PART V

PERFORMANCE INDICATORS (PIs) & PATIENT SAFETY GOALS (PSGs)

MSQH HOSPITAL ACCREDITATION PROGRAMME
7TH EDITION · CENTRALISED TRAINING

Dr Mohd Anis Haron

MSQH Surveyor
Task Force Committee
(Performance Indicator)

10 June 2026

PART I

SESSION ROADMAP

01 WHY PIs MATTER?

02 6TH → 7TH EDITION

03 THE 12-ELEMENT MANUAL

04 PI BREAKDOWN BY CATEGORY

05 PSGs

06 SURVEYOR APPLICATION

01

WHY PIs MATTER?

The measurement backbone of safe, accountable hospital care

PERFORMANCE INDICATORS: THE MEASUREMENT BACKBONE

ACCOUNTABILITY

- PIs provide objective, auditable evidence that hospitals meet accreditation standards.
- Not just intent, but measurable proof.

CONTINUOUS IMPROVEMENT

- Trend data over successive survey cycles exposes systemic gaps that single-point inspections miss.

PATIENT SAFETY SIGNAL

- Each PI is a sentinel
- PI is a quantified proxy for clinical risk, aligned directly to Patient Safety Goals.

02

6TH → 7TH EDITION

A calibrated expansion. Not change for the sake of change

THE PI LANDSCAPE: BY THE NUMBERS

6TH EDITION

~190

— Embedded in standards text

— No standard specification format

— Interpretation variability

7TH EDITION

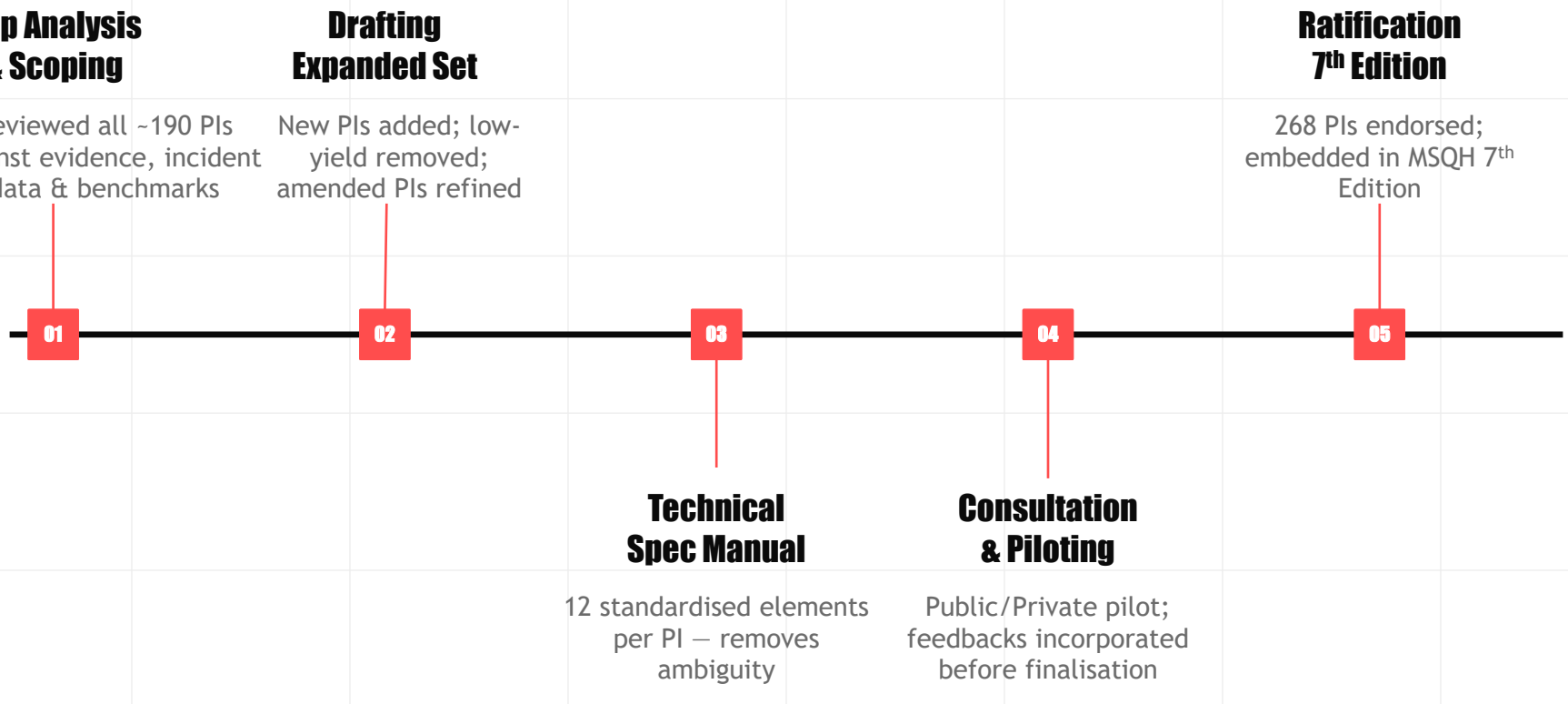
268

+ Dedicated standalone PI Manual

+ 12-element standard spec per PI

+ Consistent surveyor interpretation

CHRONOLOGY: HOW THE 7TH EDITION PI SET WAS DEVELOPED



DRIVERS FOR CHANGE: WHY UPDATE THE PI SET?

