage of Medical Reports prepared within the stipulated period (≤ 4 weeks)	90%	67.6% (JUN 2022)	67.2% (JUL 2022)	68.3% (AUG 2022)	80.3% (SEP 2022)	77.4% (OCT 2022)	73.0% (NOV 2022)
		Percentage of medical records that were dispatched within 72 hours of discharge	95%	97.7%	96.7%	97.5%	97.1%	97.1%	95.1%
7	08: Emergency Services	Percentage of inappropriate triaging (under triaging): Category Green patients who should have been triaged as Category Red.	≤0.5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Red seen immediately	100%	100%	100%	100%	100%	100%	100%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Yellow seen within 30 minutes	≥85%	100%	100%	100%	100%	100%	100%
		Waiting time relative to Triage Category: Malaysian Triage Category (MTC) Green seen within 90 minutes	>70%	100%	100%	100%	99.67%	99.58%	99.71%
		Unplanned return of patient seen at Emergency Department within 24 hours for similar complaint	Sentinel Event	0 case	0 case	0 case	0 case	0 case	0 case
8	9A: Clinical Services (Medical Related Services)	Percentage of unplanned re-admission for the same condition within 72 hours of discharge	-	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Dengue Case Fatality Rate	-	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
9	9B: Clinical Services (Surgical Related Services)	Percentage of unplanned re-admission within 72 hours of discharge	-	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Unplanned return to Operating Theatre within the same hospital admission following surgery	-	0.00%	0.00%	0.00%	0.00%	0.00%	0.86%

10	9B: Clinical Services (Dental)	Percentage of patients with waiting time of ≤ 90 minutes to see the dentist at the Dental Clinic	95%	100%	100%	100%	100%	100%	100%
		Percentage of customer complaints on dental procedure	<5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
11	9C: Clinical Services (Obstetrics & Gynaecology Services)	Emergency Caesarean Rates	<30%	21.88%	17.65%	12.38%	8.91%	11.46%	13.54%
		Elective Caesarean Rates	<30%	22.92%	21.18%	16.19%	31.68%	21.88%	26.04%
		Maternal Mortality Ratio (sentinel event)	0	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
12	9D: Clinical Services (Paediatric Services)	Number of Mortality/Morbidity audits/meetings being conducted in the department with documentation of cases discussed	-	1 case					
		Percentage of paediatric patients with unplanned re-admission for the same condition within 48 hours of discharge	≤2%	0.00%	0.45%	0.00%	0.00%	0.00%	0.00%
		Community acquired pneumonia death rate in previously healthy children aged between one (1) month and five (5) years	≤1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
13	9E: Clinical Services (Cardiology)	Percentage of "Normal" Diagnostic Angiogram	<5%	0.00%	0.00%	0.00%	0.00%	20.00%	0.00%
		Major complication rate during Diagnostic Coronary Angiogram (Death, acute myocardial infarction, stroke)	<1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Major complication rate during Percutaneous Coronary Intervention (Death, acute myocardial infarction, stroke)	<1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Percutaneous Coronary Intervention (PCI) within 90 minutes after hospital arrival "Door to Balloon" Time	90%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
14	9H: Clinical Services (Otorhinolaryngology)	Percentage of patients with waiting time of ≤ 90 minutes to see the doctor at the Otorhinolaryngology(ORL) Outpatient Clinic	≥ 90%	100%	100%	100%	100%	100%	100%
		Incidence rate of primary post-tonsillectomyhaemorrhage	≤ 3%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
15	9J: Clinical Services (Orthopaedic)	Percentage of unplanned re-admission within 72 hours of discharge	-	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Unplanned return to Operating Theatre within the same hospital admission following surgery	-	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
16	10: Anaesthetic Services	Pain score on discharge from recovery room should be less than four (4)	100%	100%	100%	100%	100%	100%	100%
		Number of patients having prolonged stay in recovery room for more than two (2) hours (sentinel event)	0	0	0	0	0	0	0
17	11: Operating Suite Services	Rate of compliance to Safe Surgery Saves Lives (SSSL) practice	-	100%	100%	100%	100%	100%	100%
		Percentage of Elective Operation Cancellation Rate	<10%	6.14%	3.78%	2.70%	1.91%	1.97%	2.33%
		Percentage of patients awaiting emergency surgery for more than 24 hours due to lack of OT time	<1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Number of patients returning to surgery within 24 hours	Sentinel Event	0	0	0	0	0	0
		Number of incidents reported in the operating room	0	0	0	0	0	0	0
18	13: Critical Care (HDU)	Rate of pressure ulcers	<3%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Rate of unplanned extubation	<5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Rate of Catheter Related Blood Stream Infection	< 5 per 1000 catheter days	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
19	13B: Critical Care Services (Labour Delivery Services)	Percentage of massive Primary Post-Partum Haemorrhage (PPH) incidence in cases delivered in the hospital (exclusion criteria: placenta previa and adherence placenta)	< 0.5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Complication rate from instrumental/vaginal deliveries: incidence of 3rd and 4th degree tears	<10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
20	13C: Chronic Dialysis Treatment	Catheter Related Blood Stream Infection (CRBSI) should not be more frequent than 3:1000	0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Annual mortality rate for dialysis patient taking of all factors should not be more than 15%	Not be more than 15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Dialysis patients achieved their Transferrin Saturation (TSATS) > 20%	≥ 80%	-	80.8%	-	-	82.1%	-
		Dialysis patients should achieved hb level 10-12g/dl	≥ 70%	-	61.5%	-	-	71.4%	-
		Patient achieved their U.R.R. >65%	≥ 85%	-	88.5%	-	-	85.7%	-
21	14: Radiology/ Diagnostic Imaging Services (Facility with Radiologist)	Percentage of Plain Films/Images Reported by Radiologists	> 95%	100%	100%	100%	100%	100%	100%
		Percentage of Radiological Examination Errors i.e. wrong marker, use of primary markers, wrong site X-rayed, wrong patient X-rayed	-	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

22	15: Pathology Services	Rejection Rate of specimens	< 1%	0.32%	0.25%	0.34%	0.26%	0.24%	0.26%
		Notification of critical laboratory tests results	-	1.29%	1.58%	1.45%	1.45%	1.00%	1.81%
23	16: Blood Transfusion Services	Cross-Match Transfusion Ratio	≤ 2.0	1.0	1.1	1.3	1.1	1.1	1.1
		Number of Adverse Events in patients [near misses, transfusion errors (incorrect blood component transfused), transfusion reactions, transfusion transmitted infections)	0	1 cases	0 case	2 cases	0 case	0 case	0 case
24	17A: Physiotherapy Services	Burns Incidence incurred with the administration of Electrotherapeutic Modalities or Thermal Agents	Sentinel Event	0 case	0 case	0 case	0 case	0 case	0 case
		Percentage of inpatient referrals seen by the physiotherapist within 24 hours	90%	100%	100%	100%	100%	100%	100%
25	17C: Dietetic Services	Percentage of in-patient referrals seen on time (4 hours) by the Dietitian	≥85%	100%	100%	100%	100%	100%	100%
		Percentage of out-patient referrals seen on time (2 hours) by the Dietitian	≥85%	100%	100%	100%	100%	100%	100%
26	18: Pharmacy Services	Percentage of Prescription Error	0%	0.17%	0.01%	0.06%	0.01%	0.10%	0.14%
		Percentage of Dispensing Error	0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
27	19: Central Sterile Supply Services (CSSS)	Percentage of sterile instrument sets rejected	<5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Percentage of incidents reported monthly that have had Root Cause Analysis (RCA) done and action taken to prevent recurrence	100%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
28	20: Housekeeping Services	Trend of performance score during in-house inspection/joint inspection	80% with minimum score of 3	86.84%	89.47%	82.89%	97.37%	85.53%	82.89%
		Customer satisfaction feedback survey	80% satisfaction level	98.99%	100%	100%	100%	99.60%	99.68%
29	21: Linen Services	Percentage of Linen (Blanket) Shortfall	2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Percentage of Linen (Bedsheet) Shortfall	2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
		Linen (Blanket) Rejection Rate	<2%	0.72%	5.33%	0.00%	2.16%	0.00%	1.44%
		Linen (Bedsheet) Rejection Rate	<2%	0.00%	1.94%	0.00%	0.00%	0.00%	0.52%
30	22: Food Services	Percentage of ready to serve food tested negative for pathogenic microorganism as per schedule	100%	-	100%	-	-	100%	-
		Occurrence of physical contamination of food served to patients	Sentinel Event	0 case	0 case	0 case	0 case	0 case	0 case
31	23A: Mortuary Services	Turnaround time of ≤ 3 hours for releasing bodies (non-police cases) to the next of kin/claimant after body registration	≥ 80%	100%	100%	100%	100%	100%	100%
		Percentage of correct bodies released to the right next of kin/claimant	≥ 99% (sentinel event needs to be investigated immediately)	100%	100%	100%	100%	100%	100%

*Source: Quality Assurance Unit.

ACCIDENT & EMERGENCY

INTRODUCTION

The Accident & Emergency Department of Putra Medical Centre is a one stop medical unit which is providing early trauma care for patients who seek early treatment. It is situated at the Ground Floor (old wing) of Putra Medical Centre with the entrance immediately accessible to most vehicles. It also serves to be one of the main entrance point to other medical services. The department operates 24 hours daily, offering a multitude of emergency medical services for the community and medical conditions, ranging from the critically ill or severely injured, to those with minor ailments falling under the scope of emergency medicine.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF INAPPROPRIATE TRIAGING (UNDER TRIAGING): CATEGORY GREEN PATIENTS WHO SHOULD HAVE BEEN TRIAGED AS CATEGORY RED.			
YEAR	TOTAL NUMBER OF MTC GREEN PATIENTS	NUMBER OF MTC GREEN PATIENTS WHO SHOULD HAVE BEEN TRIAGED AS MTC RED	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	41575	0	≤ 0.5	0
2022	48367	0	≤ 0.5	0

Table 1: Percentage of inappropriate triaging (under triaging): category green patients who should have been triaged as category red from year 2021 to 2022

Based on the data obtained, Table 1 shows 0% of inappropriate triaging (under triaging): category green patients who should have been triaged as category red from year 2021 to 2022.

MSQH KPI 2	WAITING TIME RELATIVE TO TRIAGE CATEGORY : MALAYSIAN TRIAGE CATEGORY (MTC) RED SEEN IMMEDIATELY			
YEAR	THE TOTAL NUMBER OF PATIENTS ATTENDING ED WHO ARE TRIAGED TO MTC RED IN THE TIME PERIOD UNDER STUDY	THE NUMBER OF PATIENTS ALLOCATED MTC RED WHO ARE ATTENDED BY ED STAFF IMMEDIATELY	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	38	38	100	100
2022	65	65	100	100

Table 2: Percentage of waiting time relative to triage category: Malaysian Triage Category (MTC) Red seen immediately from year 2021 to 2022

Based on the data obtained, Table 2 shows 100% of waiting time relative to triage category: Malaysian Triage Category (MTC) Red seen immediately from year 2021 to 2022

MSQH KPI 3	WAITING TIME RELATIVE TO TRIAGE CATEGORY : MALAYSIAN TRIAGE CATEGORY (MTC) YELLOW SEEN WITHIN 30 MINUTES			
YEAR	THE TOTAL NUMBER OF PATIENTS ATTENDING ED WHO ARE TRIAGED TO MTC YELLOW IN THE TIME PERIOD UNDER STUDY	THE NUMBER OF PATIENTS ALLOCATED MTC YELLOW WHO ARE ATTENDED BY ED STAFF WITHIN 30 MINUTES	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	765	765	≥ 85	100
2022	935	935	≥ 85	100

Table 3: Percentage of waiting time relative to triage category: Malaysian Triage Category (MTC) Yellow seen within 30 minutes from year 2021 to 2022

Based on the data obtained, Table 3 shows 100% of waiting time relative to triage category: Malaysian Triage Category (MTC) Yellow seen within 30 minutes from year 2021 to 2022.

MSQH KPI 4	WAITING TIME RELATIVE TO TRIAGE CATEGORY: MALAYSIAN TRIAGE CATEGORY (MTC) GREEN SEEN WITHIN 90 MINUTES			
YEAR	THE TOTAL NUMBER OF PATIENTS ATTENDING ED WHO ARE TRIAGED TO MTC GREEN IN THE TIME PERIOD UNDER STUDY	THE NUMBER OF PATIENTS ALLOCATED MTC GREEN WHO ARE ATTENDED BY ED STAFF WITHIN 90 MINUTES	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	41575	33439	> 70	100
2022	48367	48367	> 70	99.87

Table 4: Percentage of waiting time relative to triage category: Malaysian Triage Category (MTC) Green seen within 90 minutes from year 2021 to 2022

Based on the data obtained, Table 4 shows 100% of waiting time relative to triage category: Malaysian Triage Category (MTC) Green seen within 90 minutes in year 2021 and slightly decreased to 99.87% in 2022.

MSQH KPI 5	UNPLANNED RETURN OF PATIENTS SEEN AT EMERGENCY DEPARTMENT WITHIN 24 HOURS FOR A SIMILAR COMPLAINT
YEAR	NUMBER OF UNPLANNED RETURN OF PATIENTS SEEN AT THE EMERGENCY DEPARTMENT WITHIN 24 HOURS FOR SIMILAR COMPLAINT IN THE MONTH
2021	0 CASE
2022	0 CASE

Table 5: Number of unplanned return of patients seen at emergency department within 24 hours for a similar complaint from year 2021 to 2022

Based on the data obtained, Table 5 shows 0 case of unplanned return of patients seen at emergency department within 24 hours for a similar complaint from year 2021 to 2022.

ISO KPI 1	TO ATTEND (FROM TIME RECEIVED CALL UNTIL DEPART FROM PMC) EMERGENCY AMBULANCE CALL WITHIN 15 MINUTES			
YEAR	TOTAL AMBULANCE CALLS RECEIVED	AMBULANCE CALLS RESPONDED WITHIN 15 MINUTES	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	160	160	100	100
2022	162	162	100	100

Table 6: Percentage of ambulance call attended within 15 minutes from year 2021 to 2022

Based on the data obtained, Table 6 shows 100% of ambulance call attended within 15 minutes from year 2021 to 2022.

ISO KPI 2	TO ATTEND PATIENT WITHIN 8 MINUTES BY NURSES AFTER OUTPATIENT REGISTRATION FOR NON EMERGENCY CASE			
YEAR	TOTAL NUMBER OF MTC GREEN PATIENTS	NUMBER OF MTC GREEN PATIENTS WHO SHOULD HAVE BEEN TRIAGED AS MTC RED	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	41575	0	95%	100
2022	48367	0	95%	99.93

Table 7: Percentage of attending patient within 8 minutes by nurses after outpatient registration for non-emergency case from year 2021 to 2022.

Based on the data obtained, Table 7 shows 100% of patient attended by nurses within 8 minutes after outpatient registration for non-emergency cases in 2021 compared to 2022, slightly decreased to 99.93%.

ISO KPI 3	TO ATTEND PATIENT BY DOCTOR WITHIN 25 MINUTES AFTER OUTPATIENT REGISTRATION FOR NON EMERGENCY CASE			
YEAR	TOTAL NUMBER OF PATIENT	TOTAL NUMBER OF PATIENT ATTENDED BY DOCTOR WITHIN 25 MIN	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	41575	0	95	100
2022	48367	0	95	99.52

Table 8: Percentage of attending patient within 25 minutes by doctor after outpatient registration for non-emergency case from year 2021 to 2022.

Based on the data obtained, Table 8 shows 100% of patient attended by doctor within 25 minutes after outpatient registration for non-emergency case in 2021 compared to 2022, slightly decreased to 99.52%.

CONCLUSION

All patients were attended immediately throughout 24 hours by Medical Officers and Staff Nurse or Medical assistant in 2021 and 2022. Priority treatment will be given to patient by MO and staffs according to the severity of complaints. Patients are attended to promptly once they are registered in e-HIS so that triage can be done according to the patient's condition. All patients triage to Malaysian Triage Category (MTC).

NURSING

INTRODUCTION

Nursing services is a large part of the entire health organization that aims to achieve the objectives of nursing services in prevention of diseases and promotion of health. Nursing Services is the backbone of the hospital and aims to meet the needs and deliver quality nursing care. The Nursing Services shall be organized, directed and coordinated with the other services in the Facility to provide nursing care in a safe, efficient and caring manner.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF INTRAVENOUS (I/V) LINE COMPLICATIONS (NEEDLES OUT, REDNESS OF SKIN, INFECTION SITES, EXTRAVASATION)			
YEAR	TOTAL NUMBER OF INTRAVENOUS (I/V) LINES SET UP DURING THE STUDY PERIOD	TOTAL NUMBER OF INCIDENCES OF (I/V) LINE SITE COMPLICATIONS AMONG IN-PATIENTS DURING THE STUDY PERIOD	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	8324	4	≤ 0.5	0.05
2022	8901	22	≤ 0.5	0.27

Table 1: Percentage of Intravenous (I/V) line complications from year 2021 to 2022

Based on the data obtained, Table 1 shows 2 years of trending on percentage of Intravenous (I/V) line complication from 2021 - 2022. In 2021, 0.05% Intravenous (I/V) line complication was recorded and increased to 0.27% in 2022. Although the cases are in increasing trend but target of less than 0.5% is still achieved. Continuous monitoring and implementation of peripheral intravenous cannula bundle care are being carried out to minimize the IV line complication.

