ACCREDITATION STANDARDS FOR

Clinical Services

MSQH 7th Edition • Standard 9A • Staff Preparation for Accreditation Survey

Learning Objectives

By the end of this session, participants will be able to:

Understand Accreditation Standards	Explain the purpose and structure of MSQH 7th Edition Clinical Services Standards (Standard 9A) and their relevance to daily clinical practice.
Navigate the 5 Key Areas of Focus	Identify and describe the requirements under Organisation & Management, Human Resources, Policies & Procedures, Facilities & Equipment, and Safety & QI.
Interpret Criteria & Evidence of Compliance	Read and apply criteria requirements and identify the specific Evidence of Compliance (EOC) needed to demonstrate compliance for each standard.
Identify Common Gaps & How to Address Them	Recognise the most frequently cited non-compliance areas and apply corrective strategies to close gaps before the accreditation survey.
Prepare for the Accreditation Survey	Use the staff preparation checklist to ensure all required documentation, records and practices are in place and ready for surveyors.

SESSION OVERVIEW

01

Introduction & Context

Accreditation framework, 7th Edition updates, AIMS, common gaps, BCP & Antimicrobial Stewardship

02

Standard 9A — Standard Overview

Preamble, Standard 9A.1.1: Organisation & Management — criteria, org charts, governance

03

Human Resource Management

9A.2: Credentialing & Privileging, Training & Education, Staffing, Orientation & Wellbeing

04

Policies, Facilities & Equipment

9A.3: Policies & Procedures — 9A.4: Facilities, Equipment, PPM & Sustainable Care

05

Safety, Quality & Special Areas

9A.5: Safety Culture, Incident Reporting, QI Activities, Documentation — 9A.6: Special Requirements

06

Key Takeaways & Survey Readiness

Preparation checklist, key reminders, Q&A and next steps for accreditation readiness

7th Edition Accreditation Standards

7th Edition Standards

Developed from 2024; aligned with ISQua EEA Principles

Centralised Online Training

Package 1 & Package 2: GAP Analysis — Recommended for 1st Cycle

Service-Based Training

Optional sessions tailored to your clinical service

Consultant Sessions

Optional expert guidance for complex compliance areas

Mock Survey

Full or selected services — optional simulation of the real survey

ACCREDITATION:

The Act of Balancing

RESOURCES

Workforce, Infrastructure, Technology & Finances

↔

SCOPE OF SERVICES

Range & Type of Services

↔

LEVEL OF CARE

Complexity & Intensity of Care

Continuous Quality Improvement (CQI)

Accreditation evolves with each cycle — organisations continuously improve, learn and reflect.

Quality & Risk Management

Quality Management + Risk Management = Safe, effective and sustainable care.

Key Areas of Focus — Clinical Services Standards

1

Organisation & Management

2

Human Resource Development

3

Policies & Procedures

4

Facilities & Equipment

5

Safety & Quality Improvement

Focus on Quality Care & Patient Safety

Structure, Process & CQI

Accreditation addresses structure, process outcomes and continuous quality improvement.

Core Purpose: Risk Reduction

Meeting standards reduces errors, adverse events and risks to patient safety.

WHO Patient Safety Commitment

MSQH aligns with WHO World Alliance for Patient Safety — New Guidelines 2021.

Common Gaps — Clinical Services Non-Compliance

Frequently cited issues during accreditation surveys

G&M *Governance & Management*	HRM *Human Resources*	P&P *Policies & Procedures*	F&E *Facilities & Equipment*	QIA *Safety & Quality*
PIC roles & org chart	Credentialing & privileging	Not updated or implemented	PPM not carried out	Weak QIA follow-up
Doctor involvement in meetings	Competency records missing	No cross-dept review	Specialised equipment issues	Incident reporting gaps
Clinical governance & QIA	Training needs not addressed	Staff unaware of changes	Asset inventory incomplete	Risk register not updated

Business Continuity Plan (BCP)

New requirement in 7th Edition

What Accreditation Requires

- Established & documented BCP
- Tested through drills & simulations
- Evidence of implementation maintained
- Continuity of safe patient care during disruptions

10 Key Components of BCP

1. Identify Critical Services
2. Conduct Risk Assessment
3. Develop Continuity Strategies
4. Establish Roles & Responsibilities
5. Develop Communication Plans
6. Prepare Downtime Procedures
7. Ensure Resource Readiness
8. Conduct Drills & Simulations
9. Provide Staff Awareness
10. Review & Update Regularly

Antimicrobial Stewardship Programme

7th Edition — Full Implementation & Integration

Appropriate Antibiotic Use

Right drug, right dose, right duration for each patient

Monitoring & Auditing

Track and regularly audit antimicrobial use

Multidisciplinary Involvement

Clinicians, pharmacists & microbiologists working together

Data-Driven Decision Making

Evidence-based decisions and systematic reporting

Preamble — Medical Related Services (Standard 9A)

Integral Role

Medical Related Services play a key role in delivering appropriate care and reducing adverse events — regardless of where patients are treated.

Organisation & Coordination

Services must be organised, directed and coordinated with other facility services to provide high-quality inpatient and outpatient care.

Reducing Unwarranted Variation

Avoid overuse of unnecessary treatments, underuse of necessary care, and misuse or errors causing patient harm.

Teaching & Research

Medical Related Services are also involved in teaching, training, research and audit activities where applicable.