EMERGING CLINICAL RISKS

Outpatient safety, telemedicine, antimicrobial stewardship — NOT adequately measured in 6th Edition

LOW-YIELD INDICATORS

Surveyor feedback identified PIs that were ambiguous, duplicated, or no longer high-risk

GLOBAL ALIGNMENT

International shift toward outcome measures — WHO & ISQua driven

DIGITAL HEALTH TRANSITION

Some 6th Edition PIs became obsolete with digital records; new PIs address digital-era risks

03

THE 12-ELEMENT MANUAL

Every PI fully specified. No ambiguity for hospitals or surveyors

ANATOMY OF AN INDICATOR: THE 12 SPECIFICATION ELEMENTS

01 Indicator Title	**02 Justification**	03 Definition of Terms
4 Inclusion and Exclusion Criteria	05 Indicator Type	06 Formula
07 Numerator	08 Denominator	09 Target
10 Data Collection Frequency	**11 Tracer Methodology**	**12 Person in Charge**

**Highlighted elements most scrutinised during surveyor tracer walks*

READING A PI: WORKED EXAMPLE

Category 3 — Patient Care Services

01 Title	Medication Reconciliation Completion Rate within 24h of Ward Transfer
02 Rationale	Medication errors at care transitions are a leading cause of preventable adverse drug events
06 Formula	(Numerator ÷ Denominator) × 100%
07 Numerator	No. of patients with completed reconciliation within 24h of transfer
08 Denominator	Total no. of ward-to-ward transfers in the reporting period
11 Tracer	Follow transfer journey: check reconciliation form, timestamp, pharmacist sign-off
12 Person in Charge	Ward pharmacist/Nurse in charge

04

PI BREAKDOWN BY CATEGORY

Where are the new, amended, and removed PIs?

PI EVOLUTION BY CATEGORY: 6TH → 7TH EDITION

Category	Removed	Amended	New	Total 7th Ed.
Cat 1: Governance, Leadership & Direction	3	8	12	24
Cat 2: Management of Facilities & Environment	4	5	4	18
Cat 3: Patient Care Services	11	23	38	112
Cat 4: Allied Health & Support Services	5	10	14	47
Cat 5: Medication Management & Use	4	12	15	35
Cat 6: Quality, Safety & Risk Management	2	9	22	32
TOTAL	**29**	**67**	**105**	**268**

Removed Amended New 7th Ed. Total

KEY PI CHANGES: WHAT SURVEYEES NEED TO KNOW

CAT 1 Governance	12 new PIs include board-level quality review, whistleblowing awareness, and patient-family engagement. Amended PIs now require evidence of action, not just documentation of meetings.
CAT 3 Patient Care	Largest expansion — 38 new PIs covering outpatient safety, emergency care, maternal & child health, and ICU. 11 duplicated or obsolete PIs removed.
CAT 5 Medication	15 new PIs on high-alert medications, LASA drugs, and antibiotic time-out. Directly aligned with WHO Medication Without Harm goal.
CAT 6 Quality & Safety	22 new PIs on incident reporting culture, closed-loop handovers, and direct compliance with PSGs — where PIs and PSGs become one system.

05

PATIENT SAFETY GOALS

Malaysian PSGs & WHO Global Alignment

THE ALIGNMENT BETWEEN THE 7 MALAYSIAN PATIENT SAFETY GOALS (MPSG 2.0) ADOPTED IN 2022 AND THE WHO GLOBAL PATIENT SAFETY ACTION PLAN (GPSAP) 2021–2030.

This table shows how Malaysia's specific, measurable targets serve as the national implementation of the WHO's global strategic objectives and 2030 harm-reduction goals.

Malaysian Patient Safety Goal (MPSG 2.0)	WHO GPSAP Alignment (Strategic Objective & Global Target)
1. Hand Hygiene Compliance **(Target: ≥75% compliance)**	SO 3: Clinical Safety → Global Target: 50% relative reduction in healthcare-associated infections (HAIs) by 2030. → WHO Challenge #1: "Clean Care is Safer Care"
2. Prevention of Catheter-Associated Bloodstream Infection (CABSI) **(Target: ≤0.5 per 100 admissions)**	SO 3: Clinical Safety → Global Target: 50% relative reduction in healthcare-associated infections (HAIs) by 2030. → Focus: Intravascular catheter-related harm.
3. Safe Surgery Saves Lives **(Target: Zero wrong site/retained items)**	SO 3: Clinical Safety → Global Target: Zero avoidable surgical harm events (implicit in universal surgical safety checklist uptake). → WHO Challenge #2: "Safe Surgery Saves Lives"
4. Medication Safety (Medication Without Harm) **(Target: Zero severe harm or death from medication errors)**	SO 3: Clinical Safety → Global Target: 50% relative reduction in severe, avoidable medication-related harm by 2030. → WHO Challenge #3: "Medication Without Harm"
5. Transfusion Safety **(Target: Zero Incorrect Blood Component Transfusion)**	SO 3: Clinical Safety → Global Target: Zero preventable harm from blood transfusion (aligned with medication safety and correct patient identification).
6. Prevention of Patient Fall ***(Target: ≤5 per 1,000 patient-days)***	SO 3: Clinical Safety → Global Target: 50% relative reduction in deaths due to patient falls during hospitalization by 2030.
7. Proper Patient Identification **(Target: Zero incidents due to wrong ID)**	SO 3: Clinical Safety & SO 4: Patient Engagement → Global Target: Zero wrong-patient/wrong-site errors (foundational to all other safety goals).

PSG–PI ALIGNMENT: MSQH 7TH EDITION

MPSG 2.0 (MOH MALAYSIA) · WHO GPSAP 2021–2030

Hospitals are expected to actively monitor PIs corresponding to each PSG under MPSG 2.0 (MOH Malaysia, effective January 2022)

MPSG 2.0 Goal	WHO GPSAP 2021-2030	Representative PI (MSQH 7th Ed.)
Goal 7 Incident Reporting & Learning System (comm. embedded)	Strategic Objective 6: Information, Research and Risk Management	Percentage of morbidity and mortality meeting done
Goal 3 Medication Safety	Strategic Objective 3: Safety of Clinical Processes	Percentage of Prescription Error
Goal 2 Surgical Safety	Strategy Objective 1 and 3 Safety of Clinical Practices	Rate of compliance to Safe Surgery Saves Lives (SSSL) practice
Goal 1 Infection Prevention & Control	Strategy 3.3: Infection Control	Rate of Central Line-Associated Bloodstream Infection (CRBSI)
Goal 5 Patient Fall Prevention	Strategic Objective 3: Safety of Clinical Processes	Percentage of falls and near-falls