MSQH KPI 2	PERCENTAGE OF CALL BELLS TO BE ATTENDED WITHIN 45 SECONDS			
YEAR	TOTAL NUMBER OF CALL	CALL BELLS ATTENDED WITHIN 45 SECONDS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	39031	37382	90	95.80
2022	65830	61118	90	93.00

Table 2: Percentage of call bells to be attended within 45 seconds from year 2021 to 2022

Based on the data obtained, Table 2 shows 2 years of trending on percentage of call bells to be attended within 45 seconds. In 2021, average percentage of call bells attended within 45 seconds is 95.80% with average BOR of 50.21%. For year 2022, average percentage of call bells attended within 45 seconds is 93.00% with average BOR of 58.61%. Overall, target of 90% is achieved. For continuous improvement, Nursing staff have been advised to note down events which caused deferment in attending to patients' calls. Nursing Supervisors were advised to screen the raw data before tabulation of the statistic.

CONCLUSION

Overall the Nursing Department has achieved the KPI targets throughout year 2021 and 2022 for percentage of Intravenous(I/V) line complication and percentage of call bells to be attended within 45 seconds.

This achievement is also in line with the objectives set by the Ministry of Health through the Malaysian Patient Safety Goals (MPSG). Based on the achievements of 2021 and 2022, the Nursing Department will further improve the efforts and quality of services provided to patient.

INFECTION CONTROL UNIT

INTRODUCTION

The Infection Control Unit plays a very important role in providing awareness and knowledge about preventive measures and the importance of nosocomial infection control to all employees of Putra Medical Center. Provide effective infection control services in preventing and controlling infectious diseases and further improve the quality and level of patient health and reduce infection rates.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF HEALTHCARE ASSOCIATED INFECTION (HCAI)			
YEAR	NUMBER OF HOSPITALISED PATIENTS IN THE HOSPITAL ON THE DAY OF SURVEY	NUMBER OF PATIENTS WITH HEALTHCARE ASSOCIATE INFECTION (HCAI) IN THE HOSPITAL ON THE DAY OF SURVEY	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	6943	0	< 5	0
2022	8565	0	< 5	0

Table 1: Percentage of Healthcare Associated Infection (HCAI) from year 2021 to 2022

Based on the data obtained, Table 1 shows there are no recorded cases of Healthcare Associated Infection in 2021 and 2022.

MSQH KPI 2(1)	PERCENTAGE OF STAFF TRAINED IN PREVENTION AND CONTROL OF INFECTION PRACTICES (EXISTING STAFF)			
YEAR	TOTAL NUMBER OF EXISTING STAFF IN THE FACILITY (ALL CATEGORIES INCLUDING ALL ON SITE OUTSOURCED SERVICE PROVIDERS) AT A GIVEN POINT OF TIME	TOTAL NUMBER OF EXISTING STAFF IN THE FACILITY (ALL CATEGORIES INCLUDING ALL ON SITE OUTSOURCED SERVICE PROVIDERS) WHO HAVE BEEN GIVEN TRAINING IN PREVENTION AND CONTROL OF INFECTION	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	2543	2389	85	94.05
2022	2509	2373	85	94.60

Table 2(1): Percentage of staff (existing staff) trained in prevention and control of infection practices from year 2021 to 2022

Based on the data obtained, Table 2(1) shows that 94.05% of existing staffs have been trained in prevention and control of infection practices in 2021 and 94.60% in 2022.

MSQH KPI 2(2)	PERCENTAGE OF STAFF TRAINED IN PREVENTION AND CONTROL OF INFECTION PRACTICES (NEW STAFF)			
YEAR	TOTAL NUMBER OF NEW STAFF IN THE FACILITY AT A GIVEN POINT OF TIME	TOTAL NUMBER OF NEW STAFF IN THE FACILITY WHO HAVE BEEN GIVEN TRAINING IN PREVENTION AND CONTROL OF INFECTION	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	29	29	85	100
2022	80	80	85	100

Table 2(2): Percentage of staff (new staff) trained in prevention and control of infection practices from year 2021 to 2022

Based on the data obtained, Table 2(2) shows that 100% of new staffs have been trained in prevention and control of infection practices in 2021 and 2022.

MSQH KPI 2(3)	PERCENTAGE OF STAFF TRAINED IN PREVENTION AND CONTROL OF INFECTION PRACTICES (INFECTION CONTROL NURSE)			
YEAR	TOTAL NUMBER OF INFECTION CONTROL NURSE IN THE FACILITY AT A GIVEN POINT OF TIME	TOTAL NUMBER OF INFECTION CONTROL NURSE IN THE FACILITY WHO HAVE BEEN GIVEN TRAINING IN PREVENTION AND CONTROL OF INFECTION	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1	1	100	100
2022	2	2	100	100

Table 2(3): Percentage of staff (Infection Control Nurse) trained in prevention and control of infection practices from year 2021 to 2022

Based on the data obtained, Table 2(3) shows that 100% of Infection Control Nurses have been trained in prevention and control of infection practices in 2021 and 2022.

KPI 3	NUMBER OF RESISTANT ORGANISMS TO ANTIBIOTICS WITHIN A SPECIFIED PERIOD OF TIME		
TYPE OF PHYTOGENS	TARGET	2021	2022
MRSA	≤ 0.3%	5 CASES (0.07%)	4 CASES (0.05)%
ESBL - KLEBSIELLA PNEUMONIA	≤ 0.3%	0 CASE (0%)	1 CASE (0.11%)
ESBL - E-COLI	≤ 0.2%	6 CASES (0.08%)	10 CASES (0.11%)

Table 3: Percentage number of resistant organisms to antibiotics within a specified period of time from year 2021 to 2022

Based on the data obtained, Table 3 shows the percentage of antimicrobial resistance over the 2 years period from 2021 to 2022.

	ENSURE 75% HAND HYGIENE COMPLIANCE LEVEL (HAND HYGIENE).			
YEAR	THE AMOUNT OF OPPORTUNITY HAND HYGIENE THAT IS MONITORED	THE AMOUNT OF HAND HYGIENE PRACTICED	TARGET (%)	ACHIEVEMENT (%)
2021	544	446	75	82
2022	544	466	75	86

Table 4: Hand Hygiene Compliance Level from year 2021 to 2022

Based on the data obtained, Table 4 shows the percentage of hand hygiene practiced has increased in 2022 as compared to 2021. In 2022, the percentage of achievement recorded was 86% as compared to 82% in 2021.

DISEASE/ YEARS	TOTAL NUMBER OF INFECTIOUS DISEASE	
	2021	2022
D/F	84	201
INFLUENZA A	1	281
INFLUENZA B	13	339
INFLUENZA A/B	2	111
HEP. B	0	2
FOOD POISONING	3	12
THYPOID	56	143
PTB	7	2
COVID 19	1708	4318
MEASLES	1	1
DYSENTRY	6	9
LEPTOSPIROSIS	5	17
HIV	1	1
CHIKUNGUNYA	1	0
MELLODOSIS	0	1
HFMD	9	258
S/TYPHI	2	0
TOTAL	**1899**	**5696**

Table 5: Total number of infectious disease from year 2021 to 2022

Based on the data obtained, Table 5 shows the total number of infectious diseases from 2021 to 2022. In 2021 the number of infectious diseases recorded was 1899 cases while in 2022 the number of infectious diseases has increased to 5696 cases.

CONCLUSION

As a whole, the Infection Control Unit has achieved the target set throughout the year 2021. Based on the achievements of 2021, the Infection Control Unit always strives to ensure that each KPI can be implemented well in providing quality services.

MEDICAL

INTRODUCTION

Putra Medical Centre does not have a specific ward for medical in-patient cases. However, the general wards accommodate majority of medical cases to enable the best medical care services to be provided to patients.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	DENGUE CASE FATALITY RATE		
YEAR	TOTAL NUMBER OF DENGUE CASE ADMISSION	NUMBER OF DEATH DUE TO DENGUE	PERCENTAGE (%)
2021	49	0	0
2022	115	0	0

Table 1: Percentage of dengue case fatality from year 2021 to 2022

Based on the data obtained, Table 1 shows the total number of admission for dengue case in 2021 (49 cases) and 2022 (115 cases). None of the patients died due to dengue.

MSQH KPI 2	PERCENTAGE OF UNPLANNED READMISSION WITHIN 72 HOURS OF DISCHARGE (FOR ADULT PATIENTS)		
Year	TOTAL NUMBER OF PATIENTS DISCHARGED DURING THE SAME PERIOD OF TIME THE NUMERATOR DATA WAS COLLECTED	NUMBER OF PATIENTS WITH UNPLANNED RE-ADMISSION TO THE WARD WITHIN 72 HOURS OF DISCHARGE	Average Percentage (%)
2021	1574	1	0.07
2022	2059	0	0.00

Table 2: Percentage of unplanned readmission within 72 hours of discharge (for adult patients) from year 2021 to 2022

Based on the data obtained, Table 2 shows 0.07% of unplanned readmission within 72 hours of discharge (for adult patients) in 2021 as compared to 0% in 2022.

CONCLUSION

Overall throughout year 2021 and 2022, the medical unit achieved the target that has been set by the hospital. PMC managed to maintain zero death due to dengue in year 2021 and 2022. Zero cases of unplanned readmission after 72 hours of discharge in 2022 is also a positive proof of the quality of the service provided.

SURGICAL

INTRODUCTION

Putra Medical Centre does not have a specific ward for surgery. The multi-discipline surgical cases (General Surgery / Urology / ENT / Ophthalmology) will be admitted to wards at Levels 3, 4, 5, 7 and 8 after surgery.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

KPI 1	PERCENTAGE OF UNPLANNED RE-ADMISSION WITHIN 72 HOURS OF DISCHARGE		
YEAR	TOTAL NUMBER OF PATIENTS DISCHARGED DURING THE SAME PERIOD OF TIME	NUMBER OF PATIENTS WITH UNPLANNED RE-ADMISSION TO THE WARD WITHIN 72 HOURS OF DISCHARGE	AVERAGE PERCENTAGE (%)
2021	1409	0	0
2022	2064	0	0

Table 1: Percentage of unplanned readmission within 72 hours of discharge from year 2021 to 2022

Based on the data obtained, Table 1 shows 0 cases of unplanned re-admission to the ward within 72 hours of discharge.

KPI 2	RATE OF UNPLANNED RETURN TO OPERATING THEATRE WITHIN THE SAME HOSPITAL ADMISSION FOLLOWING SURGERY			
YEAR	TOTAL NUMBER OF CASES UNDERGONE SURGICAL PROCEDURE UNDER GA IN THE MONTH	NUMBER OF CASES (OF UNPLANNED RETURN TO OT) AFTER A SURGICAL PROCEDURE UNDER GA REQUIRING FURTHER INTERVENTION DURING THE SAME ADMISSION IN THE MONTH	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1396	0	0	0
2022	1378	1	0	0.07

Table 2: Rate of unplanned return to operation theatre within the same hospital admission following surgery from year 2021 to 2022

Based on the data obtained, Table 2 shows 1 case of unplanned return to operating theatre within the same hospital admission following surgery in year 2022. No case recorded in 2021.

CONCLUSION

0 case of unplanned re-admission to the ward within 72 hours of discharge recorded in 2021 and 2022. 1 case of unplanned return to operation recorded in 2022 compare to 2021, 0 case recorded.

LABOUR ROOM & NURSERY

INTRODUCTION

Putra Medical Centre maternity ward and nursery are licensed with 3 single delivery rooms and 5 bassinets under the care of nursing supervisor, midwives, and trained staff nurses. Deliveries are conducted by O&G consultants assisted by midwives. Labour room is located at Level 2 Old Wing.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF MASSIVE PRIMARY POST-PARTUM HAEMORRHAGE (PPH) INCIDENCE IN CASES DELIVERED IN THE HOSPITAL (EXCLUSION CRITERIA : PLACENTA PREVIA AND ADHERENCE PLACENTA)			
YEAR	TOTAL NUMBER OF DELIVERIES (ALL MODES OF DELIVERY) IN THE HOSPITAL	NUMBER OF PATIENTS WITH MASSIVE PRIMARY POST-PARTUM HAEMORRHAGE (PPH) IN THE HOSPITAL	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1341	2	<0.5	0.14
2022	1111	0	<0.5	0.00

Table 1: Percentage of massive primary post-partum haemorrhage (PPH)

Based on the data obtained, Table 1 shows percentage of massive primary post-partum haemorrhage (PPH) incident in cases delivered at the hospital (exclusion criteria: Placenta previa and adherence placenta) from the year 2021 to 2022. 0.14% of massive PPH in Labour Room was recorded in 2021 and 0% recorded in 2022.

MSQH KPI 2	COMPLICATION RATE FROM INSTRUMENTAL/VAGINAL DELIVERIES: INCIDENCE OF 3RD AND 4TH DEGREE TEARS			
YEAR	TOTAL NUMBER OF INSTRUMENTAL/VAGINAL DELIVERIES	TOTAL NUMBER OF PATIENTS WITH COMPLICATIONS FROM INSTRUMENTAL/VAGINAL DELIVERIES	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	781	0	<10	0
2022	691	0	<10	0

Table 2: Complication rate from instrumental/vaginal deliveries: Incidence of 3rd and 4th degree tears in 2021 and 2022

Based on the data obtained, Table 2 shows the rate of complication from instrumental/vaginal deliveries incidence of 3rd and 4th degree tears is 0% throughout the entire two years from 2021 to 2022.

MSQH KPI 3(1)	EMERGENCY CAESAREAN RATES			
YEAR	TOTAL NUMBER OF DELIVERY CASES DURING A SPECIFIC PERIOD	TOTAL NUMBER OF EMERGENCY CAESAREAN SECTIONS CONDUCTED DURING A SPECIFIC PERIOD	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1341	183	<30	13.58
2022	1111	168	<30	15.24

Table 3(1): Percentage of emergency caesarean

Based on the data obtained, Table 3(1) shows the percentage of emergency caesarean with 13.58% recorded in 2021 as compared to 15.24% in 2022.

MSQH KPI 3(2)	ELECTIVE CAESAREAN RATES			
YEAR	TOTAL NUMBER OF DELIVERY CASES DURING A SPECIFIC PERIOD	TOTAL NUMBER OF ELECTIVE CAESAREAN SECTIONS CONDUCTED DURING A SPECIFIC PERIOD	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1341	377	<30	27.93
2022	1111	248	<30	22.14

Table 3(2): Percentage of elective caesarean

Based on the data obtained, Table 3(2) shows the percentage of elective caesarean with 27.93% recorded in 2021 as compared to 22.14% in 2022.

MSQH KPI 4	MATERNAL MORTALITY RATE (SENTINEL EVENT)			
YEAR	TOTAL NUMBER OF LIVE BIRTHS	TOTAL NUMBER OF MATERNAL DEATHS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1341	0	0	0
2022	1110	0	0	0

Table 4: Maternal mortality rate

Based on the data obtained, Table 4 shows the maternal mortality rate which recorded 0% in 2021 and 2022.

ISO KPI 1	PERCENTAGE OF SWABBING WITHIN 1 HOUR AFTER DELIVERY FOR NORMAL DELIVERY			
YEAR	TOTAL VAGINAL DELIVERY	NO OF SWABBING MORE THAN 1 HOUR AFTER DELIVERY	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	781	0	100	100
2022	691	0	100	100

Table 5: Percentage of swabbing within 1 hour after delivery for normal delivery

Based on the data obtained, Table 5 shows 100% of swabbing within 1 hour after delivery for normal delivery recorded from 2021 to 2022.

ISO KPI 2	0 INCIDENT BABY GIVE TO WRONG MOTHER			
YEAR	TOTAL DELIVERY	NO OF INCIDENT BABY GIVE TO WRONG MOTHER	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1341	0	0	0
2022	1111	0	0	0

Table 6: Incident baby give to wrong mother

Based on the data obtained, Table 6 shows 0% incident of baby given to wrong mother for 2021 and 2022.

CONCLUSION

2 incidents of massive primary post-partum haemorrhage recorded from the month of January until December in 2021. The rest of KPIs achieved the set target.

PAEDIATRIC

INTRODUCTION

The pediatric ward is located at Level 5 and offers treatment services to children from age of 1 day to 16 years old.

