KEMENTERIAN KESIHATAN MALAYSIA

TECHNICAL SPECIFICATIONS HOSPITAL PERFORMANCE INDICATORS FOR ACCOUNTABILITY (HPIA) MEDICAL PROGRAMME

2025

LIST OF HOSPITAL PERFORMANCE INDICATORS FOR ACCOUNTABILITY (HPIA)

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1	Health (Clinical Outcome)	1-3
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SATELLITE INDICATORS *** Satellite indicators encompass indicators from State Health Directors KPIs or any top management's KPIs that need to be monitored by the hospital director. It is important to note that these indicators will be changed annually. Kindly refer to the respective technical specifications for each KPI.		
	INDICATORS	**STANDARDS**
	State Health Director KPI 2025	
1.	# Purata Performance Indeks Jangkitan Aliran Darah berkaitan Penjagaan Kesihatan (bacteraemia) **(State Health Director KPI 2025)**	≥ 1.00
2.	% Bayi Baru Lahir yang Menjalani Saringan Pendengaran (*Universal Newborn Hearing Screening*) dalam Tempoh 28 Hari Selepas Kelahiran di Hospital/ Fasiliti Kesihatan Kerajaan **(State Health Director KPI 2025)**	≥85 %
3.	% Peralatan Perubatan/ Sistem Kejuruteraan Fasiliti Mencapai Uptime di Bawah Perkhidmatan Sokongan Hospital (PSH) **(State Health Director KPI 2025)**	≥95 %
	Deputy State Health Director (Medical) KPI 2025	
1.	# Indeks Pencapaian Petunjuk Prestasi Utama (KPI) Kualiti Perkhidmatan Perubatan Klinikal **(Deputy State Health Director (Medical) KPI 2025)**	≥ 0.9
2.	# Purata Performance Indeks Jangkitan Aliran Darah berkaitan Penjagaan Kesihatan (bacteraemia) **(Deputy State Health Director (Medical) KPI 2025)**	≥ 1
3.	% Bayi Baru Lahir yang Menjalani Saringan Pendengaran (Universal Newborn Hearing Screening) dalam Tempoh 28 Hari Selepas Kelahiran di Hospital/ Fasiliti Kesihatan Kerajaan **(Deputy State Health Director (Medical) KPI 2025)**	≥ 85%

4.	% Hospital yang Mencapai Bed Waiting Time yang Ditetapkan **(Deputy State Health Director (Medical) KPI 2025)**	≥ 80%
5.	% Keputusan Lembaga Perubatan Selesai Bersidang dalam Tempoh Masa yang Ditetapkan **(Deputy State Health Director (Medical) KPI 2025)**	≥75%
6.	% Jururawat yang Bertugas di Penempatan Klinikal > 6 Bulan Diperakui Lulus dan Mendapat Privilege **(Deputy State Health Director (Medical) KPI 2025)**	≥ 80%

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Indicator 1	:	**# Rate of Severity of Illness (SOI) 1 Death cases per 1,000 Severity of Illness (SOI) 1 Discharge Home cases**
Element	:	**Health (Clinical Outcome)**
Rationale	:	This KPI measures the quality level of health service delivery of a casemix hospital/ institutions. This can be seen in the ratio of the number of SOI 1 Death cases in every 1,000 SOI 1 home discharge cases, treated in KKM hospitals/ institutions. This also reflects the quality of data (casemix) and quality of care.
Definition of Terms	:	Generally, there are three classifications of severity of illness (Severity of Illness; SOI) that are treated in KKM hospitals/ institutions. **The severity of the disease is as follows:** a) Severity of Disease 1 (SOI 1): without comorbidities and/ or complications, b) Severity of Disease 2 (SOI 2): with comorbidities and/or complications, c) Severity of Disease 3 (SOI 3): with comorbid and/ or major complications. This degree of severity reflects the severity of the disease and the complexity of the treatment provided. The severity of the disease based on three main components which are: a) other diagnosis (comorbid and complications), b) treatment procedures given, and c) Length of stay in ICU The disease group with SOI 1 typically describes patients who have no complications and comorbidities and receive uncomplicated treatment. Cases like this should not result in death.
Criteria	:	**Inclusion:** 1. Inpatient services. 2. Patient discharge data between 1st January – 30th September of the assessed year. **Exclusion:** Not applicable
Numerator	:	Total no. SOI 1 death (in-patient)
Denominator	:	Total no. of SOI 1 discharged home

Formula	:	$\frac{\text{Numerator}}{\text{Denominator}} \times 1000$
Standard	:	≤10 death cases per 1000 patient discharged home (SOI 1)
Data collection	:	1. **Where**: Data will be collected in the respective department that caters the above inclusion criteria.. 2. **Who**: Data collection will be carried out by the Officer, Paramedic, or Nurse in-charge designated as the Indicator Coordinator. 3. **How to collect**: Data will be extracted from the Casemix application system. 4. **How frequent**: PVF form must be submitted every six months to the Quality Unit of the hospital or institution. 5. **Who should verify**: PVF form must be verified by Head of Department, Head of Quality Unit and Hospital/ Institution Director. .
Remarks	:	1. This is a yearly indicator. If the indicator is SIQ for Jan-Jun, the SIQ form does not need to be filled. 2. Data is extracted from casemix application system on 1st week of January of the following year to evaluate the performance for January -September of the assessed year by taking into account the backlog data load of the last 3 months. 3. Reports for January to June can be extracted by the respective hospital or institution. 4. The annual report (January to September) must use data extracted by IPKKM

Indicator 2	:	# Index of unplanned readmission
Element	:	Health (Clinical Outcome)
Rationale	:	Unplanned readmission is often considered to be the result of suboptimal care in the previous admission leading to readmission.
Definition of Terms	:	**Unplanned readmission:** It includes the following criteria: • Patient being readmitted for the management of the same clinical condition (main diagnosis) he or she was discharged. • Readmission was not scheduled. • Readmission to the same hospital. • This does not include readmission requested by next-of-kin or another department.(Applicable for General Medicine and Paediatric readmission only.) • This does not include patients were readmitted for different reason but have the same underlying conditions ('other diagnosis'). **Same condition:** Same diagnosis as refer to the ICD 11. Index of unplanned readmission will be assessed based on 3 indicators: 1. Percentage of medical patients with unplanned readmission to medical ward within (≤) 48 hours of discharge. 2. Percentage of paediatric patients with unplanned readmission to paediatric ward within (≤) 48 hours of discharge. 3. Percentage of patient readmitted to psychiatric ward within 3 months of last discharge. ● Please refer and follow the technical specification of each of the indicators above.
Criteria	:	**Inclusion:** 1. Performance of all indicators as above. **Exclusion**: Not applicable
Numerator	:	Total index for each indicator
Denominator	:	Total no of indicators applicable to the hospital/ institute
Formula	:	**Index of unplanned readmission:** Total of index for each indicator Total no. of indicator applicable **SUMS OF INDEX 1,2,3** **Examples calculation of index 1:**

		Standard of indicator 1≤ 0.5% Performance of indicator 1: 0.2 % = 100-0.2 / 100-0.5 = 99.8 / 99.5 **Index = 1.003** **Examples calculation of index 2:** Standard of indicator 2 ≤ 0.5% Performance of indicator 2 :0.1% = 100-0.1 / 100-0.5 = 99.9 / 99.5 **Index = 1.004** **Examples calculation of index 3:** Standard of indicator 3 ≤ 25% Performance of indicator 3: 40% 100-40 / 100-25 = 60 / 75 **Index = 0.800** **Calculation for index of unplanned readmission:** Index 1+ Index 2 + Index 3 / 3 =1.003+1.004+0.800 / 3 **= 0.936**
Standard	:	≥1
Data collection	:	1. **Where**: Data will be collected in the respective department/ward that caters the above condition. 2. **Who:** Data will be collected by the Officer/ Paramedic/Nurse in-charge (Indicator Coordinator) of the department/unit 3. **How to collect:** Data is suggested to be collected from the record or log book/ patient's file. 4. **How frequent:** PVF to be sent 6 monthly to Quality Unit of hospital. 5. **Who should verify:** PVF must be verified by Head of Department, Head of Quality Unit and Hospital Director.
Remarks	:	1. PVF for each sub-indicator needs to be prepared and reported by the respective departments.