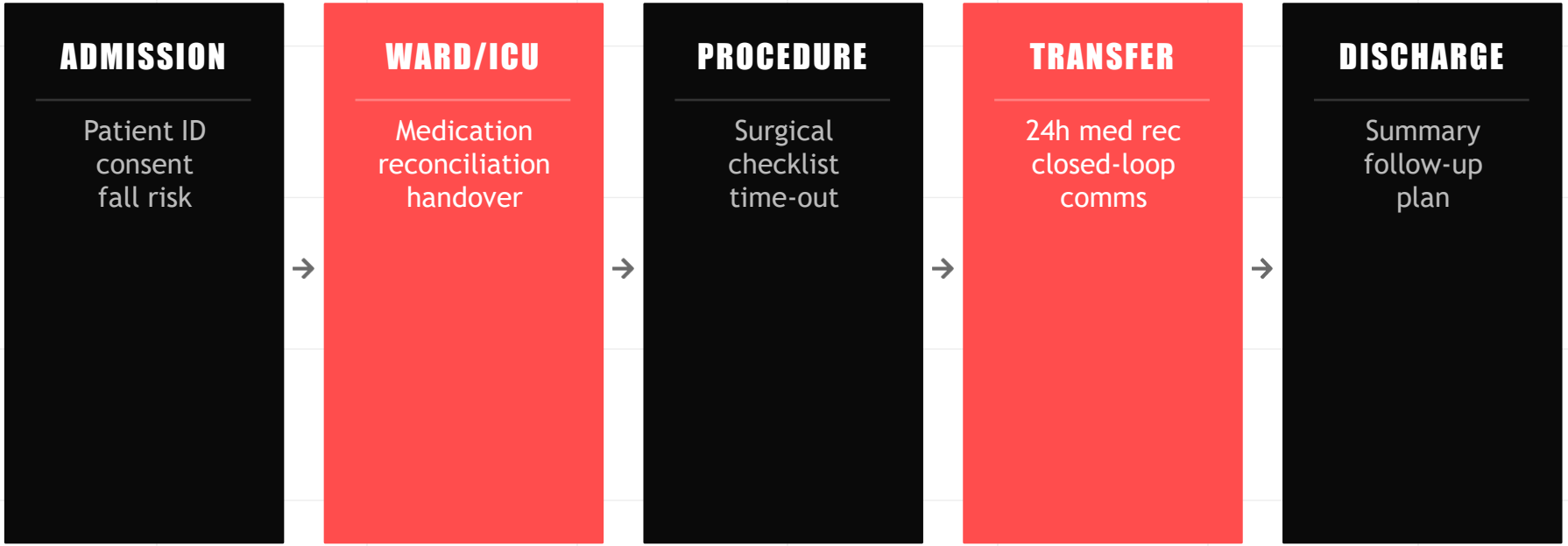
06

SURVEYOR APPLICATION

Tracer methodology & audit walk-through

TRACER METHODOLOGY: HOW SURVEYORS VERIFY PI COMPLIANCE

"A tracer follows a patient's journey — observing, interviewing, and verifying that documented PIs reflect actual practice."



Surveyor Checklist: ① Data collected? ② Frequency, correct? ③ Person in charge knows the target? ④ Evidence of action on poor results?

COMMON FINDINGS: WHAT SURVEYORS TYPICALLY IDENTIFY

✗ DATA COLLECTED, NOT USED

Hospitals collect PI data but there is no evidence of review, escalation, or corrective action when thresholds are breached.

✗ NUMERATOR/DENOMINATOR MISMATCH

Formula applied incorrectly — Denominator does not match the population defined in the PI specification.

✗ PERSON IN CHARGE UNAWARE

The designated person (Element 11) cannot articulate the PI target, trend, or current status.

✗ PSG–PI DISCONNECT

Staff do not connect daily Patient Safety Goal activities to the specific PIs those activities generate.

WHAT 'FULLY COMPLIANT' LOOKS LIKE: THE SURVEYOR STANDARD

DATA IS CURRENT

✓

PI collected at defined frequency. Most recent cycle available for review on the day of survey.

FORMULA IS CORRECT

✓

Numerator and denominator match the 7th Edition manual exactly.

TREND IS VISIBLE

✓

At least 3–6 reporting cycles plotted. Run chart or control chart preferred.

ACTION IS DOCUMENTED

✓

When PI falls below target: documented PDSA/CAP with named owner and timeline.

STAFF CAN ARTICULATE IT

✓

Person in Charge (Element 11) states the PI name, target, current result, and action underway.

PSG LINK IS EXPLICIT

✓

Hospital PSG dashboard maps each goal to its corresponding PIs. Staff understand the connection.

NEW 7TH EDITION DIMENSIONS: DIGITAL · SUSTAINABILITY · WORKFORCE

ISQua core principles now embedded across the MSQH 7th Edition — reflected in new PIs

DIGITAL CARE

New PIs: e-prescribing error rates, electronic clinical handover compliance, telemedicine patient identification verification.

SUSTAINABILITY

Waste segregation compliance, energy and water consumption benchmarks, sustainable procurement tracking.

WORKFORCE CARE

Staff injury rates, burnout monitoring, wellness programme participation, and whistleblowing policy awareness.

KEY MESSAGES FOR PARTICIPANTS

1. **Know Your Manual Inside Out**
   268 PIs, each structured across 12 elements. Use the manual as your primary reference

2. **Connect Strategy to Measurement**
   PSGs set the strategic direction; PIs are the measurable proof. Be prepared to trace every PSG to at least one PI

3. **Ownership and Accountability Are Now Explicit**
   The 12-element format names the person in charge and specifies the tracer methodology

4. **Data Without Action Is a Finding**
   Collecting data is only half the job. A hospital that measures but does not respond to its own PI results is non-compliant.