TOPIC 9A.1

Organisation & Management

Governance • Org Structure • Clinical Leadership • Communication

Standard 9A.1.1 — Organisation & Management

Purpose, Scope & Key Requirements

Purpose of the Standard

Medical Related Services must be organised, directed, and coordinated with other services to ensure safe, efficient, effective, evidence-based, and caring inpatient and outpatient care.

Patient-Centred Care

Care delivery must respect patient needs, dignity, privacy, and confidentiality of personal information at all times and in all settings.

Accessibility & Continuity

Services must be easily accessible and continuity of care must be assured throughout the patient journey — from admission to discharge and follow-up.

Business Continuity Plan (BCP)

A basic BCM programme shall be developed and maintained to support uninterrupted delivery of services during disruptions or emergencies.

Key Message: The standard focuses on coordinated, patient-centred, safe and sustainable service delivery supported by governance and continuity planning.

Criteria 9A.1.1.1 & 9A.1.1.2 — VMV Goals & Organisation Structure

9A.1.1.1 — Vision, Mission, Values

- Clearly documented and accessible to all staff
- Reflect patient safety, quality care and community needs
- Service goals measurable and aligned with scope of services
- Monitored, reviewed and communicated to all staff

EOC: Statements endorsed & dated by Governing Body; planned reviews ≥ every 3 years; evidence of staff communication.

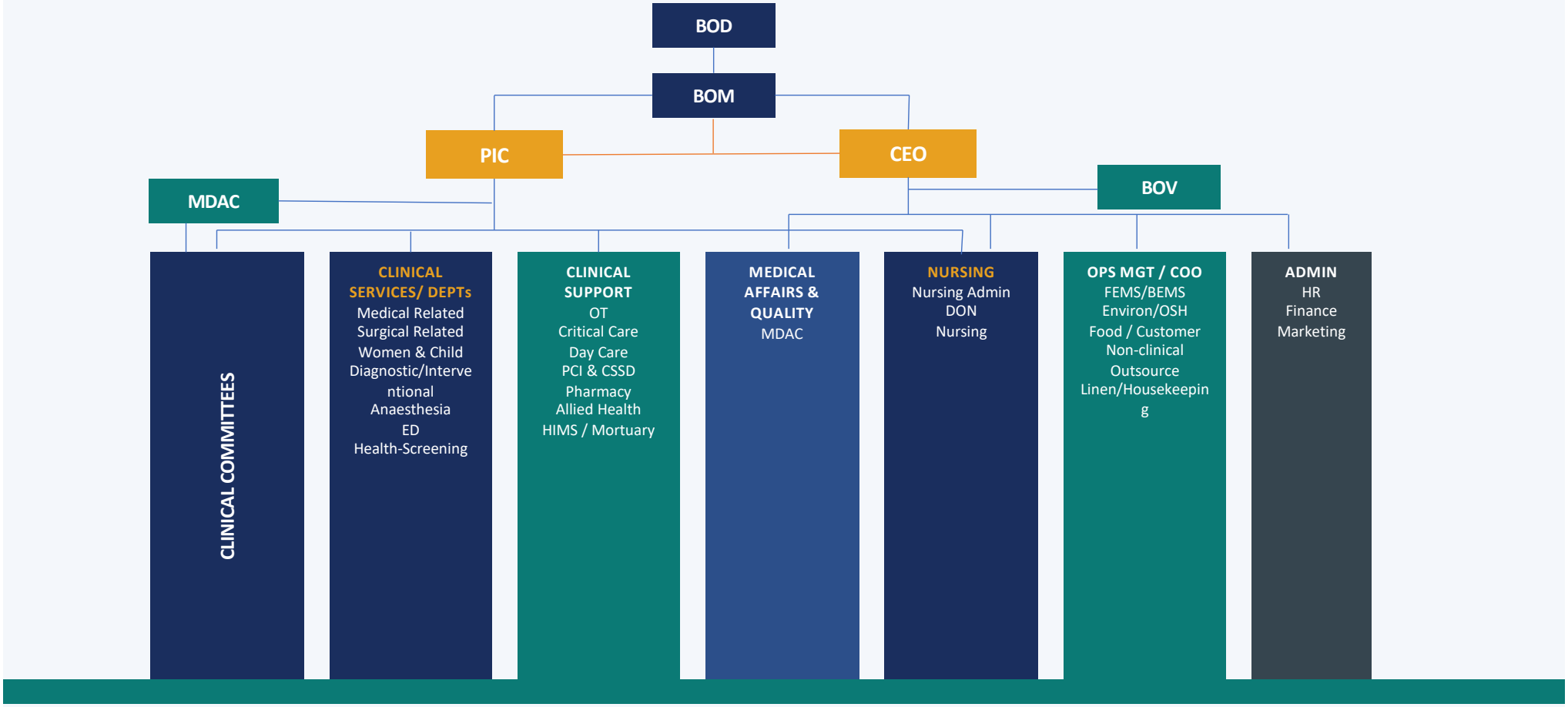
9A.1.1.2 (Core) — Organisation Structure & Reporting

- Clearly defined org chart for the Medical Related Services
- Shows structure, functions & reporting: PIC, Head of Service, consultants, medical practitioners & staff
- Relevant subspecialty services and units reflected in the chart
- Chart is accessible to staff and clients at all times
- Revised on major changes in structure, functions or staffing

EOC: Current endorsed & dated org chart; includes PIC, Head, consultants & subspecialties; updated on major changes; accessible to all.