		2. Each sub-indicator's PVF needs to be compiled by appointed personnel to generate the overall hospital performance. 3. SIQs for each sub-indicator need to be completed by the respective departments. 4. The overall hospital performance SIQ will only need to use the SIQs from respective departments.

Additional notes: Technical specifications are based on Clinical Service Quality Indicators (CliSQi) and KPI Hospital Director (Institute of Psychiatric)

Discipline	:	General Medicine
Indicator	:	**% of medical patients with unplanned readmission to medical ward within (≤) 48 hours of discharge**
Dimension of Quality	:	Effectiveness
Rationale	:	Unplanned readmission is often considered to be the result of suboptimal care in the previous admission leading to readmission.
Definition of Terms	:	**Unplanned readmission**: Patient being readmitted for the management of the same clinical condition (main diagnosis) he or she was discharged, the admission was not scheduled and it is readmission to the same hospital. This does not include readmission requested by next-of-kin or other department. **Same clinical condition:** Same diagnosis as refer to the ICD 11.
Criteria	:	**Inclusion**: 1. All medical inpatient discharges from medical wards. 2. All subspecialty patients discharged from medical ward within the same general medicine department (Includes CCU, CRW, nephrology wards etc.). **Exclusion**: 1. Patients of < 12 years of age. 2. AOR (at own risk) discharged patients during the first admission. 3. Patients that were discharged from wards under different department.
Type of indicator	:	Rate-based outcome indicator
Numerator	:	Number of medical patients with unplanned readmissions to medical department within (≤) 48 hours of discharge
Denominator	:	Total number of medical patients discharged during the same period of time the numerator data was collected
Formula	:	Numerator / Denominator x 100 %
Standard	:	≤ 0.5%
Data Collection & Verification	:	1. **Where**: Data will be collected in pre-determined specified medical wards that cater for the above condition/ record office. 2. **Who**: Data will be collected by Officer/ Paramedic/ Nurse in-charge of the department/ unit. 3. **How to collect**: For numerator, data is suggested to be collected on the day of readmission. For denominator, data is from admission & discharge record book/ Hospital Information System (HIS) 4. **How frequent**: PVF to be sent 6 monthly to Quality Unit of hospital. 5. **Who should verify**: PVF must be verified by Head of Department, Head of Quality Unit and Hospital Director.
Remarks	:	

Discipline	:	Paediatric
Indicator	:	% of paediatric patients with unplanned readmission to Paediatric Ward within (≤) 48 hours of discharge
Dimension of Quality	:	Effectiveness
Rationale	:	Unplanned readmission is often considered to be the result of suboptimal care in the previous admission leading to readmission.
Definition of Terms	:	**Unplanned readmission**: It includes the following criteria: • Patient being readmitted for the management of the same clinical condition (main diagnosis) he or she was discharged. • Readmission was not scheduled. • Readmission to the same hospital. • This does not include readmission requested by next-of-kin or other department. • This does not include patients were readmitted for different reason but have the same underlying conditions ('other diagnosis'). **Same clinical condition**: Same diagnosis as refer to the ICD 11.
Criteria	:	**Inclusion**: 1. All paediatric inpatient discharges from Paediatric Ward. **Exclusion**: 1. Neonates of ≤28 days of life.
Type of indicator	:	Rate-based outcome indicator
Numerator	:	Number of patients with unplanned readmissions to Paediatric Ward within (≤) 48 hours of discharge
Denominator	:	Total number of paediatric patients discharged during the same period of time the numerator data was collected
Formula	:	Numerator x 100 Denominator
Standard	:	≤ 0.5%
Data Collection & Verification	:	1. **Where**: Data will be collected in Paediatric Ward. 2. **Who**: Data will be collected by Officer/ Paramedic/ Nurse in-charge of the department/ unit. 3. **How to collect**: For numerator, data is suggested to be collected on the day of readmission. For denominator, data is from admission & discharge record book/ Hospital Information System (HIS). 4. **How frequent**: PVF to be sent 6 monthly to Quality Unit of hospital. 5. **Who should verify**: PVF must be verified by Head of Department, Head of Quality Unit and Hospital Director.
Remarks	:	*This indicator is also being monitored as an Outcome Based Budgeting (OBB) indicator.

Discipline	:	**Psychiatry**
Indicator	:	**% of patient readmitted to psychiatric ward within 3 months of last discharge**
Rationale	:	The quality of psychiatric care is among all reflected by readmissions to psychiatric ward. This KPI had been implemented before with the target looking at readmission to psychiatric ward within 1 month after discharge. It had been achieved and later dropped. With the improvement of services provided, the duration of patients staying well in the community should also increase accordingly. Patients receiving good quality psychiatric care should not be readmitted within 3 months.
Definition of Terms	:	Percentage of psychiatric patients readmitted to the psychiatric ward within three months after the last discharged. **Within 3 months:** ≤3 months **Readmission:** The same patient readmitted in the same unit/ hospital ≤3 months of latest discharge. **Admission:** Admitted to psychiatric ward regardless of length of stay with psychiatric diagnoses. **Discharge:** Patient's name has been removed from ward/ hospital register To determine whether a patient currently admitted qualifies to be included, count backwards for the 3 calendar months from the date of current admission (e.g. 16.12.2022 look backward until 15.9.2022).
Criteria	:	**Inclusion:** 1. All involuntary admissions to psychiatric ward. **Exclusion**: 1. Voluntary admissions 2. Elective admission e.g. admission for maintenance ECT or CT-brain 3. Patients who are on home-leaves 4. Patients admitted to forensic ward. 5. Readmission after discharged from non-psychiatric ward.
Type of indicator	:	Rate-based outcome indicator
Numerator	:	Number of patients for the month readmitted within 3 months of last discharge
Denominator	:	Total number of patients admitted in the same month
Formula	:	Numerator x 100% Denominator
Standard	:	≤25%
Data collection	:	1. **Where**: Data will be collected in wards that cater for the above condition/ record office. 2. **Who**: Data will be collected by Officer/ Paramedic/ Nurse in-charge (indicator coordinator) of the department/ unit. 3. **How to collect**: Data is suggested to be collected from Record Book / Registration Book/ Monitoring System. 4. **How frequent**: PVF to be sent 6 monthly to Quality Unit of hospital. 5. **Who should verify**: PVF must be verified by Head of Department, Head of Quality Unit and Hospital Director.
Remarks	:	Admission to the psychiatric ward (institution/ hospital) is according to the Mental Health Act 2001.