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KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF PAEDIATRIC PATIENTS WITH UNPLANNED RE-ADMISSION FOR THE SAME CONDITION WITHIN 48 HOURS OF DISCHARGE			
YEAR	TOTAL NUMBER OF PAEDIATRIC PATIENTS DISCHARGED DURING THE SAME PERIOD OF TIME THE NUMERATOR DATA WAS COLLECTED	NUMBER OF PAEDIATRIC PATIENTS WITH UNPLANNED READMISSION TO THE PAEDIATRIC WARD/HOSPITAL WITHIN 48 HOURS OF DISCHARGE	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1097	0	≤ 2	0
2022	2144	1	≤ 2	0.45

Table1: Percentage of Paediatrics Patients with unplanned readmission for the same condition within 48 hours of discharge from year 2021 to 2022

Table 1 shows in 2021 there is no cases of unplanned re-admission while in 2022 there is 1 case of unplanned readmission with percentage of 0.45%.

MSQH KPI 2	COMMUNITY ACQUIRED PNEUMONIA DEATH RATE IN PREVIOUSLY HEALTHY CHILDREN AGED BETWEEN ONE (1) MONTH AND FIVE (5) YEARS			
YEAR	TOTAL NUMBER OF CASES ADMITTED FOR COMMUNITY ACQUIRED PNEUMONIA AMONG PREVIOUSLY HEALTHY CHILDREN AGED BETWEEN 1 MONTH AND 5 YEARS	NUMBER OF DEATHS DUE TO COMMUNITY ACQUIRED PNEUMONIA AMONG PREVIOUSLY HEALTHY CHILDREN AGED BETWEEN 1 MONTH AND 5 YEARS	TARGET (%)	ACHIEVEMENT (%)
2021	50	0	≤ 1	0
2022	168	0	≤ 1	0

Table 2: Percentage of Community Acquired Pneumonia death rate from year 2021 to 2022

Based on the data obtained, Table 2 shows in 2021 and 2022, there is no cases of death due to Community Acquired Pneumonia among children aged between one (1) month and five (5) years.

MSQH KPI 3	NUMBER OF MORTALITY AND MORBIDITY AUDIT/ MEETINGS BEING CONDUCTED WITH DOCUMENTATION OF CASES DISCUSSED
Year	No of meeting/ audit conducted
2021	0
2022	2

Table 3: Number of mortality and morbidity audits/ meeting from year 2021 to 2022

Based on the data obtained, there is no meeting / audit conducted with documentation of cases discussed 2021, while there are 2 cases recorded in 2022.

	NUMBER OF CHILDREN DEATH UNDER FIVE (5)	
Year/ Diagnosis	2021	2022
Septicaemia with Severe Bronchopneumonia	0	0
Bronchopneumonia with Septicaemia Shock	0	0
Others	0	2

Table 4: Number of Children Death under five (5) from year 2021 to 2022

Based on the data obtained, there were no cases of children death under 5 years of age due to Septicemia with Severe Bronchopneumonia and Bronchopneumonia with Septicemia Shock in 2021 and 2022, but there were 2 cases of death due to other causes recorded in 2022.

CONCLUSION

In 2021 and 2022, there are no cases of death of children aged between one (1) and five (5) years caused by Community Acquired Pneumonia. This directly shows that we have delivered good quality health services.

CARDIOLOGY

INTRODUCTION

The Invasive Cardiac Catheterization Laboratory is situated at Level 1 Old Wing of Putra Medical Centre. This unit provides a comprehensive program available for patients with cardiovascular disease. It offers a wide variety of non-invasive and invasive laboratory services, providing the medical specialist with detailed clinical information about their patient.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	RATE OF "NORMAL" DIAGNOSTIC CORONARY ANGIOGRAM			
YEAR	TOTAL NUMBER OF PATIENTS WHO HAD CORONARY ANGIOGRAM DONE	NUMBER OF PATIENTS WHO HAD CORONARY ANGIOGRAM DONE AND FOUND 'NORMAL'	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	41	19	< 5	38.19
2022	42	4	< 5	11.39

Table 1: Rate of "normal" diagnostic coronary angiogram from year 2021 to 2022

Based on the data obtained, Table 1 shows the percentage of Normal Diagnostic Angiogram recorded in 2021 which is 38.19%. However the percentage has decreased to 11.39% in 2022 which showed an improvement even though the target of less than 5% was not met.

MSQH/ISO KPI 2	MAJOR COMPLICATION RATE DURING DIAGNOSTIC CORONARY ANGIOGRAM			
YEAR	TOTAL NUMBER OF PATIENTS WHO HAD DIAGNOSTIC CORONARY ANGIOGRAM DONE	NUMBER OF PATIENTS WHO HAD MAJOR COMPLICATIONS DURING/AND WITHIN 24 HOURS AFTER DIAGNOSTIC CORONARY ANGIOGRAM	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	41	0	< 1.0	0
2022	42	0	< 1.0	0

Table 2: Rate of major complication during Diagnostic Coronary Angiogram from year 2021 to 2022

Based on the data obtained, Table 2 shows no major complication during diagnostic Coronary Angiogram from year 2021 to 2022.

MSQH KPI 3	MAJOR COMPLICATION RATES DURING PERCUTANEOUS CORONARY INTERVENTION			
YEAR	TOTAL NUMBER OF PATIENTS WHO HAD PERCUTANEOUS CORONARY INTERVENTION DONE	NUMBER OF PATIENTS WHO HAD MAJOR COMPLICATIONS DURING/AND WITHIN 24 HOURS AFTER PERCUTANEOUS CORONARY INTERVENTION	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	12	0	< 1	0
2022	13	0	< 1	0

Table 3: Rate of major complication during Percutaneous Coronary Intervention from year 2021 to 2022

Based on the data obtained, Table 3 shows no major complication during Percutaneous Coronary Intervention from year 2021 to 2022.

MSQH KPI 4	PERCUTANEOUS CORONARY INTERVENTION (PCI) WITHIN 90 MINUTES AFTER HOSPITAL ARRIVAL " DOOR TO BALLOON" TIME			
YEAR	TOTAL NUMBER OF ACUTE MYOCARDIAL INFARCTION PATIENTS ADMITTED AND HAD PRIMARY PCI DONE	NUMBER OF ACUTE MYOCARDIAL INFARCTION PATIENTS WHO HAD PRIMARY PCI DONE WITHIN 90 MINUTES AFTER HOSPITAL ARRIVAL	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	0	0	90	0
2022	0	0	90	0

Table 4: No. of Percutaneous Coronary Intervention (PCI) within 90 minutes after hospital arrival "door to balloon" time.

Based on the data obtained, Table 4 shows no cases recorded for Percutaneous Coronary Intervention (PCI) within 90 minutes after hospital arrival "door to balloon" time from 2021 to 2022.

CONCLUSION

The rate for "normal" diagnostic angiogram decreased in 2022 as compared to 2021. The target was not achieved due to smaller number of patients. 0 case of major complication during Diagnostic Coronary Angiogram and Percutaneous Coronary Angiogram was recorded in 2021 and 2022. No case of Percutaneous Coronary Intervention (PCI) within 90 minutes after hospital arrival "door to balloon" time in 2021 and 2022.

ORTHOPAEDIC UNIT

INTRODUCTION

The Orthopedic department has two sections, and they are the Orthopaedic Clinic and Orthopaedic Ward. The Orthopaedic Clinics are located on Ground Floor and Level 2, while the Orthopaedic Ward is sharing with other disciplines and are located on Level 3 Old Wing, Level 4 New Wing, Level 5, Level 7 and Level 8.The operating room for orthopaedic surgery is located on Level 1 New Wing.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF UNPLANED RE-ADMISSION WITHIN 72 HOURS DISCHARGE			
YEAR	TOTAL NUMBER OF PATIENTS DISCHARGED DURING THE SAME PERIOD OF TIME THE NUMERATOR DATA WAS COLLECTED	NUMBER OF PATIENTS WITH UNPLANNED RE-ADMISSION TO THE WARD WITHIN 72 HOURS OF DISCHARGE	TARGET (%)	ACHIEVEMENT (%)
2021	1158	0	-	0
2022	1267	0	-	0

Table 1: Percentage of Unplanned Re-Admission within 72 hours discharge from year 2021 to 2022

Based on the above table, there is no unplanned re-admission within 72 hours of discharge recorded for both years 2021 and 2022.

MSQH KPI 2	RATE OF UNPLANNED RETURN TO OPERATING THEATRE WITHIN THE SAME HOSPITAL ADMISSION FOLLOWING SURGERY			
YEAR	TOTAL NUMBER OF CASES UNDERGONE SURGICAL PROCEDURE UNDER GA IN THE MONTH	NUMBER OF CASES (OF UNPLANNED RETURN TO OT) AFTER A SURGICAL PROCEDURE UNDER GA REQUIRING FURTHER INTERVENTION DURING THE SAME ADMISSION IN THE MONTH	TARGET (%)	ACHIEVEMENT (%)
2022	131	0	0	0

Table 2: Rate of unplanned return to operating theatre within the same hospital admission following surgery

Based on the above table, there is no unplanned return to operating theatre within the same hospital admission following surgery from July to December 2022.

	TOTAL NUMBER OF CASE UNDERGO SURGICAL PROCEDURE UNDER GA (JULY -DECEMBER 2022)
YEAR	PROCEDURE UNDER GA
2022	113

Table 3: Total number of case undergo surgical procedure from July - December 2022.

Based on the data obtained, total case undergo surgical procedure under GA is 113 from July 2022 until Dec 2022.

CONCLUSION

No cases of readmission of patients after discharge within 72 hours to the ward illustrates a good standard of healthcare services.

OPERATION THEATRE

INTRODUCTION

The Operating Room Unit provides surgical expertise services from various disciplines to patients. Operation Theatre is located at Level 1 New Wing. This unit is equipped with 3 operating rooms, has a connecting door to HDU and also CSSD to facilitate the management of sterile items. The Hospital's Clinical Committee, namely the Operation Theater (OT) Committee, is made up of multi-disciplinary surgeons and is responsible for improving the clinical management of this Unit.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	RATE OF COMPLIANCE TO SAFE SURGERY SAVES LIVES (SSSL) PRACTICE			
YEAR	TOTAL NUMBER OF CASES OPERATED UNDER GENERAL/REGIONAL ANAESTHESIA IN A MONTH	NUMBER OF CASES WHERE WHO SURGICAL CHECKLIST WAS USED FOR EACH PATIENT THAT HAD UNDERGONE SURGERY (EVIDENCE OF COPY OF THE CHECKLIST)	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	3032	3032	100	100
2022	3020	3020	100	100

Table1: Compliance rate to Safe Surgery Safe Lives (SSSL) practices

Based on the data obtained, Table 1 shows 100% achievements recorded throughout the year 2021 to 2022.

MSQH/ISO KPI 2	PERCENTAGE OF ELECTIVE OPERATION CANCELLATION			
YEAR	TOTAL NUMBER OF ELECTIVE SURGERY SCHEDULED IN THE CORRESPONDING PERIOD	NUMBER OF ELECTIVE SURGERY CANCELLED IN THE CORRESPONDING PERIOD	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	2698	78	<10	2.75
2022	2795	122	<10	4.46

Table 2: Percentage of elective operation cancellation from 2021 to 2022

Based on the data obtained, Table 2 shows 2.75% of elective operation cancellation recorded in 2021, with a slight increase to 4.46% in 2022.

MSQH KPI 3	PERCENTAGE OF PATIENTS AWAITING EMERGENCY SURGERY FOR MORE THAN 24 HOURS DUE TO LACK OF OT TIME			
YEAR	TOTAL NUMBER OF ELECTIVE SURGICAL PROCEDURE PERFORMED UNDER GENERAL ANAESTHESIA/ REGIONAL ANAESTHESIA/ MONITORED SEDATION/LA	TOTAL NUMBER OF PATIENTS WHO WAITED MORE THAN (>)24 HOURS FOR EMERGENCY OPERATION UNDER GENERAL ANAESTHESIA/REGIONAL ANAESTHESIA/MONITORED SEDATION/LA DUE TO LACK OF OT TIME	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	412	0	<1	0.00
2022	325	0	<1	0.00

Table 3: Percentage of patients awaiting emergency surgery for more than 24 hours due to lack of OT time from 2021 to 2022

Based on the data obtained, Table 3 shows 0% of patients awaiting emergency surgery for more than 24 hours due to lack of OT time from 2021 to 2022.

MSQH KPI 4	NUMBER OF PATIENTS RETURNING TO SURGERY WITHIN 24 HOURS			
YEAR	TOTAL NUMBER OF EMERGENCY SURGERIES DONE UNDER GENERAL ANAESTHESIA/REGIONAL ANAESTHESIA/ MONITORED SEDATION/LA	NUMBER OF PATIENTS RETURNING TO OT/SURGERY WITHIN 24 HOURS FOLLOWING AN ELECTIVE SURGICAL PROCEDURE	TARGET (CASE)	AVERAGE ACHIEVEMENT (CASE)
2021	1431	0	0	0.00

Table 4: Number of patients returning to surgery within 24 hours(July to December 2022)

Based on the data obtained, Table 4 shows 0 case of patient returning to surgery within 24 hours in 2022(July to December).

MSQH KPI 5	NUMBER OF INCIDENTS REPORTED IN THE OPERATING ROOM		
YEAR	NUMBER OF INCIDENTS (CLINICAL) REPORTED IN THE OPERATING THEATRE	TARGET (CASE)	AVERAGE ACHIEVEMENT (CASE)
2021	0	0	0.00

Table 5: Number of incidents reported in the Operating Room (July to December 2022)

Based on the data obtained, Table 5 shows 0 case of incidents reported in OT (July to December 2022).

ISO KPI 1	CASE OF AIR SAMPLING RESULT ABOVE 10 CFU (COLONY-FORMING UNIT)
YEAR	RESULT OF AIR SAMPLING - COLONY FORMING UNIT (ABOVE 10 CFU)
2021	0 CASE
2022	0 CASE

Table 6: Case of air sampling result above 10 CFU (Colony-Forming Unit) from 2021 to 2022

Based on the data obtained, Table 6 shows 0 case of air sampling result above 10 CFU (Colony-Forming Unit) recorded from 2021 to 2022.

CONCLUSION

Overall KPIs achieved the set target. Safe Surgery Save lives (SSSL) achieves the KKM objectives set through the Malaysian Patient Safety Goals (MPSG). The improvement of operating room facilities is parallel with the technological development and will be able to increase the services offered and the number of annual cases.

ANESTHESIOLOGY UNIT

INTRODUCTION

Anesthesia services are carried out by Anesthesiologists who are certified and registered with the National Specialist Registry (NSR) and have been given special rights (privileged) by the Hospital. OT has 3 Resident Anesthesiologists.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

KPI 1	PAIN SCORE ON DISCHARGE FROM RECOVERY ROOM SHOULD BE LESS THAN FOUR (4)			
Year	TOTAL NUMBER OF PATIENTS OBSERVED AND MONITORED IN THE OT RECOVERY ROOM FOR THE MONTH	NUMBER OF PATIENTS WITH PAIN SCORE LESS THAN FOUR (4) ON DISCHARGE FROM THE OT RECOVERY ROOM FOR THE MONTH	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	936	935	100	100
2022	985	985	100	100

Table 1: Percentage of pain score on discharge from recovery room should be less than four (4) for the years 2021 and 2022.

Based on Table 1, 0 patient with a pain score of more than 4 on discharge from the OT recovery room recorded in 2021 and 2022.

KPI 2	NUMBER OF PATINETS HAVING PROLONGED STAY IN RECOVERY ROOM FOR MORE THAN TWO(2) HOURS (SENTINEL EVENT)	
YEAR	TOTAL PATIENT UNDER GENERAL ANAESTHESIA	NUMBER OF PATIENTS HAVING PROLONGED STAY IN RECOVERY ROOM (> 2 HRS) HOURS
2021	936	0
2022	985	0

Table 2: Number of patients having prolonged stay in recovery room for more than two(2) hours (sentinel event) in 2021 and 2022

Based on Table 2, 0 patients having prolonged stay in recovery room for more than two (2) hours (sentinel event) recorded in 2021 and 2022.