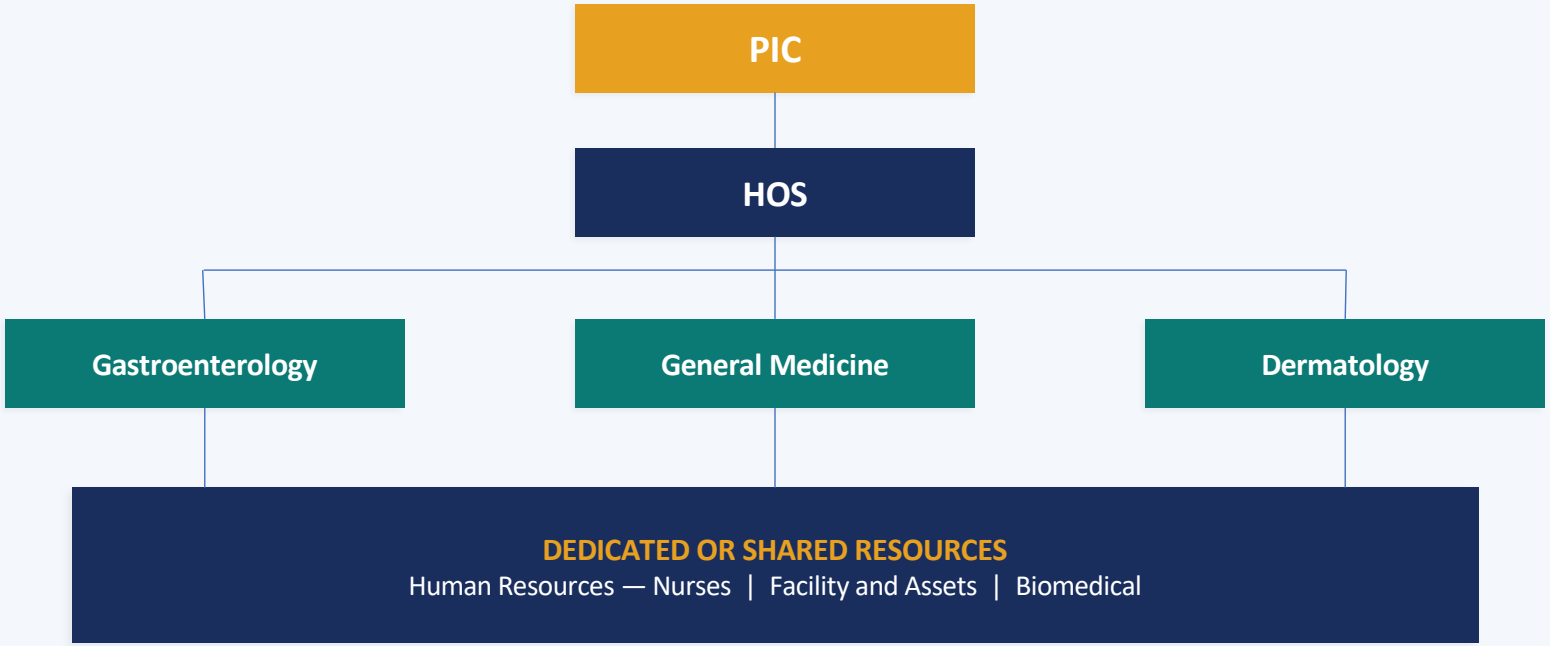
Hospital Organisation Chart

Focusing on Clinical Governance — Criterion 9A.1.1.2



Department Organisation Chart

Government / Public Hospitals — Medical Related Services (Example)