Indicator 3	:	# Index of Patient Fall
Element	:	Health (Clinical Outcome)
Rationale	:	Patient fall has the potential to cause severe harm. It can lead to prolong hospital stay, morbidity or even mortality. Patient fall is preventable with suitable safety measures such as safer environment, assessment of patient's risk and reducing the risk, close monitoring of patient. Based by recent data analysis E-incident Reporting in MOH Hospitals 2022 from Patient Safety Unit, Medical Care Quality Section, Medical Development Division MOH, the most reported incident was patient fall (2556 incidents- 30.1% of all patient safety incidents) followed by medication error (1979 incidents-23.3%) and obstetric related incidents (757 incidents-8.9%). The most common type of incidents reported for older age group was patient fall and it is second highest for pediatric age group up to adult.
Definition of Terms	:	Fall is an unintentional descent to a lower level, which may or may not result in injury. For the purpose of Malaysian Patient Safety Goals (MPSG) reporting, patient fall include witnessed and unwitnessed incidents occurring in all inpatient and outpatient healthcare facilities. However, it does not include fall due to events such as seizures, loss of consciousness, paralysis or cardiac arrest and due to external forces, non-injurious developmental fall among infant/ toddler or fall related to suicidal attempt. **Standard indicator based on Malaysian Patient Safety Goals 2.0 for Patient fall:** a) Rate Inpatient Patient Fall: ≤ 5 per 1000 patient-days b) Rate Outpatient Patient Fall: ≤ 5 %

Criteria	:	**Inclusion:** 1. Performance of all indicators as above. **Exclusion:** Not applicable
Numerator	:	Total index of each indicator
Denominator	:	2
Formula	:	**Index of Patient Fall:** $\frac{\text{Total of index for each indicator}}{2}$ **Examples: SUMS OF INDEX 1 AND 2** **Examples calculation of index 1:** Standard of indicator 1: ≤ 5 per 1000 patient-days Performance of indicator 1: 10 per 1000 patient-days $= \frac{100-10}{100-5}$ $= \frac{90}{95}$ **Indeks = 0.947** **Examples calculation of index 2:** Standard of indicator 2: ≤ 5 % Performance of indicator 2: 2% $= \frac{100-2}{100-5}$ $= \frac{98}{95}$ **Index = 1.032** **Calculation for index of patient fall:** = (Index 1+ Index 2)/2 $= \frac{0.947+1.032}{2}$ = **0.989**
Standard	:	≥1
Data collection	:	1. **Where**: Data will be collected in the respective department/ward that caters the above condition. 2. **Who**: Data will be collected by the Officer/ Paramedic/Nurse in-charge (Indicator Coordinator) of the department/unit 3. **How to collect**: Data is suggested to be collected from the record or log book/ patient's file.

		4. **How frequent**: PVF to be sent 6 monthly to Quality Unit of hospital. 5. **Who should verify**: PVF must be verified by Head of Department, Head of Quality Unit and Hospital Director.
Remarks	:	1. Malaysian Patient Safety Goal (MPSG) 2.0 Guideline

Indicator 4	:	% Performance of Patient Safety Incident Reporting and Learning System and Root Cause Analysis and Action Plan (RCA^2) for Actual Patient Safety Incidents Resulting in Severe or Death Outcome in the corresponding year
Element	:	Health (Quality Care)
Rationale	:	To ensure the implementation of Patient Safety Incident Reporting and Learning System along with proper remedial action or risk reduction strategy, especially for Root Cause Analysis carried out for incidents resulting in severe or death outcome. This is to encourage reporting and ensure the safety of patients in the hospital by reducing or preventing future similar incidents.
Definition of Terms	:	**Recommendation:** Any corrective action, risk reduction strategy and remedial measure to prevent or reduce incident. Also known as 'Action Plan' in RCA report. Strength of 'Action Plan' is based on the 'Action Hierarchy' in the 2017 Guideline on Implementation of Incident Reporting and Learning System 2.0 and is classified into strong, intermediate and weak 'Action Plan'. **Root cause analysis (RCA^2):** Is a structured investigation that aims to identify the 'root cause' of the problem and actions necessary to eliminate it. It is a risk management tool to understand WHY the problem occurs. **Patient safety incident:** An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient. An incident can be a reportable circumstance, near miss, no harm incident or harmful incident (adverse event). **Patient Outcome:** The impact on a patient, whether wholly or partially resulting from an incident. Severity, duration of harm and treatment implication is taken into account when determining the outcome. The classification of outcome is based on the 2017 Guideline on Implementation of Incident Reporting and Learning System 2.0 for Ministry of Health Hospitals.

Criteria	:	**Inclusion:** 1. For the purpose of monitoring of the indicator, only actual patient safety incidents which resulted in severe or death outcome will be taken into the calculation for action taken for RCA^2 within the time frame of the cohort (date taken is the date of incident reported). 2. The total number of all patient safety incidents (actual and near miss) reported is calculated by counting all incidents reported within the time frame of the cohort (date taken is the date of incident reported). **Exclusion:** 1. Recommendation in RCA^2 report that occur during disaster.
Formula	:	$\frac{\text{Total No. all of Patient Safety Incident Reported } \mathbf{(x)^*}}{\text{Incident Constant } \mathbf{(k)}} \times \left(\frac{\text{Total no. of RCA}^2 \text{ report (severe and death outcome) with at least 1 intermediate or strong action plan carried out } \mathbf{(N)}}{\text{Total no. of RCA}^2 \text{ report (severe and death outcome) } \mathbf{(D)}} \right) \times 100$ *Where maximum of X = K
Total No. of Patient Safety Incident Reported (x)	:	Total numbers of all patient safety incident (actual and near miss) reported within the time frame of cohort (X) (date taken is the date of incident reported). The maximum number for (X) is capped to the Incident constant (K) in the formula.
Incident Constant (k)	:	The constant is derived from the median number of all patient safety incidents (actual and near miss) reported by hospital category for the previous year.
Numerator (N)	:	Total number of RCA^2 report for patient safety incidents resulting in severe and death outcome with at **least 1 intermediate or strong action plan carried out*** within the time frame of cohort (date taken is the date of incident reported). Note : The numerator is the number of RCA^2 report with at least 1 strong or intermediate action plan carried out. If the RCA^2 report had more than one strong or intermediate action plan carried out for the report, it is still counted as 1.

		*An action plan is considered carried out if initial action toward its implementation is already in place, which includes a request letter or writing of paperwork for implementation.
Denominator (D)	:	Total number of RCA[2] report for patient safety incidents resulting in severe and death outcome within the time frame of cohort (date taken is the date of incident reported).
Standard	:	≥ 70%
Data collection	:	1. Where: Data will be collected in the Quality Unit 2. Who: Data will be collected by the Quality Officer/ Paramedic/ Nurse in-charge (Indicator Coordinator) of the department/ unit. 3. How to collect: Data is collected from the Action Plan Table in the RCA report submitted to the Quality Unit. 4. How frequent: PVF to be generated 6 monthly by the Quality Unit of the hospital. The cohort for patient safety incident and RCA[2] report (date taken is the date of incident reported) is according to: • January - June: 1st October (previous year) to 31st March (current year) • July - December: 1st April (current year) to 30th September (current year) • January – December : Please refer to the generated performance based on the tool for calculation (excel) given. 5. Who should verify: PVF must be verified by Head of Quality Unit, and Hospital Director.
Remarks	:	Tool for calculation (excel) is available at: https://tinyurl.com/hpia-rca-23-kkm

Additional notes for implementation:
Note the strength of action and example of action plan in the Action Hierarchy table. The light blue shaded area in the table indicates strong and intermediate action plans that are easier to implement.