5. **New Domains Are Real and Here to Stay**
   Digital Care, Sustainability, and Workforce Care are not cosmetic. These standards have their own PIs, they will grow, and your performance in them will be scrutinised

PERFORMANCE INDICATORS:

TRACKING, TRENDING, ANALYSIS & SIQ

Criterion changes · Tracking & Trending · Analysis · SIQ · RCA · Monitoring · Closure

Dr Mohd Anis Haron
MSQH Surveyor & Task Force Committee (Performance Indicator)
10 June 2026 · Centralised Training on MSQH 7th Edition Standards

APPLIED MODULE

PART II

MSQH 7th Ed.

MODULE ROADMAP

A | CRITERION CHANGES ON PI

B | TRACKING & TRENDING

C | ANALYSING FINDINGS

D | WHEN A PI TRIGGERS SIQ

E | ROOT CAUSE ANALYSIS (RCA)

F | MONITORING, RE-EVALUATION & CLOSURE

A

CRITERION CHANGES

What the 7th Edition now requires not just collection, but action

CRITERION CHANGES: FROM COLLECTION TO GOVERNANCE

WAS	NOW	
PIs reported periodically in quality meeting minutes	PIs must be tracked with defined frequency, plotted as trends, and reviewed with evidence of action when thresholds are breached	Reporting → Governance
Numerator/Denominator defined loosely within standard text	Every PI has a dedicated 12-element specification. Formula, data source, denominator — non-negotiable and surveyor-verifiable	Implied → Specified
Person responsible assumed (e.g. 'Quality Unit')	Element 11 names a specific designated person who must articulate current PI status, target, and corrective action	Collective → Accountable
Threshold breaches logged, no escalation pathway	A breach triggers structured response: root cause investigation, improvement plan, documented closure within timeframe	Logging → Closing the Loop

WHAT SURVEYORS NOW EXPECT: 4 MANDATORY EVIDENCES

A PI is only compliant when ALL four evidences are present

E1 DATA COLLECTION

Completed collection forms, electronic extracts, or log sheets for the defined period — with denominator population clearly identified

E2 TREND CHART

Minimum 3 consecutive data points plotted as a run chart, control chart, or tabulated trend with visible threshold line

E3 ANALYSIS & INTERPRETATION

A written or minuted statement explaining what the trend means — not just the number, but the clinical or operational significance

E4 ACTION & CLOSURE

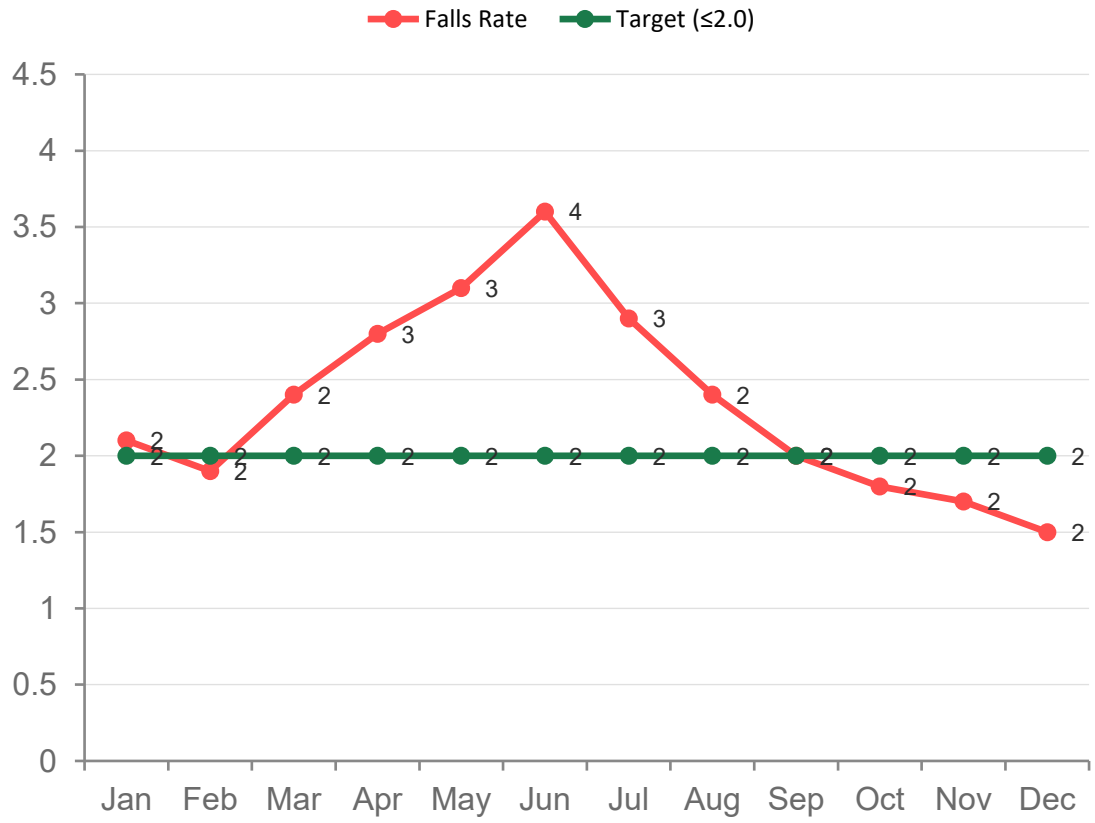
Where threshold was breached: documented corrective action plan with named owner, timeline, and re-measurement evidence

B

TRACKING & TRENDING

How to collect, plot and read PI data, with worked examples

WORKED EXAMPLE 1: IN-PATIENT FALLS RATE (PER 1,000 OCCUPIED BED DAYS)



READING THIS CHART

Jan–Jun: Deteriorating

Rate rises from 2.1 to 3.6 — above target. Sustained breach requiring escalation.