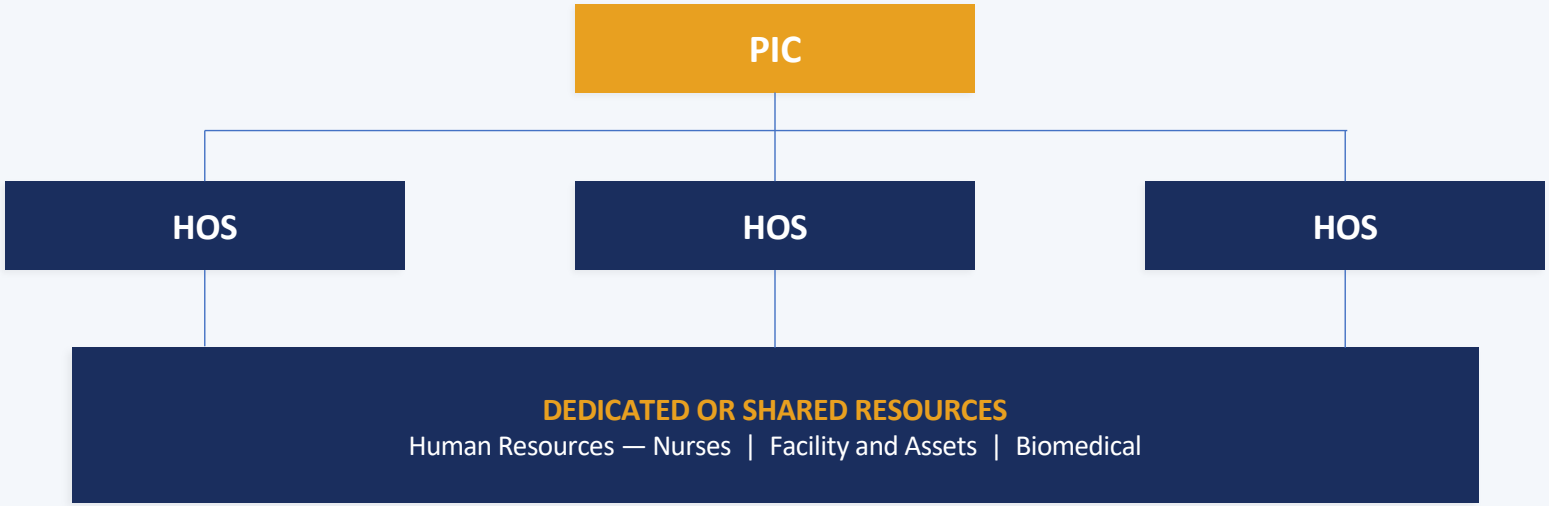


EOC Requirement: The organisation chart must be current, endorsed, dated, and accessible to all staff and clients. Subspecialty services and units must be reflected. Update whenever major changes occur in structure, functions, or staffing.

Department Organisation Chart

Applicable for Private Hospitals — Multiple HOS Reporting to PIC

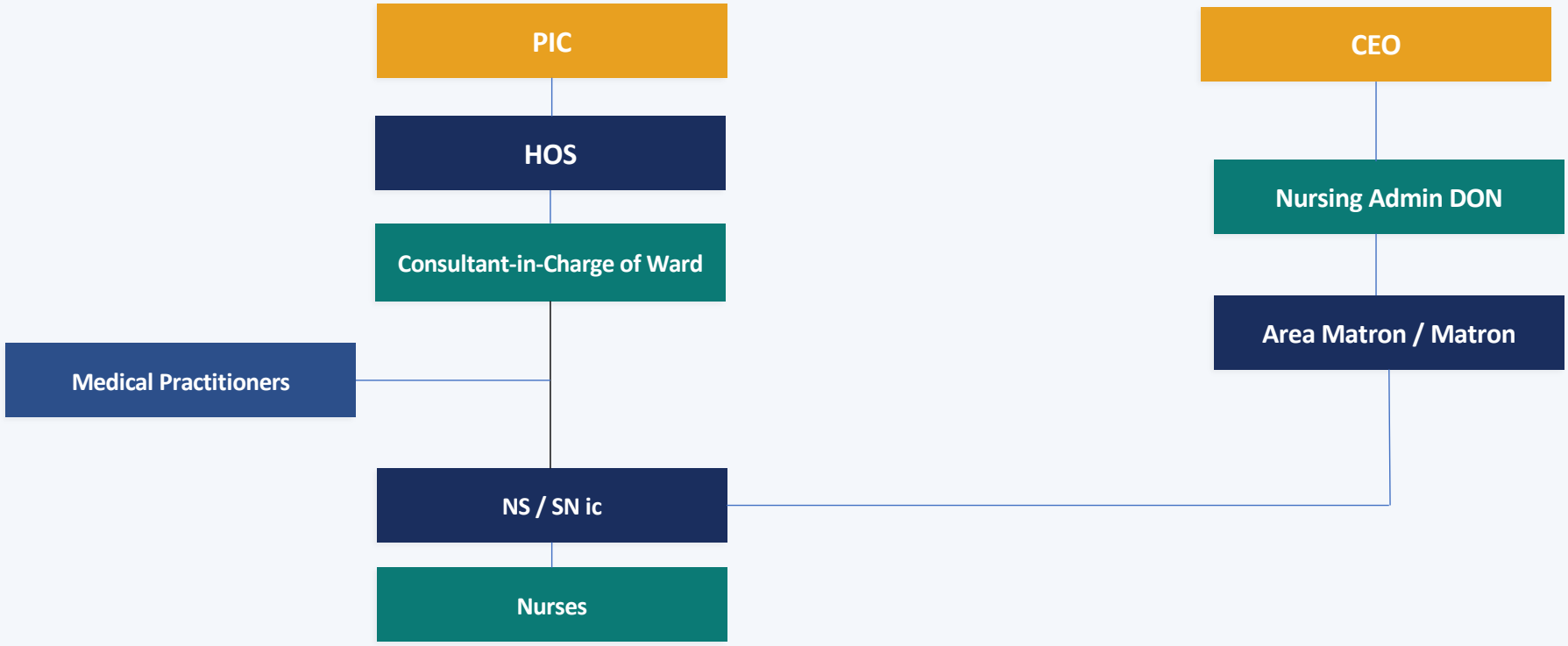
PRIVATE HOSPITALS



Private Hospital Model: Multiple Heads of Service (HOS) report directly to the PIC. Each HOS oversees their respective specialty area and shares common resources including nursing staff, facility assets, and biomedical equipment.