Action Hierarchy

	Action Category	Example
Stronger Actions (these tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main patient entrance into the building with powered sliding or swinging doors to reduce patient falls.
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose meters and test strips and select the most appropriate for the patient population being served.
	Engineering control (forcing function)	Eliminate the use of universal adaptors and peripheral devices for medical equipment and use tubing/fittings that can only be connected the correct way (e.g., IV tubing and connectors that cannot physically be connected to sequential compression devices or SCDs).
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize on the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.
	Tangible involvement by leadership	Participate in unit patient safety evaluations and interact with staff; support the RCA[2] process; purchase needed equipment; ensure staffing and workload are balanced.
Intermediate Actions	Redundancy	Use two RNs to independently calculate high-risk medication dosages.
	Increase in staffing/decrease in workload	Make float staff available to assist when workloads peak during the day.
	Software enhancements, modifications	Use computer alerts for drug-drug interactions.
	Eliminate/reduce distractions	Provide quiet rooms for programming PCA pumps; remove distractions for nurses when programming medication pumps.
	Education using simulation- based training, with periodic refresher sessions and observations	Conduct patient handoffs in a simulation lab/environment, with after action critiques and debriefing.
	Checklist/cognitive aids	Use pre-induction and pre-incision checklists in operating rooms. Use a checklist when reprocessing flexible fiber optic endoscopes.
	Eliminate look- and sound-alikes	Do not store look-alikes next to one another in the unit medication room.
	Standardized communication tools	Use read-back for all critical lab values. Use read-back or repeat-back for all verbal medication orders. Use a standardized patient handoff format.
	Enhanced documentation, communication	Highlight medication name and dose on IV bags.

Weaker Actions (these tasks require more reliance on humans to remember to perform the task correctly)	Double checks	One person calculates dosage, another person reviews their calculation.
	Warnings	Add audible alarms or caution labels.
	New procedure/ memorandum/policy	Remember to check IV sites every 2 hours.
	Training	Demonstrate correct usage of hard-to-use medical equipment.

(Source: National Patient Safety Foundation. Improving Root Cause Analyses and Actions to Prevent Harm. Version 2, 2016; based on VA National Center for Patient Safety.)

Indicator 5	:	**# Index of paramedics who have a CURRENT trained status in Basic Life Support (BLS) in the corresponding year** **A: acute care area** **B: non acute area**
Element	:	**Health (Quality Care)**
Rationale	:	Basic Life Support is an important skill for all healthcare personnel to have and it is an important element of the Continuous Professional Development. Therefore, continuous updating of this skill will ensure the current and latest management of patient care is being practised.
Definition of Terms	:	Index of paramedics who have a CURRENT trained status in Basic Life Support (BLS) will be assessed based on 2 indicators: 1. **Acute care area:** Emergency and Trauma Department, and Intensive Care Area (ICU, CCU, OT, HDW, Labour Room, Burn Unit, PICU, NICU, Neuro ICU and Haemodialysis Unit). **Standard in acute area: ≥ 70%** 2. **Non acute area:** all other clinical and administrative areas – e.g., Quality Unit, Public Health Unit, Occupational & Health Unit, Nursing Administrative Office. **Standard in non-acute area: ≥ 30%** **CURRENT trained status:** The valid period of certification is determined by either the National Committee on Resuscitation Training (NCORT) or the relevant State/Hospital committee. **Paramedic:** Refer to the medical assistant and nurse who work in the hospital.
Criteria	:	**Inclusion:** 1. Paramedic who is currently working in the acute/ non acute care area for more than 6 months **Exclusion:** 1. Paramedic who was transferred-in to the acute/ non acute care area for less than 6 months. 2. Paramedic who is currently working in the acute/ non acute care area for less than 6 months. 3. Paramedic who has been on medical leave for more than 6 months. 4. Paramedic who are not fit to perform resuscitation. e.g., spine problem, special needs.

Numerator	:	Total index of each indicator
Denominator	:	Total no. of indicator applicable * If the facility does not have acute area, ONLY indicator of non acute area is applicable.
Formula	:	Index of paramedics who have a CURRENT trained status in Basic Life Support (BLS): Total of index for each indicator Total no. of indicator applicable **Examples: SUMS OF INDEX 1 AND 2** **Examples calculation of index 1:** Standard of paramedics who have a CURRENT trained status in Basic Life Support (BLS) in acute areas: ≥ 70% Performance of indicator 1: 73% Measurement of index for indicator 1: = 73 70 **Index = 1.042** **Examples calculation of index 2:** Standard of paramedics who have a CURRENT trained status in Basic Life Support (BLS) in non-acute areas: ≥ 30% Performance of indicator 2: 28% Measurement of index for indicator 2: = 28 30 **Index = 0.9333** **Calculation for index of** paramedics who have a CURRENT trained status in Basic Life Support (BLS): = (Index 1+ Index 2)/2 = 1.042 + 0.9333 2 = **0.988**
Standard	:	A: Acute area ≥ 70% B: Non-Acute area ≥ 30% Index: ≥ 0.9
Data collection	:	1. **Where**: Data will be collected in the respective department/ ward that caters the above condition. 2. **Who**: Data will be collected by the Officer/ Paramedic/ Nurse in-charge (Indicator Coordinator) of the department/ unit

		3. **How to collect**: Data will be collected from the record book from each unit/ department/ ward. 4. **How frequent**: PVF to be sent 6 monthly to the Quality Unit of the hospital 5. **Who should verify**: PVF must be verified by Head of Quality Unit, and Hospital Director.
Remarks	:	1. This is a yearly indicator. If the indicator is SIQ for Jan-Jun, SIQ form does not need to be filled. 2. Reporting for the period from January to June will use the cumulative data as of June. 3. Reporting for the period from January to December will use the cumulative data as of December.

Indicator 6	:	% of fire drill that has been carried out by the hospital in the corresponding year
Element	:	Health (Quality Care)
Rationale	:	Fire drills are essential in any workplace or public building for practicing what to do in the event of a fire. Not only do they ensure that all staff, customers, and visitors in the premises understand what they need to do in case of fire, but they also help to test how effective the fire evacuation plan is and to improve certain aspects of the fire provisions.
Definition of Terms	:	**Fire Drill:** A practice of the emergency procedures to be used in case of fire with the involvement of Fire & Rescue Department.
Criteria	:	**Inclusion:** 1. All fire drills that have been planned in the corresponding year **Exclusion:** Not applicable
Numerator	:	Number of fire drill that has been carried out according to the plan in the corresponding year
Denominator	:	1
Formula	:	Numerator x 100% Denominator
Standard	:	100%
Data collection	:	1. **Where**: Data will be collected in the respective department/ ward that caters the above condition. 2. **Who**: Data will be collected by the Officer/ Paramedic/Nurse in-charge (Indicator Coordinator) of the department/unit 3. **How to collect**: Data will be collected from the record book/ registration book from each unit/ department/ ward or any form of documentation. 4. **How frequent**: PVF to be sent 6 monthly to the Quality Unit of the hospital 5. **Who should verify**: PVF must be verified by Head of Quality Unit, and Hospital Director.
Remarks	:	1. This is a yearly indicator. If the indicator is SIQ for Jan-Jun, SIQ form does not need to be filled. 2. Any SIQ due to cancellation and/or postponement from Fire & Rescue Department will NOT be included in Hospital Report Card measurement.