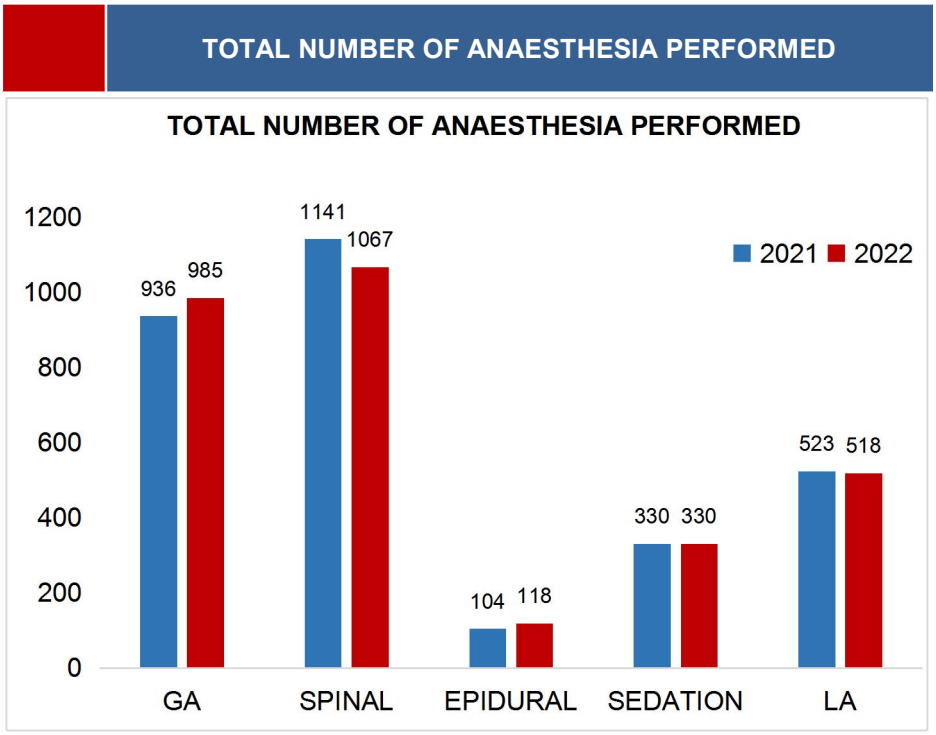

Diagram 1: Graph of the total number of anesthesia performed from 2021 to 2022

Diagram 1 shows the total number of anesthesia performed from 2021 to 2022. There was a total of 3018 anesthesia performed in 2022 and 3034 in 2021.

CONCLUSION

Overall, 0 patient with a pain score of more than 4 on discharge from the OT recovery room was recorded in 2021 and 2022. 0 patient having prolonged stay in recovery room for more than two(2) hours (sentinel event) in 2021 and 2022. The target is achieved for both KPIs.

CENTRAL SUPPLY STERILE DEPARTMENT (CSSD)

INTRODUCTION

The Central Supply Sterile Department (CSSD) is located on Level 1 next to the Operating Room. This department provides sterilization services and supply quality sterile equipment to all related departments.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF STERILE INSTRUMENT SETS REJECTED			
YEAR	TOTAL NUMBER OF INSTRUMENT SETS STERILIZED	TOTAL NUMBER OF REJECT STERILE INSTRUMENT SETS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1295	0	< 5	0.00
2022	1288	0	< 5	0.00

Table 1: Percentage of sterile instrument sets rejected in 2021 to 2022

Based on the data obtained, Table 1 shows 0% of sterile sets rejected in 2021 and 2022.

MSQH KPI 2	PERCENTAGE OF INCIDENTS REPORTED MONTHLY THAT HAVE HAD ROOT CAUSE ANALYSIS (RCA) DONE AND ACTION TAKEN TO PREVENT RECURRENCE			
YEAR	PERCENTAGE OF INCIDENTS REPORTED MONTHLY THAT HAVE HAD ROOT CAUSE ANALYSIS (RCA) DONE AND ACTION TAKEN TO PREVENT RECURRENCE	NUMBER OF INCIDENTS REPORTED AND WHERE ROOT CAUSE ANALYSIS IS DONE AND ACTIONS TAKEN	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	0	0	100	0
2022	0	0	100	0

Table 2: Percentage of incidents reported monthly that have had root cause analysis (RCA) done and action taken to prevent recurrence from year 2021 to 2022

Based on the data obtained, Table 2 shows no incident reported from year 2021 to 2022.

ISO KPI 1	0 CASE OF SHORT OF SURGICAL INSTRUMENT IN THE SET			
YEAR	TOTAL NUMBER OF OT CASES	TOTAL NUMBER OF SHORT OF INSTRUMENTS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	3032	0	0	0
2022	2624	0	0	0

Table 3: Case of short of surgical instrument in the set from year 2021 to 2022

Based on the data obtained, Table 3 shows 0 case of short of surgical instrument in the set recorded in 2021 and 2022.

CONCLUSION

Overall, 0 rejection rate of sterile sets by end users, especially the Operating Theatre and also 0 case of short of surgical instrument in the set reported in 2021 and 2022, and 0 case of incidence reported in CSSD. This shows that the CSSD is effectively run.

HIGH DEPENDENCY UNIT (HDU)

INTRODUCTION

High Dependency Unit (HDU) is a multidisciplinary unit located on Level 1 New Wing of Putra Medical Centre (PMC) next to the Operating Theatre. This unit provides services to all critically ill patients who require intensive care or life support assistance in a safe and comfortable environment. The unit is equipped with 10 beds including an isolation room.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	RATE OF PRESSURE ULCER			
YEAR	TOTAL NUMBER OF PATIENTS ADMITTED TO THE CRITICAL CARE UNIT DURING THE MONTH	NUMBER OF PATIENTS WHO DEVELOPED NEW PRESSURE ULCERS (INCLUDING THOSE WITH PRE-ADMISSION PRESSURE SORES WHICH HAVE WORSENED) DURING THEIR STAY IN THE CRITICAL CARE UNIT IN THE MONTH	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	299	16	<3	4.80
2022	372	2	<3	0.50

Table 1: Rate of pressure ulcers from year 2021 to 2022

Based on the data obtained, Table 1 shows rate of pressure ulcer in HDU which was 4.80% in 2021 and reduced to 0.50% in year 2022.

MSQH KPI 2	RATE OF UNPLANNED EXTUBATION			
YEAR	TOTAL NUMBER OF PATIENTS INVASIVELY VENTILATED IN THE CRITICAL CARE UNIT	NUMBER OF UNPLANNED EXTUBATION IN THE CRITICAL CARE UNIT	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	28	0	<5	0
2022	43	0	<5	0

Table 2: Percentage rate of unplanned extubation from year 2021 to 2022

Based on the data obtained, Table 2 shows rate of unplanned extubation in HDU is 0% throughout the 2021 and 2022.

MSQH KPI 3	RATE OF CATHETER RELATED BLOOD STREAM INFECTION			
YEAR	TOTAL NUMBER OF PATIENTS - DAYS WITH CENTRAL VENOUS CATHETER/S IN THE CRITICAL CARE UNIT	NUMBER OF PATIENTS WHO DEVELOPED CATHETER-RELATED BLOOD STREAM INFECTION	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	18	0	<5 PER 1000 CATHERER DAYS	0
2022	15	0	<5 PER 1000 CATHERER DAYS	0

Table 3: Percentage rate of Catheter Related Blood Stream Infection from year 2021 to 2022

Based on the data obtained, Table 3 shows 0% of catheter related blood stream infection in HDU for 2021 and 2022.

ISO KPI 1	PERCENTAGE OF ADMITTED HDU PATIENT FREE FROM PHEBLITIS DURING LENGTH OF STAY			
YEAR	TOTAL NUMBER OF HDU PATIENT	NO OF HDU PATIENT FREE FROM PHEBLITIS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	331	331	90%	100
2022	378	371	90%	98.05

Table 4: Percentage of admitted HDU patient free from pheblitis during length of stay from year 2021 to 2022

Based on the data obtained, Table 4 shows 100% of admitted HDU patients free from phlebitis during length of stay in 2021 and 98.05% in 2022.

CONCLUSION

The number of patients getting pressure ulcer in 2022 decreased compared to 2021 due to staff's awareness on handling patient and the usage of ripple mattress / KAP mattress for critical ill patient / intubated patient. There was no unplanned extubation from year 2021 until 2022. The average number of patients who developed catheter related blood stream infection in 2022 is 0% due to staff awareness on the importance of proper handling of Central Venous Line (CVL) to prevent Catheter-related bloodstream Infection (CRBSI) in patients. More than 90% of HDU patients are free from pheblitis in 2021 and 2022.

DIALYSIS

INTRODUCTION

The Dialysis Department in Putra Medical Centre is equipped with 2 Toray and 7 Dialog Machines with water treatment system. The Dialysis Department is situated at Level 3 Old Wing.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	CATHETER RELATED BLOOD STREAM INFECTION (CRBSI) SHOULD NOT BE MORE FREQUENT THAN 3:1000			
YEAR	TOTAL DIALYSIS PATIENT	CATHETER RELATED BLOOD STREAM INFECTION (CRBSI)	TARGET	AVERAGE ACHIEVEMENT (%)
2021	387	0	NOT BE MORE FREQUENT THAN 3:1000	0
2022	347	0	NOT BE MORE FREQUENT THAN 3:1000	0

Table 1: Percentage of Catheter Related Blood Stream Infection (CRBSI) should not be more frequent than 3:1000 from year 2021 to 2022

Based on the data obtained, Table 1 shows 0% of Catheter Related Blood Stream Infection (CRBSI) recorded from year 2021 to 2022.

MSQH KPI 2	ANNUAL MORTALITY RATE FOR DIALYSIS PATIENT TAKING OF ALL FACTORS SHOULD NOT BE MORE THAN 15%			
YEAR	TOTAL DIALYSIS PATIENT	NO OF MORTALITY CASE	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	387	0	NOT BE MORE THAN 15%	0
2022	347	0	NOT BE MORE THAN 15%	0

Table 2: Annual mortality rate for dialysis patient taking of all factors from year 2021 to 2022

Based on the data obtained, Table 2 shows 0% of annual mortality rate for dialysis patient taking of all factors recorded from year 2021 to 2022.

MSQH KPI 3	AVERAGE PERCENTAGE OF DIALYSIS PATIENTS ACHIEVED THEIR TRANSFERRIN SATURATION (TSATS) > 20% (SAMPLE TAKEN IN EVERY 4 MONTHS)			
YEAR	AVERAGE DIALYSIS PATIENT	AVERAGE DIALYSIS PATIENTS ACHIEVED THEIR TRANSFERRIN SATURATION (TSATS)	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	33	27	80	81.81
2022	28	21	80	77.29

Table 3: Average percentage of dialysis patients achieved their Transferrin Saturation (TSATS) > 20% (sample taken in every 4 months) from year 2021 to 2022

Based on the data obtained, Table 3 shows the average percentage of dialysis patients achieved their Transferrin Saturation (TSATS) > 20% in 2021 which is 81.81% and slightly decreased to 77.29% in 2022.

MSQH/ISO KPI 4	AVERAGE PERCENTAGE OF DIALYSIS PATIENTS ACHIEVED THEIR HEMOGLOBIN > 10GM AND ABOVE (SAMPLE TAKEN IN EVERY 3 MONTHS)			
YEAR	AVERAGE DIALYSIS PATIENT	AVERAGE DIALYSIS PATIENTS ACHIEVED THEIR HEMOGLOBIN	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	32	23	70	72.03
2022	28	19	70	66.85

Table 4: Average percentage of dialysis patients achieved their Hemoglobin > 10gm and above (sample taken in every 3 months) from year 2021 to 2022

Based on the data obtained, Table 4 shows the average percentage of dialysis patients achieved their Hemoglobin > 10gm and above in 2021 which is 72.03% and decreased to 66.85% in 2022.

MSQH/ISO KPI 5	AVERAGE PERCENTAGE OF DIALYSIS PATIENTS ACHIEVED THEIR U.R.R. >65% (SAMPLE TAKEN IN EVERY 3 MONTHS)			
YEAR	AVERAGE DIALYSIS PATIENT	NO. OF DIALYSIS PATIENTS ACHIEVED THEIR U.R.R. >65%	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	32	28	85	86.83
2022	28	20	85	71.13

Table 5: Average percentage of dialysis patients achieved their U.R.R. >65% (sample taken in every 3 months) from year 2021 to 2022

Based on the data obtained, Table 5 shows the average percentage of dialysis patients achieved their U.R.R. >65% in 2021 which is 86.83% and decrease to 71.13% in 2022.

ISO KPI 1	PERCENTAGE OF DIALYSIS PATIENT COMPLETE THEIR 4 HOURS TREATMENT WITHOUT COMPLICATION			
YEAR	Total Treatment	No of Dialysis Patient Completed their 4 Hours Treatment Without Complication	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	4774	4697	95	98.39
2022	4309	4253	95	98.70

Table 6: Percentage of dialysis patient complete their 4 hours treatment without complication from year 2021 to 2022

Based on the data obtained, Table 6 shows the percentage of dialysis patient completed their 4 hours treatment without complication in year 2021 which is 98.39% and increased to 98.70 in 2022.

CONCLUSION

Majority of the KPIs achieved the set targets in 2021 compared to 2022. Effective action plans will be implemented in order to improve the services delivered to patient.

MORTUARY UNIT

INTRODUCTION

The PMC mortuary receives patients who have passed on and no readily available relatives to bring the deceased home immediately. It is also storage for amputated body parts, which are not collected immediately. The deceased will be treated with almost respect and dignity is preserved.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

KPI 1	PERCENTAGE OF BODIES RELEASED TO THE RIGHT NEXT OF KIN/ CLAIMANT			
YEAR	TOTAL NUMBER OF BODIES RECEIVED IN THE MORTUARY DURING THE MONTH	NUMBER OF BODIES RELEASED TO THE RIGHT NEXT OF KIN/ CLAIMANT	TARGET (%)	ACHIEVEMENT (%)
2021	74	74	≥ 99	100
2022	75	75	≥ 99	100

Table 1: Percentages of bodies released to the the right next of kin/claimant in year 2021 to 2022

Based on the data obtained, Table 1 shows 100% of bodies released to the right next of kin / claimant throughout 2021 and 2022.

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KPI 2	TURNAROUND TIME OF< 3 HOURS FOR RELEASING BODIES (NON- POLICE CASES)TO THE NEXT OF KIN/CLAIMANT			
YEAR	TOTAL NUMBER OF BODIES RECEIVED (NON-MEDICO-LEGAL CASES) IN THE MORTUARY DURING THE MONTH	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	TARGET (%)	ACHIEVEMENT (%)
2021	91	91	≥ 80	100
2022	75	75	≥ 80	100

Table 1: Percentages of bodies released to the the right next of kin/claimant in year 2021 to 2022

Based on the data obtained, Table 2 shows 100% of bodies released to the right next of kin / claimant less than 3 hours throughout 2021 and 2022.

CONCLUSION

The indicator reflects the efficiency of the Mortuary Services. 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. All bodies were released to correct next-of-kin/claimant for 2021 and 2022. Staff adopting the process of correct identifications in the Patient Safety Goals policy. All bodies were released to next of kin within 3 hours from the time received in the mortuary for 2021 and 2022.

ADMISSION & RECORDS DEPARTMENT

INTRODUCTION

Admission and Records Department is responsible for registering outpatient and inpatient before getting their treatment at Putra Medical Centre (PMC). Located at Ground Floor of the hospital, this department is also responsible for assisting patient under insurance to request for Guarantee Letter.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH/ISO KPI 1	AVERAGE TIME TO REGISTER ADMISSION WITHIN 9 MINUTES (ONLY APPLICABLE WHERE BED IS AVAILABLE)			
YEAR	TOTAL NUMBER OF ADMISSION	TOTAL TIME TO REGISTER ADMISSION	TARGET (MINUTES)	AVERAGE ACHIEVEMENT (MINUTES)
2021	6943	58574	10	8.42
2022	8565	61756	9	7.25

Table 1: Average time to register admission within 9 minutes from year 2021 to 2022

Based on the data obtained, Table 1 shows the average time to register for admission in 2021 is 8.42 minutes as compared to 7.25 minutes in 2022.

ISO KPI 2	ZERO MISTAKE IN IN-PATIENT PATIENT INFORMATION CAUSED BY FRONT DESK	
YEAR	TOTAL NUMBER OF ADMISSION	NO. OF MISTAKE DURING REGISTRATION TARGET: 0 MISTAKE
2021	6943	1
2022	8565	0

Table 2: Number of mistake during in-patient registration from year 2021 to 2022

Based on the data obtained, Table 2 shows the number of mistake in in-patient patient information caused by front desk for year 2021 (1 case) and 2022 (0 case).

CONCLUSION

In summary, KPI of average time to register admission was achieved for 2021 and 2022. 0 case of mistake in in-patient patient information caused by front desk was recorded in 2022 as compared to 1 case recorded in 2021.

OCCUPATIONAL HEALTH, SAFETY AND ENVIRONMENT

INTRODUCTION

Putra Medical Centre (PMC) has a fundamental responsibility and commitment to provide employees with a safe and healthy environment in their workplace and surrounding area.