Ward Organisation Charts

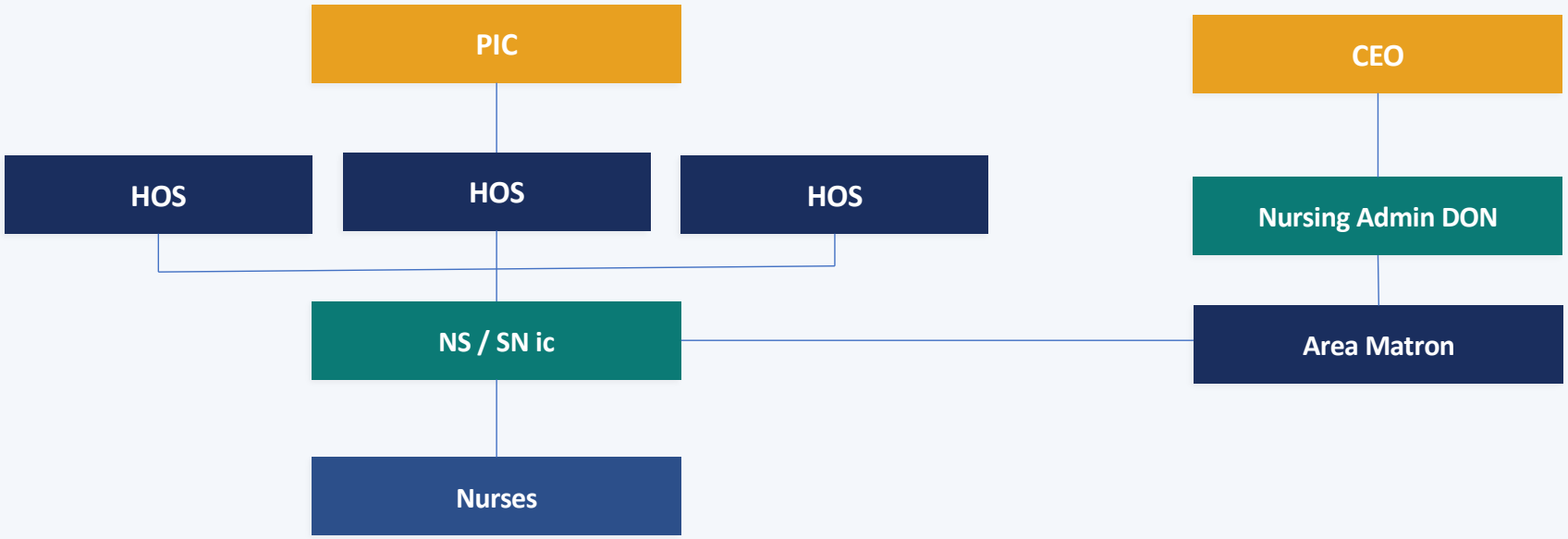
Government / Public Hospitals — Dual Reporting: Medical and Nursing Lines



Ward Organisation Charts

Applicable for Private Hospitals — Multiple HOS with Shared Nursing Admin Line

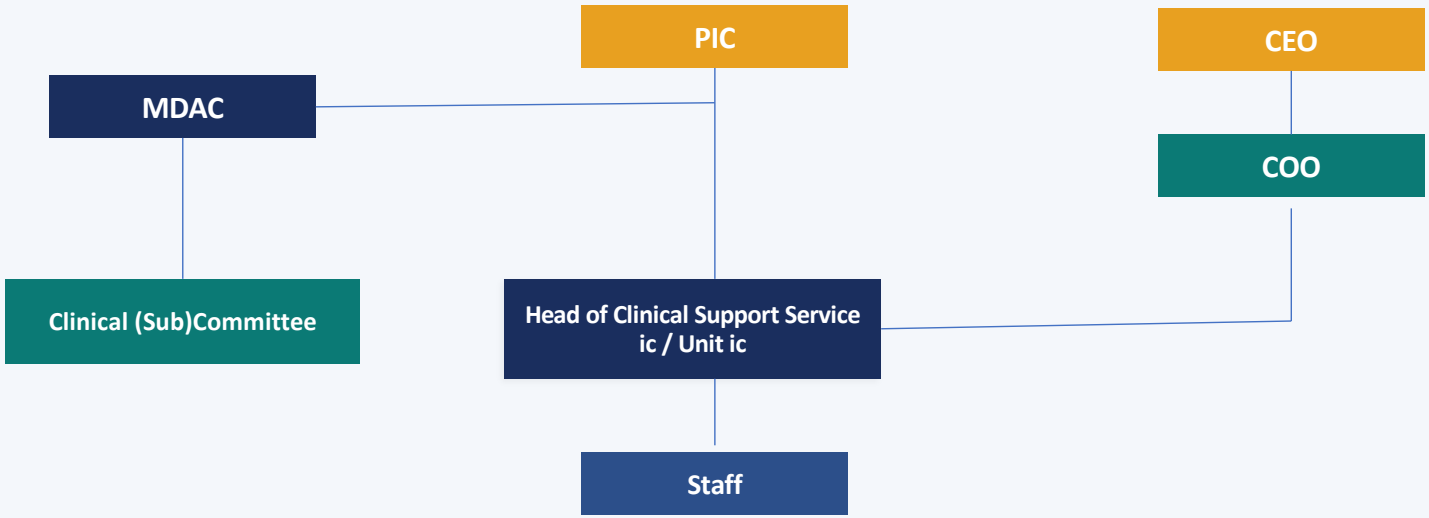
PRIVATE HOSPITALS



Private Hospital Note: Each HOS manages their ward independently but shares NS/SN ic and nursing staff under the Nursing Admin Line (CEO → DON → Area Matron). All ward org charts must be current, dated and accessible.