Indicator 7	:	**% of clinical department conducting clinical audit in the hospital/institution in the corresponding year**
Element	:	**Health (Quality Care)**
Rationale	:	Clinical audit is at the heart of clinical governance. It offers the mechanisms for reviewing the quality of care provided to patients. It addresses quality issues systematically and explicitly, providing reliable information and highlight the need for improvement.
Definition of Terms	:	**Clinical audit** *is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.* *Where indicated, changes are implemented and further monitoring is used to confirm improvements in healthcare delivery. (Source: National Institute for Clinical Excellence 2002)* **Completed 1st cycle** *means that the clinical audit is finished and the re-audit is being planned*
Criteria	:	**Inclusion:** 1. All **CLINICAL** departments. 2. Clinical audit conducted in the corresponding year or 1 year prior and completed 1st cycle in the corresponding year. **Exclusion:** 1. New service that was established in less than 12 months.
Numerator	:	Number of clinical departments that conducted at least one clinical audit in the corresponding year
Denominator	:	Total number of clinical departments in the hospital/ institution
Formula	:	Numerator x 100% Denominator
Standard	:	≥ 30%
Data collection	:	1. **Where**: Data will be collected in the respective department/ ward that caters the above condition. 2. **Who**: Data will be collected by the Officer/ Paramedic/ Nurse in-charge (Indicator Coordinator) of the department/ unit 3. **How to collect**: Data is suggested to be collected from the record or log book/ patient's file/ etc 4. **How frequent**: PVF to be sent 6 monthly to the Quality Unit of the hospital 5. **Who should verify**:

		PVF must be verified by Head of Quality Unit, and Hospital Director.
Remarks	:	1. Clinical department for non-specialist hospital refers to Emergency & Trauma Department, Obstetrics & Gynaecology Ward, Paediatric Ward, Female Ward and Male Ward. (Total of 5 Departments for non-specialist hospital) 2. Clinical department for specialist hospital refers to all hospital that has resident specialist. 3. A subspecialty that has its own appointed Head of Department (HOD) is considered a clinical department and needs to conduct its own clinical audit. 4. Refer to Clinic Audit Guideline 2023. 5. This is a yearly indicator. If the indicator is SIQ for Jan-Jun, SIQ form does not need to be filled.

Indicator 8	:	% of Hospitals Achieving the Specified Bed Waiting Time
Element	:	Responsiveness
Rationale	:	This KPI refers to the performance of each Ministry of Health (MOH) hospital in ensuring that non-critical patients from the Emergency Department, who have been decided for admission to regular wards (non-critical beds), are admitted within the stipulated time frame. This KPI is implemented in all MOH hospitals with an Emergency Department. Bed Waiting Time (BWT): Measures the time between the decision for admission to a ward in the Emergency Department (ED) and the patient's admission to a bed in the ward. This KPI serves as an indicator to monitor the effectiveness of patient bed management in each hospital, and it falls under the jurisdiction of the Hospital Director. Prolonged waiting time is a source of patient dissatisfaction in health care. In patient flow there are few indicators related to timely and efficient transitions in care. One of it is bed waiting time. Prolonged bed waiting time is one of the key factors contributing to emergency department (ED) overcrowding. Prolonged stay in Emergency Department also associated with higher inpatient mortality rates and longer hospital length of stay. Prolonged bed waiting time is also one of the result from inefficient discharge process. Managing demand for admission at ED to inpatients' wards is one of the important aspects in Hospital Operation Management. Efforts to reduce may improve outcomes for ED patients who are admitted to the hospital. Every hospital must look into continuously improving it.
Definition of Terms	:	**Bed Waiting Time (BWT):** The average waiting time for a bed from the doctor's order for admission to a regular ward until the patient is transferred to the bed. **Regular/Non-Critical Ward:** Wards other than critical wards/areas/rooms such as ICU, CCU, PICU, NICU, HDW, SCN, Burn Unit, including acute beds in regular wards. The beds involved are sub-acute beds and regular beds in non-critical wards.

<table>
<tr><td></td><td></td><td>Critical Patients: Patients requiring specialized observation who need to be placed in critical wards/rooms/areas.</td></tr>
<tr><td>Criteria</td><td>:</td><td>Inclusion:
1. Hospitals with Emergency and Trauma Department services.
2. Involves patients who receive treatment in the Emergency Department and are confirmed for admission to non-critical wards.
3. Non-critical patients who are suitable to be placed in sub-acute beds and regular beds in non-critical wards.

Exclusion:
1. Critically ill patients who should be placed in a critical ward/acute beds but are instead placed in sub-acute/regular beds in a non-critical ward (due to the unavailability of beds in the critical ward).
2. Referral cases for admission (step-up/step-down).
3. Patients requiring isolation (e.g., infectious disease patients) or close monitoring (e.g., mental health patients).
4. Isolation ward space that is permanent, temporary, or transit.
5. Patients who need to undergo procedures while being transferred to the ward (e.g., X-ray).
6. Patients who need to be sent directly to the operating theatre for any procedure.
7. Covid-19, SARI, ILI, PUI patients, and patients requiring a PCR test in the Emergency Department (before ward admission).</td></tr>
<tr><td>Numerator</td><td>:</td><td>The total time for all patients (samples) recorded in one week.</td></tr>
<tr><td>Denominator</td><td>:</td><td>The number of patients (samples) recorded in one week</td></tr>
<tr><td>Formula</td><td>:</td><td>Numerator
Denominator

Example Calculation:
<table>
<tr><th>Patient (A)</th><th>Admission Decision by Doctor in Emergency Department</th><th>Patient Arrival at Assigned Ward Bed</th><th>Bed Waiting Time (in minutes) (B)</th></tr>
<tr><td>Ali</td><td>11:00 AM</td><td>11:45 AM</td><td>45</td></tr>
<tr><td>Mei Mei</td><td>11:10 AM</td><td>12:30 PM</td><td>80</td></tr>
</table></td></tr>
</table>

		<table><tr><td>Chandran</td><td>11:33 AM</td><td>12:12 PM</td><td>39</td></tr></table> Average Weekly BWT= Total (B) / Total (A) Total (B)=45+80+39=164minutes Total (A)=3 patients Average Weekly BWT =164 / 3 = 54.67 minutes
Standard	:	i) The average weekly BWT is ≤ 360 minutes for hospitals with an official annual Bed Occupancy Rate (BOR) (from the previous year) of ≥ 85%. ii) The average weekly BWT is ≤ 240 minutes for hospitals with an official annual Bed Occupancy Rate (BOR) (from the previous year) of < 85%.
Data collection	:	1. **Where**: Data will be collected in the Emergency & Trauma Department. 2. **Who**: Data will be collected by the Officer/ Paramedic/Nurse in-charge (Indicator Coordinator) of the department/unit 3. **How to collect**: Data is suggested to be collected from the record or log book/ patient's file. Data to be collected twice a year for period of one week each with minimum sample size of 200 or universal sampling. 4. **How frequent**: PVF to be sent 6 monthly to the Quality Unit of the hospital 5. **Who should verify**: PVF must be verified by Head of Quality Unit, and Hospital Director.
Remarks	:	1. Reporting for the period of January – December will use the performance of July – December of the current year. 2. Data collection must be conducted twice a year for a one-week period during the early and late phases of the year (Monday to Sunday). 3. The dates for data collection will be determined by the respective State Health Departments. The sample size is 200 cases or the total number of all cases throughout the one-week data collection period. 4. The data involves patient admissions to Medical, Surgical, Orthopedic, Pediatric, and Gynecology wards, or relevant female, male, and pediatric wards.