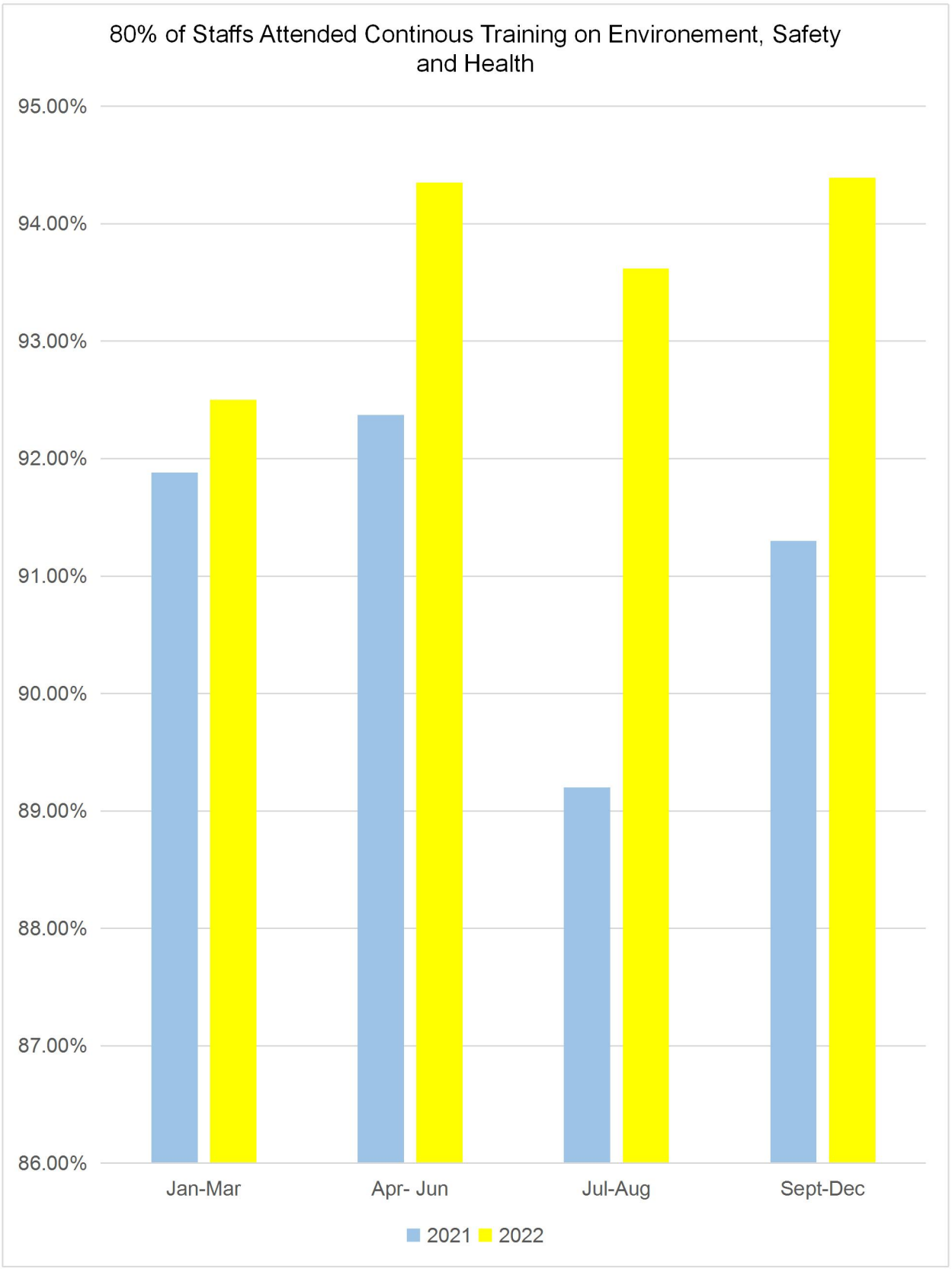
Thus, knowledge on Environmental, Occupational Safety and Health (OSH) Programs are important aspects of patient and staff safety for all health care personnel to acquire. It is an important element of continuing improvement of the environment and occupational safety and health to ensure staffs are aware of, and work and provide care in a safe environment.

Therefore, there are proxy indicators of the effectiveness of the hospital's program and risk management pertaining to Environment, Occupational Safety and Health in the hospital.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	**80% OF STAFF GIVEN CONTINUOUS TRAINING IN SPECIFIC ASPECTS OF ENVIRONMENT, SAFETY AND HEALTH. TARGET: 80%**			
MONTH	**JAN - MAR**	**APR - JUN**	**JUL - SEPT**	**OCT - DEC**
NO OF STAFF ATTENDED CONTINUOUS TRAINING 2021	1381	1259	1215	1259
TOTAL OF STAFF 2021	1503	1363	1362	1379
PERCENTAGE OF STAFF ATTENDED CONTINUOUS TRAINING 2021	**91.88%**	**92.37%**	**89.20%**	**91.30%**
NO OF STAFF ATTENDED CONTINUOUS TRAINING 2022	1296	1320	1395	1446
TOTAL OF STAFF 2022	1401	1399	1490	1532
PERCENTAGE OF STAFF ATTENDED CONTINUOUS TRAINING 2022	**92.50%**	**94.35%**	**93.62%**	**94.39%**
80% OF STAFF ATTENDED CONTINUOUS TRAINING IN HEALTH AND SAFETY REQUIREMENT	**JAN - MAR**	**APR - JUN**	**JUL - SEPT**	**OCT - DEC**
2021	**91.88%**	**92.37%**	**89.20%**	**91.30%**
2022	**92.50%**	**94.35%**	**93.62%**	**94.39%**

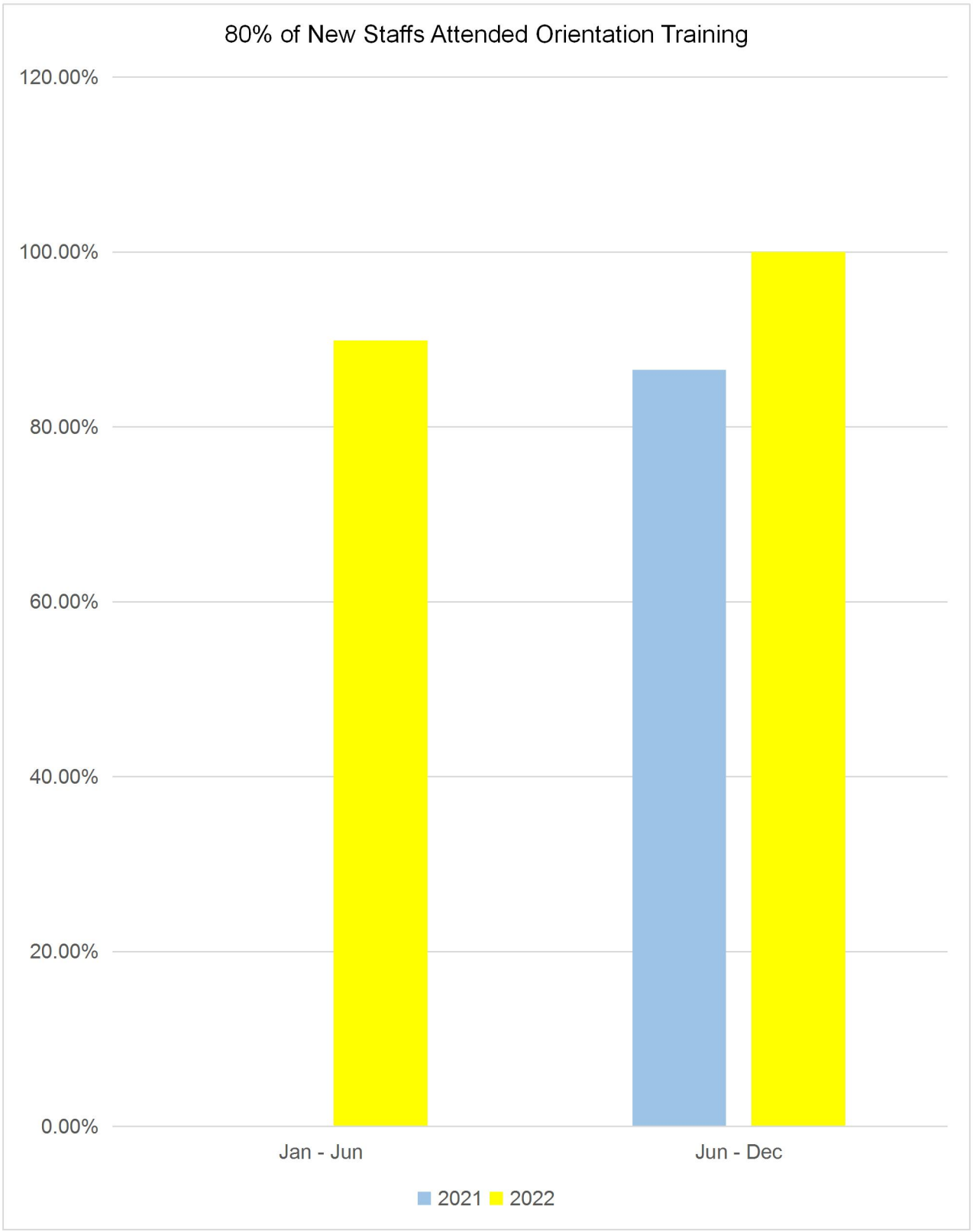
Table 1: Percentage of staff given continuous training in specific aspects of environment, safety and health.



Based on the data obtained, Diagram 1 shows the key performance indicator was achieved for year 2021 and 2022 as the target of achievement is at least 80%.

MSQH KPI 2	80% OF NEW STAFF (INCLUDES ALL ON-SITE OUTSOURCED SERVICE PROVIDERS) GIVEN ORIENTATION ON ENVIRONMENT, SAFETY AND HEALTH POLICY AND PROGRAMME. TARGET: 80%	
Month	**Jan - June**	**Jul - Dec**
No of new staff attended 2021	0	71
No of onsite outsourced services providers attended 2021	0	0
Total of staff and outsources services providers attended 2021	0	79
Total of staff and outsources services providers 2021	0	71
Percentage of staff attended orientation 2021	**0.00%**	**89.90%**
Month	**Jan -June**	**Jul - Dec**
No of new staff attended 2022	45	69
No of onsite outsourced services providers attended 2022	0	0
Total of staff and outsources services providers attended 2022	45	69
Total of staff and outsources services providers 2022	52	69
Percentage of staff attended orientation 2022	**86.54%**	**100.00%**
Month	**Jan- June**	**Jul - Dec**
2021	**0.00%**	**89.90%**
2022	**86.54%**	**100.00%**

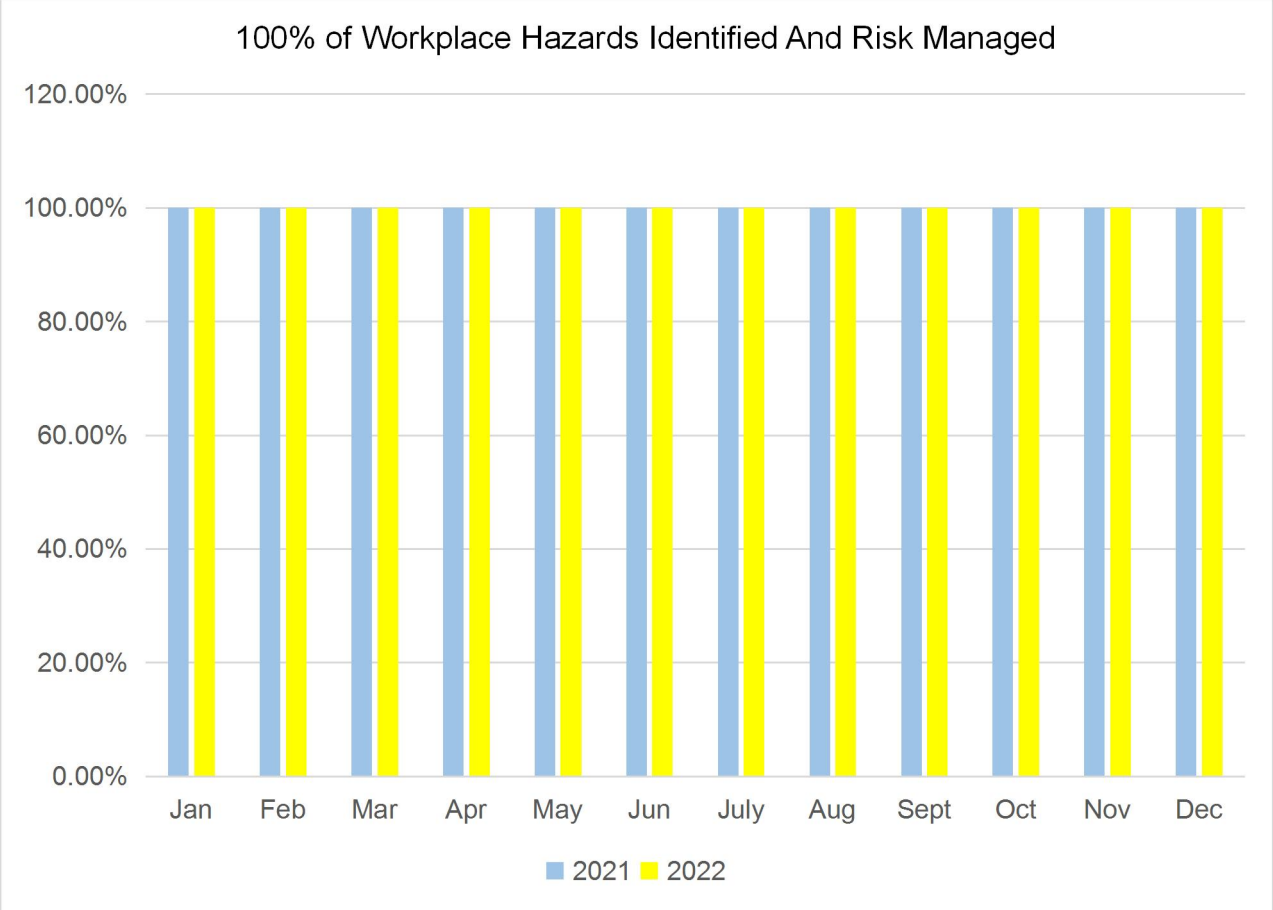
Table 2: Percentage of new staff (includes all on-site outsourced service providers) given orientation on environment, safety and health policy and programme.



Based on the data obtained, Diagram 2 shows the key performance indicator was achieved for year 2022. However for year 2021 (January till June), the key performance indicator was not achieved due to Covid 19 pandemic. Therefore, orientation training was not conducted during that period to reduce the risk of Covid transmission.

MSQHKPI 3	100 % OF WORKPLACE HAZARDS IDENTIFIED AND RISK MANAGED			
YEAR	TOTAL NUMBER OF RISK IDENTIFIED	HAZARD IDENTIFIED & MANAGED	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	12	12	100	100
2022	12	12	100	100

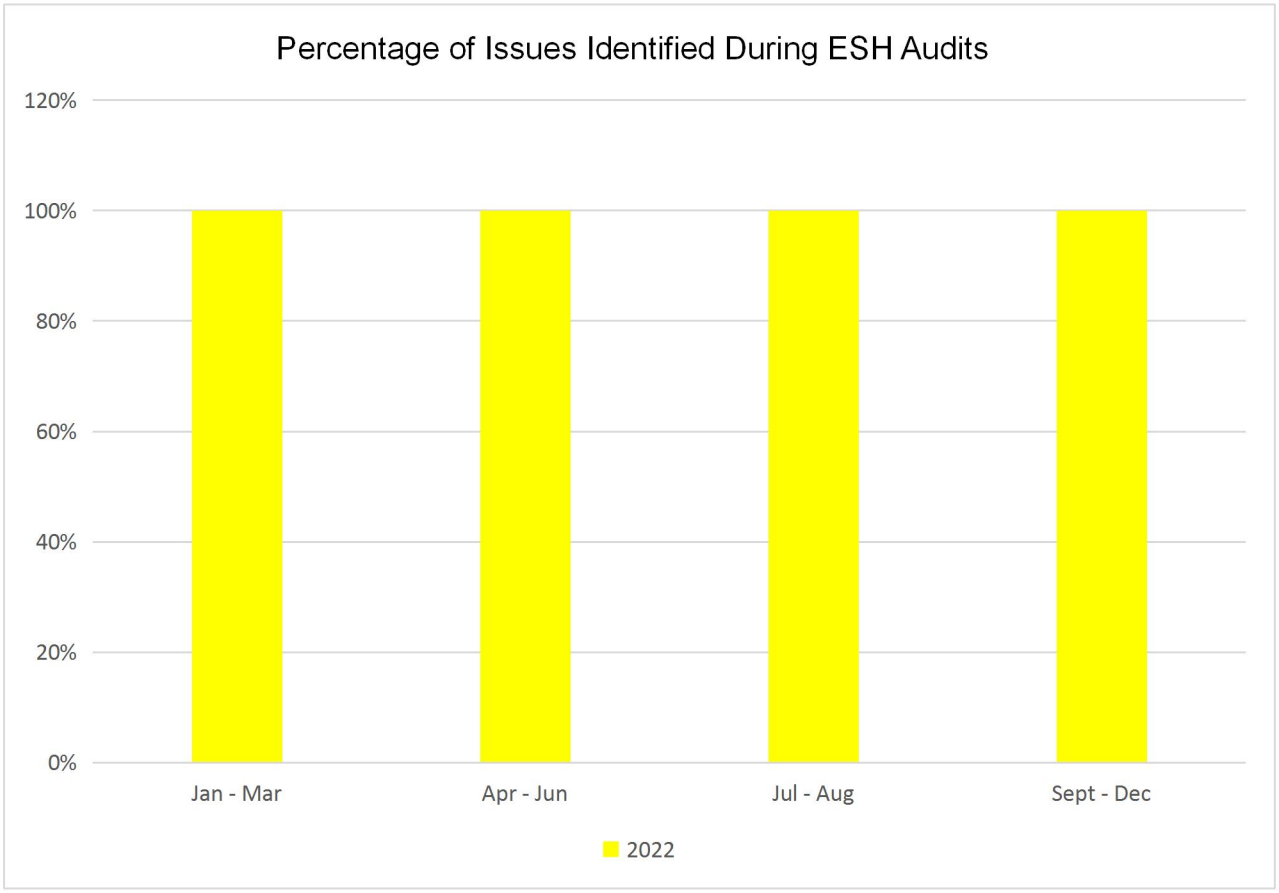
Table 3: Percentage of workplace hazards identified and risk managed for year 2021 to 2022



Based on the data obtained, Diagram 3 shows the key performance indicator was achieved for year 2021 and 2022 as there was no incident reported for the period 2021 / 2022.