Clinical Supporting Service Organisation Chart

Governance, Advisory and Operational Reporting Lines — Criterion 9A.1.1.2



KEY REPORTING LINES: Gold = Senior Leadership Teal = Advisory/Governance Navy = Operational/Service Heads

The Head of Clinical Support Service reports to both the COO (operationally) and PIC (clinically). MDAC provides advisory support to the PIC via the Clinical (Sub)Committee.

Governance, Leadership & Clinical Responsibility — 9A.1.1.3 to 9A.1.1.6

9A.1.1.3 — Organisation & Governance

- Governing Body ensures safe, efficient, caring patient care
- Services respect patient dignity, privacy & confidentiality
- Medical practitioners involved in developing policies

EOC: Operational policies; Medical Staff By-Laws; MDAC meeting minutes; Head of Service involvement.

9A.1.1.4 — Clinical Governance Oversight

- Established mechanism for interaction with Governing Body
- Medical practitioner appointed as Head of Service
- MDAC advises Governing Body on planning & improvement

EOC: Letter of appointment of Head of Service; MDAC ToR; minutes demonstrating governance discussions.

9A.1.1.5 (Core) — Clinical Leadership

- Head of Service represents in committees & subcommittees
- Participates in clinical staff liaison meetings
- Provides regular input to Senior Management Team

EOC: Letter of representation; committee minutes (Blood Transfusion, Infection Control); SMT meeting minutes.

9A.1.1.6 — Clinical Responsibility & Continuity

- Responsibility for assessment, planning & continuity of care
- Clinical independence with safe, coordinated care
- Clinical decisions evidence-based; current practice

EOC: Medical Staff By-Laws; clinical notes; patient care plans; follow-up and continuity evidence.

Communication, Training, Statistics & BCP — 9A.1.1.8 to 9A.1.1.11

9A.1.1.8 Communication & Coordination

Regular staff meetings; minutes maintained and communicated to all staff.

EOC: Minutes accessible & acknowledged; meetings per schedule; follow-up on decisions.

9A.1.1.9 Training & Competency Development

Training needs identified systematically; structured programmes; appropriate supervision.

EOC: Structured training programmes; training records; supervision documentation.

9A.1.1.10 Statistics & Performance Monitoring

Statistics and records maintained for service planning, monitoring and QI.

EOC: Workload/census records; annual reports; incident reports; performance data.

9A.1.1.11 (New) BCP & Risk Management

BCP based on service priorities and risks; includes key actions, staff and alternatives.

EOC: Documented BCP; Risk Register with ownership; drill records; regular review evidence.

TOPIC 9A.2

Human Resource Development & Management

Credentialing • Privileging • Training • Wellbeing

Credentialing & Privileging — Standard 9A.2.1

Core requirement for safe, competent clinical practice

Qualified Leadership

Medical Related Services led by a qualified and competent medical practitioner

Competent Workforce

Clinical staff possess required qualifications, credentials, skills & competencies. Scope aligned with training & experience.

Service Excellence

Appropriate staffing supports goals and objectives. Ensures safe, effective, evidence-based, patient-centred care.

9A.2.1.1 (CORE)

Criterion:

There is documented evidence of appropriate training and competency for granting clinical privileging. Criteria for credentialing and privileging are clearly specified, documented and uniformly applied. Current APC, NSR certification and outcomes of privileged procedures are documented and monitored.

EOC:

Documented C&P policies and procedures; APC, NSR and privileging certificates; peer/referee recommendations; competency records and log books; list of procedures requiring C&P; records of procedures performed and outcomes.

9A.2.1.2 (CORE)

Criterion:

Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at the point of care. Clinical privileges clearly define the approved scope of practice.

EOC:

Formal letter of assignment or certificate of privileging with validity timeline; evidence of review and renewal; updated list of staff with conferred privileges accessible at point of care; evidence staff practise within approved privileges.

9A.2.1.3

Criterion:

Clinical staff perform within the privileges conferred. Verification of procedures performed by individuals at the point of care is maintained within the awarded privileging rights.

EOC:

List of procedures privileged; clinical notes with indication for each procedure clearly documented; evidence of verification at point of care.

9A.2.1.4

Criterion:

There are written and dated specific job descriptions for all categories of staff including: qualification, training and experience required; lines of authority; accountability, functions and responsibilities; reviewed when required or on major changes.

EOC:

Updated specific job description for each staff; job description includes specialisation skills; relevant privileges granted where applicable; acknowledged by staff, signed by Head of Service and dated.

Staff Training, Education & Appraisal — Standard 9A.2.2

9A.2.2.1

Continuing Education

Continuing education for all staff including medical practitioners — preparation for current and future changes.

EOC: Training calendar; life support training records; certificates of attendance.

9A.2.2.2

Educational Needs & QI

Educational activities planned based on audit results, incident reports, M&M reviews and complaints.

EOC: Evidence of audit activities included in educational programme planning.

9A.2.2.3

Clinical Supervision

Sufficient skilled staff to supervise students. Appropriate patient-to-trainee ratio maintained per MOU.

EOC: Supervision as per MOU; adequate skilled trainers available.

9A.2.2.4

Training Needs Assessment

Training needs assessed; staff development plan to maintain competency and support advancement.

EOC: TNA completed; development plan; training schedule; training modules.

9A.2.2.5

Performance Evaluation

All staff receive appraisal at probationary completion and annually thereafter.

EOC: Performance appraisal records at probation and annually.

9A.2.2.6

Clinical Research

Where appropriate, the Facility endeavours to undertake clinical research using available resources.