Indicator 9	:	**% of patients with waiting time of ≤ 90 minutes to see doctor at the Specialist Clinic**
Element	:	**Responsiveness**
Rationale	:	1. MOH aims for waiting time for consultation at clinic to be less than 90 minutes, in line with patient-centered services. Waiting time is the time patient first registers in the hospital till the time patient is seen by doctor. 2. The waiting time is based on patient's experience from the time the patient first registers at the first counter in the hospital till seen by doctor. 3. For hospitals to eliminate or reduce waiting time, it is important to balance between the demand for appointments and the supply of appointments. One needs to identify opportunities for improvement by strengthening the policy of outpatient services in hospital.
Definition of Terms	:	**Waiting time:** Time of registration or time of appointment given to patient (whichever is later) till the doctor consultation.
Criteria	:	**Inclusion:** 1. Patient coming for the purpose of doctor's consultation. 2. The first clinic consultation for patient with multidisciplinary clinic appointment. 3. Visiting clinic in non-specialist hospital. **Exclusion:** 1. Patients come without an appointment ("walk-in" patients). 2. Patients that need to do procedures in another department on the same day before seeing the doctors (e.g., blood taking or imaging). 3. Patient come to Opthalmology Specialist Clinic, Orthopaedic Specialist Clinic and Geriatric Specialist Clinic
Numerator	:	Number of patients with waiting time of ≤ 90 minutes for to see doctor at the Specialist Clinic
Denominator	:	Total number of patients at the Specialist Clinic
Formula	:	$\frac{\text{Numerator}}{\text{Denominator}} \times 100\%$
Standard	:	≥ 90%
Data collection	:	1. **Where:** Data will be collected in the respective department/ward. 2. **Who:** Data will be collected by the Officer/ Paramedic/Nurse in-charge (Indicator Coordinator) of the department/unit.

		3. **How to collect:** Data is suggested to be collected from the record or log book/ patient's file/ waiting slip. Data will be collected for a whole week (5 Working Days: Monday – Friday or Sunday – Thursday) and will be done 4 times per year (Quarterly). 4. **How frequent:** PVF to be sent 6 monthly to Quality Unit of hospital. Quality Unit will compile the performance data of all Specialist Clinics to generate hospital performance. 5. **Who should verify:** PVF must be verified by Head of Department, Head of Quality Unit and Hospital Director.
Remarks	:	1. Outpatients Department (OPD) will be included only IF the Hospital does not have any visiting specialist clinic and OPD is operated by the Hospital. 2. PVF for each sub-indicator needs to be prepared and reported by the respective departments. 3. Each sub-indicator's PVF needs to be compiled by appointed personnel to generate the overall hospital performance. 4. SIQs for each sub-indicator need to be completed by the respective departments. 5. The overall hospital performance SIQ will only need to use the SIQs from respective departments.

Indicator 10	:	% of workplace inspection performed quarterly in the corresponding year
Element	:	Responsiveness
Rationale	:	To ensure safety of the patient and healthcare workers involved.
Definition of Terms	:	**Workplace:** Refers to any premises or part thereof where work is conducted. In a hospital setting, this includes specific units or departments, each considered a distinct workplace due to its unique tasks, risks, and work procedures. Examples include the Emergency Department, Intensive Care Unit, Surgery Department, laboratories, operating theaters, and administrative offices. **Workplace Inspection:** An audit that is conducted by the hospital's Safety and Health Committee (JKKK) / OSH unit. **Audit finding:** Any finding in the KKP(BKP)/PTK-01 Form that can be used for the purpose of monitoring and improvement.
Criteria	:	**Inclusion:** Not applicable **Exclusion:** 1. Areas under construction.
Numerator	:	Number of workplace inspection performed quarterly
Denominator	:	At least 3 workplaces had been inspected quarterly (Total= 12 workplace inspection/ year)
Formula	:	**Quaterly Performance** Numerator x 100% Denominator (3) **Yearly Performance** Numerator x 100% Denominator (12)
Standard	:	100%
Data collection	:	1. **Where**: Data will be collected from the hospital's Safety and Health Committee (JKKK) / OSH unit/ departments 2. **Who**: Data will be collected by the hospital's Safety and Health Committee (JKKK) / Person in charge of safety (Safety Officer).

		3. **How to collect**: Data will be collected from the record book/ audit finding report/ minutes regarding safety/ monitoring system by the hospital's Safety and Health Committee (JKKK). 4. **How frequent**: PVF to be sent 6 monthly to Quality Unit of hospital. 5. **Who should verify**: PVF must be verified by Head of Quality Unit, and Hospital Director.
Remarks	:	1. Based on the requirements in Occupational Safety and Health Act 1994 (Act 514), Safety and Health Committee must be established in the hospital. 2. Workplace inspections need to be conducted in the hospital by Safety and Health Committee or any person appointed. 3. KKP(BKP)/PTK-01 Form is used for the purpose of workplace inspection in the hospital and other healthcare facilities under MOH. 4. All the findings identified and documented during the assessment/ audit, should be presented and discussed in the Safety and Health Committee Meeting, chaired by the Hospital Director. 5. Control measures to improve the workplace inspection finding and effectiveness of the control measures also can be discussed during the meeting. 6. The head of the OSH Unit needs to make sure that the Workplace Inspection Report of the corresponding year is sent to the State KPAS officer. 7. The head of the OSH Unit needs to make sure that the HPIA report is sent to Penyelaras OSH, Bahagian Perubatan, JKN. 8. The Penyelaras OSH, Bahagian Perubatan, JKN needs to compile the Work Place Inspection State Report to the Occupational Safety and Health Unit, Medical Development Division by 14 January of the next year for the corresponding year.

Indicator 11	:	**% of hospital or medical institutional staff undergo health screening for risk of Non-Communicable Disease (NCD)**
Element	:	**Responsiveness**
Rationale	:	National Health Screening Initiative (NHSI) is one of the initiatives under the 3rd Pillar of *Agenda Nasional Malaysia Sihat* (ANMS) which is *Kawalan Kesihatan Kendiri*. Health screening allow early detection of NCD, offering early treatment and ensure productivity among staff.
Definition of Terms	:	**Health screening:** Test/ screening/ assessment to detect early symptoms of chronic disease, facilitating prevention and treatment of disease. **Compulsory test/ screening :** I. Body Mass Index (BMI). II. Waist circumference III. Random Blood Sugar (RBS) or Fasting Blood Sugar (FBS). IV. Blood Cholesterol V. Blood Pressure Measurement VI. Smoking status VII. Mental health screening **Frequency of screening :** Once a year **Risk of Non-Communicable Disease (NCD):** The main risk factor of NCD is unhealthy lifestyle such as unhealthy eating, inactivity, smoking, alcohol consumption and unhealthy stress. **Non-Communicable Disease (NCD):** NCD include hypertension, diabetic, heart disease and hyperlipidaemia **Staff :** Public servant working in hospital or medical institution under Ministry of Health (MOH) **Eligible staff :** Staff with unknown NCD and non-pregnant staff **Under Treatment:** Currently under follow up in hospital or clinic
Criteria	:	**Inclusion:** 1. Staff who is eligible for screening and working in hospital or medical institution as of 1st January of current year. **Exclusion:** 1. Staff who has established NCD such as hypertension, diabetic, heart disease and hyperlipidaemia

		2. Pregnant staff 3. Concession company staff.
Numerator	:	Number of staff working in hospital or medical institution as of 1st January of current year who has undergo screening.
Denominator	:	Number of staff who are eligible for screening and working in hospital or medical institution as of 1st January of current year.
Formula	:	Numerator x 100% Denominator
Standard	:	≥ 70%
Data collection	:	1. **Where**: Data will be collected from the OSH unit/ respective department. 2. **Who**: Data will be collected by the Officer/ Paramedic/Nurse in-charge (Indicator Coordinator) of the department/unit. 3. **How to collect**: Data is suggested to be collected from record or log book either physically or online. 4. **How frequent**: PVF to be sent 6 monthly to the Quality Unit of the hospital. 5. **Who should verify**: PVF must be verified by Head of Quality Unit, and Hospital Director.
Remarks	:	1. This is yearly indicator. If the indicator is SIQ for Jan-Jun, SIQ form does not need to be filled.