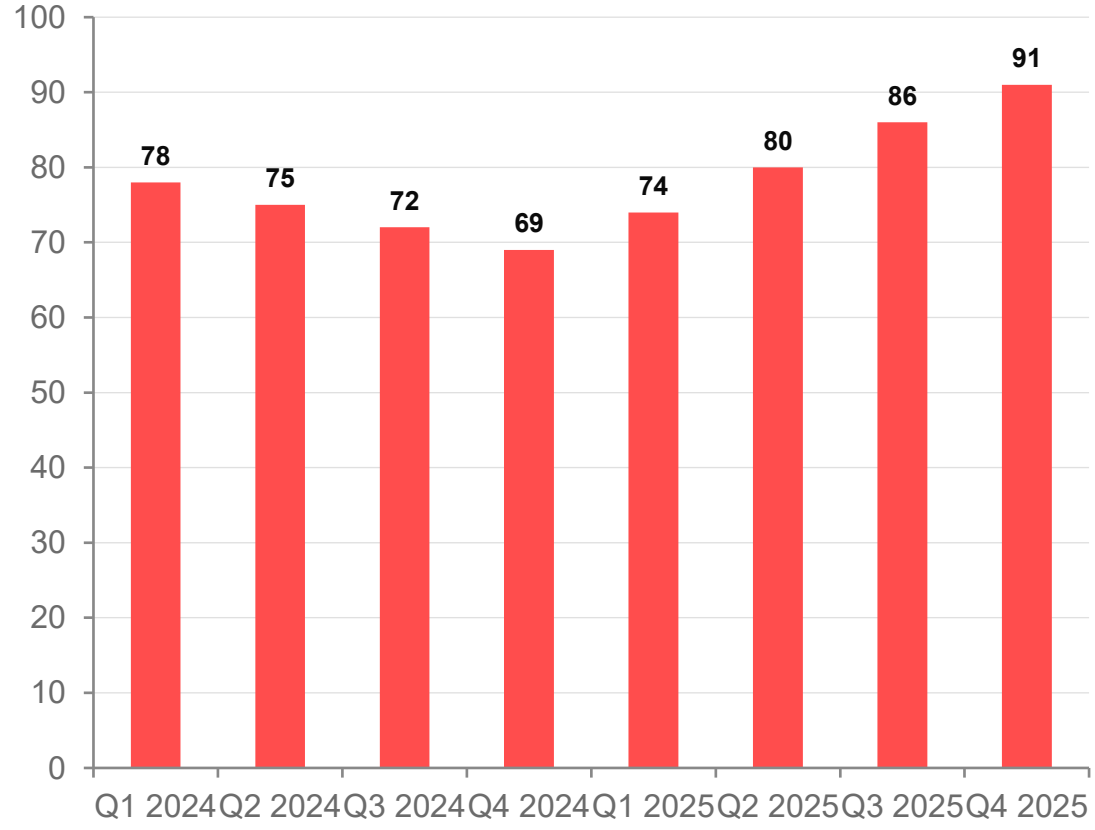
June: Peak 3.6 — Trigger

Breaches trigger threshold ≥3.5. Formal investigation is mandatory.

Jul–Dec: Post-Intervention

Following RCA and intervention, rate declines steadily to 1.5 — below target. Sustained 6 months.

WORKED EXAMPLE 2: MEDICATION RECONCILIATION COMPLIANCE RATE (%)



THRESHOLD ZONES

TARGET

≥90%

Fully compliant. Continue monitoring.

ALERT

75-89%

Below target. Action plan within 30 days.

BREACH/SIQ

<75%

Critical. Formal investigation. Escalate to leadership.

CONSTRUCTING THE PI TRACKING TABLE: WHAT MUST BE DOCUMENTED

Every PI must have a completed tracking register. This is the source document surveyors will request.

Period	Num	Denom	Result	Target	Status	Action Taken	PiC
Jan 25	67	85	78.8%	≥90%	⚠ Alert	SOP reminder issued	Pn. Rohani
Feb 25	62	85	72.9%	≥90%	✗ Breach	SIQ raised. RCA initiated	Pn. Rohani
Mar 25	70	85	82.4%	≥90%	⚠ Alert	Training completed	Pn. Rohani
Apr 25	80	88	90.9%	≥90%	✓ Met	Sustained — continue	Pn. Rohani
May 25	82	90	91.1%	≥90%	✓ Met	Target maintained	Pn. Rohani

Surveyor test: Ask 'Pn. Rohani' to explain the Feb result and the action taken. If she is not able to explain — this is a non-compliance finding.

C

ANALYSING FINDINGS

From numbers to interpretation — What the data is telling you

THE 4-LEVEL PI ANALYSIS FRAMEWORK

Analysis must answer: So what? Why? What next?

L1 DESCRIBE

What is the number?

- State result, compare to target
- Identify above/at/below threshold
- Note direction vs prior period

L2 CONTEXTUALISE

Why might this be happening?

- Isolated dip or sustained trend?
- External factors — staffing, season?
- Compare to benchmark if available

L3 INTERPRET

What does it mean for patients?

- Link to patient harm risk
- Relate to the PSG this PI supports
- Determine if SIQ threshold is met

L4 DECIDE & ACT

What must happen next?

- If met: document & maintain
- Alert zone: 30-day action plan
- Breach: escalate, investigate, RCA

WORKED ANALYSIS NARRATIVE: FEBRUARY 2025 — MEDICATION RECONCILIATION

PI: Medication Reconciliation Rate · Result: 72.9% · Target: ≥90% · Status: BREACH

L1 DESCRIBE

The rate for February 2025 was 72.9% (62/85 eligible transfers): 17.1 points below the ≥90% target. This is a deterioration from January (78.8%) and falls in the critical breach zone (<75%).

L2 CONTEXTUALISE

February coincided with two senior nurses on extended leave and a newly rotated MO unfamiliar with the reconciliation SOP. The denominator (85 transfers) was consistent with prior months, ruling out a denominator anomaly.

L3 CLINICAL INTERPRETATION

Incomplete reconciliation at transfer is a known high-risk failure for adverse drug events. 23 transfers (27.1%) had no reconciliation within 24h. One missed anticoagulant dose was recorded this period. SIQ criterion met.