MSQH KPI 4	PERCENTAGE OF ISSUES IDENTIFIED DURING ENVIRONMENTAL AND SAFETY AUDITS ARE CLOSED OR FOLLOWED THROUGH TARGET: > 50%			
2022	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
TOTAL NUMBER OF ISSUES CLOSED OR FOLLOWED THROUGH	21	22	22	22
TOTAL NUMBER OF ISSUES IDENTIFIED DURING ENVIRONMENTAL AND SAFETY AUDITS	21	22	22	22
PERCENTAGE OF ISSUES IDENTIFIED DURING ENVIRONMENTAL AND SAFETY AUDITS ARE CLOSED OR FOLLOWED THROUGH (2022)	100%	100%	100%	100%

Table 4: Percentage of issues identified during environmental and safety audits are closed or followed through for year 2021 to 2022



Based on the data obtained, Diagram 4 shows the key performance indicator was achieved for year 2022 as all departments audited passed the regular audits as required.

MSQH KPI 5	PERCENTAGE OF INTERNAL AND EXTERNAL PLANNED DRILLS ARE CARRIED OUT AND DOCUMENTED INCLUDING RECOMMENDATIONS AND FOLLOWED THROUGH ACTIVITIES. TARGET: 100%
2022	JANUARY - DECEMBER
TOTAL NUMBER OF DRILLS CONDUCTED (INTERNAL AND EXTERNAL DISASTER) WITH THE ISSUES CLOSED OR FOLLOWED THROUGH	2
TOTAL NUMBER OF DISASTERS IDENTIFIED IN THE INTERNAL AND EXTERNAL DISASTER PLANS	2
PERCENTAGE OF INTERNAL AND EXTERNAL PLANNED DRILLS ARE CARRIED OUT AND DOCUMENTED INCLUDING RECOMMENDATIONS AND FOLLOWED THROUGH ACTIVITIES (%)	**100**

Table 5: Percentage of internal and external planned drills are carried out and documented including recommendations and followed through activities in year 2022

Based on the data obtained, KPI was achieved for year 2022. Internal Drills conducted were Fire and Mass Casualty Drill on 15 June 2022 and Code Blue Drill on 26 Oct 2022 (2 events).
Additionally, there was an external drill conducted by Malaysia Airport which PMC was invited to participate on 12 Oct 2022. Thus, total drills carried out during year 2022 were achieved as planned with additional 1 external drill.

MSQH KPI 6	PERCENTAGE OF WORKPLACE HAZARDS IDENTIFIED AND RISKS MANAGED			
YEAR	TOTAL NUMBER OF WORKPLACE HAZARDS OCCURRING AMONG STAFF, PATIENTS AND VISITORS IN ALL SECTORS OF THE FACILITY OVER A SPECIFIC PERIOD	TOTAL NUMBER OF WORKPLACE HAZARDS OCCURRING AMONG STAFF, PATIENTS AND VISITORS IN ALL SECTORS OF THE FACILITY IDENTIFIED AND RISKS MANAGED OVER A SPECIFIC PERIOD	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2022	0	0	100	0

Table 6: Percentage of workplace hazards identified and risks managed in year 2022

Based on the data obtained, KPI achieved for workplace hazards identified and risk managed, as zero incident was reported during year 2022.

CONCLUSION

Based on the above key performance indicators provided, the environment, occupational safety and health programs were effective and fulfill the requirements as required according to the current Acts, Regulations & Guidelines by the relevant agencies.

FACILITY AND BIOMEDICAL ENGINEERING

INTRODUCTION

Maintenance Department is located at basement of Putra Medical Centre building. Maintenance Department's responsibility is to response to all work requests. The responsibilities of Maintenance Department are:

a) To ensure the hospital operation is running smoothly
b) To repair the equipment
c) To do trouble-shooting
d) To carry out the Plan Preventive Maintenance program and etc.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH/ISO KPI 1	PERCENTAGE OF PLANNED PREVENTIVE MAINTENANCE BEING DONE ON SCHEDULE			
YEAR	NUMBERS OF ASSET SCHEDULED FOR PLANNED PREVENTIVE MAINTENANCE FOR THE MONTH	NUMBERS OF ASSET UNDERGONE PLANNED PREVENTIVE MAINTENANCE FOR THE MONTH	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1529	1463	98	96.05
2022	1237	1209	98	97.99

Table 1: Percentage of planned preventive maintenance being done on schedule for the year 2021 to 2022.

Based on the data obtained, Table 1 shows the average percentage of Plan Preventive Maintenance of asset being done on schedule for the year 2021 and 2022. Overall, average statistics of PPM being done in 2022 have increased as compared to 2021 with 97.99% and 96.05% respectively. The average percentage was not achieved due to the asset was in use and cannot be located during PPM.

MSQH KPI 2	PERCENTAGE OF SYSTEM/SERVICE UPTIME			
YEAR	TOTAL NUMBERS OF EACH TYPE OF CRITICAL SYSTEM/EQUIPMENT/ ASSET USED IN THE FACILITY FOR THE MONTH	THE UPTIME PERIODS OF EACH SYSTEMS/ EQUIPMENT/ASSETS IN THE FACILITY THAT HAD PROVIDED ITS PRIMARY FUNCTION FOR THE MONTH	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2022	4746	4647	92	97.91

Table 2: Percentage of system/service uptime in the facility from year 2021 to 2022

Based on the data obtained, Table 2 shows the average percentage of service uptime from July to December 2022. Target objective was achieved with 97.91%.

MSQH KPI 3	REPAIR TIME - PERCENTAGE OF REPAIR /WORK ORDERS COMPLETED WITHIN 7 WORKING DAYS			
YEAR	NUMBERS OF REPAIR/WORK ORDERS ISSUED FOR THE MONTH	NUMBERS OF REPAIR/WORK ORDERS COMPLETED WITHIN 7 WORKING DAYS AS SCHEDULED FOR THE MONTH	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2022	2381	2341	7 WORKING DAYS	97.57%

Table 3: Percentage of repair/work orders completed within 7 working days as scheduled

Based on the data obtained, Table 3 shows the average percentage of repair/work orders completed within 7 working days from July to December 2022 with achievement of 97.57%.

ISO KPI 2	PERCENTAGE OF WORK ORDER COMPLETED ON SCHEDULED			
YEAR	TOTAL WORK ORDER REQUESTED	TOTAL WORK ORDER COMPLETED ON TIME	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	2422	2381	98	98.25
2022	3618	3581	98	98.90

Table 4: Percentage of work order completed on scheduled

Based on the data obtained, Table 4 shows the percentage of work order completed as scheduled in 2021 which recorded 98.25%, with a slight increase to 98.90% in 2022.

CONCLUSION

As a conclusion, the percentage of Plan Preventive Maintenance being done on schedule throughout the year 2021 to 2022 is increasing. However, the target is not achieved due to some of the equipment cannot be located and some are in-use. Therefore, Bio medical Engineer will reschedule with vendor and ensure that the equipment are ready and available during the PPM. The percentage of service/system uptime is calculated from July 2022 to December 2022 where the target is achieved. That can be done by closely monitoring the work order to reduce downtime and ensure that the asset/system is in good working condition. Last but not least, for the percentage of repair/work orders completed within 7 working days from July 2022 to December 2022 reached 97.57%. Most of the pending work requests were due to waiting for replacement part from vendor and vendor's schedule for checking and repairing. The action plan is to reschedule and re-plan work accordingly.

MEDICAL RECORD

INTRODUCTION

The Medical Records Unit is responsible for ensuring that patients' medical records are managed efficiently and safely at all times. The hospital is currently using Hospital Information Management System to manage patient's records. This unit located at the Basement of the Hospital.

The Medical Records Unit practices the concept of centralizing medical records management services that include storage, maintenance and disposal. This unit is also responsible for managing applications for the production of medical reports.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF MEDICAL REPORTS PREPARED WITHIN THE STIPULATED PERIOD (≤ 4 WEEKS)			
YEAR	THE NUMBER OF MEDICAL REPORT THAT SHOULD BE COMPLETED	TOTAL NUMBER OF LATE MEDICAL REPORT	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	2113	504	90	76.22
2022	2183	662	90	70.29

Table 1: Percentage of Medical Reports prepared from year 2021 to 2022

Based on the data obtained, table 1 shows the percentage of medical reports prepared within the stipulated period (≤ 4 weeks) was 76.22% in 2021 and 70.29% in year 2022.

MSQH KPI 2	PERCENTAGE OF MEDICAL RECORDS THAT WERE DISPATCHED WITHIN 72 HOURS OF DISCHARGE				
YEAR	TOTAL PATIENT DISCHARGE	TOTAL DISCHARGE SUMMARY COMPLETE WITHIN 72 HOURS	TOTAL DISCHARGE SUMMARY COMPLETE MORE THAN 72 HOURS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	8396	8240	284	95	98.17
2022	10019	9735	152	95	97.19

Table 2: Percentage of Discharge Summary completed within 72 hours from year 2021 to 2022

Based on the data obtained, Table 2 shows the percentage of medical records that were dispatched within 72 hours of discharge was 98.17% in 2021 and 97.19% in 2022.

ISO KPI 1	TO SCAN DISCHARGE DOCUMENTS WITHIN 48 HRS FROM THE TIME DISCHARGE DOCUMENT RECEIVED			
YEAR	TOTAL DISCHARGE DOCUMENTS	DISCHARGE DOCUMENT SCANNED WITHIN 72 HOURS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	9778	9778	100	100
2022	11044	11044	100	100

Table 3: Percentage of Discharge Documents scanned within 48 hrs from year 2021 to 2022

Based on the data obtained, Table 3 shows the percentage of Discharge Documents scanned within 48 working hours was 100% for both years 2021 and 2022.

ISO KPI 2	MISSING RECORD	
YEAR	TOTAL MISSING RECORD	TARGET (0 MISSING RECORD)
2021	0	0
2022	0	0

Table 4: Number of missing record from year 2021 to 2022

Based on the data obtained, Table 4 shows the number of missing record which was 0 case for both years 2021 and 2022.

	TOTAL PRODUCTION OF PATIENT'S MEDICAL RECORD
YEAR	WALK-IN REQUEST
2021	2113
2022	2183

Table 5: Total Production of patient's Medical Record from year 2021 to 2022

Based on the data obtained, table 5 shows the total production of patient's medical record was 2113 reports in year 2021 and 2183 reports in year 2022. All requests for medical report is through walk-in applications.

	TOTAL NUMBER OF MEDICAL REPORTS PROVIDES MORE THAN 4 WEEKS				
YEAR	INSURANCE	KWSP/PERKESO	MEDICAL BOARD	LAWYER CASE	OTHERS
2021	1,267	134	0	608	111
2022	1,413	190	2	462	116

Table 6: Total number of medical reports provides more than 4 weeks from year 2021 to 2022

Based on the data obtained, the number of medical reports provided to the insurance party is the highest compared to other applications. In 2022, the number of medical report applications recorded 2183 reports as compared to 2113 reports in 2021.

CONCLUSION

The medical record unit is fully utilizing Hospital Information System (HIS) to manage Electronic Medical record (EMR) for outpatient and inpatient. The 100% target for a complete discharge summary to be completed within 72 hours (working days) from the time of discharge is still not achieved. However, there is an increase towards the target with 98.17% in 2022 as compared to 97.19% in 2021. The improvement of the discharge summary form carried out by the Medical Records Unit contributed to this increase in 2022. The role of the Clinical Committee and the Medical Records Committee also contributed to this performance. However, the achievement is still below the KPI target according to the MSQH regulations. Further improvement measures are necessary to maintain and to achieve the MSQH requirements.

DIAGNOSTIC IMAGING

INTRODUCTION

Diagnostic Imaging Department is located at the 1st Floor of Old Wing building. This department provides services for general x-ray, CT scan, MRI, fluoroscopy, mammogram, ultrasound, mobile x-ray for ward & mobile c-arm for Operation Theatre (OT).

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF IMAGES REPORTED BY RADIOLOGIST			
YEAR	TOTAL NUMBER OF PATIENTS UNDERGOING RADIOLOGICAL EXAMINATIONS (PLAIN IMAGES AND SPECIAL EXAMINATION)	TOTAL NUMBER OF RADIOLOGICAL EXAMINATIONS (PLAIN IMAGES AND SPECIAL EXAMINATION) REPORTED BY RADIOLOGIST	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	18432	18432	>95	100%
2022	21433	21433	>95	100%

Table 1: Percentage of images reported by Radiologist from year 2021 to 2022

Based on the data obtained, Table 1 shows the percentage of images reported by Radiologist, which is 100% for both year 2021 & 2022.

MSQH KPI 2	PERCENTAGE OF RADIOLOGICAL EXAMINATION ERRORS I.E. WRONG MARKER, USE OF PRIMARY MARKERS, WRONG SITE X-RAYED, WRONG PATIENT X-RAYED			
YEAR	TOTAL NUMBER OF RADIOLOGICAL EXAMINATIONS/IMAGING DONE IN THE SAME PERIOD	TOTAL NUMBER OF RADIOLOGICAL EXAMINATIONS THAT HAD TO BE REPEATED DUE TO WRONG PART, WRONG VIEW, WRONG SITE OR WRONG PATIENT X-RAYED	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	18432	0	0	100%
2022	21433	0	0	100%

Table 2: Percentage of radiological examination errors from year 2021 to 2022

Based on the data obtained, Table 2 shows 0% of radiological examination error reported for both year 2021 and 2022.

ISO KPI 1(1)	TO PROVIDE IMAGE & REPORT FOR GENERAL X-RAY, MAMMOGRAM AND ULTRASOUND - WITHIN 1 HOUR DURING WORKING HOURS OF RADIOLOGIST.			
YEAR	TOTAL NUMBER OF GENERAL X-RAY, MAMMOGRAM AND ULTRASOUND IMAGES	TOTAL NUMBER OF GENERAL X-RAY, MAMMOGRAM AND ULTRASOUND IMAGES REPORTED WITHIN 1 HOUR)	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	15105	15105	100	100
2022	17779	17779	100	100

Table 3: Percentage of image & report for general x-ray, mammogram and ultrasound provided within 1 hour during working hours of radiologist from year 2021 to 2022

Based on the data obtained, Table 3 shows 100% of image and report for general x-ray, mammogram and ultrasound provided within 1 hour during working hours of radiologist from year 2021 to 2022.

ISO KPI 1(2)	TO PROVIDE IMAGE & REPORT FOR CT SCAN, MRI AND SPECIAL PROCEDURE - WITHIN 2 HOURS DURING WORKING HOURS OF RADIOLOGIST.			
YEAR	TOTAL NUMBER OF CT SCAN, MRI AND SPECIAL PROCEDURE IMAGES	TOTAL NUMBER OF CT SCAN, MRI AND SPECIAL PROCEDURE IMAGES REPORTED WITHIN 2 HOURS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	4008	4008	100	100
2022	4767	4767	100	100

Table 4: Percentage of image & report for CT scan, MRI and special procedure provided within 2 hours during working hours of radiologist from year 2021 to 2022

Based on the data obtained, Table 4 shows 100% of image and report for CT scan, MRI and special procedure provided within 2 hours during working hours of radiologist from year 2021 to 2022

ISO KPI 2	WRONG MARKER			
YEAR	TOTAL NUMBER OF IMAGES	TOTAL NUMBER OF WRONG MARKER	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	12128	1	0	0.0075
2022	13877	0	0	0

Table 5: Percentage of wrong marker from year 2021 to 2022

Based on the data obtained, Table 5 shows 0.0075% of wrong marker in 2021 as compared to 0% in 2022.