Indicator 12	:	% of bills payment within 14 days
Element	:	Fair Financing & Governance
Rationale	:	This refers to the percentage of bill payments settled within 14 days in accordance with Treasury Instruction (AP) 103(a). The Department Head must ensure that all bills are paid promptly within 14 days from the date of receipt, in a complete and accurate manner. More effective monitoring can be implemented at the department level to ensure that all payments are made promptly for better future financial planning.
Definition of Terms	:	**Within 14 days:** Time from all completed documents received until payment **Bills:** Complete documentation of all bills submitted to the financial department.
Criteria	:	**Inclusion:** 1. All bills received by the financial department **Exclusion:** Not applicable
Numerator	:	All bills paid by the financial department within 14 days
Denominator	:	All bills received by the financial department
Formula	:	Numerator x 100% Denominator
Standard	:	≥99%
Data collection	:	1. **Where**: Data will be collected in the administrative unit/financial unit 2. **Who**: Data will be collected by the Officer unit in-charge 3. **How to collect**: Data will be collected from from the registration book or computerized record system 4. **How frequent**: PVF to be sent 6 monthly to the Quality Unit of the hospital 5. **Who should verify**: PVF must be verified by *Penolong Pegawai Tadbir* / Deputy Director (Administration), and Hospital Director.
Remarks	:	1. Surat Pekeliling KSU KKM Bil.11 Tahun 2019

Indicator 13	:	% of assets in the hospital that were registered within 2 weeks
Element	:	Fair Financing & Governance
Rationale	:	To assure the assets attained are safe for usage and is acceptable for maintenance by concession company (ie cost effectiveness of assets management and applied patient safety criteria)
Definition of Terms	:	**Assets:** Hospital properties that were received in the current year. **Registered within 2 weeks:** Upon completing and passing the process of testing and commissioning.
Criteria	:	**Inclusion:** Assets that must be registered are: 1. Asset received through purchase/hire purchase with government funds 2. Asset received as gifts or transfers 3. Asset through legal processes or agreements **Exclusion:** Not applicable
Numerator	:	Number of assets that were registered within 2 weeks
Denominator	:	Total number of assets that were received in the current year
Formula	:	Numerator x 100% Denominator
Standard	:	100%
Data collection	:	1. **Where**: Data will be collected from the administration unit/ departments. 2. **Who**: Data will be collected by the Officer/ staff of the Administration unit in-charge for assets and inventory. 3. **How to collect**: Data will be collected from the record book/ registration book/ monitoring system in the administrative unit/ department. 4. **How frequent**: PVF to be sent 6 monthly to the Quality Unit of the hospital 5. **Who should verify**: PVF must be verified by *Penolong Pegawai Tadbir* / Deputy Director (Administration) and Hospital Director.
Remarks	:	1. Pekeliling Perbendaharaan - Tatacara Pengurusan Aset Alih Kerajaan

Indicator 14	:	**% of new hospital staffs who attended the Orientation Programme within 3 months of their placement at the Unit or Department in the hospital**
Element	:	**Fair Financing & Governance**
Rationale	:	Orientation Programme is a platform used to provide information in regards to the institution/ hospital to the newcomers (i.e. staffs). This Orientation Program will assist the new staffs to be familiarized with the institution/ hospital, hence, indirectly it will boost their productivity and their self confidence in the new environment.
Definition of Terms	:	**New staffs:** Newly reported personnel (transferred in/ newly appointed/ new placement) to the hospital/ institution. **Orientation Program:** Program organized/ conducted by the Hospital/ Institution comprises of introduction of the system, work process and environment. **3 months:** Period begins from the date of reporting or the date of postponement, whichever is later.
Criteria	:	**Inclusion:** 1. Orientation Programme that was conducted by the Hospital/ Institution **Exclusion:** 1. Staffs whom transferred out/resigned from the hospital ≤ 3 months after reporting for duty. 2. Staffs who underwent training outside <1 year for training purpose
Numerator	:	Number of new staffs who attended the Orientation Program within 3 months of their placement in the hospital
Denominator	:	Total number of new staff reported to the hospital.
Formula	:	Numerator x 100% Denominator
Standard	:	100%
Data collection	:	1.**Where**: Data will be collected in every unit/ department/ wards. 2. **Who**: Data will be collected by the Officer/ staff in-charge for the Orientation Program in each department/ unit/ ward (Administrative unit/ department responsible for the overall data collection)

		3. **How to collect**: Data will be collected from the record book/ human resource record. 4. **How frequent**: PVF to be sent 6 monthly to the Quality Unit of the hospital 5. **Who should verify**: PVF must be verified by Head of Department/Unit, Head of Quality Unit, and Hospital Director.
Remarks	:	1. Staff who reported after 31st March or after 30th September of the current year will be carried to the next term/ year of the denominator which means; ● 1st Term Evaluation: For staffs who reported duty on 1st October of the previous year to the 31st March of the current year. ● 2nd Term Evaluation: For staffs who reported duty on 1st April of the current year to the 30th September of the current year.

SATELLITE INDICATORS

SATELLITE INDICATORS *** Satellite indicators encompass indicators from State Health Directors KPIs or any top management's KPIs that need to be monitored by the hospital director. It is important to note that these indicators will be changed annually. Kindly refer to the respective technical specifications for each KPI.		
	INDICATORS	**STANDARDS**
State Health Director KPI 2025		
4.	# Purata Performance Indeks Jangkitan Aliran Darah berkaitan Penjagaan Kesihatan (bacteraemia) **(State Health Director KPI 2025)**	≥ 1.00
5.	% Bayi Baru Lahir yang Menjalani Saringan Pendengaran (*Universal Newborn Hearing Screening*) dalam Tempoh 28 Hari Selepas Kelahiran di Hospital/ Fasiliti Kesihatan Kerajaan **(State Health Director KPI 2025)**	≥85 %
6.	% Peralatan Perubatan/ Sistem Kejuruteraan Fasiliti Mencapai Uptime di Bawah Perkhidmatan Sokongan Hospital (PSH) **(State Health Director KPI 2025)**	≥95 %
Deputy State Health Director (Medical) KPI 2025		
1.	# Indeks Pencapaian Petunjuk Prestasi Utama (KPI) Kualiti Perkhidmatan Perubatan Klinikal **(Deputy State Health Director (Medical) KPI 2025)**	≥ 0.9
2.	# Purata Performance Indeks Jangkitan Aliran Darah berkaitan Penjagaan Kesihatan (bacteraemia) **(Deputy State Health Director (Medical) KPI 2025)**	≥ 1
3.	% Bayi Baru Lahir yang Menjalani Saringan Pendengaran (Universal Newborn Hearing Screening) dalam Tempoh 28 Hari Selepas Kelahiran di Hospital/ Fasiliti Kesihatan Kerajaan **(Deputy State Health Director (Medical) KPI 2025)**	≥ 85%
4.	% Hospital yang Mencapai Bed Waiting Time yang Ditetapkan **(Deputy State Health Director (Medical) KPI 2025)**	≥ 80%