L4 DECISION & ACTION

SIQ raised. RCA initiated within 72h. Immediate interim: verbal briefing at ward handover to confirm reconciliation status. Re-measurement: March 2025, expected ≥82%. Full target recovery: April 2025.

D

WHEN A PI TRIGGERS SIQ

Sentinel & Significant Incident/Quality — Definitions and obligations

WHAT IS A SIGNIFICANT INCIDENT/QUALITY (SIQ) EVENT?

An unintended or unexpected event which could have, or did, lead to patient harm. In PI management, an SIQ is triggered when a PI falls below a defined critical threshold, OR when a discrete adverse event identified through PI monitoring meets sentinel event criteria.

PI-TRIGGERED SIQ
Pattern of poor performance

- PI falls into critical breach zone for ≥2 consecutive periods
- Sustained deterioration despite documented action plan
- PI reaches 'never event' level defined in manual
- Threshold breach coincides with documented patient harm

DISCRETE/SENTINEL EVENT
Single incident meeting severity criteria

- Unexpected death not related to natural course of illness
- Serious physical or psychological injury, or risk thereof
- Wrong patient, wrong site, wrong procedure
- Retained surgical item, 10× medication overdose, Never Event

SIQ OBLIGATION: WHAT MUST HAPPEN AND WHEN

IMMEDIATE 0–24h

IDENTIFY & CONTAIN

Verbal notification to HOD and Quality Unit. Immediate patient harm mitigation.

72 HOURS

SIQ FORM & TEAM

SIQ form submitted. Incident logged. RCA team convened: HOD, quality manager, frontline staff.

14 DAYS

RCA COMPLETED

Full Root Cause Analysis. Fishbone/5-Whys or structured tool. Findings documented.

30 DAYS

ACTION PLAN

SMART corrective action plan with named owners and timelines submitted to Quality Committee or equivalent.

3 MONTHS

RE-MEASUREMENT

PI re-measured post-intervention. Improvement vs baseline documented.

CLOSURE

FORMAL CLOSURE

Appropriate Committee/Authority reviews sustained improvement. Formal closure memo issued.

E

ROOT CAUSE ANALYSIS

Full worked RCA — Medication Reconciliation SIQ, Ward 4A, February 2025

RCA STEP 1: PROBLEM STATEMENT & INCIDENT SUMMARY

PROBLEM STATEMENT

Medication reconciliation was not completed within 24 hours of ward transfer for 23 of 85 patients in February 2025 (Ward 4A). One patient on anticoagulant therapy had a dose missed, resulting in sub-therapeutic INR and prolonged hospital stay.

Date Identified	04 Feb 2025	**Department**	Ward 4A, Medical
PI Involved	Medication Reconciliation Rate	**Patient Harm**	Missed anticoagulant → prolonged stay
SIQ Reference	SIQ-2025-024	**RCA Lead**	Dr. Azmi Razak, HOD Medical

RCA Team: Head of Department (Medical) · Quality Manager/Patient Safety Officer · Ward Nurse In-Charge · Clinical Pharmacist · Attending Medical Officer

RCA STEP 2: TIMELINE OF EVENTS — WHAT HAPPENED?

02 Feb 08:30 — Patient transferred ICU→Ward 4A. Transfer form completed but medication reconciliation not initiated at handover.

02 Feb 14:00 — Nurse shift change. Incoming nurse not briefed on pending reconciliation. No alert in EMR system.

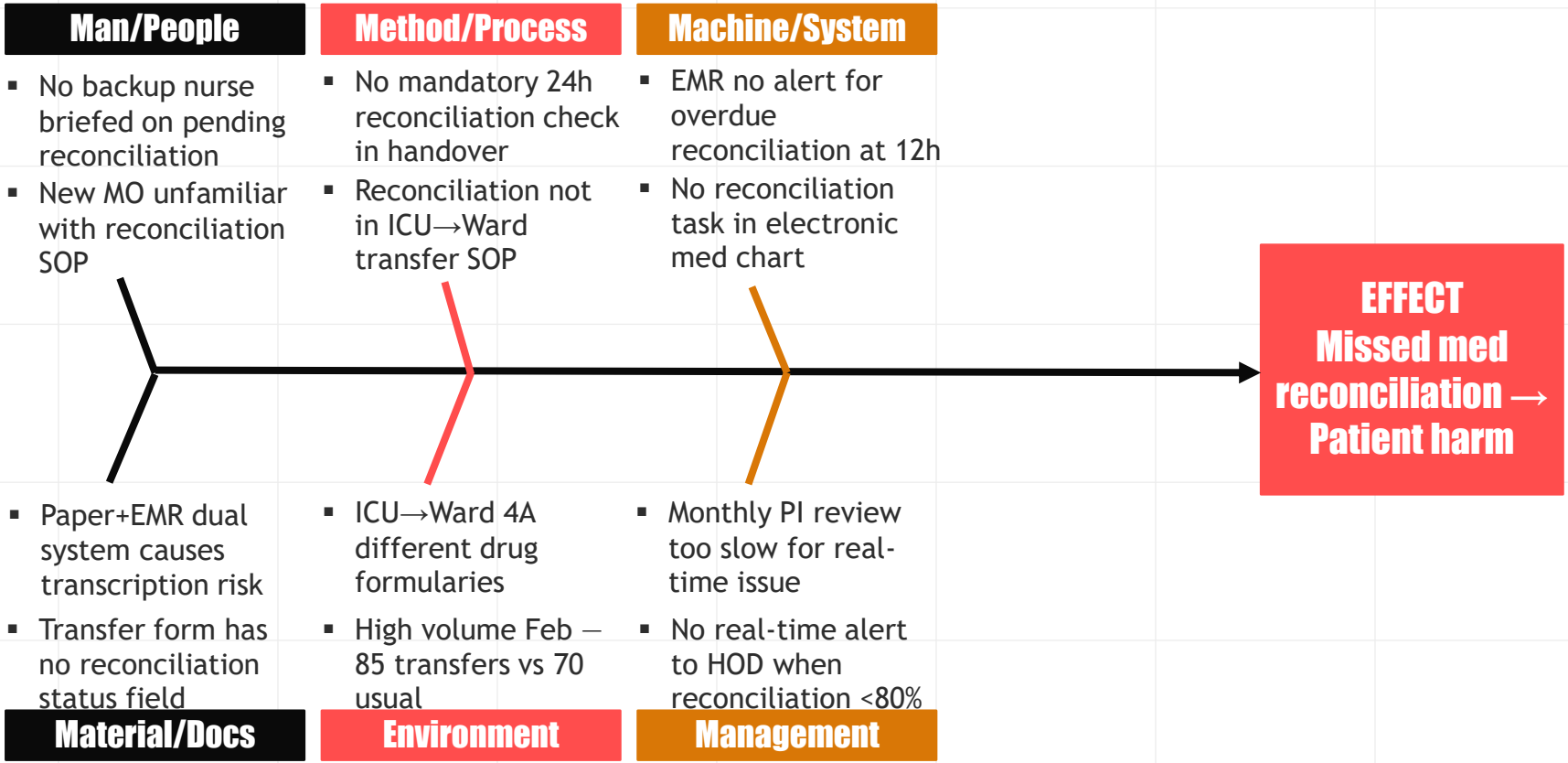
02 Feb 22:00 — Evening drug round. Warfarin not charted on Ward 4A sheet. Dose not administered — no order present.