EOC: Research protocols, policies and consent documentation.

Staffing, Deployment & Orientation — Standards 9A.2.3 & 9A.2.4

9A.2.3 — Staffing Level & Competency

- Number of staff proportional to patient load and intensity of care
- Qualifications and experience appropriate to complexity of care
- Staffing during leave, illness and double-shift duties covered
- Adequate staffing maintained throughout operational hours
- Relevant medical practitioners on call where required

EOC: Staff deployment plans; duty roster; staff-to-patient ratio; contingency during shortage.

9A.2.4 — Staff Orientation Programme

A structured orientation introduces new staff to services, operational policies and facility expectations to prepare them for their roles.

- All newly appointed, contracted and outsourced staff
- Covers service-specific and facility-wide topics
- Includes relevant policies, procedures and safety protocols

EOC: Orientation policy; programme topics; attendance list for all new staff.

Standard 9A.2.5 (NEW)

Staff Wellbeing & Healthy Work Environment

9A.2.5.1
(Core)

Physical, Mental & Spiritual Wellbeing

Policies for promotion of staff wellbeing.
EOC: Wellness programme; supervision; appraisal with feedback.

9A.2.5.2
(Core)

Psychological Safety & Grievance Mechanism

Safe mechanism for grievances, suggestions & safety reports — non-retaliation assured.
EOC: Grievance mechanism; anti-bullying & staff protection policies.

9A.2.5.3

Staff Feedback & Workplace Experience

System to gather staff feedback and improve work environment.
EOC: Staff satisfaction surveys; evidence of action taken.

9A.2.5.4

Workforce Monitoring & Retention

Track sick leave and staff turnover; data used to improve wellbeing & retention.
EOC: Workforce data monitored; trends analysed; improvements implemented.

TOPIC 9A.3

Policies & Procedures

Development • Documentation • Communication • Integration

Policies & Procedures — Standard 9A.3.1

9A.3.1.1 (Core)

Written Policies & Procedures

Consistent with facility policies, regulatory requirements, current standard practices and Patients & Family Rights.

EOC: Documented policies; consistent with regulations; periodic review; endorsed and dated.

9A.3.1.2

Development & Revision

Developed by a committee in collaboration with staff, medical practitioners and management.

EOC: Committee meeting minutes; cross-departmental reference; documented cross-dept policies.

9A.3.1.3 (Core)

Documentation Requirements

Addresses organisational structure, CPGs, continuity of care, incident reporting, AI programmes and risk registry.

EOC: Policies addressing all required items (a) to (r).

9A.3.1.4

Communication of Policies

Current policies communicated to all staff through training, briefing and circulation.

EOC: Training and briefing records; circulation list and acknowledgement.

9A.3.1.5 (Core)

Integration into Patient Care

Policies actively integrated into care — not just documented but practised.

EOC: Compliance verified via interviews, observations, audits and grievance reviews.

9A.3.1.6

Accessibility of Policies

Copies of policies, protocols, Acts, Regulations and statutory requirements accessible to staff.

EOC: Relevant policies and statutory requirements accessible on-site.

24-Hour Services — Criterion 9A.3.1.7

24

HOURS

Medical Related Services operate 24 hours providing care appropriate to patient activities.

EOC

Operational policy on 24-hour services

Appropriate staffing levels and skill mix at all times

Authorised on-call roster maintained and accessible

TOPIC 9A.4

Facilities & Equipment

Safety • Maintenance • Environmental Stewardship

Facilities & Equipment — Standards 9A.4.1 & 9A.4.2

9A.4.1.1

Adequate Facilities & Equipment

EOC: Adequate space; equipment matching service complexity; facilities for safe care.

9A.4.1.2

Safety of Facilities

EOC: Safe design & layout; adequate equipment & supplies; planned preventive maintenance.

9A.4.1.3

Communication Systems

EOC: Appropriate telecommunication and intercommunication systems available.

9A.4.1.4 (New)

Environmentally Sustainable Care

EOC: Evidence of initiatives promoting environmentally sustainable care.

9A.4.2.1

Facilities for Patient Care

EOC: Accessible floor plan; patient satisfaction feedback; incident reports on facilities.

9A.4.2.2

Emergency & Non-Emergency Equipment

EOC: Emergency equipment available; scheduled trolley checking carried out.

9A.4.2.3

Equipment Standards Compliance

EOC: Documented compliance with standards and statutory requirements.

9A.4.2.4 (Core)

Comprehensive Maintenance (PPM)

EOC: PPM records; replacement programme; complaint records; asset inventory & disposal.

Specialised Equipment, Upgrading & Outpatient Facilities

9A.4.2.5
Specialised Equipment — Authorised Use Only

- Only trained and authorised staff operate specialised equipment and AI technologies
- Maintain list of special equipment; user training and competency records
- Letter of authorisation; updated list of authorised staff accessible at point of care

Evidence of Compliance (EOC)

- List of special equipment and authorised staff
- User training records and competency assessments
- Letter of authorisation for each staff member
- Evidence staff practise only within authorised scope

9A.4.2.6
Equipment Upgrading

- Equipment upgraded in a planned and systematic manner
- Aligned with advances in medical technology
- Planned replacement programme documented and approved

Evidence of Compliance (EOC)

- Documented equipment upgrading plan
- Planned replacement programme approved by management
- Records of equipment upgrades carried out

9A.4.3
Outpatient Services Facilities

- Specialist outpatient: prompt attention, accessibility & patient comfort (9A.4.3.1)
- Adequate rooms ensuring patient privacy and confidentiality (9A.4.3.2)
- Monitoring devices available where required

Evidence of Compliance (EOC)

- Evidence of service flow, appointment systems and patient comfort measures
- Adequate consultation rooms with privacy
- Patient satisfaction feedback on outpatient facilities

TOPIC 9A.5

Safety & Quality Improvement

Risk Management • Incident Reporting • Safety Culture • Performance

Safety & Performance Improvement — Standard 9A.5.1

9A.5.1.2

Assigned Responsibilities for QI

Head of Services assigns responsibilities for planning, monitoring and managing safety & QI.