5.	% Keputusan Lembaga Perubatan Selesai Bersidang dalam Tempoh Masa yang Ditetapkan **(Deputy State Health Director (Medical) KPI 2025)**	≥75%
6.	% Jururawat yang Bertugas di Penempatan Klinikal > 6 Bulan Diperakui Lulus dan Mendapat Privilege **(Deputy State Health Director (Medical) KPI 2025)**	≥ 80%

HOSPITAL REPORT CARD

HOSPITAL REPORT CARD		
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Weighted Percentile – Point – Scoring Concept (PPS-C)

The hospital report card system by the Ministry of Health Malaysia uses a **weighted Percentile – Point – Scoring Concept (PPS-C)** to assess hospital performance comprehensively. Here is a detailed breakdown of the process:

Scoring Components and Weightage

1. HPIA Index (50%)
2. Casemix Performance (10%)
3. Cluster Performance (25%)
4. Patient Satisfaction Questionnaire-18 (PSQ-18) (15%)

Step-by-Step Calculation

1. HPIA Index

- Step 1: Calculate the HPIA index based on specific indicators.
- Step 2: Analyze hospital performance based on hospital types using the percentile method to ensure fair comparison.
- Step 3: Generate a score on a scale of 1 to 5 based on the percentiles.
  - E.g., Percentile ranges may correspond to scores as follows:
    - 90th percentile or higher = 5
    - 75th-89th percentile = 4
    - 50th-74th percentile = 3
    - 25th-49th percentile = 2
    - Below 25th percentile = 1

- **Step 4:** Apply the weightage (50%) to the generated score.

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2. Casemix Performance

- Repeat Steps 1–4 for Casemix Performance, applying a weightage of 10%.

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3. Cluster Performance

- Repeat Steps 1–4 for Cluster Performance, applying a weightage of 25%.

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4. PSQ-18

- Repeat Steps 1–4 for PSQ-18, applying a weightage of 15%.

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5. Total Scoring and Ranking

- Add up the weighted scores from all four elements to derive the total score for each hospital.
- Rank the hospitals using centiles to determine overall performance.
- Assign star ratings:
    - 4-star and 5-star hospitals are those that score in the top centiles based on the ranking.

This method ensures that hospital performance is evaluated systematically and fairly, accounting for diverse factors like hospital type, service complexity, and patient satisfaction.

Cluster Hospital Performance

SEKSYEN	PERKARA	TATACARA	SKOR	PERATUS(%)
A	Tadbir Urus	Pengurusan Organisasi Kluster di JKN dan Kluster	7	20
B	Pengurusan	Pentadbiran Kluster merangkumi LNPT, pengurusan waran secara kluster dan pengurusan perolehan secara kluster	7	20
C	Perkhidmatan Kecemasan & Trauma	Status Perkhidmatan ETD; dijalankan secara lawatan pakar/ koordinasi atau bersepadu dan membentuk jabatan yang diketuai oleh Ketua Jabatan	4	10
	Perkhidmatan Perubatan Dalam (Internal Medicine)	Perkhidmatan *Internal Medicine* dijalankan secara lawatan pakar/ koordinasi atau bersepadu dan membentuk jabatan yang diketuai oleh Ketua Jabatan	4	10
	Perkhidmatan lain-lain; 3 terbaik	Tiga (03) perkhidmatan terbaik yang dijalankan di dalam kluster	12	10
	Perkhidmatan yang dijalankan secara *Niche*	Perkhidmatan yang dijalankan secara *Niche* di hospital-hospital di dalam kluster	2	10
D	*Process Improvement*	Merangkumi pengurusan aliran pesakit, BWT dan pengurusan rekod pesakit secara Kluster, ID Kluster dan Bil perubatan	6	20
		JUMLAH	**42**	**100**

Casemix Performance

Bahagian A: Tadbir Urus		Pemarkahan	Markah maksimum
A1	Pelantikan Penyelaras Casemix Hospital	1. Ada lantikan (1 markah) 2. Tiada pelantikan (0 markah)	1
A2	Pelantikan Jawatankuasa Casemix Hospital	1. Ada lantikan (1 markah) 2. Tiada pelantikan (0 markah)	1
A3	Pelaksanaan Mesyuarat Jawatankuasa Casemix Hospital	1. Laksana lebih dari sekali setahun (2 markah) 2. Laksana sekali setahun (1 markah) 3. Tidak melaksanakan (0 markah)	2
Bahagian C: Amalan Penambahbaikan Kualiti Berterusan (Wajaran 50%)			
C1	Peratus ketepatan dokumentasi klinikal bagi diagnosis utama	1. 90 - 100% (4 markah) 2. 80 - 89% (3 markah) 3. 70 - 79% (2 markah) 4. 60 - 69% (1 markah) 5. <60% atau tidak melaksanakan audit (0 markah)	4
C2	Peratus kesempurnaan dokumentasi klinikal bagi diagnosis-diagnosis lain	1. 90 - 100% (4 markah) 2. 80 - 89% (3 markah) 3. 70 - 79% (2 markah) 4. 60 - 69% (1 markah) 5. <60% atau tidak melaksanakan audit (0 markah)	4
C3	Tarikh penghantaran laporan Audit Dokumentasi Diagnosis Klinikal dan Kod Klasifikasi yang lengkap ke JKN	1. Dihantar pada tahun semasa audit (2 markah) 2. Dihantar pada Januari tahun berikutnya (1 markah) 3. Dihantar selepas 31 Januari tahun berikutnya atau tidak melaksanakan audit (0 markah)	2
C4	Bilangan kes kematian dengan darjah keterukan penyakit 1 (SOI1) dalam setiap 1,000 kes discaj pulang ke rumah SOI1	1. ≤ 5 kes (2 markah) 2. 6 - 15 kes (1 markah) 3. ≥ 16 kes (0 markah)	2
C7	Pelaksanaan latihan kesedaran casemix kepada warga kerja hospital anjuran hospital	1. Laksana (1 markah) 2. Tidak dilaksanakan (0 markah)	1

C8	Pelaksanaan latihan dokumentasi diagnosis dan penetapan kod klasifikasi anjuran hospital	1. Laksana kedua-dua latihan (2 markah) 2. Laksana salah satu latihan (1 markah) 3. Tidak laksana (0 markah)	2
C9	Pelaksanaan latihan penyelaras casemix hospital / jabatan anjuran hospital	1. Laksana (1 markah) 2. Tidak dilaksanakan (0 markah)	1

Patient Satisfaction Questionnaire (PSQ – 18)

• Mengandungi lapan belas (18) soalan berkaitan kajian kepuasan pelanggan (KKP).
• Menggunakan 5 mata skala Likert (*5-point Likert scale*)
• Penilaian adalah merangkumi 7 dimensi;
  ○ Dimensi 1: Kepuasan pesakit
  ○ Dimensi 2: Kualiti teknikal
  ○ Dimensi 3: Sikap *Interpersonal*
  ○ Dimensi 4: Komunikasi
  ○ Dimensi 5: Aspek kewangan
  ○ Dimensi 6: Waktu bersama dengan doktor
  ○ Dimensi 7: Akses dan keselesaan
• Purata keseluruhan markah diambil kira sebagai pencapaian akhir PSQ-18.