03 Feb 07:00 — Morning ward round. MO notes warfarin not given. Reconciliation still incomplete at 22.5 hours post-transfer.

03 Feb 11:00 — INR checked — sub-therapeutic (1.4 vs target 2.0–3.0). Hospital stay extended ~3 days for INR monitoring.

04 Feb 09:00 — Quality Officer flags case in PI monthly review. February rate: 72.9% (<75%). SIQ-2025-024 raised. RCA initiated.

RCA STEP 3: CAUSE-AND-EFFECT ANALYSIS (FISHBONE/ISHIKAWA)



RCA STEP 3 (CONT.): 5 WHYS ANALYSIS — PRIMARY CAUSAL CHAIN

Starting point: Anticoagulant dose not administered on 02 Feb 2025

WHY 1

Q: Why was the anticoagulant not administered?

A: It was not charted on the Ward 4A medication sheet at the time of the evening drug round.

WHY 2

Q: Why was it not charted?

A: Medication reconciliation had not been completed after ICU transfer — The ICU drug regimen had not been reviewed by Ward 4A.

WHY 3

Q: Why was reconciliation not completed?

A: No nurse or MO was assigned responsibility for reconciliation at transfer, and the handover checklist had no reconciliation sign-off step.

WHY 4

Q: Why was no one assigned?

A: The ICU-Ward transfer SOP does not define a named responsible person, and there is no system-generated alert when reconciliation is incomplete beyond 12 hours.

WHY 5

Q: Why does the SOP not define this, and why is there no alert?

A: ROOT CAUSE: Medication reconciliation is not integrated into either the transfer SOP or the EMR. It is an implicit nursing task with no accountability structure, escalation pathway, or real-time monitoring.

RCA STEP 4: ROOT CAUSES SUMMARY & RECOMMENDATIONS

ROOT CAUSES

- No named accountable person for reconciliation at ward transfer
- Reconciliation not in ICU-to-Ward transfer checklist
- EMR does not generate alert for overdue reconciliation
- Dual documentation (paper+EMR) creates transcription risk
- No real-time PI dashboard — deterioration only visible at month-end
- Inadequate induction for rotated staff on reconciliation SOP

RECOMMENDATIONS (SMART)

Revise ICU–Ward Transfer SOP: Named pharmacist sign-off on reconciliation within 4h	Chief Pharmacist 28 Feb
Add reconciliation status field to electronic transfer checklist with mandatory flag	IT/ Pharmacy 31 Mar
Configure EMR to generate escalation alert at 12h post-transfer if not completed	HIS Manager 31 Mar
Mandatory briefing + competency sign-off for all newly rotated staff	Nursing Mgr 15 Feb
Real-time reconciliation compliance dashboard visible to Ward In-Charge	Quality Unit 30 Apr

F

MONITORING & CLOSURE

Closing the improvement loop — From intervention to sustained performance

THE IMPROVEMENT LOOP: PDSA LINKED TO PI RE-MEASUREMENT

PLAN

Define problem using RCA. Set SMART(Specific, Measurable, Achievable, Relevant, and Time-bound) improvement target. Assign owners. Agree interventions (SOP revision, EMR alert, training).

DO

Implement agreed interventions. Document what changed, by whom, when. Run pilot on Ward 4A before hospital-wide rollout.