EOC: QI progress minutes; letter of assignment; job description.

9A.5.1.3

Incident Reporting & Corrective Actions

Staff trained; incident reports completed, investigated; corrective actions implemented.

EOC: Incident system; RCA; CAPA; sentinel event investigation; grievance; minutes; feedback.

9A.5.1.4
(Core)

Peer Group for Clinical Evaluation

Medical practitioners provide peer group structures for safety and performance improvement.

EOC: QI activities; minutes of meetings; audit reports; mortality reviews.

9A.5.1.5

Tracking & Trending of Indicators

Track and trend mortality, readmission, infection and specialty-specific performance indicators.

EOC: Performance indicators monitored; M&M audit minutes; tracking records; remedial measures.

9A.5.1.6
(New)

Safety Culture Assessment

The Service participates in the Facility's safety culture assessment — values, beliefs & behaviours.

EOC: Safety Culture Survey completed by staff.

9A.5.1.7

Communication of QI Activities

Feedback on safety and QI regularly communicated to staff through education and meetings.

EOC: Results accessible via education sessions, meetings and digital communications.

Safety Culture in Healthcare

Criterion 9A.5.1.6 (New) — Shared Values, Beliefs, Norms & Behaviours | EOC: Safety Culture Survey completed by staff

Shared Values

Patient safety as priority in all decisions and actions

Shared Beliefs

Incidents reported openly so improvements can be made

Shared Norms

Checking patient identity before procedures — expected practice

Shared Behaviours

Hand hygiene, speaking up, following safety protocols daily

A Positive Safety Culture:

- Open communication; fear-free incident reporting
- Learning from mistakes; teamwork & accountability
- Leadership commitment to patient safety
- Transparency and mutual respect across all levels

How Safety Culture is Assessed:

Safety Culture Surveys:	Staff complete validated safety culture questionnaires
Focus Group Discussions:	Structured discussions to explore staff perceptions
Observation Exercises:	Direct observation of safety behaviours and practices
Safety Audits:	Formal audits reviewing compliance with safety standards

Why It Matters:

- Improves patient safety; reduces risks
- Strengthens quality improvement
- Supports accreditation & governance

EOC: Safety Culture Survey results maintained; evidence of action taken based on findings.

Documentation & Special Requirements — 9A.5.1.8 & 9A.6

9A.5.1.8 — Documentation & Confidentiality

Appropriate documentation of safety and performance improvement activities is maintained. Confidentiality is preserved at all times.

EOC: Documentation on QI activities and performance indicators.

Staff Preparation Checklist — What to Have Ready for the Survey

- Incident reports filed, investigated, corrective actions documented
- Audit and M&M meeting minutes accessible and up-to-date
- Safety culture survey completed; results shared with staff
- QI activities assigned, monitored and results communicated
- Risk register updated with ownership and treatment actions
- All QI documentation marked confidential where applicable

STANDARD 9A.6

Special Requirements

Critical Quality & Safety — High-Risk Clinical Services

Cardiology

Invasive Catheterisation Lab (ICL)

- Strict sterile technique and infection control
- Cath lab equipment checks and PPM records
- Credentialing & privileging for invasive procedures
- Radiation safety and dose monitoring
- Incident reporting for procedural complications

Pharmacy / Medical Oncology

Cytotoxic Drug Reconstitution (CDR)

- Designated CDR area with safety cabinets
- Staff trained & credentialed in cytotoxic handling
- PPE requirements and spill management protocols
- Cytotoxic waste disposal procedures
- Policy on preparation, labelling and administration

Radiotherapy

Critical Quality & Safety Requirements

- Radiation protection policies and safety protocols
- Equipment QA programme and calibration records
- Trained & authorised staff only operate equipment
- Patient treatment verification and documentation
- Incident reporting for radiation safety events

KEY TAKEAWAYS

Accreditation is built on structure — ensure your org charts, governance frameworks and reporting lines are clear, endorsed and accessible.

Every criterion has a corresponding Evidence of Compliance. Know what documents, records and observations surveyors will look for in your service.

Safety culture is not a survey exercise — it is a daily commitment to open communication, incident reporting and continuous learning.

Staff wellbeing, credentialing and training are non-negotiable. Ensure all records are current, endorsed and accessible at the point of care.

Accreditation is not a one-time event — it is a continuous cycle of improvement that begins with each staff member's daily practice.

Organise | **Document** | **Practise** | **Improve** | **Sustain**

KEY TAKEAWAY

Be Ready.
Be Evidence-Based.
Be Compliant.

Accreditation is not a one-time event — it is a commitment to continuous improvement in the quality and safety of patient care.

Questions & Answers

Thank you for your participation.