ISO KPI 3	TO ATTEND MOBILE RADIOGRAPHY CASE WITHIN 15 MINUTES			
YEAR	TOTAL MOBILE RADIOGRAPHY CASE	TOTAL MOBILE RADIOGRAPHY CASE ATTENDED WITHIN 15 MINUTES	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2022	175	174	70	99.58

Table 6: Percentage of mobile radiography case attended within 15 minutes in 2022.

Based on the data obtained, Table 6 shows 99.58% of mobile radiography case attended within 15 minutes in 2022. The target is achieved.

CONCLUSION

The waiting time and completion period of the report measured so far achieved the target. Based on the data obtained, most of KPIs achieved the set target.

LABORATORY DEPARTMENT

INTRODUCTION

Laboratory Department provides diagnostic services to customers in the fields of Haematology, Chemical Pathology, Serology and Blood Transfusion Services. Tests that are not carried out in the Laboratory will be outsourced to contracted external laboratories with Putra Medical Centre such as Innoquest and Pantai Premier.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	NOTIFICATION OF CRITICAL LABORATORY TESTS RESULTS			
YEAR	TOTAL NUMBER OF LABORATORY TESTS DONE IN THE FACILITY INCLUDING POCT FOR THE CORRESPONDING PERIOD	NUMBER OF TIMELY NOTIFICATION OF CRITICAL RESULTS FOR ALL LABORATORY TESTS DONE IN THE FACILITY INCLUDING POCT RESULTS FOR THE CORRESPONDING PERIOD	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	14608	267	-	1.43

Table 1: Percentage of notification of critical laboratory tests results for year 2022(July to December).

Based on Table 1, 1.43% of critical laboratory tests results are timely notified to related department from July to December 2022.

MSQH KPI 2	REJECTION RATE OF SPECIMENS			
YEAR	TOTAL NUMBER OF SPECIMENS SENT FOR TESTING IN THE SAME PERIOD	TOTAL NUMBER OF SPECIMENS REJECTED	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	39519	72	< 1%	0.21
2022	28425	88	< 1%	0.28

Table 2: Rejection rate of specimens

Based on Table 2, rejection rate of specimens in 2021 is 0.21% and slightly increased to 0.28% in 2022.

ISO KPI 1	TURNAROUND TIME (TAT) FOR URGENT FULL BLOOD COUNT LESS THAN 45 MINS			
YEAR	TOTAL OF URGENT FBC PERFORMED	TOTAL URGENT FBC RESULTS OBTAINED IN THE HIS SYSTEM WITHIN 45 MINUTES	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2022	2162	2149	> 90	99.48

Table 3: Percentage of Turnaround Time (TAT) for urgent full blood count less than 45 mins in 2021

Based on the data obtained, Table 3 shows the percentage of Turnaround Time (TAT) for urgent full blood count less than 45 mins in 2021 is 99.48%.

ISO KPI 2	TEST RELIABILITY BASED ON VALID COMPLAINT FROM DOCTOR
YEAR	TOTAL COMPLAINT
2021	0 CASE
2022	0 CASE

Table 4: Test reliability based on valid complaint from doctor in 2021 and 2022

Based on the data obtained, Table 4 shows 0 case of complaint from doctors on reliability of tests.

ISO KPI 3	ERROR IN SAMPLE HANDLING FOR EG. WRONG LABEL, WRONG BLOOD TYPE, WRONG PATIENT DETAILS ETC.
YEAR	TOTAL ERROR
2021	0 CASE
2022	0 CASE

Table 5: Error in sample handling for eg. wrong label, wrong blood type, wrong patient details etc. in 2021 and 2022

Based on the data obtained, table 5 shows 0 case of error (wrong label, wrong blood type, wrong patient details etc.) recorded in 2021 and 2022.

	Workload Analysis		
Year	Total out-patient	Total in-patient	**TOTAL**
2021	42789	19654	**62443**
2022	38367	27380	**65747**

Table 6: Workload Analysis in 2021 to 2022

Based on the data obtained, Table 6 shows the total case/procedure done in 2021 (62443 cases) and 2022 (65747 cases).

CONCLUSION

In conclusion, most of the KPIs achieved the set target.

BLOOD TRANSFUSION

INTRODUCTION

The Blood Transfusion Unit has an important function in providing safe and effective transfusion services, determining clinical transfusion practices that are in line with national and international policies and expanding the scope of blood transfusion services through training for medical, para-medical and non-medical personnel. This unit functions as a referral and consultation center for problems related to transfusion medicine. The Blood Transfusion Committee is one of the mandatory Clinical Committees for the Hospital and is chaired by a Surgeon.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	CROSS-MATCH TRANSFUSION RATIO			
YEAR	NUMBER OF RED CELL UNITS TRANSFUSED	NUMBER OF RED CELL UNITS CROSS - MATCHED	TARGET (%)	AVERAGE CROSS-MATCH TRANSFUSION RATIO
2021	286	338	≤ 2.0	1.1
2022	183	210	≤ 2.0	1.1

Table 1: Cross Matched Transfusion Ratio from year 2021 to 2022

Based on collected data, CT Ratio is less than 2.0. The set KPI target is achieved for both years 2021 and 2022.

MSQH KPI 2	NUMBER OF ADVERSE EVENTS IN PATIENTS NEAR MISSES, TRANSFUSION ERRORS (INCORRECT BLOOD COMPONENT TRANSFUSED, TRANSFUSION REACTIONS, TRANSFUSE TRANSMITTED INFECTIONS)	
YEAR	NUMBER OF INCIDENCES OF BLOOD TRANSFUSION RELATED ADVERSE EVENTS IN PATIENTS FOR THE CORRESPONDING PERIOD	TARGET
2021	1	0
2022	3	0

Table 2: Transfusion Reactions from year 2021 to 2022

Number of transfusion reactions for 2021 and 2022 is 1 and 3 respectively. Standard precautionary measures were taken.

	USAGE OF BLOOD AND BLOOD PRODUCTS					
Year	Whole Blood/Packed cells	Fresh Frozen Plasma	Cyroprecipitate	Platelets	Others	**Total**
2021	286	16	4	14	0	**316**
2022	182	19	16	38	0	**239**

Table 3: Usage of Blood and Blood Products from year 2021 to 2022

Total usage of Blood and Blood products for year 2021 and 2022 is 316 pints and 239 pints respectively.

CONCLUSION

3 cases of transfusion reactions reported in year 2022 compared to 1 case of transfusion reaction reported for year 2021. Although in 2021 and 2022 there were cases of blood transfusion errors, the error that occurred was NOT the error in the process carried out or the product given to the patient. The error that occurred was a case of an unexpected patient transfusion reaction. Taking this parameter as a case of error is according to the regulations of the National Blood Bank.

PHYSIOTHERAPY DEPARTMENT

INTRODUCTION

Physiotherapy Department is located at Level 3, established to provide physiotherapy services suitable and in line with the objective, vision and mission set by the hospital. Physiotherapy Department prepares various services such as electrotherapy, exercises, chest physiotherapy and manual techniques.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH /ISO KPI 1	PERCENTAGE OF BURNS INCIDENCE INCURRED WITH THE ADMINISTRATION OF ELECTROTHERAPEUTIC MODALITIES OR THERMAL AGENTS			
YEAR	TOTAL ELECTROTHERAPEUTIC PROCEDURE	NUMBER OF INCIDENCES OF BURNS SUSTAINED DURING DELIVERY OF ELECTROTHERAPEUTIC MODALITIES OR THERMAL AGENTS	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	3708	0	0	0
2022	4559	0	0	0

Table 1: Percentage of burn incidence from year 2021 to 2022

Based on the data obtained, Table 1 shows no incidences of burn that has been reported throughout the entirety of two years ranging from 2021 to 2022.

MSQH/ISO KPI 2	PERCENTAGE OF INPATIENT REFERRALS SEEN ON TIME (≤ 24 HOURS) BY THE PHYSIOTHERAPIST			
YEAR	TOTAL NUMBER OF IN-PATIENTS REFERRED FOR PHYSIOTHERAPY SERVICES	TOTAL NUMBER OF IN-PATIENTS RECEIVING INTERVENTION BY PHYSIOTHERAPISTS MORE THAN 24 WORKING HOURS	TARGET (%)	ACHIEVEMENT (%)
2021	860	0	85	100
2022	1441	0	90	100

Table 2: Percentage of inpatient referrals seen on time (≤ 24 hours) by the physiotherapist

Based on the data obtained, Table 2 shows the percentage of in-patient receiving physiotherapy intervention upon referral within 24 working hours which is 100% for both year 2021 and 2022 with the total of 860 and 1,441 in-patients respectively.

YEAR	IN-PATIENT	OUTPATIENT
2021	2811	1306
2022	4974	1374

Table 3: In-patient and Outpatient from year 2021 to 2022

Based on the data obtained, Table 3 shows increase in the number of in-patient and out-patient for the year 2022 as compared to 2021.

YEAR	ELECTRO & HEAT	EXERCISE THERAPHY	CHEST PHYSIO	TOTAL
2021	586	3173	1216	**4975**
2022	827	3173	3402	**7402**

Table 4: Total number of treatment from year 2021 to 2022

Based on the data obtained, Table 4 shows the total number of treatments in Physiotherapy Department from year 2021 and 2022. The total number of combined treatments for the year of 2021 and 2022 are 4975 and 7402 respectively.

CONCLUSION

For year of 2022 the target for in-patient receiving intervention by physiotherapists within 24 hours has been increased from 85% to 90% after taking into account the achievements that exceeded the target throughout year 2021. Total patient (in-patient and out-patient) increased drastically in year 2022 compared to the previous year, 2021. Total number of treatment for electro and heat therapy and chest physiotherapy increased in year 2022 compared to 2021. However there is a decline of exercise therapy in year 2022 compared to its previous year. These positive outcomes indicate utmost support from internal and external specialists/doctors as well as outstanding and quality treatment provided by Physiotherapy Department.

DIETETIC SERVICES

INTRODUCTION

Dietetic Unit provides hospital support service for inpatient and outpatient. Dietitian's office is located at Level 6, Putra Medical Centre. Dietitian provides medical nutrition therapy counseling to inpatient and outpatient. Dietitian works hand in hand with others healthcare professionals to provide optimum results in nutrition interventions and shorten patient's length of stay in hospital.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF IN-PATIENT REFERRALS SEEN ON TIME (4 HOURS) BY THE DIETITIAN			
YEAR	TOTAL NUMBER OF IN-PATIENTS REFERRED TO THE DIETICIAN	NUMBER OF IN-PATIENTS SEEN BY DIETICIAN WITHIN 4 HOURS OF REFERRAL	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	245	245	≥85	100
2022	384	384	≥85	100

Table 1: Percentage of in-patient referrals seen on time (4 hours) by the Dietitian from year 2021 to 2022

Based on the data obtained, Table 1 shows the unit has achieved the target that has been set for both years which is 100%. The total inpatient referral increased from 245 in 2021 to 384 cases in 2022.

MSQH KPI 2	PERCENTAGE OF OUT-PATIENT REFERRALS SEEN ON TIME (2 HOURS) BY THE DIETITIAN			
YEAR	TOTAL NUMBER OF OUT-PATIENTS REFERRED TO THE DIETICIAN	NUMBER OF OUT-PATIENTS SEEN BY DIETICIAN WITHIN 2 HOURS OF REFERRAL	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	45	45	≥85	100
2022	82	82	≥85	100

Table 2: Percentage of out-patient referrals seen on time (2 hours) by the Dietitian from year 2021 to 2022

Based on the data obtained, Table 2 shows the unit has achieved the target that has been set for both years which is 100%. The number of outpatient referral increased to 82 cases in 2022 as compared to 45 cases in 2021

ISO KPI 1	PERCENTAGE OF PATIENTS ARE SEEN BY DIETITIAN LESS THAN 1.0 HOURS FOR CRITICAL CASE			
YEAR	TOTAL NUMBER OF IN-PATIENTS REFERRED TO THE DIETICIAN	NUMBER OF PATIENT SEEN BY DIETITIAN LESS THAN 1.0 HOURS FOR CRITICAL CASE	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	54	54	80	100
2022	96	96	80	100

Table 3: Percentage of patients are seen by dietitian less than 1 hour for critical case from year 2021 to 2022

Based on the data obtained, Table 3 shows 100% of patients are seen by dietitian less than 1 hour for critical case from year 2021 to 2022.

ISO KPI 2	PERCENTAGE OF PATIENTS ARE SEEN BY DIETITIAN LESS THAN 3 HOURS FOR NON-CRITICAL CASE			
YEAR	TOTAL NUMBER OF PATIENT REFERRED TO THE DIETICIAN	NUMBER OF PATIENT SEEN BY DIETITIAN LESS THAN 3 HOURS FOR NON-CRITICAL CASE	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	92	92	80	100
2022	264	264	80	100

Table 4: Percentage of patients are seen by dietitian less than 3 hours for non-critical case from year 2021 to 2022

Based on the data obtained, Table 4 shows 100% of patients are seen by dietitian less than 3 hours for non-critical case from year 2021 to 2022.

	Total patient referral		
Year	Total out-patient referral	Total in-patient	**TOTAL**
2021	45	245	**290**
2022	82	384	**466**

Table 5: Total patient referral from year 2021 to 2022

CONCLUSION

Overall KPIs achieved the set target. Referral cases increased in 2022 partly due to patient's growing awareness towards the prevention of disease instead of curing illnesses through medication prescribed by doctors. Incorporation of holistic approach in patient's treatment is vital as it can give patient a quality of life after discharging from hospital.

FOOD SERVICE

INTRODUCTION

Food service is one of the hospital support service which provides food for inpatient during their stay for treatment in the hospital. Food service involves menu planning for inpatient to suit their preferences. During preparation of meals, the aspect of food safety and quality are also considered.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	OCCURRENCE OF PHYSICAL CONTAMINATION OF FOOD SERVED TO PATIENTS			
YEAR	TOTAL FOOD SERVED	NUMBER OF CONTAMINATION FOOD	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	72436	0	<1	0
2022	83448	0	<1	0

Table 1: Number of occurrence of physical contamination of food served to patients from year 2021 to 2022

Based on the data obtained, Table 1 shows 0 case of occurrence of physical contamination of food served to patients from year 2021 to 2022.

MSQH KPI 2	PERCENTAGE OF READY TO SERVE FOOD TESTED NEGATIVE FOR PATHOGENIC MICROORGANISM AS PER SCHEDULE			
YEAR	TOTAL NUMBER OF SAMPLES (6-10) OF READY TO SERVE FOOD (COOKED AND FRESHLY CUT) FOR IN-PATIENTS TESTED FOR PATHOGENIC MICRO-ORGANISM	NUMBER OF SAMPLES OF READY TO SERVE FOOD (COOKED AND FRESHLY CUT) FOR IN-PATIENTS TESTED NEGATIVE FOR PATHOGENIC MICRO-ORGANISM	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	24	24	100	100
2022	24	24	100	100

Table 2: Percentage of ready to serve food tested negative for pathogenic microorganism as per schedule from year 2021 to 2022

Based on the data obtained, Table 2 shows 100% of ready to serve food tested negative for pathogenic microorganism as per schedule in year 2021 and 2022.

	100% OF FOOD SERVICE PREMISE AUDIT CONDUCTED (CAFETERIA & CATERERS PREMISES) AS PER SCHEDULE.			
YEAR	TOTAL FOOD SERVICE PREMISE AUDIT	FOOD SERVICE PREMISE AUDIT CONDUCTED	TARGET (%)	ACHIEVEMENT (%)
2021	12	12	100	100
2022	12	12	100	100

Table 3: Number of food service premise audit conducted from year 2021 to 2022

Based on the data obtained, Table 3 shows 24 series of food service premise audit conducted as per schedule for cafeteria and caterers' premises in year 2021 and 2022.

	TOTAL NUMBER OF ORDERING OF HOSPITAL FOOD		
YEAR	ACTIVE WARD	NON-ACTIVE WARD	**TOTAL**
2021	9266	8843	**18109**
2022	11784	9078	**20862**

Table 4: Total patient that ordering hospital food from year 2021 to 2022

Based on the data obtained, Table 4 shows the total number of hospital food orders in year 2021 which was 18109 orders, with an increase in 2022 with 20862 orders.

CONCLUSION

Pathogenic microorganism can cause food poisoning and other diseases to the consumer. Thus, audit and continuous teaching & training will be provided to the food handlers, for example hand washing technique etc.

PHARMACY

INTRODUCTION

Pharmacy Department provides services for outpatients and inpatients. Pharmacy Department is located at the ground floor close to the Accident and Emergency Department to facilitate emergency matters that require medication. The Pharmacy Department is headed by registered Pharmacist.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF PRESCRIPTION ERROR			
YEAR	TOTAL NUMBER OF PRESCRIPTIONS (OUTPATIENTS AND INPATIENTS) WRITTEN BY DOCTORS	NUMBER OF PRESCRIPTION ERRORS (OUTPATIENTS AND IN-PATIENTS)	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2022	43809	37	0	0.08

Table 1: Percentage of prescription error (July - December 2023)

Based on the data obtained, Table 1 shows the prescription error rate by doctors in 2022 (July - December) is 0.08% (37 errors out of 43809 prescription). This new KPI was included from July 2022. Prescription error by the doctor will be clarified with the doctor concerned and rectified immediately.