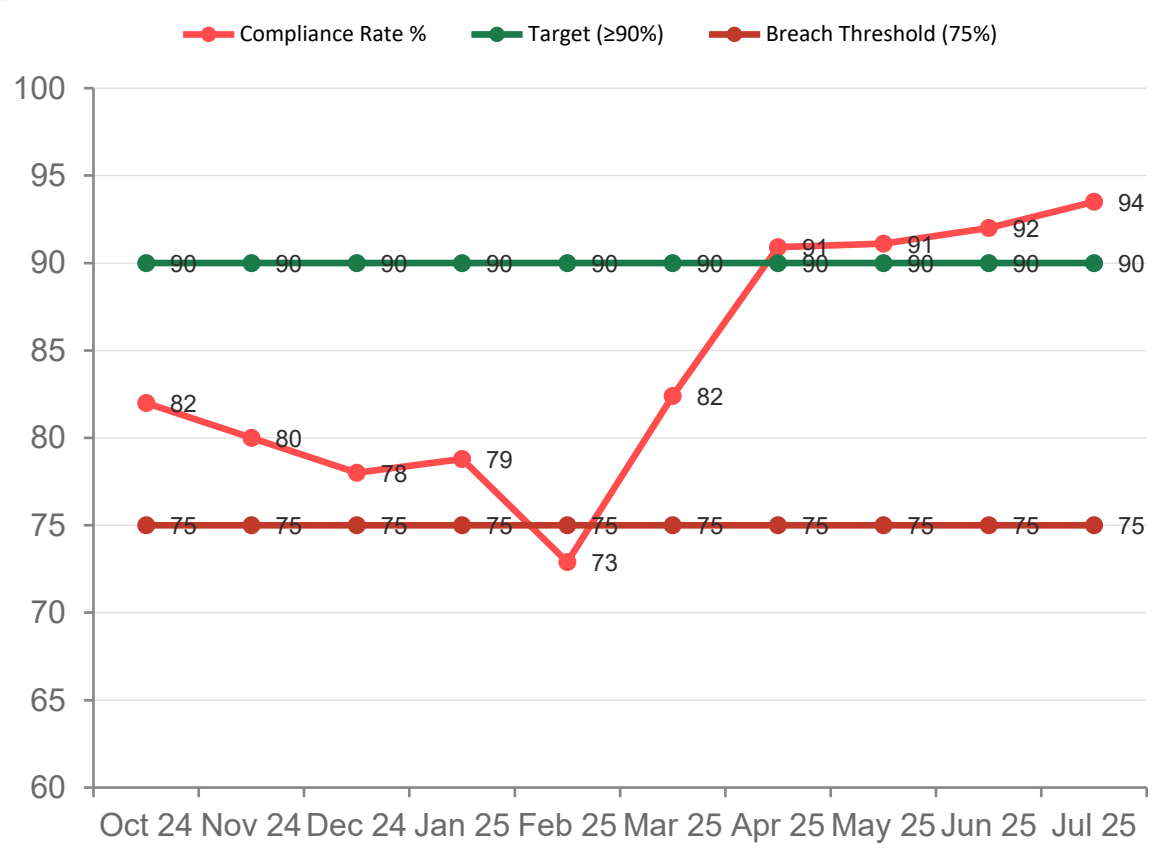
STUDY

Recalculate PI at re-measurement date. Plot on trend chart. Apply 4-Level Analysis. Compare pre- and post-intervention results.

ACT

If target met: standardise the intervention, update SOP. If not: revise plan, repeat cycle. Document at Quality Committee or equivalent.

RE-MEASUREMENT: POST-RCA TREND — MEDICATION RECONCILIATION RATE



IMPROVEMENT STORY

Oct 24–Feb 25

Pre-intervention. Decline from 82% to 72.9%. Feb triggers SIQ.

Mar 25: Partial Recovery

Interim measures active. Rate 82.4% — out of breach zone, below target.

Apr 25: Target Met

Full EMR alert + revised SOP active. Rate 90.9%. Target achieved.

May–Jul 25: Sustained

Target maintained x3 cycles (91.1%, 92%, 93.5%). Closure criteria met.

FORMAL CLOSURE: 4 CRITERIA REQUIRED

An SIQ is not closed until all four closure criteria are independently verified by the Quality Committee or equivalent

CC1 SUSTAINED TARGET ACHIEVEMENT

PI result meets or exceeds defined target, preferably for a minimum of 6 data points or reporting cycles. Single-period recovery is insufficient.

CC2 ALL RECOMMENDATIONS IMPLEMENTED

Every RCA action plan item evidenced — revised SOP, system change, training records, or competency sign-off.

CC3 NO RECURRENCE OF CAUSAL FACTORS

Structured review confirms root causes are no longer present — via direct observation or staff interview.

CC4 APPROPRIATE COMMITTEE/AUTHORITY ENDORSEMENT

Closure reviewed and endorsed at appropriate Committee/Authority. Minutes must reflect the decision and evidence.

SIQ CLOSURE DOCUMENT: WHAT MUST BE RECORDED?

SIGNIFICANT INCIDENT/QUALITY (SIQ) — FORMAL CLOSURE DOCUMENT			
SIQ Reference No.	SIQ-2025-024	**Department/Ward**	Ward 4A, Medical
Date SIQ Raised	04 February 2025	**Date of Closure**	31 July 2025
PI Involved	Medication Reconciliation Rate	**Root Cause (Primary)**	No accountability structure in transfer SOP
Baseline Result	72.9% (Feb 2025) — Breach	**Result at Closure**	93.5% (Jul 2025) — Target Sustained ×3
Interventions	SOP revised · EMR alert configured · Mandatory training · Dashboard deployed	**Evidence of Closure**	3 consecutive months ≥90% (May, Jun, Jul 2025)
Reviewed By	Appropriate Committee/Authority — 30 July 2025	**Closure Decision**	APPROVED — No further active monitoring required. Routine PI cycle continues.

KEY PARTICIPANTS TAKEAWAYS: WHAT TO PREPARE FOR SURVEY?

1. **Demand Trends, Not Snapshots**
   Be ready to present PI trend charts, not isolated data points.
2. **Test the Person in Charge Directly**
   Expect to be questioned directly. You must be able to state your current result, your target, whether a breach has occurred, and what action was taken.
3. **Follow the Breach**
   If any period in your trend chart breaches the threshold, have the corresponding action plan ready. No action plan may be treated as non-compliance.
4. **Scrutinise RCA Quality**
   Your RCA must trace back to system, process, or design failures. A superficial analysis will be seen as evidence of a weak safety culture.
5. **Insist on Re-Measurement**
   present an intervention with a re-measurement with a post-intervention data point compared to your baseline
6. **Verify Formal Closure**
   Ensure closure of SIQ was approved by the appropriate Committee/Authority, not just by individual clinicians.

TRACK.
TREND.
INVESTIGATE.
IMPROVE.

The PI is not a number to report.
It is a system to govern.

Dr Mohd Anis Haron · MSQH 7th Edition
Centralised Training · 10 June 2026 · Q&A 16:15–16:30

PERFORMANCE INDICATORS APPLIED MODULE

Criterion Changes
Tracking & Trending
Analysis & Interpretation
SIQ Trigger & Obligation
Root Cause Analysis (RCA)
Monitoring & Formal Closure

MSQH 7TH EDITION

Malaysian Society for Quality in Health
www.msqh.com.my