MSQH/ISO KPI 2	PERCENTAGE OF DISPENSING ERROR			
YEAR	TOTAL NUMBER OF PRESCRIPTIONS DISPENSED (OUTPATIENTS AND INPATIENTS)	NUMBER OF DISPENSING ERRORS (OUTPATIENTS AND IN-PATIENTS)	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	64374	1	-	0.002
2022	83605	0	-	0

Table 2: Percentage of dispensing error from year 2021 to 2022

Based on data obtained, Table 2 shows the number of medication dispensing error to patient in 2021 (1 case) and 2022 (0 case).

ISO KPI 1	WAITING TIME PREPARATION FOR OUT PATIENT LESS THAN 15 MINUTES			
YEAR	TOTAL PRESCRIPTIONS	NO OF PRESCRIPTION FOR WAITING TIME LESS THAN 15 MINUTES	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	56514	56514	100	100
2022	74868	74853	100	99.98

Table 3: Percentage of waiting time for outpatient preparation less than 15 minutes from year 2021 to 2022

Based on data obtained, Table 1 shows the percentage of medication preparation for outpatient less than 15 minutes in 2021 is 100% out of 56514 prescriptions and in 2022 is 99.98% out of 74868 prescriptions.

ISO KPI 2	WAITING TIME PREPARATION FOR IN PATIENT LESS THAN 20 MINUTES			
YEAR	TOTAL PRESCRIPTIONS	NO OF PRESCRIPTION FOR WAITING TIME LESS THAN 20 MINUTES	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	7824	7824	100	100
2022	9617	9614	100	99.97

Table 4: Percentage of waiting time preparation for inpatient less than 20 minutes from year 2021 to 2022

Based on data obtained, Table 4 shows the percentage of medication preparation for inpatient less than 20 minutes in 2021 is 100% out of 7824 prescriptions and in 2022 is 99.97% out of 9617 prescriptions.

	TOTAL COST OF EXPIRED DRUG (RM)
2021	36,764
2022	41,240

Table 5: Total cost of Expired Drug from year 2021 to 2022

CONCLUSION

The prescription errors by doctors did not cause error in dispensing medicine to the patients because the doctors were informed and the prescription error corrected upon error detection. In 2022, dispensing error was reduced as compared to 2021. The waiting time for outpatient and inpatient KPI was not achieved due to increase in total number of prescription in certain month. Total cost of expired drug in 2022 increased due to MCO from 2020 to 2021.

PURCHASING

INTRODUCTION

Purchasing department assists in keeping the financial health of organization, and is responsible for acquiring the goods and services the business requires to operate effectively. Some companies refer to purchasing department as procurement department.

Purchasing department facilitates smooth movement of the day-to-day operations by monitoring supply chains and taking care of tedious tasks which includes negotiating with vendors so that other department(s) can focus on their main tasks. When it comes to sourcing and procurement, it defines the purchasing process and how purchasing department functions.

The objective of purchasing department is to respond to relevant requestor upon receiving request (non-stock draft purchase order) within 45 minutes in the year of 2021. Subsequently, the objective has been improved to 30 minutes in 2022. The below tables shown the achievement of the objective for purchasing department in the year of 2021 and 2022 respectively.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

ISO KPI 1	TO RESPONSE WITHIN 30 MINUTES TO RELEVANT HOD UPON RECEIVING NON-STOCK DRAF PO			
YEAR	TOTAL OF DPO RECEIVED	DPO WHICH EXCEED 30 MINUTES TO RESPOND	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1741	0	100	100
2022	1702	0	100	100

Table 1: Percentage of response within 30 minutes to relevant HOD upon receiving non-stock draft PO

Based on the data obtained, Table 1 shows the percentage of response within 30 minutes to relevant HOD upon receiving non-stock draft PO. In the year of 2021, a total of 1741 draft purchase orders (PO) were received and all of the draft PO (100%) been responded within 45 minutes. Thereafter, the objective was further improved to 30 minutes in the year of 2022. Whilst in 2022, a total of 1702 draft POs were received and 100% of the draft POs been responded within 30 minutes.

CONCLUSION

It could be evidenced that despite the reduction of responded time which implied improvement for the objective and target, purchasing department continues to strive its very best towards achieving its departmental objective and target throughout 2021 and 2022.

HUMAN RESOURCE

INTRODUCTION

Human Resource Department is responsible for managing human resource affairs and services in accordance with the laws and regulations that have been set at the Hospital. Human Resource Department is located at level 4 Old Wing.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH/ISO KPI 1	AVERAGE NUMBER OF 4 MAN HOURS TRAINING NURSING PER EMPLOYEE FOR (FULL TIME EQUIVALENT) HAD ATTENDED A YEAR			
YEAR	TOTAL STAFF COMPLETE TEACHING AND TRAINING (HOURS)	NUMBER OF NURSING STAFF ATTEND TEACHING AND TRAINING	TARGET (HOURS)	AVERAGE ACHIEVEMENT (HOURS)
2021	11973	2358	4	5.07
2022	13407	2672	4	5.01

Table 1: Average number of 4 man hours training for nursing per employee (full time equivalent) attended from year 2021 to 2022

Based on the Table 1 we can clearly see that in year 2021 and 2022, the KPI achieved the set target with Nursing staff completing more than 4 man hours of teaching and training for each month.

MSQH/ISO KPI 2	AVERAGE NUMBER OF 2 MAN HOURS TRAINING FOR NON-NURSING PER EMPLOYEE FOR (FULL TIME EQUIVALENT) HAD ATTENDED A YEAR			
YEAR	TOTAL STAFF COMPLETE TEACHING AND TRAINING (HOURS)	NUMBER OF NON-NURSING STAFF ATTEND TEACHING AND TRAINING	TARGET (HOURS)	AVERAGE ACHIEVEMENT (HOURS)
2021	7784	1966	2	3.96
2022	9663	2053	2	4.72

Table 2: Average number of 2 man hours training for non-nursing per employee (full time equivalent) attended from year 2021 to 2022

Based on the Table 2 we clearly can see that in year 2021 and 2022, the KPI achieved the set target with Non-Nursing staff completing more than 2 hours of teaching and training for each month.

CONCLUSION

In 2021 and 2022, both KPIs achieved the set target. Each head of department will monitor the staff in attending teaching and training e.g. CME, CNE, etc in order to achieve these KPIs.

PR & MARKETING

INTRODUCTION

PR and Marketing Unit acts as an intermediary for the Hospital in delivering information to the public and ensuring that customers receive the correct information. It provides assistance services to customers and also handle and resolve customer complaints. PR and Marketing Unit is responsible for marketing and promoting products and services available in the hospital.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	HOSPITAL WIDE PATIENT SATISFACTION SURVEY			
YEAR	TOTAL NUMBER OF PATIENTS WHO PARTICIPATED IN THE PATIENT SATISFACTION SURVEY	NUMBER OF PARTICIPATING PATIENTS (OUT-PATIENT & IN- PATIENTS) WHO INDICATED THEY WERE 'SATISFIED' IN THE PATIENT SATISFACTION SURVEY WITH > 80% SATISFACTION LEVEL	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	1286	1286	> 80% PATIENT SATISFACTION LEVEL	100
2022	54868	54586	> 80% PATIENT SATISFACTION LEVEL	99.53

Table 1: Percentage of hospital wide patient satisfaction survey

Based on the data obtained, Table 1 shows the percentage of hospital wide patient satisfaction survey recorded in 2021 which is 100%. However the percentage has slightly decreased to 99.53% in 2022.

MSQH KPI 1	CUSTOMER COMPLAINTS SHOULD NOT BE MORE THAN 8 CASES PER MONTH (RATING AS 1)	
YEAR	TOTAL NUMBER OF OFFICIAL COMPLAINTS RECEIVED (RATING AS 1)	TARGET (CASE PER MONTH) ACHIEVEMENT
2021	0	10
2022	6	10

Table 2: Customer complaints should not be more than 8 cases per month (rating as 1) in 2021 to 2022

Based on the data obtained, Table 2 shows total of 6 complaints (Rating as 1) received in 2022 compared to 0 complaint (Rating as 1) in 2021.

	ORGANIZED/INVOLVED IN 2 INTERNAL/EXTERNAL HEALTH AWARENESS PROGRAM PROMOTION ACTIVITIES/COMMUNITY ACTIVITIES	
YEAR	TOTAL PROMOTION ACTIVITIES OF INTERNAL / EXTERNAL HEALTH PROGRAMS / COMMUNITY ACTIVITIES	TARGET
2021	0	20* *2 ACTIVITIES PER MONTH
2022	15	20* *2 ACTIVITIES PER MONTH

Table 3: Internal/external health program promotion activities/community activities from year 2021 to 2022

Based on the data obtained, Table 3 above shows no activities took place (0 activities) in year 2021 due to Movement Control Order (MCO). In year 2022, a total of 15 health awareness program promotional activities were successfully carried out.

CONCLUSION

Overall, throughout the year 2021 and 2022, the PR & Marketing Unit have worked diligently to achieve all KPIs that has been set. PR & Marketing's objective is to ensure customers receive the correct information.

Customer service KPI or metric is a performance measurement that is used by PR & Marketing team to monitor, visualize, analyze and optimize customer relations.

From the analysis and variance, PR & Marketing team can extend their best marketing approach to further capture the attention of the customers with best tailored promotional packages to suit the customer's needs.

BILLING

INTRODUCTION

Billing Unit consists of two sections, inpatient and outpatient which are responsible for managing and checking all the hospital charges. The Billing Unit is on the Ground Floor beside the Pharmacy department.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

ISO KPI 1	TO ATTEND 100% OUTPATIENT BILL WITHIN 12 MINUTES			
YEAR	TOTAL OUTPATIENT BILL	TOTAL OUTPATIENT BILL PROCESSED WITHIN 12 MINUTES	TARGET (%)	ACHIEVEMENT (%)
2021	93448	93448	100	100
2022	83313	83313	100	100

Table 1: Percentages of outpatient bill attended within 12 minutes.

Based on data obtained, Table 1 shows the achievement of attending 100% outpatient bill within 12 minutes in 2021 and 2022.

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ISO KPI 2	TO PREPARE 100% INPATIENT BILL WITHIN 10 MINUTES			
YEAR	TOTAL INPATIENT BILL	TOTAL INPATIENT PATIENT BILL PROCESSED WITHIN 12 MINUTES	TARGET (%)	ACHIEVEMENT (%)
2021	9773	9773	100	100
2022	11246	11246	100	100

Table 2: Percentages of preparing outpatient bill within 10 minutes.

Based on data obtained, Table 2 shows the achievement of preparing 100% inpatient bill within 10 minutes in 2021 and 2022.

ISO KPI 3	MISTAKE IN COLLECTION
2021	0 CASE
2022	0 CASE

Table 3: Mistake in collection.

Based on data obtained, Table 3 shows 0 case of mistake in collection

CONCLUSION

Overall throughout year 2021 and 2022, the Billing unit achieved the target that have been set.

HOUSEKEEPING

INTRODUCTION

The main function of housekeeping is overall cleanliness, waste management, infection control, safety and security of the patients as well as the infrastructure and interior fixtures and furnishings. Housekeeping refers to general cleaning of hospital and clinics, including the floor, walls and furniture. Housekeeping services are available 24 hours and 7 days a week.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	TREND OF PERFORMANCE SCORE DURING IN-HOUSE INSPECTION/JOINT INSPECTION	
YEAR	AVERAGE SCORE OF PERFORMANCE TREND SHOWING 80% WITH MINIMUM SCORE OF 3 FOR CLEANSING SERVICE IN ALL AREAS OF THE FACILITY	TARGET (%)
2021	85.78	80% WITH MINIMUM SCORE OF 3
2022	86.07	80% WITH MINIMUM SCORE OF 3

Table 1: Trend of performance score during in-house inspection/joint inspection from 2021 to 2022

Table 1 shows the trend of performance scoring during in-house and joint inspection on housekeeping for the year 2021 and 2022. The target of Key Performance Indicator (KP1) is 80% with minimum score of 3. The data shows positive achievement for the score throughout the year. Trend of performance score during in-house/joint inspection showing score of 3 (Good) in most of general and ward areas. The average score from January to December in the year 2021 is 85.78% and for the year 2022 is 86.07%. Overall it shows that housekeeping staff's performance met the targeted goal and objective by providing good cleaning service.

MSQH/ISO KPI 2	CUSTOMER SATISFACTION FEEDBACK SURVEY			
YEAR	TOTAL NUMBER OF PATIENTS WHO PARTICIPATED IN THE PATIENT SATISFACTION SURVEY	NUMBER OF PARTICIPATING PATIENTS (OUT-PATIENT & IN-PATIENTS) WHO INDICATED THEY WERE 'SATISFIED' IN THE PATIENT SATISFACTION SURVEY WITH > 80% SATISFACTION LEVEL	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2022	3930	3924	80% SATISFACTION LEVEL	99.82

Table 2: Percentage of customer satisfaction feedback survey for year 2022

Table 2 shows customer feedback survey data for the year 2022. Percentage of customer satisfaction feedback survey from the months of January till December shows that more than 95% of patients are satisfied with housekeeper's performance and cleanliness of hospital.

CONCLUSION

The Housekeeping Department works to ensure the Hospital is always clean, tidy and free from infection. The Housekeeping Department also coordinates regular cleaning and pest control services for areas within the hospital premises. Above discussion shows that the majority of patients are satisfied with cleanness of hospital and performance of housekeepers are met with targeted objective and goal. However, there are also several feedbacks/complaints from the locations involved regarding the sanitary service which is at the medium unsatisfactory level, especially in the bathroom service. The housekeeping staff to prioritize a good level of hygiene and this matter is very important to make patients more comfortable.

LINEN

INTRODUCTION

The Linen Unit is one of the units that provide clinical support services at the Hospital and this service is provided through an External Contractor Service. Employees of this unit manage and operate matters related to linen in terms of monitoring, management, delivery and storage of clean linen supplies (according to the number of pars that have been determined) as well as collection of dirty linen.

KEY PERFORMANCE INDICATOR YEAR 2021-2022

MSQH KPI 1	PERCENTAGE OF LINEN (BLANKET) SHORTFALL			
YEAR	TOTAL QUANTITY OF LINEN BY TYPES (BLANKET) AND PAR LEVELS ACTUALLY SUPPLIED TO THE FACILITY	TOTAL QUANTITY LINEN (BLANKET) SHORTFALL	TARGET (%)	AVERAGE ACHIEVEMENT (%)
2021	8377	0	2	0
2022	8336	0	2	0

Table 1: Percentage of Linen (blanket) shortfall from year 2021 to 2022

MSQH KPI 2	PERCENTAGE OF LINEN (BEDSHEET) SHORTFALL			
YEAR	TOTAL QUANTITY OF LINEN BY TYPES (BEDSHEET) AND PAR LEVELS ACTUALLY SUPPLIED TO THE FACILITY IN A MONTH	TOTAL QUANTITY LINEN (BEDSHEET) SHORTFALL	TARGET (%)	ACHIEVEMENT (%)
2021	9141	0	2	0
2022	9288	0	2	0

Table 2: Percentage of Linen (bedsheet) shortfall from year 2021 to 2022

MSQH KPI 3	LINEN (BLANKET) REJECTION RATE			
YEAR	TOTAL QUANTITY OF LINEN (BLANKET) SUPPLIED TO THE FACILITY	TOTAL QUANTITY OF LINEN (BLANKET) REJECTED BY THE FACILITY	TARGET (%)	ACHIEVEMENT (%)
2021	8377	10	<2	0.12
2022	8336	69	<2	0.83

Table 3: Percentage of Linen(blanket) rejection rate from year 2021 to 2022

MSQH KPI 4	LINEN (BEDSHEET) REJECTION RATE			
YEAR	TOTAL QUANTITY OF LINEN (BEDSHEET) SUPPLIED TO THE FACILITY	TOTAL QUANTITY OF LINEN (BEDSHEET) REJECTED BY THE FACILITY	TARGET (%)	ACHIEVEMENT (%)
2021	9,141	45	<2	0.49
2022	9,288	40	<2	0.43

Table 4: Percentage of Linen(bedsheet) rejection rate from year 2021 to 2022

The above Tables show the data of linen shortfall and linen rejection rate for year 2021 until 2022. Table 1 and Table 2 show 0% shortfall for both blanket and bedsheet. Table 3 shows the blanket rejection rate for the year 2021 and 2022. Data shows the rejection rate for blanket slightly increased to 0.83% in 2022 as compared to 0.12% in 2021. Table 4 shows the bed sheet rejection rate for year 2021 and 2022. Data shows the rejection rate for bed sheet slightly decreased to 0.43% in 2022 from 0.49% in year 2021.

CONCLUSION

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).